OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Andrew Scott Anderson**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 1818/2005(8)
DELIVERED ON:	16 October 2009
DELIVERED AT:	Brisbane
HEARING DATE(s):	23-27 March 2009
FINDINGS OF:	Christine Clements, Deputy State Coroner
CATCHWORDS:	CORONERS: Inquest – Death in care of 14 year old, Child Safety (Communities), self inflicted gun shot, consideration of options for placement of child, limited availability of foster parent families, suitability of relative carer, excessive case load pressure, absence of supervision by carer and case worker, insufficient response when child missing, illicit drug and chroming use, attempted self harm, failure to transfer case

REPRESENTATION:

Counsel Assisting: instructed by the Office of the State Coroner	Mr Mark Green
Counsel for the Department of Child Safety instructed by the Department of Child Safety:	Mr Philip Scott, Crown Law
Counsel for Ms Willis: Instructed by Messrs Hall Payne Lawyers	Ms Catherine Hartigan

Introduction

Andrew Scott Anderson was born on 10 September 1990. He died on 25 July 2005, just six weeks short of his fifteenth birthday. He died due to a self inflicted bullet wound which caused a fatal head injury. This inquest will review the events of his life leading to his tragic death. The three main issues will be:

- Andrew's life and the significant people involved in his life leading up to 19 March 2004 when he was placed in the care of the Department of Child Safety.

- Andrew's life after he was placed in the care of the Department of Child Safety up to the time of his death.

- A review of the care and supervision provided by the Department of Child Safety, (now the Department of Communities).

This inquest has not received direct evidence from Andrew's father, Scott Anderson who refused to participate. Shortly before the inquest commenced a letter was received from a psychiatrist indicating it would be detrimental to Mr Anderson's mental health to provide evidence. Mr Anderson declined the opportunity to provide any further material to the inquest.

Family upbringing

Andrew's father, Scott Anderson separated from Andrew's mother soon after his birth. She suffered depression and died in 1995 due to a prescription drug overdose. The information available to this inquest suggests her death was intentional. Andrew, his sister and half brother lived with Scott Anderson who employed a young woman as a nanny to assist him. That young woman, Toni, effectively became Andrew's mother from the time he was eleven months old. Toni and Scott married in 1993 and the family unit continued until February 2004 when Toni left Scott, Andrew and his sister. Toni and Scott subsequently divorced. The other child had already been placed in care.

It is mainly through Toni's evidence that Andrew's early childhood years were retold. Toni Anderson was an impressive and caring young woman who gave her evidence knowing it would be painful to her to revisit the pivotal eleven years of her life she shared with Scott Anderson and his children. In the early years of the marriage she described a happy young family where she provided a stable and loving home environment. She was supported by Scott who provided financially for the family. Often he had to be away from the family due to work and Toni found herself cast in the role of disciplinarian and guide to the children. Scott was content to relax and enjoy the children when he was able to spend time with them free from work commitments. Toni recalled Andrew as a sweet, timid child who was less mature than his peers.

It was as early as kindergarten age when Toni noticed Andrew was somehow different from other children. She noticed him sitting alone, and unable to sit still or concentrate. By the time he had reached grade six in primary school, Andrew was

identified in the school as problematic in his behaviour. Toni said he simply could not cope in the classroom situation and would get up and leave. Throughout their marriage, Scott and Toni were dedicated and committed in their efforts to help Andrew. A referral from a school counsellor while the family was living in Brisbane ultimately led them to a child psychiatrist, Dr Todd Wakefield.

Over the years there were varying diagnoses including Attention Deficit Disorder, Attention Deficit Hyperactivity Disorder, depression, and anti social disorder. They were advised Andrew required more discipline. Toni felt Andrew and the family benefited from the advice from this doctor over a three year period, but the family then moved to Toowoomba and the support ceased. Over the years Toni and Scott attempted to help Andrew with medication, behaviour modification programs and by themselves attending parenting classes, but the situation did not improve. As Andrew grew older he was unable to be left unsupervised due to his unpredictable and sometimes dangerous behaviours. On one occasion Toni left him in the car for a brief period while she was in the bank. She returned to find he had lit a fire in the back seat of the car.

The home environment was no longer happy but constantly stressed. Toni recognised Andrew's behaviour worsened when his father was away. He was very dependent on his father giving him attention. Toni indicated Scott was himself unpredictable and somewhat ambivalent towards his son. The situation at school deteriorated when Andrew reached high school. The parents were constantly summoned to school to attempt to negotiate a way of managing Andrew's behaviour in the school environment. Andrew was repeatedly suspended and ultimately required to change schools.

The first involvement of the Department of Child Safety (the Department) was in 1999 when Scott Anderson advised he was unable to care for Scott's half brother. In 2000, a protection notification was recorded after Scott told the Department that Andrew was destroying the family and Scott could not keep bashing Andrew. Toni was unaware of this contact. In 2003 Scott contacted the Department again stating he could no longer deal with Andrew's significant behaviour problems but he failed to attend an arranged meeting indicating alternative counselling was in place.

