QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION:	**Non-inquest findings into the death of CJ, a 14 year old boy**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
DATE:	17/06/2022
FILE NO(s):	2018/5530
FINDINGS OF:	Ainslie Kirkegaard, Acting Brisbane Coroner
CATCHWORDS:	CORONERS: youth suicide; death in care (child protection); domestic & family violence; child protection intervention; trauma-informed child protection practice; Queensland child safety system reform

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Background

1. CJ was a 14 year old boy who was found deceased at his foster carers' home on 10 December 2018.

2. His death was reported to the coroner because he died in circumstances indicating he intentionally took his own life.

3. At the time of his death, CJ was the subject of a long term guardianship order made under the *Child Protection Act 1999* on 4 September 2018 and was in the care of the chief executive of the former Department of Child Safety, Youth and Women. He had been placed with approved foster carers and their family, who lived locally. As such, CJ's death is also reportable as a death in care under section 9(1)(d)(i) of the *Coroners Act 2003*.

4. CJ was in grade 8 at a rural high school. He was described as a smart young man, a 'scallywag', always full of life and having a great sense of humour. His school attendance was significantly impacted by frequent and lengthy suspensions. Despite his lengthy behaviour record, many school staff had a special appreciation for CJ and his sense of humour and larrikin nature. The school principal described CJ as having a strong moral compass, often playing the role of policeman when attempting to stand up for his friends or something he believed in. While he did not always go about this in the right way, school staff appreciated CJ would engage in conversations to understand his behaviour and would mostly accept the consequences.

Family involvement with Child Safety Services

5. CJ was his parents' third child and younger brother to an 18 year old boy and a 16 year old girl, and a half-brother to an 11 year old boy who was born to his mother from another relationship. CJ's mother was 23 years old when he was born. CJ had a close relationship with his sister and got along well with his older brother. His half-brother had diagnoses of Reactive Attachment Disorder, Post-Traumatic Stress Disorder, Conduct Disorder and Attention Deficit Hyperactive Disorder.

6. CJ's parents had been in a defacto relationship. Their relationship was characterised by domestic and family violence including coercive control. His mother described his father as very controlling, never allowing her to take the children anywhere without him.

7. The couple separated in 2004, before CJ was eight months old and while his mother was still breastfeeding. It appears CJ remained with her for a short time before living with his father and his two older siblings. His mother says his father took CJ and his siblings from her without her permission and would only let her see the children 'on his terms.' For example, she alleged he would coerce her into having sex with him so that she could spend time with her children.

8. CJ had extensive involvement with the Department over the course of his life dating back to when he was a few months old. All four children were subject to numerous child safety notifications, investigations and interventions since their early years. The family had interactions with child safety services from 2004 up to CJ's death in 2018, other than in 2007 and 2008. The multiple notifications and investigations primarily focussed on CJ's mother's capacity to care for her children.

9. Between December 2005 (when CJ was 14 months old) and his death in December 2018, CJ was recorded as the subject child in five Notifications and sixteen Child Concern Reports to Child Safety Services.

10. In total, Child Safety Services received eighteen reports of child harm to CJ and his siblings before formal intervention with the family occurred in 2016, two years before CJ died.

11. The most significant concerns related to:

    (a) Both parents' use of violence toward CJ and his siblings, which included reports of physical, verbal and emotional abuse. In relation to the father's use of violence, these concerns were significant and appear to span approximately 14 years between 2004 and March 2018 and included allegations that the father:
        (i) non-lethally strangled CJ;
        (ii) dragged CJ by the hair and threatened him with a knife;
        (iii) force-fed CJ and flushed his head down the toilet;
        (iv) exposed CJ and his siblings to domestic and family violence perpetrated toward their stepmother; and
        (v) sexually abused CJ and his sister.

    (b) Multiple reports that CJ perpetrated physical and sexual abuse and/or inappropriate sexual conduct toward other family members and peers. These concerns included:
        (i) CJ exhibiting sexually inappropriate behaviours toward his sister and his mother;
        (ii) CJ non-lethally strangling his sister and his half-brother;
        (iii) CJ allegedly raping his half-brother in February 2017**.** This was reported to police and investigated, but it appears there was insufficient evidence to proceed with charges; and
        (iv) CJ exhibiting sexually inappropriate and aggressive behaviour toward other students at school where CJ was enrolled from July 2017 up until his death.

