CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Tiahleigh Alyssa-Rose Palmer**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2015/4373
DELIVERED ON:	18 JUNE 2021
DELIVERED AT:	BRISBANE
HEARING DATE(s):	8 – 9 JUNE 2021
FINDINGS OF:	Jane Bentley, Deputy State Coroner
CATCHWORDS:	Coroners: inquest, Child Safety; foster care, missing children, murder, rape, incest, Thorburn.

REPRESENTATION:

Counsel Assisting:	Ms Kate McMahon
Department of Children, Youth Justice and Multicultural Affairs:	Ms Karen Carmody (instructed by DCYJMA)
Richard Thorburn:	Mr Matthew Hickey (instructed by Alexander Law)
Julene Thorburn:	Mr James Benjamin (instructed by Gilmore Lawyers)
Trent Thorburn:	Ms Katarina Prskalo (instructed by Legal Aid Qld)
Joshua Thorburn:	Mr Malcolm Harrison (instructed by Hannay Lawyers)

Contents

Introduction 4
Background 4
Autopsy 5
Police Investigation 5
  Criminal Proceedings 9
Tiahleigh's involvement with the Department of Child Safety 12
  Chronology of Departmental Involvement 13
  Systems and Practice Review Report 17
  Queensland Child Death Case Review Panel Report 23
  Reviews conducted by the Queensland Family and Child Commissioner 26
  The Department's Response to the Departmental and QFCC Reviews 31
Review of the Domestic and Family Violence Death Review Unit 31
The Inquest 42
  Richard Thorburn 43
  Julene Thorburn 46
  Joshua Thorburn 46
  Trent Thorburn 47
  Detective Senior Sergeant Chris Knight 47
Findings and Conclusions 48
  The scope of the Coroner's inquiry and findings 48
  Submissions 49
  Findings of Fact 50
Comments and recommendations 53
Findings required by s. 45 54
    Identity of the deceased 54
    How she died 54
    Place of death 54
    Date of death 54
    Cause of death 54

Introduction

1. Section 45 of the *Coroners Act* 2003 provides that when an inquest is held the coroner's written findings must be given to the family of the person in relation to whom the inquest has been held, each of the persons or organisations granted leave to appear at the inquest and to officials with responsibility over any areas the subject of recommendations.

2. These are my findings in relation to the death of Tiahleigh Alyssa-Rose Palmer. They will be distributed in accordance with the requirements of the Act and posted on the web site of the Coroners Court of Queensland.

3. These findings and comments confirm the identity of the deceased person, when, where and how she died and the cause of her death.

Background

4. At the time of her death Tiahleigh was aged 12 years and 6 months.

5. She loved hip hop dancing, cheer leading, animals and horse riding. She was described as a "delightful girl" and "a child people fell in love with" by those who knew her. Despite being subjected to neglect, abuse, abandonment and adversity, Tiahleigh remained a kind and gentle girl. She had many friends at high school. She was not "streetwise" but immature and naïve for her age. Although in the past she had experienced some behavioural issues as a result of the harm that she had suffered, she had not been involved in the justice system and had no history of self-harm, drug or alcohol use.

6. Tiahleigh went missing on 30 October 2015.

7. At that time she was living with foster carers Richard Neville Thorburn,

his wife, Julene Thorburn, and their sons, Joshua Dillon Thorburn and Trent Jordan Thorburn.

8. At about 5.15pm on 5 November 2015 three men looking for a fishing spot found Tiahleigh's near naked and decomposed body on the water's edge of the Pimpama River on Kerkin Road North. She was obviously deceased and had been for some time.

Autopsy

9. An autopsy was conducted but the cause of Tiahleigh's death could not be determined due to the level of decomposition.

10. Tiahleigh was found in a prone position with her head and arms submerged in the water and her back, buttocks and parts of her legs exposed. A torn pair of underpants was around the top of her right thigh.

11. There were no fractures of the skull or any other bones.

12. Tiahleigh was not pregnant.

13. There were no definite antemortem injuries.

Police Investigation

14. At about midday on 30 October 2015 a youth worker attended Tiahleigh's school to take her to attend a program. The youth worker found that Tiahleigh was not there and had not been present at any of her classes that day. The youth worker contacted her foster parents. Mr Thorburn said that he had dropped her at school between 8.10 and 8.30am. He attended the school and asked the Principal why he hadn't been informed that Tiahleigh wasn't at school.

15. The youth worker and Mr Thorburn attended the Browns Plains Police Station at about 1pm on 30 October 2015 and reported Tiahleigh as

missing.

16. In fact, Tiahleigh was last seen by an independent witness leaving her weekly dance class at about 5.45pm on 29 October 2015. Mr Thorburn did not take her to school on 30 October 2015.

17. On the evening of 28 October 2015 Trent sent his cousin some Facebook messages in which he told her that he'd had sexual intercourse with Tiahleigh. He said that it had only occurred once and that Tiahleigh had instigated it and threatened to hurt his dog if he didn't comply with her wishes.

18. He wrote:

> *i just want the kid gone and out of my life but i know she is also a sauce of income for mum and dad as well and i cant risk us loosing money because she is gone. also if tia did say something to children services and she is pregnant then it all gets investigated and i could go to jail because a court isn't going to believe me over her*

19. Trent's cousin told her mother about this disclosure the next afternoon and her mother told Julene Thorburn (her sister). Mrs Thorburn discussed it with Trent that afternoon and he admitted that he had engaged in a secret sexual relationship with Tiahleigh and that he was worried that she may be pregnant. Shortly thereafter Mrs Thorburn told Mr Thorburn of this. Mr Thorburn said that he was concerned that Trent may go to prison. They discussed that Tiahleigh had complained of stomach pains that afternoon and that this could be consistent with her being pregnant.

20. Joshua was at dance class on the afternoon of 29 October 2015 as was Tiahleigh. She told him she was not feeling well. He phoned his mother who picked Tiahleigh up from dancing and took her home.

21. Tiahleigh continued to feel unwell that afternoon. She was unable to

eat dinner and Mrs Thorburn gave her some Panadol and put her to bed early.

22. It was agreed between Mr and Mrs Thorburn that Mrs Thorburn would visit her sister and the cousin to whom Trent had confessed. She left the house at about 7pm. Tiahleigh was in bed. Trent and Joshua were not home. Joshua was still at dance class. Trent left home to go to dance class shortly before Mrs Thorburn left the house. Mr Thorburn stayed at home with Tiahleigh.

23. Whilst Joshua and Trent were at dance class Mrs Thorburn phoned Joshua and asked him if Trent was okay and told him to watch Trent.

24. Between 7.30pm and 9.30pm on 29 October 2015, whilst Mr Thorburn was at home alone with Tiahleigh, he killed her.

25. Mrs Thorburn returned home about 9.30pm.

26. Mrs Thorburn asked if Tiahleigh was all right.

27. Mr Thorburn replied, “It is all taken care of.”

28. He told her not to ask any more questions as she did not need to know and he had taken care of it.

29. Trent arrived home soon after. Joshua arrived home next and found his family sitting on the couch. Mr Thorburn told Joshua and Trent that Tiahleigh was no longer with them and he hoped they understood. He told his family that the next day they would do things as normal as they all had to protect Trent so they would keep to the story that Tiahleigh went to school that morning. He told them to say none of them had seen Tiahleigh that night. He told them he had hidden Tiahleigh’s body and he would dispose of it the next day. He told them not to come home the following night so he could get rid of the body. The family then went to bed.

30. Later that night Mrs Thorburn went to go into Tiahleigh’s room and Mr

Thorburn said he had told her not to go in there. She asked why and he said, "I told you, it's taken care of, don't ask questions."

31. At about 5.30am the next day Mrs Thorburn saw that Tiahleigh was not in her room.

32. Mr Thorburn pretended to be concerned when advised that Tiahleigh had not attended school the next day and he assisted police to search for her.

33. At about 8pm on 30 October 2015 Mr Thorburn told Mrs Thorburn that he had something to do and she shouldn't ask him any questions. He reversed his car into the shed at the back of their property.

34. When Trent and Joshua returned home Mrs Thorburn told them that Mr Thorburn was out disposing of Tiahleigh's body.

35. Mr Thorburn arrived home at about 11pm covered in dirt and told Mrs Thorburn, "It's done."

36. He had taken Tiahleigh's body to a secluded area near the river in Pimpama and left her there, naked except for a pair of underpants, with her head and arms partially submerged in the water.

37. Mr Thorburn then continued to give false accounts and statements to the police and told his wife and sons to give false accounts and statements to the police to corroborate his lies. On 29 June and 1 July 2016 Mr Thorburn gave false evidence in hearings conducted by the Crime and Corruption Commission.

38. Mrs Thorburn told police that she had picked up Tiahleigh from dance class, took her home, she was not feeling well and didn't eat much dinner and then she went to bed at 8pm. She told police her husband took Tiahleigh to school the next morning. She repeated those lies when giving sworn evidence to the CCC on 29 June 2016.