Scott was apparently dealing with his own demons as well as the increasing stress on his marriage and his difficulty in managing his anger and frustration with Andrew despite all his efforts. In the last twelve months of the marriage Scott was receiving treatment for depression. Toni indicated she was kept apart from certain areas of Scott's life. There were friends and associates she knew very little of and Scott's involvement with another person was a final stressor which contributed to the failure of the marriage. After the marriage ended in February 2004, Scott told Toni he was using amphetamines. Both of them suffered from the loss of their marriage. Scott retreated with the children and initially wanted no contact with Toni or her involvement with the children. Toni felt she had lost her identity as wife and mother and mourned the loss. She thought Andrew considered the separation would be positive for him with more time with his father after her departure.

On 19 March 2004, Scott was again summoned to attend Andrew's school due to his son's misbehaviour. Scott attended the school but his frustration finally overcame

him and he lost control and physically assaulted Andrew to such an extent that the male school principal sought to intervene to protect Andrew. Scott then assaulted the principal. The police and Child Safety authorities were called. Andrew was taken into emergency care and for the duration of his life, remained subject to the authority, care and control of the Department.

Andrew's life in care between 19 March 2004 and 25 July 2005

Andrew was taken to hospital after his father assaulted him. From there he was placed in emergency care and then with a foster family. The Department determined quite properly, he could no longer live with his father. Although there was some initial contact with Toni, her very recent separation and loss of self confidence to deal with Andrew meant she did not propose to the Department that she could care for Andrew. It does not appear from the Department's records that Toni was ever seriously considered, or reconsidered as a carer for Andrew. In retrospect, Toni thought she might have considered the possibility if provided with professional assistance. It must be said Scott's attitude to Toni at the time may also have influenced the Department.

In March 2004, the Department was severely limited in its capacity to place children in foster care. Andrew was placed with a family where the parents were caring for their own three children as well as five foster children. Perhaps unsurprisingly, especially with a child with Andrew's history of difficult behaviours, the placement failed. The lack of alternative foster home placement led to Andrew being placed in a communal youth home supervised by a rotation of youth workers.[1]

Andrew was the youngest of the group and was exposed to an older peer group already involved in offending behaviours and the juvenile justice system. It was during July and August 2004 that there were reports of Andrew sniffing paint and absenting himself from the group home and living on the streets in Toowoomba. Toni visited Andrew while he was at the communal youth house. She was concerned with the apparent laxity in supervision, particularly for Andrew who had not previously managed to avoid trouble if left unsupervised. She noticed he was drawn to the older boys and impressed by them. As she saw it, "*He would just be attracted by anyone who was anti social*." [2]

This placement also became untenable, partly because there were times when Andrew returned and stayed with his father, Scott who did not support the placement at the youth home. The department experienced extreme difficulty in trying to communicate with and work with Scott regarding his son's future. He was ambivalent towards his son as far as making a true commitment to working with the department towards Andrew's return to his full time care, but he undermined placements arranged by the department in the interim. One wonders what impact this must have had on Andrew who continually wanted to be with his father.

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[1] RAPT placement
[2] Transcript 1, Page 60, lines 53-54

Placement with Grandfather

Eventually, on 13 August 2004, when no other options appeared available, an arrangement was reached for Andrew to stay with his grandfather, Scott's father, Nelson Anderson. Scott had taken the decision out of the Department's hands by removing the boy to Brisbane.

On 6 September 2004, Andrew's Family Services Officer was Karla Johnson. She applied for Nelson to be formally assessed for suitability as a "relative carer". The assessment was to establish whether Nelson could provide a stable placement. It was noted there was unsupervised contact between the father, Scott and the son, Andrew, although reunification was not being considered at the time due to the father's ambivalence.

With respect to Andrew's education, the case worker stated; "*Andrew does not see the need to attend school. He may benefit from an alternative educational program with supports*".[3] It is noted Andrew had been in the department's care since March 2004 and there is no evidence of him attending school from that time.

The request for assessment of the grandfather also noted that previous placements had broken down due to Andrew's inappropriate behaviour and therefore the proposed placement should be supported. Andrew was noted to have offending behaviours and could be at risk of entering the juvenile justice system. It was also noted the father's ambivalence to the child was a risk to his emotional wellbeing and the grandfather might be able to monitor this with respect to appropriate times for contact.

The request also went on to record Andrew was a suicide risk, but refusing to attend counselling. It was noted he had supports through Kids Help line and the child safety officer and there should be "*gentle discussion at a later date*".

The request recorded the information sourced from Andrew's father that Andrew had been diagnosed with ADHD but the Community Youth Mental Health Service diagnosis was of substance abuse, particularly chroming. Andrew refused any support about this issue. There was also a notation Andrew was collecting weapons, in particular knives while previously living in the community shared house. Although this was concerning there was no history of Andrew using the knives against others.

Finally, the request noted his father was verbally and physically abusive to Andrew and had harmed him in the past. Sadly, Andrew saw nothing wrong in his father's behaviour.

A social work consultant, Lisa Liu was contracted to perform the assessment. She reviewed departmental material before visiting Nelson Anderson at his home at Newnham Road, Mt Gravatt East on 10 September 2004. It was recorded that Nelson was approaching his seventy first birthday.

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[3] Exhibit B 49.2

Although the report by Ms Liu is detailed factually it failed to elicit basic information about Nelson which was essential to consider. The report also appears to have accepted at face value what Nelson told the interviewer without any checking.

Clearly from the evidence given to this inquest, Nelson must have tailored his answers and avoided providing information to Ms Liu. However, having listened to Nelson Anderson's evidence, it is hard to match up the person described by Ms Liu with the Nelson Anderson who presented before court. It was hard not to form the impression that in giving his evidence, Nelson tailored his answers when it suited him. He refuted any criticism of his son, Scott regarding his relationship with Andrew. Overall, he was unable to conceal various matters concerning his life and what happened with Andrew. It is difficult to understand how Ms Liu's report missed so much vital information.

Mr Anderson apparently informed Ms Liu he was a retired taxi driver since 1998, but her report failed to elicit the important information about what he did since retirement. He continued to drive taxis part time two days a week. The shifts were for 12 hours from 4pm until 4am and he left Andrew completely unsupervised.

Ms Liu's report goes into great detail about Nelson's series of personal relationships and marriages over the years. The last four paragraphs relate to Nelson's involvement with a woman from the Philippines since 1993 when he was on holiday there. They married and she brought her children to Australia but the marriage ended and they divorced in 2004.

What is missing from Ms Liu's report is the information that Nelson continued his involvement with the Philippines where he visited for three weeks every two to three months. Again, this was vital information relevant to consideration of whether Nelson was truly available to care for Andrew in a meaningful way.

On the vital issue of Nelson's capacity to be a suitable parental figure for Andrew, Ms Liu's report is inadequate. It describes Nelson's motivation to care for Andrew in the following way;

> "*Scott (Nelson) wants to care for Andrew as he enjoys children and believes Andrew needs a chance to experience a stable, loving family home. Andrew wants to live with him and Scott (the father).....has contact with Andrew when they come down to Brisbane to stay for a weekend. Scott has a current partner who lives in Brisbane and he stays with her....."*[4]

There is no evidence that Ms Liu spoke with Andrew about this topic or observed any interaction between Andrew and his grandfather. Under the heading "*Parent and child's view on placement*", the document simply records:

> *"As I have not had contact with the father of Andrew, I am unable to comment on their views about this placement."*[5]

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[4] Exhibit B52.1, paragraph 12
[5] Exhibit B52.1, paragraph 15

There is nothing to indicate she ever spoke with or considered Andrew's view.

It was recorded the grandfather was aware Andrew had not attended school, was chroming and involved in theft. He told the interviewer he would need help to establish links with school and help from a therapist to manage Andrew's behaviours.

Nelson appears to have been more open with the interviewer about his son Scott than he was in giving evidence in the inquest. He detailed incidents of uncontrolled rage from the time he was a child and that everyone is afraid of Scott when he is in a rage because he can't control it.

Nelson readily informed this court he was an alcoholic but Ms Liu's report records he consumes about four cans of beer and twenty cigarettes a day. Of course Nelson may simply have misled Ms Liu but it is alarming, even acknowledging the benefit of hindsight, that Ms Liu's assessment of Nelson's capacity to care for Andrew was so misguided. Reading her report it is hard to reconcile the benign grandfather figure depicted with Nelson Anderson as he presented to the court.

Ms Liu recorded:

> *"Scott (Nelson) aims to provide these needs by providing Andrew with love and understanding, hugs, routines to ensure stability and consistency and by working with the department to ensure that all other needs are met, such as therapeutic appointments and contact with family. He told me he sets reasonable limits and consequences if these limits are tested.*
>
> *He anticipates that he will require ongoing timely communication from the Toowoomba Area Office about the case plan, specific contact arrangements and information on Andrew's therapeutic and educational needs."*[6]

Andrew's life while living with his grandfather

There is no reason to doubt Nelson Anderson approached the task of caring for his grandson with the best of intentions. He told the inquest he had not had much involvement with Andrew when he was a young child. He believed his son Scott had lost his way since the end of the marriage with Toni, whom he held in high regard. He said Andrew's death had devastated Scott.

Despite the high ideals of providing Andrew with a loving, caring, stable home environment, Nelson quickly discovered the challenge of caring for Andrew was well beyond his capacity. Andrew came to stay with him on 13 August 2004. A month later on 10 September he was interviewed by Ms Liu and she recorded his aspiration

[6] Exhibit B52.1, paragraph 13.2

of "*meeting Andrew's needs with love and understanding, hugs, routines to establish stability and consistency*".[7]

Nelson's stated philosophy of caring for Andrew was not reflected in the interaction between grandfather and grandson. Nelson was asked in the inquest whether Andrew was already staying with him by the time of the interview. He said, *"Well Scott had brought a caravan, a twenty six foot caravan and put it in my back yard, and part of the time Andrew was living there , you know, with loud music and all that sort of business, and he just wouldn't listen to me, so I put an axe through his- the stereo system."*[8]

Another telling description of the completely inappropriate placement of Andrew with his grandfather was revealed as follows. Nelson was asked, "*how was Andrew when he first came to live with you?*" He said,

> *"Well first couple of days he was pretty good, but he wouldn't do anything around the house, he always had loud music on, and I have even got a chair at home he carved a swastika in it. When I asked him why he done it, he said because he was bored."*

As well as obvious paint sniffing, Nelson was aware his own son Scott smoked marijuana at the house while Andrew was present. Other witnesses, including Scott's young girl friend, confirmed Scott used amphetamines daily during this time.