39. On 30 June 2016 Mrs Thorburn gave sworn evidence that on the

morning of 30 June 2016 Tiahleigh was, “good as gold, normal cheery self.”

40. After her arrest on 20 September 2016, by which time police had irrefutable evidence of Mrs Thorburn’s lies and perjury, she admitted that she had deliberately perjured herself.

41. Not only did Mrs Thorburn lie herself but she encouraged her sons to do the same.

42. In a conversation with her sons on 12 September 2016 she said, “We have to stick to the same story about her going to school the next day and whatever”.

43. Joshua told police and gave sworn evidence that Tiahleigh was in bed on the night of 29 October 2015 and he saw her the next morning and spoke to her before she left with his father to go to school.

44. The guilt of Mr Thorburn, Mrs Thorburn, Trent and Joshua was revealed by their conversations which were covertly recorded. Between 26 August 2016 and 20 September 2016 an electronic surveillance device was installed in their home and multiple conversations were recorded in which the family discussed the sexual contact Trent had with Tiahleigh and the efforts to conceal this from police. The family also discussed how they planned to mislead police and the CCC by lying. In those conversations Mr Thorburn coached his family as to what they should say to investigators and urged them to continue to confirm their false accounts.

Criminal Proceedings

45. On 20 September 2016 Richard Thorburn was arrested and charged with Tiahleigh’s murder. He was also charged with attempting to pervert the course of justice (in relation to his false statements to police and advising his wife and sons to make similar false statements) and interfering with a dead body.

46. He pleaded guilty to all charges (although he did not disclose how he killed Tiahleigh) and in the Brisbane Supreme Court on 25 May 2018 he was sentenced to life imprisonment for the murder and four years imprisonment for the charge of attempting to pervert the course of justice. He was eligible to apply for parole after serving 20 years of that sentence i.e. 12 September 2036.

47. Trent Jordan Thorburn was charged with incest, attempting to obstruct the course of justice and two counts of perjury.

48. He pleaded guilty to those offences and in the District Court at Beenleigh on 14 September 2017 he was sentenced to four years imprisonment suspended after he had served 16 months imprisonment for an operational period of five years. He was released from prison on 20 January 2018. He sought leave from the Court of Appeal to appeal that sentence on the ground that it was manifestly excessive. The Court of Appeal refused leave to appeal.

49. Julene Thorburn was charged with attempting to pervert the course of justice and perjury arising out of her lies to police and her false evidence to the CCC. She pleaded guilty to both charges and was sentenced in the District Court at Beenleigh on 3 November 2017 to 12 months imprisonment and 18 months imprisonment, to be served concurrently, suspended after serving 6 months imprisonment for an operational period of three years.

50. Joshua Thorburn, who was 19 years old at the time of offending and 20 years old by the time he was sentenced, was charged with attempting to pervert the course of justice and perjury arising out of his lies to police and his false evidence to the CCC. He pleaded guilty to both charges and was sentenced in the District Court at Beenleigh on 27 July 2017 to 9 months imprisonment and 15 months imprisonment, to be served concurrently, suspended after serving 3 months in prison, for an operational period of three years.

51. On 4 May 2016 Richard Thorburn was charged with thirteen offences

in relation to two girls who attended the family day care operated by his wife at their residence. The girls were 4 years old and 11 years old at the time. They commenced attending the day care after the July school holidays in 2015.

52. Mr Thorburn was unemployed and stayed at home during the day. He was not authorized to have sole supervision of the children attending the day care. He committed the offences in the home when the children were there and either when his wife was in another room or when she was taking the other children to school. Sometimes he drove the children to school and one of the offences occurred in the car on the way to school.

53. The 4 year old child disclosed the offending to her father on 26 April 2016. It was reported to the family day care management company and then to the police. Julene Thorburn resigned from the company soon after.

54. Mr Thorburn was charged with the following charges, all committed between 1 July 2015 and 28 April 2016 at the family home:

- Raping the 11 year old;
- Indecently dealing with her (four counts)
- Permitting himself to be indecently dealt with by her;
- Wilfully exposing her to an indecent film;
- Indecently dealing with the 4 year old (four counts);
- Permitting himself to be indecently dealt with by her (two counts);
- Attempting to rape her.

55. Mr Thorburn participated in an interview with police and denied any such offending.

56. He entered pleas of guilty to those offences. He then attempted to withdraw his pleas on the basis that he had complete amnesia and was pressured into pleading guilty by his legal representatives. Mrs Thorburn told his solicitor that he had lost his memory, didn't recall who she was and could not make phone calls. That information was

inconsistent with observations of Mr Thorburn at the prison making phone calls and the opinions of numerous psychologists who considered that he was “malingering”. The application to withdraw the pleas was rejected by His Honour Judge Chowdury DCJ who found that Mr Thorburn was a dishonest witness and he had entered the pleas of his own free will.

57. Mr Thorburn was sentenced for those offences in the Beenleigh District Court on 20 November 2020, to a head sentence of five years imprisonment with a parole eligibility date of 12 September 2038.

Tiahleigh’s involvement with the Department of Child Safety

58. By the time she was killed at the age of 12 years, Tiahleigh had been effectively rejected by both of her parents and had lived in nine different households and a residential care facility.

59. In the two years prior to her death she was subject to a short term custody order granting custody to the Chief Executive, Department of Child Safety, Youth Justice and Multicultural Affairs (the department), (which was at that time known as the Department of Communities, Child Safety and Disability Services).

60. Less than a month after her birth, the department first received concerns about Tiahleigh’s welfare. The concerns were in relation to domestic and family violence, her mothers’ parenting capacity and motivation, and her mothers’ substance misuse, including reports that Tiahleigh had gone through drug withdrawal at birth.

61. Tiahleigh went into out-of-home care when she was seven years of age following periods of care with her mother, father and maternal grandmother. After going into care, Tiahleigh was diagnosed with Reactive Attachment Disorder (this diagnosis was changed in November 2014 to Adjustment Disorder) and she demonstrated ongoing challenging behaviours. This was unsurprising considering her tumultuous life and her lack of attachment to a primary care giver.

62. Tiahleigh went into the care of the department in 2010 following ongoing concerns about Tiahleigh's mother's ability and motivation to care for her children, concerns regarding emotional abuse, neglect and physical abuse, transience and homelessness, domestic and family violence from mother's partners toward her and drug misuse. After some years, even though the situation for Tiahleigh's mother improved and there was considerable contact, the relationship between them continued to be strained and attachment difficulties persisted, with Tiahleigh expressing sadness and feelings of being not wanted by her mother and family.

63. At the time of her death Tiahleigh was subject to a Short-Term Custody Order. An application for a Long-Term Order granting guardianship to the chief executive was made on 22 October 2015.

64. Shortly prior to her death Tiahleigh's mother indicated to the department that she had decided to relinquish guardianship of Tiahleigh and would not contest the Long-Term Guardianship Order to the department on the next court date of 5 November 2015.

Chronology of Departmental Involvement

65. In May 2003 Tiahleigh and her sibling were assessed as being children in need of protection (CINOP) due to neglect and emotional harm by their mother. They were placed with foster carers under a voluntary care agreement and an Intervention with Parental Agreement (IPA) was commenced.

66. When Tiahleigh was three months old it was reported to the department that her mother had been seen yelling at her and did not show her any affection.

67. In August 2003 both children were returned to the care of their mother where they remained until May 2008 (although two further reports of neglect and physical harm were received in April and May 2004 which were found to be unsubstantiated).

68. In May 2008 there were two notifications of physical harm to Tiahleigh by her mother but these were found to be unsubstantiated. In September 2008 a notification of neglect and emotional harm to Tiahleigh by her mother was found to be substantiated and she was again assessed as a CINOP and placed with carers under a voluntary care agreement.

69. It was alleged that in October 2008 Tiahleigh's mother had been heard to verbally abuse her by swearing at her and calling her derogatory names.

70. On 3 October 2008 Tiahleigh went to live with her father.

71. In October 2008 two child concern reports were received and it was assessed that Tiahleigh had suffered emotional harm.

72. In December 2008 an IPA was opened due to concerns of domestic and family violence perpetrated against the mother by her partner at the time, alcohol misuse, excessive discipline, criminal activity and failure to meet the basic needs of the children as a result of transience and homelessness. Tiahleigh's mother largely failed to address the child protection concerns in the period of the IPA but it was closed on 25 August 2009 when Tiahleigh was again placed with her father who was assessed as a safe parent. He told the department he would not let the children return to their mother's care as he understood the concerns.

73. However, in January 2009 it was assessed that Tiahleigh had suffered emotional abuse and in May 2009 and September 2009 it was assessed that she had suffered neglect and emotional abuse.

74. On 15 January 2010 the department was told that Tiahleigh had been left in the care of her maternal grandmother. The maternal grandmother had been assessed as unable to care for Tiahleigh's mother who had been placed in the care of the department. The department investigated and concluded that the maternal

grandmother was not willing and able to care for Tiahleigh and it was not safe for her to be returned to her father or her mother.