When asked what Andrew did day to day, the true state of Nelson's physical and emotional availability to his grandson was revealed;

> *"Well I wasn't around much, but he seemed to be sniffing paint all the time and he'd keep denying it, but you could see the brown marks on his lips, and I have got a small place under the house where I have a lounge chair there and I went down there and had a look and there was paint tins all over the place."*[9]

Indeed Nelson wasn't around much for Andrew. According to his passport he was absent from Australia in the Philippines for 19 days from 14 October 2004, and then for 22 days from 12 January 2005 and another 22 days from 27 April 2005. The department appears to have had no inkling that Nelson was away overseas, although Nelson indicated he rang the department and advised he did not want to continue to care for Andrew. He told them Andrew was living on Macleay Island. He said they indicated Andrew was not supposed to be living with Scott and asked whether he had done anything to get him back. Nelson's response is again illuminating;

> *"No, I was only pleased to see the back of him"*- referring to Andrew.[10]

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[7] B52.1 paragraph 13.2
[8] Transcript 1, page 21, l 52-56
[9] Transcript 1, PAGES 21-22
[10] T page 45, line 46

Andrew ended up going to Macleay Island with his father who lived there briefly while trying to establish a small business. The venture was unsuccessful and by January 2005 father and son returned to Brisbane. Andrew remained living between his grandfather's home and his father's young girlfriend's parents' home. He did not attend school and he increasingly mixed with an older group of drug using people who gravitated to his grandfather's house. It was clear from the evidence that Andrew's father Scott also independently knew some of these people and sourced drugs from them.

Andrew's wellbeing can be gauged during this period from three episodes.

At the end of August 2004, after placement with his grandfather, he rang Kids Helpline stating he was unhappy living with his grandfather. He voiced thoughts of suicide.

The second incident occurred in early September when police took him to hospital after an episode of chroming. It was shortly after this occurred the department approved his grandfather as carer. A month later Andrew again attended hospital due to cuts to his wrists. He indicated he had been assaulted by others but this appears unlikely. He resisted help from the hospital. His father sent his young girlfriend to the hospital when Andrew was released rather than picking up Andrew himself.

The events leading to Andrew's death on 25 July 2005

The inquest heard evidence from various people who came into contact with Andrew after his placement at his grandfather's home. Many of these people were clearly unreliable, drug affected at the time of the events and subsequently unwilling to divulge what they knew had occurred. What was common from all of this evidence was that Andrew was mixing with an older group of people who were involved in the use of marijuana, amphetamines and other drugs. In particular, he became friendly with an Alex O'Sachy and his brother Daniel O'Sachy. Andrew's grandfather considered Alex an unsuitable person for Andrew to mix with but he was powerless in his own home to exclude the various people that came and went.

On 23 July 2004, Andrew spent most of the day with his father. On his return home to his grandfather's residence, Andrew showed Nelson a hand gun, which Nelson recognised as a 25 calibre berretta. It did not have a magazine. Andrew said it was an early birthday present, but not from whom he had received the weapon. The grandfather did not pursue the issue of who had given it to him. He told him to get rid of it but did nothing more. When asked about the source of the weapon, and whether he had spoken to the boy's father about it, Nelson said, *"No, let sleeping dogs lie. What you don't know doesn't hurt you*."

He clearly failed to protect Andrew, a vulnerable, moody fourteen year old from the very real threat of harm this weapon presented.

There was evidence given to the inquest which detailed how Andrew spent the evening of 22 July. He was at Alex O'Sachy's place with Alex O'Sachy. There were other adults present. The group was using alcohol, marijuana and amphetamines. The evidence was Andrew was involved in this activity and accessed the drugs from

Alex O'Sachy. Alex O'Sachy was in jail when evidence was taken for the inquest. He was completely unhelpful and obstructive in withholding information from the inquest.

I reject his assertion he has lost his memory about Andrew and the events of the night prior to Andrew shooting himself. He acknowledged, reluctantly, he knew both Andrew and Scott Anderson. He denied supplying drugs or involvement with guns.

Further information about guns was provided to the inquest. On 22 July, Andrew told the group at Alex O'Sachy's there were four guns in a vehicle at his grandfather's house. He said they belonged to his father, Scott. An attempt was made to obtain these guns with a plan of using them to buy or swap for drugs. The car could not be accessed and the guns were not sighted.

Nelson Anderson told police Andrew was at home on the morning of 23 July 2005 and that Alex O'Sachy was also at the house with Andrew when Nelson left for the day. The grandfather was planning to meet friends as he usually did on Saturdays at the Chinese Club. It is not known whether Alex O'Sachy was in fact present when Andrew discharged the hand gun nor is it known where Andrew obtained ammunition.

On 23 July, Andrew was anticipating spending time with his father. He expected his father to pick him up for a roast at his father's girlfriend's parents' place. Andrew rang his father to check arrangements but his father told him he should catch a bus. A series of phone calls occurred with the boy berating his father for unreliability and the father blaming the son for past misdeeds and contributing to the break up of the family. In the early afternoon Andrew rang his father again.

He simply said, "*Good bye Dad".* Then there was a sound described as a loud popping sound followed by a thump. Scott told police he immediately feared Andrew had shot himself. Why he thought this, was left unexplained. His girlfriend's father drove Scott to Nelson's house and the ambulance was called. Scott Anderson was the first person to enter the house and he indicated Andrew was alone in the house, unconscious, with a gun shot wound to the head. There was also evidence that a phone call was made to Giovanni De Bella, another associate of Scott Anderson who was allegedly also involved in drugs.

The phone call was very soon after Andrew was shot and informed Mr De Bella of the incident. There was evidence he too immediately drove to the scene and parked across the road. One can only speculate why Mr De Bella attended but did not apparently go into the house to assist.

Andrew was taken to hospital but did not regain consciousness. Despite surgery he was unable to be saved and he died on 25 July 2005, six weeks prior to his fifteenth birthday. Ante mortem toxicology indicated the presence of cannabis, low level benzodiazepines and above therapeutic level of anti depressant mirtazapine.

There is insufficient evidence to make a finding on the source of the weapon used by Andrew to inflict self injury. Both Alex O'Sachy and Scott Anderson indicated to police the circumstances in which they handled the weapon. Because of the timing and their contact with Andrew on the day and previous evening as well as the day on

which Andrew shot himself, they remain the most likely sources of the weapon and ammunition. It is possible the weapon may have been obtained from one source and the magazine and/or ammunition from another source.

There was also evidence there were other guns in the boot of the car at Nelson Anderson's address. Nelson gave evidence the boot lock had been broken and he noticed a screw driver. There was the opportunity and several people present at the scene prior to the arrival of police when any other weapons, if they were in fact hidden in the car, could have been removed from the scene. Andrew clearly knew of the existence of the guns in the car. He may have simply directly accessed one from the car.

This inquest remains unable to make specific findings concerning these issues.

Investigation of Andrew's death

Detective Sergeant Anthony McNae investigated Andrew's death thoroughly and with obvious concern that a fourteen year old boy in the care of the department had died in such tragic circumstances. The weapon was unable to be identified on any register of firearms. There were shot gun rounds found in Andrew's room, but no other ammunition. There was evidence connecting Andrew's father Scott with the older drug using group of people with whom Andrew was known to associate in the months leading to his death. There was evidence Alex O'Sachy rang Andrew's father with condolences indicating some familiarity.

Detective McNae encountered reluctance by many of the people involved in Andrew's life to be forthcoming about this tragedy. The common thread of involvement in illegal use of drugs bound the group together. There was a reluctance to assist with the investigation or to incriminate each other.

The role of the Department of Child Safety

I do not propose going through all of the evidence of the involvement of the Department in the life of Andrew Anderson which is detailed in the transcript. At the outset it is acknowledged the Department was operating in difficult times with limited resources of staff and limited availability of suitable foster parents to care for a young person such as Andrew.

Since Andrew's death there have been both internal and external review processes of the management of Andrew's care. There have been positive changes made within the Department.

However, despite the difficulties faced by the Department it cannot be denied Andrew Anderson was not adequately assessed, monitored, placed, reviewed or provided for from the time he was placed in the protective care and custody of the Department.

The first response to the crisis precipitated by Andrew's father assaulting the boy was timely and appropriate. Emergency placement was provided. A senior and experienced team leader, Alison Willis, attended the school and set in motion the process to bring Andrew into the care of the Department. However, there was a

delay of about 3 weeks before a case worker was assigned by another section and by that stage a decision had been made placing Andrew in a foster home. An application for a court assessment order was required to enable the case worker to assess and investigate Andrew's needs and available options. In due course an application for a child protection order was made and Andrew's father, Scott Anderson, consented to that order which gave temporary custody to the Department.

Ironically the order was due to expire in July 2005, the month Andrew died.

Resources were so scarce there was only one foster family available to Andrew, although had there been an opportunity for a case worker to be involved from the very start, one wonders if other options might have been considered. As already referred to, the chance of this foster placement being successful was remote given the parents' huge responsibility in caring for their own three children and an additional five foster children.

Initially there was good ground work performed by the first case worker, Emma Lusk in attempting to identify Andrew's particular difficulties, but when the home placements failed and Andrew was placed in a communal share house, the downward spiral commenced. Since Andrew's death and the reviews, there is information to indicate there are more external supports available to assist young people like Andrew if unable to be placed in foster homes. The evidence is clear it was from the time of placement in the communal youth house that Andrew was first involved with older adolescents who were themselves already offending and accustomed to the juvenile justice system. Andrew's challenging behaviours appear to have worsened from this time, including the commencement of paint sniffing.

Andrew's father Scott was an unreliable and often an unhelpful and obstructive person for the Department to work with. The Department of course attempted to work towards reunification but it was acknowledged in evidence Scott Anderson never engaged with the Department in addressing the issues of child safety which caused him to be placed in care in the first instance. Despite this knowledge that Andrew was overly influenced and dependent on his father who had physically assaulted and rejected him, the Department failed to manage this very difficult relationship between father, son and the Department. When the placement at the communal house broke down and Andrew was in temporary overnight accommodation, his father stepped in, told the Department he had taken Andrew and was placing him in "boot camp". This was in August 2004. What in fact occurred was Andrew was taken to his grandfather's home in Brisbane.