75. On 20 January 2010 Tiahleigh was placed with a foster carer until 8 October 2012 when she was placed with another foster carer. On 4 January 2013 she was placed in a residential facility for two weeks and then with a further foster carer for one month. On 22 March 2013 she was placed with other foster carers where she remained until 16 January 2015. She was then placed in the care of the Thorburns.

76. Tiahleigh was subject to a Temporary Assessment Order (TAO) followed by a Court Assessment Order (CAO) and then a two-year Child Protection Order (CPO) granting custody of her to the department which was made on 22 July 2010.

77. Tiahleigh’s father disengaged with the department and his last contact with Tiahleigh was in August 2010. Despite his lack of engagement the department persisted in attempts to engage him until June 2013.

78. Between 2010 and 2013 contact between Tiahleigh and her mother was inconsistent as her mother failed to attend most scheduled visits. The mother recommenced contact with Tiahleigh in October 2013 at which time she was in a new relationship and pregnant. Initial phone contact progressed to face to face contact in February 2014 and then unsupervised overnight contact in June 2015 and Tiahleigh spent the whole weekend at her mother’s residence in late June 2015. However, Tiahleigh was struggling with her feelings of abandonment by her mother especially in the context of her brother having been reunited with the mother and her mother being pregnant. Tia said that she could not understand why two of her siblings were “at home” while she could not live with her mother and she blamed herself for this.

79. A further CPO was made on 18 October 2012 which expired in October 2014.

80. Tiahleigh had monthly contact visits with her maternal grandmother until April 2014 when she refused to attend any more visits.

81. In October 2014 a further one-year child protection order was made which expired on 23 October 2015.

82. On 21 September 2015 Tiahleigh's mother decided that Tiahleigh should remain in the care of the department on a long-term order and she would relinquish guardianship of her. She stated she did not want to continue with structured contact with Tiahleigh as Tiahleigh could see her when she wished to.

83. On 22 October 2015 an application was made for a long-term order granting guardianship of Tiahleigh to the department until she was 18 years old.

84. At the time of her death Tiahleigh had lived with her mother, her father, her maternal grandmother, had spent some time in a residential facility and had lived in six households of foster care including her final placement in which she was killed. In total she had been moved between different households fifteen times. She had been the subject of a total of twelve orders and agreements:

- three voluntary care agreements;
- two IPA's;
- one TAO;
- one CAO;
- two interim CPOs;
- three CPOs;
- and there was an application before the court for a long-term order (the thirteenth order).

85. Despite this lack of stability, the department's goal was not one of permanency for Tiahleigh. Although her mother had indicated that she would be unable to care for Tiahleigh in the future and that she wished to relinquish guardianship of her, the case notes indicate that

Child Safety Officers (CSOs) considered that should her mother change her mind in the future the long-term order could be revoked.

Systems and Practice Review Report

86. As was recognized by the Child Death Case Review (CDCRP), discussed below, this review was conducted prior to Mr Thorburn being charged with Tiahleigh's murder. Therefore the review did not consider whether the process in relation to approval of the Thorburn's as foster carers was appropriate. The department declined to carry out another review after he was charged despite that being a recommendation of the CDCRP.

87. The ultimate finding by the panel was that the death of Tiahleigh was not the result of any action or inaction by the department. (Of course, this finding was made in the absence of the knowledge that she was killed by the foster carer in whose care she had been placed by the department).

88. The review panel found that the department's work with Tiahleigh was generally of a high standard and her needs were met on an ongoing basis. She had a strong care team built around her that met and communicated regularly and was responsive to her changing needs.

89. The panel identified that there were concerns in two areas:

- permanency planning for Tiahleigh, and,
- the department's response after she went missing.

Lack of Permanency Planning

90. The review panel concluded that a more timely decision about permanency may have been appropriate in 2012 when there had been little change by either parent in addressing the child protection concerns, however, the panel decided it was out of the scope of their review and did not explore the issue in detail or discuss it with departmental staff.

91. It is clear from a review of the records relating to Tiahleigh that the foster care agency (Key Assets), Evolve (the service provider engaged by the department to provide therapeutic services to Tiahleigh) and the department placed significant weight on the mother's wishes, her feelings, the implications for her of decisions, the need for her to be "fully on board" with any decisions. Evolve strongly advocated for Tiahleigh's reunification with her mother. On 14 July 2015 the Evolve clinician noted:

> *I believe that everyone is doing their best and acting with good intention – it's just that this is a difficult and complicated situation – I imagine from [Tiahleigh's] perspective it is difficult to think about leaving a place where you feel settled and cared about, and where you care about your foster parents, have adults with time to respond to you individually, have activities you love (and you can't do when you go home) and go to a home you haven't lived in for some time and aren't certain about. Change is difficult and anxiety provoking and I can understand that this is a challenging time for [Tiahleigh].*

92. The Evolve clinician noted that the previous foster carer wanted to keep Tiahleigh until she was 18 because "she fell in love with her" but that when the mother came back on the scene everyone involved had to process that the mother's circumstances had changed, that she was a different person now and that before she was young and had made some wrong choices.

93. She noted that the Thorburns also said they wanted to keep Tiahleigh long term but "they were unintentionally undermining the reunification process as they started to believe they were the best people to look after" Tiahleigh.

94. It was noted that the Evolve clinician had a good relationship with Tiahleigh's mother and was a "great support" to her and spoke about her dilemmas. She wanted the mother to engage in therapy despite

numerous attempts when the mother did not participate.

95. The Evolve clinician stated that, whilst the foster carers had the support of the foster agency, the mother had no support at stakeholder meetings and therefore she “mostly aligned with the mother as she believed it was important for her to be supported.”

96. The Senior Team Leader (STL) was noted to state that the long-term plan for Tiahleigh was for a LTGO with the main focus on rebuilding and strengthening the relationship with her mother so that some level of contact could be established and if matters progressed well, “there would always be an option of discharging the LTGO if appropriate at any stage”.

97. The panel noted that Tiahleigh was put in a position where she was asked to choose between living with her mother and remaining in foster care. This was unfair as it was not her decision. The various tools available to child safety officers to assist in obtaining views from children were not utilized in dealings with Tiahleigh.

98. The panel found that the placement needs for Tiahleigh were met to a high standard and she was supported by a strong and stable care team which was highly responsive to her changing needs and behaviours.

Inadequacy of Response when Tiahleigh was Missing

99. Tiahleigh started leaving her foster home without permission when she began high school in early 2015. However, this was mainly instances of her going to friend’s houses after school without informing her foster carers. She had never stayed away from home overnight and in most cases when she went to see friends her whereabouts was known or easily ascertained. She had never failed to attend school without permission.

100. However, when it became apparent that Tiahleigh had not attended school on Friday 30 October 2015 the department took no action in

response until the following week which resulted in the inability of Queensland Police Service to issue a media release until nearly a week later on Thursday 5 November 2015.

Chronology

101. The STL was told by the Thorburns on the afternoon of 30 October 2015 that Tiahleigh was missing.

102. The STL did not make a case note or refer the report to the Child Safety After Hours Service Centre (CSAHSC).

103. Tiahleigh's CSO was on leave that week so did not receive the email sent to her by Key Assets advising that Tiahleigh was missing.

104. On Monday 2 November a manager from Key Assets emailed Tiahleigh's care team proposing a stakeholder meeting and stating:

> *It would be beneficial to meet as a care team and look at putting together a safeguarding action plan. Essentially, we would look at what support and strategies can be put in place to reduce the risk of Tiahleigh absconding in the future.*

105. There was no evidence to support a conclusion that Tiahleigh had absconded but this was the conclusion that was immediately drawn.

106. The Critical Incident Report (CIR) was not completed until the STL did it on Tuesday 3 November at which time she contacted QPS and asked them to prioritise the matter. The Regional Director (RD) and the Assistant Regional Director (ARD) of the department were not advised until Wednesday 4 November 2015. Due to confusion over the identity of Tiahleigh's legal guardian, the Director-General did not give consent for her photo to be released as part of the QPS media release until Thursday morning.

107. By that time Tiahleigh, an immature 12-year-old girl, had not been seen for six full days.

108. The STL said that on Friday when she was first told by the Thorburns that Tiahleigh was missing she thought that it was not unusual for Tiahleigh to go missing for a short period. When she found out on the Monday that Tiahleigh was still missing she felt “uneasy”.

109. The STL said that all stakeholders had a discussion and agreed that it was very unusual for Tiahleigh to be missing for so long as:

- she never went far when she ran away – usually only into the backyard;
- she was scared of the dark and always returned home before dark;
- she usually ran away to get attention so would let someone know where she was;
- she had only skipped school once before and had never left the school grounds previously;
- she did not have the skills to stay missing for a long period.