However, it was incumbent on the Department to ensure the provision of stable accommodation for Andrew and then to address his needs for specialist intervention regarding his behaviours. Without this there was little chance he would ever be successfully re-integrated into mainstream education. Indeed, it does not appear Andrew returned to school at all after coming into the care of the Department. By this time, Andrew's case was again being managed within the team led by Alison Willis. There was no consideration that the Department might act to recover Andrew into their custody.

In hindsight, Ms Willis conceded there was missed opportunity to engage with Andrew's stepmother Toni to consider whether, with support, she may be an alternative carer for Andrew. Instead of immediately taking some action to recover Andrew into the Department's care and control, the situation was allowed to take its course and some ratification of the process occurred by way of the relative carer assessment of Nelson Anderson.

I have already referred to the inadequate way in which the assessment of Nelson Anderson as a suitable relative carer was performed. Although the assessment reads well and sounds a positive proposition, it did not stand scrutiny on hearing evidence from Nelson Anderson. It is hard to imagine that Nelson Anderson could have concealed the limits of his likely capability and experience as a parent when interviewed by an experienced practitioner. In review it appears the Department was too ready to accept and authorise the grandfather as a suitable carer simply due to his availability, rather than properly exploring alternatives.

But the report did qualify the endorsement of the grandfather to care for Andrew with an acknowledgement that Nelson would need support. As far as can be gleaned, he received minimal support from the Department with the exception of the basic monetary allowance for a carer. Nelson could not identify a particular person to contact within the Department if he needed guidance. There is nothing to indicate there was ever a home visit after the initial assessment of Nelson Anderson. This failure by the Department remained unexplained except that the Toowoomba department decided to transfer the file, to the Mount Gravatt office.

This attempted "transfer" of the file between offices was particularly galling to listen to. Again I note the overall under-resourcing and stress on departmental staff across the state. I note at the time Andrew was first placed in care it coincided with the department's response to the CMC report regarding overall management of child safety in Queensland. It was, and still is, a difficult time to work in the Department which bears the critical responsibility for child safety.

However, stating the obvious cannot be avoided. The proposed transfer from Toowoomba to Mt Gravatt commenced on 2 September 2004. It stalled. The stumbling block was at the Toowoomba office which failed to forward sufficiently detailed material to enable the receiving office to accept the referral. It is not sufficient action or a discharge of responsibility for a senior team leader to say she rang and left messages which were not returned. Indeed an examination of the records show an attempt to transfer the file did not in fact occur until the responsible team leader, who had assumed carriage of the file, went on leave and delegated the task to someone else in her absence. It was not til mid February 2005 that paperwork was received by Mount Gravatt. Andrew's whereabouts were unknown by this time and the information about Andrew was so outdated that it was unsurprising the receiving office asked questions before agreeing to accept the referral.

Meanwhile, Andrew had left the Toowoomba area and moved to Brisbane, and then back and forwards, including a period on Macleay Island. He was sometimes in the care and at the residence of his grandfather and sometimes with his father, the person from whose care the Department had originally removed Andrew. The bureaucratic war between departmental offices in Toowoomba and Brisbane

continued as to whose responsibility it was to care for Andrew. The result was a tragedy for Andrew. From October 2004, no-one took responsibility for properly supervising and maintaining contact with Andrew. Of course he was difficult, and the family was difficult but it is the Department's responsibility, not the child's, to ensure he was safe.

As for Andrew, he kept contact when he wanted to, primarily by phone. He remained torn by a father who fluctuated in his availability, both physical and emotional to his son. He became involved in chroming, marijuana and ultimately amphetamine use as his interactions with older drug using adults increased. He did not return to school. From the evidence it can be inferred he was depressed and became suicidal. There was notification of Andrew's risk of suicide after a call he made to Kids Helpline. There was a referral to counselling over the phone but still no face to face meeting with Andrew or consideration of exactly how he was getting along at his grandfather's home. There was then at least one serious attempt at suicide when Andrew cut his wrists, left a note on a mirror stating an intention to suicide and was admitted to hospital.

Although this was flagged within the system even this extreme incident did not prompt further intervention or support for Andrew or his family, who were clearly, not coping.

One difficulty which was revealed was the system of the carer assessment being signed off by the Manager for child safety, but the document, which included vital information about the need to support the family, was not copied and returned to the case worker. This must be remedied.

Had there been some supervision or review or visit to Andrew and his grandfather, it would have been readily apparent they were not getting along and the grandfather had no control or influence over the boy, nor his own adult son, whom he feared.

The Department's records also indicate there was some forewarning in a phone discussion that Nelson was going overseas. Instead of any proper inquiry, it was simply assumed the grandfather would take the boy with him if this was to happen and he would need to obtain a passport. The evidence of course was that Nelson had no intention of taking the boy with him during the three periods overseas totalling 63 days which fell between 14 October 2004 and 18 May 2005. The Department was unaware Nelson went overseas until after his final return. Certainly Nelson was evasive and no doubt reticent in volunteering information, but it remained the Department's responsibility to ensure stable arrangements for Andrew's care were in place.