110. The STL said that Tiahleigh’s mother was frantic but the STL reassured her that the department was taking the matter very seriously (in fact the department had done practically nothing at that time – the STL had not even recorded Tiahleigh’s disappearance on the department’s database). The STL then spoke to her manager about completing the CIR but he told her to “hold off” until they could chat about it further. He requested that inquiries be made with school friends etc to locate Tiahleigh.

111. As a result the CIR was not completed until Tuesday (the fifth day that Tiahleigh had been missing).

112. The ARD and RD were advised that Tiahleigh was missing on Wednesday but they were all at a meeting so didn’t read the entire email that they received and didn’t realize that Tiahleigh had been missing since Friday. They were advised of those details that evening. They then realized it was urgent that something be done but

needed to “brief up” to the DG which was difficult as nobody had recorded any information on the department database (ICMS). STL and her manager were called into the regional office on Thursday morning (the seventh day of Tiahleigh’s disappearance).

113. For some reason, the STL said this was “distressing” for her as she was taken away from the support of her colleagues. Her manager agreed it was “uncomfortable” but he understood “it had to be done”. Clearly Tiahleigh’s welfare and their lack of action was not their most immediate concern even after she had been missing for seven days.

114. The department implemented new processes so that when a CIR was made the CSOs would feel more comfortable.

115. Some hours were then spent while high level departmental officers were confused about the guardianship of Tiahleigh (although it was the Chief Executive of that department who was her legal guardian) and who could provide consent for her photo to be released to the media.

116. The department has now implemented a new process whereby a child’s status re guardianship is noted on ICMS.

117. The panel could not comment on the police action between Friday and Thursday and stated the panel were unable to hold discussions with police. The reason for this inability is not stated.

118. The panel determined that it was reasonable to assume on Friday 30 October that Tiahleigh could be missing for a short period of time, however, there was no escalation process when Tiahleigh was not found that afternoon. To go missing overnight was out of character for Tiahleigh and the recording of a CIR should have been a priority by Monday morning. Further, the fact that she was missing on Friday afternoon should have been reported to the Child Safety After Hours Centre so the matter could be monitored over the weekend. There was no coordinated approach and an urgent stakeholder meeting

should have been organized.

119. The panel identified that service improvement should be considered in the following areas:

- new department guidelines for children missing from out-of-home care;
- focus on establishment of robust care teams;
- permanency planning for children in care;
- court reforms in terms of permanency planning.

120. As stated, the panel came to the final conclusion that the death of Tiahleigh was not the result of the department's action or inaction. It is difficult to accept this conclusion taking into account that Tiahleigh was killed by the person who was chosen by the department to care for her in the home to which she was sent by the department. It is noted that this was not known to the review panel at the time the review was finalized and the department decided not to reconsider the matter after Mr Thorburn admitted to killing Tiahleigh.

Queensland Child Death Case Review Panel Report

121. The CDCRP met on 1 September 2016 to review the circumstances of Tiahleigh's involvement with the department.

122. The Panel found:

- The QFCC conducted a review into responses to missing children after Tiahleigh's death;
- There were clear problems regarding the co-ordination of services at the time Tiahleigh went missing which were addressed by the SPR and the QFCC reports;
- The case work and interagency work up until Tiahleigh went missing were reasonably sound in that:
    - There was regular contact between the care team workers and the carers;

    - Tiahleigh appeared to be settling into the foster home:
    - Her behaviour had improved:
    - She was making friends at school;
- Permanency decision-making concerning Tiahleigh was problematic:
    - Her previous foster carer continued to be involved in her life which created confusion and instability for her as that person had made the decision to discontinue fostering Tiahleigh but then continued to have contact with her for about 22 months;
    - There were clear signs that the previous foster carer was not suitable but the placement was continued until she discontinued it rather than the department making a timely decision;
    - There was insufficient proactive planning around placement;
    - The department continued to attempt to reunify Tiahleigh with her mother even after assessment indicated this should be stopped and the effort directed at achieving long term stability for Tiahleigh;
- Evolve were the service funded by the department to provide therapeutic support to Tiahleigh but the Panel were unsure:
    - What work Evolve was undertaking with Tiahleigh;
    - Whether Evolve had the capacity to do what was expected of them;
    - Whether the department was too reliant on Evolve as a single source of therapeutic work.
- Neither the department nor QPS escalated concerns over Tiahleigh's disappearance from school in a timely manner as it was considered that she would reappear even when the length of time she was gone was uncharacteristic for her:
    - There was a lack of interagency communication;
    - The senior team leader of the department failed to make any case note of her disappearance and did not consider

escalating the matter to the after-hours staff.

123. The Panel found there was a lack of action by the department in failing to record a critical incident and following up to ensure a prompt police response.

124. The Panel noted that the review by QFCC resulted in immediate changes to the practices of the Department of Education (DET) in relation to notifying carers when children are missing from school.

125. The Panel noted that when the internal review panel conducted the internal SPR it did not have all of the information available to the CDCRP (as Richard Thorburn had not at the time of the internal review been charged with Tiahleigh's murder) and made the following recommendation:

    a. *Findings and recommendations of the Panel in this case are based only upon information available to the Panel at the time of writing, and this information now appears incomplete.*

    b. *Therefore, it is recommended that the department extend its internal review to consider all the additional information that is now available, and to present a further report to the Panel for consideration.*

126. The Panel recommended a further review to consider the placement of Tiahleigh with the Thorburns and that all possible actions were taken to safeguard Tiahleigh whilst she was in their care.

127. The department decided not to act on that recommendation and an addendum SPR was not undertaken.

Reviews conducted by the Queensland Family and Child Commissioner

When a Child is Missing

128. The QFCC was asked to conduct a broad whole-of-government systems review to ensure the child safety, education, health and police service system worked effectively and "everything possible was done when concerns were first raised about Tiahleigh's recent disappearance".

129. The review identified a number of areas which were of concern including:

- Inconsistency in guidance for agencies and carers, state-wide practice consistency and data collection and sharing;
- Lack of media protocols regarding releasing information about a missing child publicly, media releases and media campaigns;
- A culture of considering children who are absent from their placement as "absconders" rather than missing children;
- Children missing from out-of-home care are not easily distinguished as a separate group from all children who are reported as missing;
- Children living in out-of-home care may account for 30% of all children reported missing to the QPS;
- An average of 5% of children living in out-of-home care are recorded by Child Safety Services as missing or absent from their placement each year;
- Key government agencies, including the QPS, the department and DET are not routinely sharing information where there is no clear legislated ability or policy mandate to do so;
- Procedures and processes guiding agencies in identifying

vulnerability and responding when a child is missing from out-of-home care or absent from their placement cause confusion and misunderstanding;

- There was a lack of clear and consistent definition and guidance in identifying when a child from out-of-home care is considered missing or absent from their placement to inform immediate and longer term action;
- There needs to be an increased collaborative approach and improved practice in responding to children missing from out-of-home care;
- The QPS must be able to immediately gather critical information to assist with locating a missing child;
- It is vital that the QPS can take direct action when preparing a media release requesting public assistance in locating a child missing from out-of-home care;
- A QPS media release with a child's photo is not likely to lead to their being identified as a child under the care of the department and therefore, the written approval of the Chief Executive for such a media release is not required.

130. The report contained the following statistics in relation to numbers of children reported missing in Queensland:

Year	Missing	Located
2009-10	3535	3508
2010-11	4102	4100
2011-12	4516	4516
2012-13	4485	4485

2013-14	4005	3981
2014-15	3582	3580
2015-16	3526	3524
2016-17	5594	5594
2017-18	5590	5590
2018-19	6124	6124
2019-20	5858	5827
TOTAL	50,917	50,829

131. The above figures reveal that in the last ten years eighty-eight missing children have not been located.

132. QPS data indicates children aged 16 years or younger, from out-of-home care could, on average, account for around 30 per cent of all children reported missing to the QPS.

133. The QFCC made 29 recommendations arising from the review.

134. The Queensland Police Service provided evidence of the implementation of the recommendations which related to police procedures which included:

- Changes to the policies relating to the publishing of Amber Alerts in relation to children in out-of-home care;
- Removal of the requirement to seek authority from the Chief Executive of the Department for a media release in relation to missing children;
- A cessation of the use of the word “abscond” in relation to children in out-of-home care which is replaced by “missing” or “absent from

placement";

- Missing children are now defined as persons under 18 years rather than persons under 16 years;

- New joint agency protocols and updates to police procedures include clearer processes outlining QPS contact with the department, biological parents, carers and service providers when a child is missing from out-of-home care;

- New procedures for school-based police officers;

- Updated reporting to the Coroner to include information as to whether a missing child is in out-of-home care;

- Training of key staff on the new procedures for Amber Alerts.

135. The Department of Education also provided details of the implementation of the recommendations of the QFSS which include:

- A process to notify parents if their child is absent from school as soon as practicable;

- Working on consistency for all policies and procedures for children living in out-of-home care, including processes for monitoring continuity of enrolment for children who move placements;

- DET have established the "Our Child" IT system which allows the QPS to access real time student personal information for students in out-of-home care who are reported missing.

136. In 2019 the QFCC published a report "When a Child is Missing: Post-Implementation Review" and found that the recommendations of the report had "*generally been implemented by the responsible agencies. In particular, the policy and procedural changes required by each recommendation were promptly dealt with.*"

Keeping Queensland’s Children More than Safe: Review of the Foster Care System: Blue Card and Foster Care Systems Review

137. Following the death of Tiahleigh, the QFCC reviewed the system of foster care in Queensland and identified systemic improvements for the safety of children.

138. The QFCC noted that the foster care system had been the focus of a number of previous reviews and was, at that time, one of the issues being considered by The Royal Commission into Institutional Responses to Child Sexual Abuse.

139. The QFCC found that Queensland’s foster care system generally operates as intended and in line with relevant legislation by assessing applicants to make sure they can provide safe and caring environments and they are suitable to be foster or kinship carers. However, the review identified opportunities to build stakeholder confidence, strengthen carer assessment and strengthen safeguards for children in care.

140. The QFCC made forty-two recommendations in relation to those three identified issues.

141. The department was directly responsible for the implementation of thirty-three of those recommendations. As at 1 June 2021 the department has completed thirty of these recommendations and one is superseded. Dr Meegan Crawford, the Chief Practitioner of the department has provided information that the completion of the recommendations has led to substantial change in the department’s practice including the establishment of the Continuous Quality Improvement Program and major changes to the carer assessment and approval process and carer training. Dr Crawford advises that the department continues to enhance and improve the foster and kinship carer assessment and training.

The Department's Response to the Departmental and QFCC Reviews

142. The department provided a comprehensive statement of the Chief Practitioner, Dr Meegan Crawford, setting out the department's implementation of the recommendations of the SPR review, the CDRCP review and the reviews conducted by the QFCC.

143. I am satisfied that all recommendations have been or continue to be addressed by the department.

Review of the Domestic and Family Violence Death Review Unit

144. The DFVDRU of the Coroners Court of Queensland reviewed the circumstances surrounding the killing of Tiahleigh and provided the following report:

> ***DCSYW SERVICE CONTACT***
>
> *The voluminous[1] amount of case notes in relation to Tiahleigh's child protection history and Department of Child Safety, Youth and Women (DCSYW) engagement with foster carers, has clearly demonstrated that Tiahleigh presented with challenging behaviours both at home and at school. The overall impression from the file material is that case management was appropriate for Tiahleigh in relation to her needs, and at times very thorough. Most case planning was planned and not reactive, with appropriate consideration given to the ability of Tiahleigh's various carers to manage her needs and also Tiahleigh's own views and wishes. Tiahleigh's mother, Ms Palmer was engaged with regularly and appropriately. Generally meaningful interagency collaboration was undertaken regularly with a focus on meeting Tiahleigh's complex needs.*

[1] Over 10,000 pages.

The only identified area of DCSYW practice in which improvements could clearly have been made were in two areas; being the timeliness of permanency planning, and foster care considerations.

Permanency Planning

In relation to permanency planning, DCSYW staff appear to have made soft decisions in relation to permanency planning, and overemphasised mother Ms Palmer's desire to reunify, rather than analysing what was in the best interests of Tiahleigh. Coupled with Ms Palmer's inability to consistently meet case planning requirements, proper consideration as to whether Long Term Orders should be sought for Tiahleigh did not occur. As a result, Tiahleigh was subject to three temporary (short term) child protection orders from January 2010 to the time of her death; it was only on 22 October 2015 some seven days prior to her death that an application had finally been made for Long Term Guardianship to the Chief Executive.

Perusal of the file notes indicates that in 2012, at the conclusion of the first Short Term Child Protection order, permanency planning should have been thoroughly considered for Tiahleigh. At this time Ms Palmer had not met case plan goals and despite efforts made by DCSYW Ms Palmer's visits were sporadic. Further, from June 2013 Structured Decision Making Tools indicated that the DCSYW should stop working towards reunification[2], however this was 'overridden' by DCSYW staff. It was not until October 2013 that Ms Palmer recommenced contact with Tiahleigh, and as such efforts were made to reunify, however by September 2015 Ms Palmer had finally decided that she no longer sought the care of Tiahleigh. Consequently in September 2015 the DCSYW made a decision to apply for Long

[2] The Family Risk Assessment (FRA) risk outcome for Tiahleigh was 'very high'; indicating that the DCSYW should stop working towards reunification and begin permanency planning.

Term Guardianship of Tiahleigh. In all, Tiahleigh spent five years on temporary (short term) child protection orders.

Whilst outside of the Terms of Reference for the DCSYW's Systems and Practice Review (SPR), the SPR did note the issue of inadequate permanency planning. In completing the SPR, reviewers were able to interview DCSYW and external staff to gain contextual information. During SPR review team discussions with the Fostering Agency, agency staff noted that permanency 'was a tricky issue'[3] as initially Ms Palmer wanted to reunify however then changed her mind. DCSYW workers who had engaged with the family outlined that there had been 'difficulties' regarding decision making for Tiahleigh's permanency as Ms Palmer successfully parented Tiahleigh's two other siblings[4]. The Team Leader discussed that while the DCSYW was 'heading towards a Long Term Guardianship order' for Tiahleigh, it was important that Ms Palmer was 'fully on board with the final decision'. Further, and of note, DCSYW notes indicate that the Evolve clinician assigned to this case 'strongly advocated for the reunification to proceed' as late as July 2015[5]. Other issues were identified with the foster carers who had care of Tiahleigh prior to the Thorburn's, who were also thought to have been 'undermining' the reunification process as they believed that they were best able to provide for Tiahleigh long term[6]. The Evolve clinician also stated to the review team that she shared Ms Palmer's uncertainty as to what was best for Tiahleigh. At any rate, the clear goals of providing for the care and needs of Tiahleigh appears to have been eclipsed by a

[3] DCSYW Detailed Systems and Practice Review Report; 27 April 2016.
[4] DCSYW Detailed Systems and Practice Review Report; 27 April 2016.
[5] However no reference to this could be found within the EVOLVE file notes.
[6] The EVOLVE clinician believed that these carers were '*unintentionally undermining the reunification process'*, and at some point this became '*like a custody battle'*. Tiahleigh was subsequently removed from these carers and placed with the Thorburn's. Issues in relation to time delays for Tiahleigh's removal from these carers and issues in relation to the Matter of Concern process has been adequately noted in the SPR and CDCRP.

variety of complex and competing concerns which has resulted in inadequate long term planning, in this case manifesting in several short term orders.

Prior to Tiahleigh's death, the DCSYW practice of consecutively applying for short term orders for a child occurred regularly, and was indicative of poor case management. For example, inadequate case planning may have led to insufficient evidence being available to provide to the courts to inform a Long Term Guardianship (LTG) application and as such DCSYW staff would therefore apply for a Short Term Order which requires less evidence, and less preparation, to successfully be granted. Whilst widely known that an LTG order should generally be sought at the conclusion of the first 2 year Short Term Child Protection Order if it remains unsafe to return home and there is little likelihood of it becoming safe to return home in the foreseeable future (in order to successfully offer a child permanency in their placement), no robust policy supported this practice.

Foster carer considerations

Motivation to care

Evident within the file notes, SPR and CDCRP review, Tiahleigh presented with many challenging behaviours. As such, the DCSYW had assessed Tiahleigh as having 'high and complex needs' and as such any foster carer for Tiahleigh would receive the 'complex support needs allowance' to help care for her[7]. For an example of the financial benefits of caring for a child assessed as 'complex needs', currently the universal base fortnightly carer allowance is $567.42 for a child aged 11 or older (less for young children). Including the allowances

[7] Complex Support Needs Allowance; Policy number CPD612-2, DCSYW.

provided to care for a 'complex needs' child[8], total payments for a complex child range from $958.44 to $1399.72 per fortnight, and this excludes any further incidental payments required[9] to support the complex placement such as all clothing (including school uniforms), all recreation and leisure activities costs, transportation costs and indirect costs such as laundry, bedding, household cleaning and meal preparation costs (which are all reimbursed to the carer by the DCSYW).

The agency supporting the foster carer assessment and placement process for the Thorburn's was 'Key Assets Fostering' which is a non-government, not-for-profit children's services agency that provides support for foster carers, children and young people in care. During the initial foster carer assessment application process[10] Key Assets Fostering, Mr and Mrs Thorburn raised very specific concerns in relation to finances.