From October 2004, Andrew's situation became the focus of a report to SCAN, the interdepartmental group which includes health, child safety, education and police, which considers children at risk. Police reported Andrew had been located in the household occupied by Alex O'Sachy and his brother Daniel. Alex was affected by paint sniffing, and, inexplicably, Andrew was left in the "care" of the also unreliable brother, Daniel. The information went back to the Toowoomba office, who remained responsible for Andrew. Any proper inquiry at this time would have revealed the approved carer, Nelson Anderson had left the country on 14 October and was not

due to return until 1 November. Whatever supervision his father, Scott offered during this time did not safeguard Andrew from further exposure and involvement with drug taking and offending older people.

Andrew's name was maintained in SCAN meetings convened in Brisbane from October 2004 through to April 2005 when the case was closed on the basis of information the Toowoomba office was managing Andrew's care. It was not doing so in any meaningful way. The team leader, Alison Willis had assumed the case work role for Andrew from 17 November when the existing case worker herself moved into another role. There was some information during this period that Andrew was back with his father on Macleay Island.

On 22 February 2005, Nelson Anderson contacted the Department and indicated Andrew was missing, but possibly at his sister's back in Toowoomba. By 9 March, Nelson confirmed he was no longer prepared to care for Andrew due to Andrew's behaviour as well as the behaviour of his own adult son, Scott. Nelson said both were using drugs and that Scott would come in and take Andrew whenever he felt like it. He could not say where his son or grandson was, possibly in Gympie.

Nelson had been deleted on the departmental records as carer on 9 February.

Again there was an impasse. Notes indicate although neither the Department nor the grandfather knew where Andrew was, except that he was probably with his father, a formal notification and follow up of his whereabouts was not commenced. The grandfather declined to go to police to make a report as he said the boy was with his father. The police could do nothing without a report. The Department did not pursue the issue either. The team leader did not escalate Andrew's particular matter with her manager.

Despite this advice of Andrew essentially being unaccounted for, the team leader did not re-open a SCAN notification or pursue further police assistance to locate Andrew when the SCAN case based from Brisbane was closed.

The manner of Andrew's death could not have been anticipated but there was a series of escalating incidents indicating he was in trouble and likely to come to further harm.

His father must bear the burden of remembering these events and look back with regret that his own actions might have been different.

The Department must also respond to Andrew's tragic death. There was evidence of serious consideration and review by both internal and external review processes being undertaken. I will not detail the changes already made.

The evidence at inquest revealed the buck passing between offices and the time that elapsed during which Andrew remained practically unknown with regard to his whereabouts and activities. Senior managers failed to reassign Andrew or to intervene and check on his well being.

Although it is not necessarily helpful to identify a particular officer who should have stepped up and accepted responsibility to make sure Andrew was cared for, it is important there is a real response to Andrew's death. Senior managers must accept responsibility, make decisions and take action when critical events occur.

Findings required by s45

I am required to find, as far as is 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 issue, the manner and circumstances of the death. As a result of considering all of the material contained in the exhibits and the evidence given by witnesses at the inquest, I am able to make the following findings in relation to the other aspects of the death.

Identity of the deceased

The deceased person was Andrew Scott Anderson

Place of death

He died at Princess Alexandra Hospital, Brisbane, Queensland.

Date of death

Andrew Anderson died on 25 July 2005.

How he died

Andrew Scott Anderson was living at his grandfather, Nelson Anderson's home at Newnham Street, Upper Mt Gravatt. He was placed with his grandfather as a suitable relative carer by the (then) Department of Child Safety, (now Department of Communities) after his father, Scott Anderson assaulted him. There was significant history of Andrew's behavioural difficulties which impacted on Andrew's ability to remain within the education system and on his family. He was taken into care on 19 March 2004. Andrew did not attend school after this time. His residential placements were unstable and he became involved in the inhalation of stimulants, smoking marijuana and the use of amphetamines. He appeared to be depressed and he self harmed requiring a hospital admission in October 2004.

On 22 July 2005 he spent time with his father before returning to his grandfather's home. He showed his grandfather a 25 calibre handgun indicating it was an early birthday present but not indicating the source. There was no magazine or ammunition with the gun. His grandfather told him to get rid of it, but did not confiscate it.

On the evening of 22 July he was in company of several adults at a nearby residence and participated in the use of marijuana and amphetamines. He revealed to the group the presence of some guns in the boot of a vehicle at his grandfather's house.

On 23 July 2005 he was in telephone contact with his father, Scott Anderson throughout the day trying to negotiate with his father to pick him up to have a meal together. His father was unavailable and told the boy to catch a bus. Andrew rang his father again and said, "*Good bye Dad*". There was then a loud popping sound and

the sound of a fall. The father presumed Andrew had shot himself. He rushed to the grandfather's residence where he found Andrew unconscious with a fatal gun shot wound to the head. Andrew did not regain consciousness and died in hospital two days later.

Cause of Death

The cause of death was a gunshot wound to the head.