Mr and Mrs Thorburn both outlined to assessors that they had a 'history of struggling financially' and Ms Thorburn stated that financial concerns was one of the only areas that have been any source of major concern for the Thorburn's as a couple. The Key Assets assessor went on to note[11] that 'Key Assets Social Worker staff will need to be mindful of (the financial limitation of the couple) with regards to targeted support provided' however the meaning behind this statement is unclear. In itself financial concerns should not and would not raise suspicion in relation to motivation to provide foster care. However, viewed in the context of carers who, without adequate reasoning, outlined they

[8] The Complex Support Needs Allowance is paid in addition to both the Fortnightly Caring Allowance and the High Support Needs Allowance.
[9] For Tiahleigh, carers were often paid to replace soiled bedding, mattresses, clothing, etc.
[10] As outlined in Form 3A Foster Carer Applicant Assessment and Recommendation Form Initial Approval Only; dated 14 July 2014.
[11] In the Financial Supports/Stability section within Form 3A Foster Carer Applicant Assessment and Recommendation Form Initial Approval Only; dated 14 July 2014.

only wished to care for children with high or complex needs, it would have been expected that this motivation be fully investigated by the foster carer agency.

Ability to care

As has been previously identified, the initial Foster Carer Agreement[12] noted that '(Mr and Ms Thorburn) both feel that they have the capacity to care for child/children displaying a range of high to complex needs'. Mr and Ms Thorburn had expressed to Key Assets Fostering staff that they wished to care for any child with high or complex needs, and this included children with highly sexualised behaviours, however explanation for this desire was at no time provided by the Thorburn's or requested by the agency. Key Assets Fostering staff did note that Ms Thorburn changed her placement matching during the assessment, no longer wishing to care for girls with sexualised behaviours. This was reportedly based on conversations during training modules completed by Key Assets staff regarding the difficulties of parenting teenage girls with highly sexualised behaviour in a household with teenage boys[13]. Key Assets Fostering staff noted that this change 'indicates that Ms Thorburn had thought about what we had discussed and chose to take a conservative course of action when it came to considering this type of placement'[14]. No further consideration of the carer's capacity to care for children with high needs was documented.

Despite a lack of evidence located within the file notes, Key Assets Fostering staff assessed that Mr and Mrs Thorburn had 'demonstrated an ability to identify the personal experiences

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[12] Key Assets Fostering; dated 16 July 2014.

[13] Both boys had appropriately sought Blue Cards as part of the assessment process and when turned 18 were appropriate included in the assessment as 'another adult household member'.

[14] Key Assets Fostering Assessment; Rick and Julene Thorburn.

which have shaped who they are as adults and reflect on how these will be relevant in the care they are able to provide a child with complex needs'[15]. However, it is unclear whether the Thorburn's fully realised the challenges associated with caring for high and complex needs children. For example, Mr and Mrs Thorburn stated that the best way they could manage the stresses of dealing with a child with complex needs and high needs is to 'talk about them openly with each other, to take some time out of the house…and to seek external help in needed. They were quick to advise that they would not hesitate in seeking support from KAF if they needed it'[16].

This statement appears naïve when in consideration of the multitude of challenges that exist in caring for children with complex needs, especially in consideration of the absence of any experience in caring for children with average needs. This naivety was also evident in Ms Thorburn's prior willingness to care for sexualised girls in her family home without having considered the complexities that such a placement would have brought with it; and in consideration that her understanding in relation to such a placement was only identified during foster carer training it must be considered that the family were not prepared. Further, Key Assets Fostering staff noted that 'the level of care and attention that Joshua and Trent (the Thorburn's two sons) have been given by both of their parents is indicative of the level of care that Mr and Ms Thorburn would be able to give a child', however no consideration was given to the fact that neither of Mr and Mrs Thorburn's children presented as high or complex needs, and the family had a distinct lack of experience with high or complex needs children, or any child in the care of the DCSYW. The Thorburn's were ultimately recommended as

[15] Key Assets Fostering Assessment; Rick and Julene Thorburn.
[16] Form 3A Foster Carer Applicant Assessment and Recommendation Form; Initial Approval Only.

being able to meet the standards of care[17] of a high or complex need child.

Approximately 12 months after having been approved as foster carers, and following Tiahleigh's placement with the Thorburns[18], the Thorburn's began exploring the possibility of starting a home day care service from their home[19]. Key Assets Fostering staff were supportive of this however did note[20] that 'consideration also needed to be given to the couple's ability to continue to meet Key Assets expectation regarding time available to provide the required level of care' in the context of attending stakeholder meetings, team meetings and to still 'meet the demands of reunification'[21].

Despite this concern, in emails[22] between DCSYW staff and Key Assets Fostering, the focus of emails appeared to be switching the 'primary carer' status of Ms Thorburn to Mr Thorburn, and this appears to be in an attempt to allow an increased number of children[23] to be cared for in the family home. Notably, one Key Assets Fostering worker sent an email to the DCSYW Child Safety Officer (CSO) outlining that the Thorburn's need the income from the family daycare to 'support their household'. Further, the Key Assets Fostering staff wrote 'Rick and Julene…require additional employment to support their household. The carer allowances they receive are spent entirely

[17] Statement of standards, section 122, *Child Protection Act 1999*. The statement of standards provides sets an expectation of quality care for children in care, and forms a basis for assessing whether a care environment is suitable. The application of the standards to the child's care must take into account what is reasonable having regard to the length of time the child is in the care of the carer or care service, and the child's age and development.
[18] In July 2015.
[19] This was documented in the Thorburn's 12 month Foster Carer Applicant Assessment and Recommendation Form; Renewal of Approval Only dated 24 September 2015.
[20] In the Foster Carer Applicant Assessment and Recommendation Form; Renewal of Approval Only dated 24 September 2015.
[21] In the Foster Carer Applicant Assessment and Recommendation Form; Renewal of Approval Only dated 24 September 2015.
[22] Various dates within July 2015.
[23] Unclear whether this refers to daycare children or DCSYW children.

on Tia'. Therefore, whilst concern was initially raised about the Thorburn's capacity to care, this appeared overshadowed by the seemingly pressing financial needs of the Thorburn's. As such, it does not appear that issues of capacity to continue to support Tiahleigh in the context of establishing a family day care centre, were fully explored by either Key Assets or the DCSYW.

Foster carer shortage

Prior to the Thorburn's carer assessment having been finalised (and prior to the Thorburn's having been assessed as suitable to care), a Senior Service Support Officer from the Placement Services Unit of the DCSYW sent an internal email to members of Logan Child Safety Service Centre, Foster Care Queensland, and two independent panel members outlining that 'an urgent placement is required to push through the Thorburn application for a child in care'[24]. This was in relation to another child, '"A"', who had been placed with the Thorburn's prior to Tiahleigh. Further information within the email outlined that '[the DCSYW Regional Director] has asked for this assessment to be progressed sooner'[25].

'"A"' was described[26] as a 'young girl with developmental needs who is currently residing in a highly unsuitable residential facility', had been residing in 'transitional' placements since June 2014, and 'as such it was identified (by Key Assets) that the Thorburns would be suitable'. "A" was aged 16 and had 'extremely limited functioning', her reported level of functioning was between 2 and 4 years old and Education Queensland reported her functional IQ to be 43. Whilst "A" had not exhibited 'overt' sexual behaviours at school, it was noted that 'some of

[24] Email dated 1 August 2014; the previous day, on 31 July 2014, the Thorburn's application had been forwarded on to be quality assured at the next foster carer panel.
[25] Email dated 1 August 2014.
[26] The current review did not have access to "A"'s file. "A"'s description was only made available via email correspondence via DCSYW and Foster Care Queensland staff.

her comments would indicate her being a victim of abuse'[27]. "A" had been subsequently been assessed as 'Complex Needs Level 1'[28].

The DCSYW Placement Services Unit outlined that they did not support "A" being placed with the Thorburns prior to the Thorburns foster carer approval[29], and as such "A" was placed in a residential facility awaiting the Thorburn's approval[30]. An 'out of session' telelink was set up by the DCSYW and Foster Care Queensland. Mr and Mrs Thorburn were subsequently approved as foster carers by the DCSYW Foster Carer Panel on 7 August 2014, at which point "A" transitioned to their care.

The circumstances of "A"'s placement with the Thorburns highlights the pressures DCSYW are under to locate quality placements. "A"'s placement appeared rushed and emails suggest that the DCSYW and Key Assets had already made the decision to place "A" with the Thorburns prior to the approval process having taken place. Further, emails suggest that the Regional Director of the CSSC was also placing emphasis on 'progressing the application' which suggests that there was strong support for the carers to be approved. Further, there was indication that "A" had been a victim of sexual abuse and was potentially sexually active, in which case considering Mr and Ms Thorburn's consideration that they did not want children with sexualised behaviours placed with them, it would have been pertinent to note that whilst not overtly sexualised, "A" may not have been an appropriate placement.

It is well known that the DCSYW faces problems with recruiting

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[27] This was also noted by Key Assets fostering, with information provided by the CSO that "A" had stated 'sex hurts'.
[28] This rating indicates that carers would be paid a high and complex needs allowance to care for "A".
[29] Suggesting that at some point another service provider, or CSSC staff, may have suggested this occur.
[30] Email 19 August 2014.

and retaining foster and kinship carers, in an environment where there are large numbers of children with complex and extreme needs[31]. As such, there is often a heightened mismatch between foster carers and children due to the reduced pool of foster carers to draw on[32]. As is outlined in the 2013 Queensland Child Protection Commission of Inquiry, this is an extremely complex topic, with arguments including the proposed introduction of 'professional carers'[33] to the use of boarding schools to offer children in the care of DCSYW with stability not otherwise able to be offered[34].

Following the Inquiry, the Queensland Government considered the merits and impacts of each recommendation and released its response to the report in December 2013[35]. The Queensland Government accepted 115 of the Commission's recommendations in full and the remaining 6 recommendations in-principle. The Queensland Government committed $406 million in funding over the 5 years from 2014-15 to 2018-19 to implement the Commission of Inquiry child protection reforms.

In 2017, the Queensland Family and Child Commission finalised the 'Keeping Queensland's children more than safe: Review of the foster care system, Blue Card and Foster Care Systems Review' specifically in response to Tiahleigh's case. As part of

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[31] Queensland Child Protection Commission of Inquiry (2013) *Taking Responsibility: A Roadmap for Queensland Child Protection;* State of Queensland.

[32] Queensland Child Protection Commission of Inquiry (2013) Taking Responsibility: A Roadmap for Queensland Child Protection; State of Queensland.

[33] For example, those that are paid wages to care for children. A recommendation (8.10) from the Queensland Child Protection Commission of Inquiry (2013) Taking Responsibility: A Roadmap for Queensland Child Protection; State of Queensland, that the DCSYW investigate the feasibility of engaging professional carers to care for children with complex or extreme needs, in terms of, for example, remuneration arrangements and other carer entitlements, contracting/employment arrangements, and workplace health and safety considerations.

[34] Some councils in the United Kingdom utilise this approach. As of 2012, DCSYW was paying for five Queensland children in care to attend and live in boarding schools. As outlined in Queensland Child Protection Commission of Inquiry (2013) Taking Responsibility: A Roadmap for Queensland Child Protection; State of Queensland.

[35] Queensland Government response to the Queensland Child Protection Commission of Inquiry final report.

its inquiry, the Royal Commission researched aspects such as recruiting, assessing and training carers. Many recommendations were made that addressed issues prominent in Tiahleigh's case, such as to ensure that carers are equipped with the skills to manage complex behaviour and trauma[36], and a revision of carer training to ensure that there is increased support and supervision for new carers[37]. Of note however, no specific recommendations were made to increase foster carer recruitment.

In response to the QFCC report, also in 2017 the Premier and Minister for the Arts, The Honourable Annastacia Palaszczuk responded that 'the 2017-18 Budget will invest $1.37 billion to keep children safe and support vulnerable Queenslanders'.

145. I agree with the conclusions of the DVDRU which has once again been an invaluable resource to the CCQ.

The Inquest

146. The inquest commenced on 8 June 2021 after a pre-inquest hearing on 11 May 2021. The only issue to be explored at the inquest was how Tiahleigh died. Four witnesses were called. All witnesses were legally represented. None of the parties submitted that further witnesses were required or that other issues should be considered.

147. A brief of evidence was tendered which included the complete Queensland Police Service brief in relation to the murder charge against Mr Thorburn, the evidence in relation to the incest and perjury charges against Trent, Joshua and Mrs Thorburn and the brief in relation to the child sexual offending to which Mr Thorburn pleaded

[36] Recommendation 29; Keeping Queensland's children more than safe: Review of the foster care system; Blue Care and Foster Care Systems Review (2017) Queensland Family and Child Commission.
[37] Recommendation 32; Keeping Queensland's children more than safe: Review of the foster care system; Blue Care and Foster Care Systems Review (2017) Queensland Family and Child Commission.

guilty.

148. The brief also included records obtained from Queensland Corrective Services in relation to Mr Thorburn since his incarceration and recordings of phone calls he made to Ms Thorburn from the prison for the periods 1 to 15 October 2019 and 2 May 2021 to 1 June 2021.

Richard Thorburn

149. Mr Thorburn commenced his evidence by producing a typed signed statement which he said he wanted to read to the court. He then read aloud the document which I now recount in full:

> 1. *There has been much speculation about the cause of Tiah's death. I was never given the opportunity in court to give an account of what has happened.*
> 2. *On the night Tiah died, we got into an argument.*
> 3. *She was messing about and wouldn't go to bed.*
> 4. *She was being stubborn and it escalated to her running away again.*
> 5. *She packed her bag and started off down the driveway.*
> 6. *I tried to talk her around and get her to come back to the house and told her that she was being silly.*
> 7. *I followed her down the driveway to the front gate which was around 200 metres and I decided I will bring her back to the house.*
> 8. *I put my arm around her from behind and tried to walk her back, but she started struggling and I had to hold her tighter.*
> 9. *She started screaming at me and was swearing.*
> 10. *I told her to stop because our neighbour is close to our driveway, and it was very late.*
> 11. *She got worse so I put my hand over her mouth and kept going.*
> 12. *When we got to the veranda, I let her go and she fell to the ground.*

13. *I picked her up and put her on the seat and she fell to the side again.*
14. *She didn't respond to me when I spoke to her.*
15. *Her eyes were closed, and I didn't think she was breathing.*
16. *I must have accidentally suffocated her with my hand over her mouth and holding her so tightly around the waist and tummy.*
17. *I can't think what happened after this. I don't know if I tried to resuscitate her.*
18. *I know that I am responsible for Tiah's death, and it is something I struggle to live with.*
19. *Sorry could never take any everyone's pain but I am truly very sorry.*

150. Under questioning from Counsel Assisting Mr Thorburn said that he could not recall what the argument was about. He said he wrote the statement about four years ago when he was in prison. At that time he was seeing a psychologist and she said he should write it down. He said the only addition to the notes he wrote at that time was the first sentence of the typed document. He said that he read his document to his solicitor in the morning before he gave evidence and his solicitor had it typed. When asked to produce his original document he said that he had thrown it away that morning.

151. Mr Thorburn said he in fact had no independent recollection of what happened to Tiahleigh and he was relying on the note he had apparently written some years before as he had completely lost his memory in prison. He said he found that note about a month ago.

152. Mr Thorburn was played the recording of the phone call he had with his wife on 1 June 2021 where he (RT) and Mrs Thorburn (JT) spoke about the fact that the media would be in court for the inquest. The following is a transcript of the relevant parts of that conversation:

RT: *When we go into the court room If they want anything out of me they can tell a heap of people to fuck off otherwise*

they'll get nothing - I will go to my grave with what I've got. If the Coroners Court don't like that well that's their fucking problem not mine

JT: *we would all talk a lot happier and as ourselves without them there but everything we say and do they are going to twist to put in the news – and that's what makes it very restrictive – so it makes us very reserved to speak at all.*

RT: *That's what I say – just say the words, "I can't recall" and what have they got then? Fuck all. Just leave it up to me to say everything. I can say and do what I want but you, you can't, you know.*

JT: That's it – we've got to live our lives out here without them hassling us or without discrimination from anybody and everybody and anything we say and do they are going to twist and make us look disgusting aren't they.

RT: That's right – that's what the fuckwits do.

153. It was suggested to Mr Thorburn that this conversation was inconsistent with his alleged loss of memory and in fact consistent with a deliberate lack of cooperation but he did not accept that suggestion.

154. Counsel Assisting suggested to Mr Thorburn that he had a predilection for sexual offending against young girls. He said that he could not recall ever doing that, although he could not deny that he had, but he didn't know why he would as he had no sexual feeling at all. When Mr Thorburn was asked whether he may have sexually interfered with Tiahleigh he became irate and abusive.

155. He then became even more uncooperative and continued to deny that he had any recollection of killing Tiahleigh, any of the circumstances surrounding her death or the sexual offences against the children in his wife's day care to which he pleaded guilty.

Julene Thorburn

156. Ms Thorburn gave evidence that Mr Thorburn had never told her the details of Tiahleigh's death – only that he had "taken care of it".

157. He also told her, "What you aren't told you can't repeat."

158. She said that Mr Thorburn told her that he wrote the document about Tiahleigh's death before his memory loss but after that he'd had dreams in which he was chasing Tiahleigh and holding his hand over her mouth.

159. Ms Thorburn said that Mr Thorburn and Tiahleigh were often alone together, especially after she started the home day care business.

160. She said that about three months before Tiahleigh was killed Tiahleigh told her that she had a secret but if she told anyone that secret she would be removed from the Thorburn family.

161. Ms Thorburn said that Mr Thorburn never specifically said that he killed Tiahleigh to protect Trent. He said he was concerned that Trent could go to prison but never said that was the reason he killed Tiahleigh.

Joshua Thorburn

162. Joshua gave evidence that Mr Thorburn told him that he killed Tiahleigh because Trent had had sex with her and he was worried that Trent would go to prison. He said that Mr Thorburn never told him how he killed Tiahleigh or the circumstances of the disposal of her body.