The evidence is that Andrew deliberately discharged the weapon and would have had sufficient knowledge to understand the risk of serious harm or death. However, it is also clear he lacked the capacity due to depression and immaturity to critically evaluate his actions at the time which appear to have been an attempt to gain his father's attention. It was also noted his ante mortem toxicology revealed the presence of cannabis, low level benzodiazepine and high level antidepressant. It was unclear whether any of the prescribed medications had indeed been prescribed or whether they were illicitly obtained.

Concerns, comments and recommendations

Section 46 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.

As already referred to the Department has reviewed the way in which Andrew Anderson's care was managed. I commend the reports of both the Child Death Case Review and the Child Death Case Review Committee.

I make the following comments to emphasize the importance of certain matters which arose in considering Andrew's care. Some of these issues have already been addressed by the Department's reviews. The purpose is to assist in preventing deaths of other young people in the care and custody of the Department of Communities.

(1) Transfer of a case file between offices

At a structural level the Department must create a system and allocate responsibility to ensure that where a child is "mobile" between different offices that child's needs are properly met. Identification that this problem has arisen must attract mandatory review and responsibility by a more senior level of practitioner to address how the child's needs are met.

The Department has responded to this issue with a suggested time frame in which a transfer should occur. The responsibility to make this happen must be accepted initially by the relevant case worker. There should be a requirement for that officer to formally advise their line manager as soon as circumstances arise indicating the need for transfer. There should then be a joint responsibility to ensure the transfer happens within the required time frame, and ensure delivery of services, and continuation of essential case work services during the transition by whatever are the appropriate mechanisms.

A deadline should be set by which time the line manager must escalate any problem with the transfer to higher management within both offices.

(2) Where a child in care/custody is missing

The guidelines for responding to this situation must be reviewed within the regime of the SCAN process so that there is a timely decision made about what is to happen. Dong nothing should not be an option and a review of how the Department works with Queensland Police should be considered.

(3) Placement of child in a particular residential arrangement

It is noted that the Placement Services Unit now manages the assessment and placement of a particular child in a suitable residential arrangement. The provision of information from the case worker into that placement decision is now provided for but it is recommended that the assessment report, which is signed off by the child safety manager, is copied and returned directly to the case worker. This will enable better understanding of the situation in which the child is placed and to ensure the child and family are supported through the placement.

(4) Assessment of relative carers

Where a placement with a relative carer is proposed, the assessment process must comply with legislative requirements to ensure the child's needs are met and the placement is suitably supported by resources, including where appropriate, physical visits to ensure the child is properly cared for.

The assessment of family members must be considered within the criteria set by legislation and proposed carers must meet those requirements. There must be a proper consideration of who might meet the child's needs, and not just a consideration of who is readily available. The Department must be satisfied that the person/family is suitable and has capacity to perform the role.

Where a qualified approval is given subject to the provision of conditions or supports, the Department must meet its responsibility to provide these supports and continue to monitor suitability. Where a placement is made with a relative carer, it is recommended the assessing report writer observes interaction between the child and proposed carer, and the child's wishes are taken into account in accordance with their age as appropriate.

The evidence in this inquest showed the potential availability and suitability if supported, of another 'relative carer", namely a step mother. This was not considered and it was suggested the Department does not consider step parents as possible relative carers. If this is indeed the policy it should be reconsidered to also include step parents as possible suitable relative carers.

(5) Dealing with difficult families

Discussion and policy papers have been written in response to the Department's review to guide practitioners in how to deal with difficult children and their family members. What has not happened yet is the development of training for case workers around these polices directly available. This should be a priority.

(6) Other services

In the course of the inquest there was mention of early intervention resources to assist families at a time when it is first identified there are problems. Andrew's family attempted to the best of their ability and resources to access professional help and advice to guide them in managing Andrew as a young child. Their efforts were unsuccessful and the family unit fractured before the final crisis which precipitated Andrew being taken into care. There must be greater priority for identifying and supporting families when the first indication of potential child safety issues arise.

There was mention of the positive benefits available through the EVOLVE program which was piloted in limited areas. Subject to proper evaluation confirming the benefit to families of this program, resources should be made available to make this accessible state wide.

(7) General Resources available to Child Safety (Communities)

Although there were some identified problems which should have been addressed by officers and were not, this should be considered against the background of very high case loads, pressure and insufficient foster families and other options and supports available to the department.

It is recommended that the department with responsibility for families and children in care must receive priority funding. This must focus on early intervention and support to families where there is a risk identified to children as well as support to children in the care.

(8) Disciplinary/training issues

The Department is addressing disciplinary issues with a team leader involved in the supervision of Andrew's care. The only remark made is that the Department's actions in suspending the person did not occur until immediately before the inquest commenced. This was four years after Andrew's death. It is hoped there is a conscientious and careful review of what actions the Department might take to prevent another death such as Andrew's. Issues of training and supervision of staff are paramount to ensuring our most vulnerable children are protected whilst in the State's care.

Conclusion

Andrew Anderson died tragically whilst in the care of the (now) Department of Communities. This inquest was convened in the hope of gaining a better understanding of how this tragedy occurred and how a similar event might be avoided in the future. It has been a distressing process for all those involved and the court extends condolences to Andrew's family and the carers and workers involved in his short life. The court thanks all those who have assisted this inquest, in particular witnesses who were brave enough to provide their evidence in circumstances of personal grief and some risk.

Chris Clements
Deputy State Coroner