Trent Thorburn

163. Trent said that Mr Thorburn never said to him that he killed Tiahleigh to protect Trent but Trent believes that was his reason.

164. Tiahleigh didn't disclose any previous sexual relationships to Trent. He believed she may have had boyfriends at school such as would be usual for a twelve-year-old child.

Detective Senior Sergeant Chris Knight

165. DSS Knight was the officer in charge of the investigation into the death of Tiahleigh.

166. DSS Knight said that his knowledge of the evidence and his continuing involvement in the case since the day Tiahleigh went missing lead him to draw the following conclusions:
    - Tiahleigh was killed by Richard Thorburn when they were home together on the night of 29 October 2015;
    - Richard Thorburn stored her body in the back shed;
    - Her body was still in his shed when he reported her missing to police on 30 October 2019;
    - He moved her body on the evening of 30 October 2019.

167. DSS Knight does not accept that Richard Thorburn's account as given in court that morning is true due to the following:
    - Julene told police that she had put Tiahleigh to bed before she left to go to her sister's house;
    - Tiahleigh had never run away from the Thorburns or any other foster home - the only time she had been missing previously she had gone to a friend's house after school;

- Police never found Tiahleigh’s school uniform or her school bag so that is inconsistent with Mr Thorburn’s account that she packed a bag to run away with;
- Richard Thorburn knew what had happened between Trent and Tiahleigh and Julene said that he told her that had “fixed it” which is inconsistent with his version of an accidental killing;
- There was never any evidence obtained of Tiahleigh being outside the house and screaming or yelling that night;

168. DSS Knight said that it is his belief that it is most likely that Tiahleigh did not die from any injury or injuries which caused her to bleed in any significant manner.

169. DSS Knight said that one of the hindrances to the police investigation into Tiahleigh’s death was the fact that QPS was forced to execute search warrants on the department to obtain relevant information.

Findings and Conclusions

The scope of the Coroner’s inquiry and findings

170. An inquest is not a trial between opposing parties but an inquiry into a death. The scope of an inquest goes beyond merely establishing the medical cause of death.

171. The focus is on discovering what happened; not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred and, in appropriate cases, with a view to reducing the likelihood of similar deaths.

172. As a result, a coroner can make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future. A

coroner must not include in the findings or any comments or recommendations, statements that a person is or may be guilty of an offence or is or may be civilly liable.

173. Proceedings in a coroner's court are not bound by the rules of evidence. That does not mean that any and every piece of information however unreliable will be admitted into evidence and acted upon. However, it does give a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its origin or source when determining what weight should be given to the information.

174. A coroner should apply the civil standard of proof, namely the balance of probabilities. However, the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, then the clearer and more persuasive the evidence needs to be for a coroner to be sufficiently satisfied it has been proven.

175. If, from information obtained at an inquest or during the investigation, a coroner reasonably suspects a person has committed an offence, the coroner must give the information to the Director of Public Prosecutions in the case of an indictable offence and, in the case of any other offence, the relevant department. A coroner may also refer a matter to the Criminal Misconduct Commission or a relevant disciplinary body.

Submissions

176. I have considered the submissions of Counsel Assisting and the parties and discuss them further, below.

Findings of Fact

Departmental Involvement

177. I find that there was a lack of permanency planning for Tiahleigh. At no time in her short life had she experienced any real stability. Rather than the focus being on Tiahleigh's best interests, the department focussed on her mother. Tiahleigh's psychologist (the Evolve clinician) believed it was her role to support Tiahleigh's mother. It is unclear who took on the role of supporting Tiahleigh.

178. In summary, the case planning for Tiahleigh was, insignificant aspects, not focused on what was in Tiahleigh's best interests and Tiahleigh's right to have stability and permanency, but instead, on supporting her mother and ensuring that her mother's interests and "rights" were considered.

179. Perhaps the most concerning aspect of the department's involvement with Tiahleigh was the lack of concern or action when it was known that she was missing from about lunch time on 29 October 2015. The Senior Team Leader went home that afternoon without advising anyone that Tiahleigh was missing. She didn't make any effort to find out whether she had been found over the weekend. When she arrived at work on Monday and found Tiahleigh was still missing she "felt uneasy".

180. It is inconceivable that the disappearance of any little girl, who was not in care, would be treated in such a dismissive manner. Although this lack of concern was attempted to be explained by Tiahleigh's habit of absconding this was not borne out by the facts. She was not a child who absconded or ran away. She had on occasion gone to a friend's house after school without advising anyone but had never stayed away overnight and was said to be scared of the dark.

181. It is also of significant concern that it took the department some five days to decide who could release a photo of Tiahleigh to the police for

publication. Further, when the responsible child safety officers were asked to attend the city office to sort the matter out they complained that they felt uncomfortable about having to do so.

182. The circumstances seem to indicate a failure to prioritise the danger that Tiahleigh may have been in and instead concentrate on administrative procedures (although not as a matter of any urgency).

183. However, I note that the departmental involvement with Tiahleigh has been the subject of numerous review and reports and that the many recommendations made have been addressed and implemented – by the department and other involved agencies. I therefore make no recommendations in relation to this aspect of the coronial investigation.

184. In relation to DSS Knight's concerns about the inability of QPS to obtain information from the department without search warrants, I note that this concern was raised in the inquest into the death of Mason Lee and that aspect of information sharing has been addressed by the department. It has been further addressed following Tiahleigh's death both by legislative amendments and new policies and procedures.

The Killing of Tiahleigh

185. I find that Trent was having a sexual relationship with Tiahleigh at the time of her death.

186. I do not accept that Richard Thorburn has no memory of the incident. His claimed amnesia is inconsistent with opinions of prison psychologists, observations of prison employees (e.g. that he was able to recall how to make phone calls using the Arunta system when he claimed total and complete memory loss) and phone calls between him and his wife that are evidence in this inquest.

187. His statements in the phone call of 1 June 2021 are clearly inconsistent with memory loss. Rather, they are evidence of his intention to mislead the inquest and take "to his grave" the circumstances of Tiahleigh's death and his disposal of her body.

188. I do not accept that Richard Thorburn accidentally killed Tiahleigh. I find that he did so deliberately.

189. Taking into account the lack of injuries to Tiahleigh's body evident at autopsy and the lack of any evidence of blood at the house I find that it is most likely that Richard Thorburn choked or asphyxiated Tiahleigh thereby causing her death.

190. Richard Thorburn may have killed Tiahleigh because he was concerned that she would disclose her relationship with Trent, however, in considering that possibility, I note that it was in fact very unlikely that she was pregnant and Trent had already disclosed it to his cousin on Facebook.

191. Another possibility is that Richard Thorburn was himself having a sexual relationship with Tiahleigh and, when he found out that she had disclosed sexual activity with Trent, was concerned that his own behaviour with her would be revealed. In considering this possibility I note that Richard Thorburn had a predilection for young girls. He pleaded guilty to sexual offending against a four-year-old and an eleven-year-old who were in his wife's care at the same time Tiahleigh was living at his house. He had access to Tiahleigh – his family all gave evidence that he and Tiahleigh would have been alone together. Tiahleigh told Julene Thorburn that she had a secret some three months before her death and also said that if anybody knew about the secret she would be removed from their care. I also take into account that Tiahleigh was found clad only in a pair of torn underpants and Mr Thorburn, being the only person apparently who could explain why that was and what happened to her clothes, refused to do so.

192. Whilst Mr Thorburn's barrister conceded that it was a possibility that Mr Thorburn had been sexually offending against Tiahleigh, I accept his submission that the circumstantial evidence is insufficient to allow me to draw that conclusion. The most probable reason that Mr Thorburn killed Tiahleigh was the reason that he gave to his family – he killed her to cover up the fact that Trent had been abusing her and in an effort to protect Trent from being convicted of incest and imprisoned.

193. I find that Mr Thorburn is completely without remorse for any of his offending. In fact, when one listens to the phone discussions between him and his wife, it is clear that he perceives himself as being unfairly dealt with and victimised by the media and public opinion, as does Ms Thorburn.

Comments and recommendations

194. Noting the numerous reviews that have been conducted in relation to the involvement of government agencies with Tiahleigh, the recommendations arising out of those reviews and the implementation of those recommendations by the government agencies, I make no recommendations in relation to that matter.

195. I respectfully recommend that if and when Richard Thorburn applies for release on parole the Parole Board Queensland take into account these findings particularly in relation to Mr Thorburn's lack of remorse for killing Tiahleigh and his lack of cooperation with this inquest.

Findings required by s. 45

Identity of the deceased – Tiahleigh Alyssa-Rose Palmer

How she died – Richard Thorburn deliberately killed Tiahleigh. It is most likely that he asphyxiated or choked her and thereby caused her death.

Place of death – 85 – 89 Flesser Road, CHAMBERS FLAT, QLD, 4133

Date of death– 29 October 2015

Cause of death – Undetermined

I close the inquest.

Jane Bentley

Deputy State Coroner

SOUTHPORT