    (c) CJ's mother's unspecified mental health issues, harmful alcohol and illicit substance use and experiences of childhood trauma (including childhood sexual abuse) which were said to affect her capacity to care for CJ and his siblings; and

    (d) CJ's mother attempting to relinquish care of him on multiple occasions in the two years preceding his death. She had difficulty managing CJ's behaviours which included ongoing self-harm/suicidal ideation and alleged verbal, physical and sexual abuse toward other family members. The main concern with CJ in her care was a perceived pattern of his mother scapegoating him and then relinquishing care of CJ when she was unable to manage his behaviours.

12. It is evident CJ experienced significant cumulative trauma throughout his life, including exposure to domestic and violence and alleged experiences of child abuse and child sexual abuse.

13. His mother says she felt undermined by Child Safety Services when she tried to set limits, for example not smoking at her house, but child safety officers were telling CJ he could smoke out the back.

14. Child safety records document CJ's father as highly controlling, withholding the children after the couple separated, preventing the mother from having access to the children and subjecting her and the children to lengthy family court proceedings.

15. In June 2006 the mother removed the children from the father and stayed with them at a refuge. It is not known when the children returned to live with the father, but they were in his full-time care in July 2008.

16. CJ's father remarried in 2010, after which he says noticed a change in his relationship with CJ.

17. CJ spent most of his early childhood in his father's care, while his mother pursued residency of CJ and his siblings through the family court system. It appears that CJ was formally placed

with his father in 2012, by order of the Federal Court Circuit of Australia. The order allowed the children to visit their mother every second weekend.

18. Between 2011 and 2016, the three children were in their father's primary care and having weekend contact with their mother and half-brother.

19. In January 2012, the children went to stay with their mother for a period of time after their stepmother called her asking her to collect the children because their father had been violent towards her. CJ's father and his second wife separated at around this time. His violence towards his second wife included pushing, strangling, pulling her out of a car by her hair and ramming her car.

20. In March 2013 concerns were raised in relation to CJ's challenging behaviours including throwing tantrums, swearing at people, sexualised behaviours and choking himself.

21. In September 2016, CJ and his sister returned to live with their mother reporting they were scared of their father, who beat CJ 'frequently.'

22. On 26 February 2017, CJ's mother confronted him about his half-brother's disclosures of sexually inappropriate behaviour between the boys. CJ became aggressive, denied the allegations and grabbed a knife and locked himself in the bathroom. After this he returned to live with his father, and his half-brother went to live with his aunt.

23. In mid-2017, CJ reportedly disclosed years of physical abuse by his father. CJ's sister told her mother one of her father's friends had touched her inappropriately and she refused to return to live with her father.

24. CJ's mother subsequently sought and was granted a five-year domestic and family violence protection order against CJ's father on 7 June 2017. The order also named all the children as protected persons. The protection order specifically prohibited CJ's father from having any contact with CJ, his sister and his half-brother except with prior written permission from CJ's mother. CJ's father took CJ to his mother's and made no plans to resume care for him.

25. CJ tried to hang himself that day.

26. CJ did not want to return to his father's care.

27. CJ enrolled in Year 7 at the local high school in July 2017. He had previously been enrolled in Year 7 at two other high schools that year. He had attended four different primary schools from Prep in 2010 to Year 6 in 2016.

28. On 6 November 2017, the school made a child protection notification in relation to sexual abuse towards CJ by his father and sexualised behaviour by CJ towards other family members.

29. As at November 2017, CJ's mother was having difficulty coping with CJ and his half-brother's sexualised behaviours. A safety plan was developed under which CJ went to stay with his aunt and her partner. CJ did not exhibit any sexualised behaviours while staying with his aunt. CJ's half-brother entered a residential placement in mid-November 2017.

30. CJ's mother felt he was influenced in his behaviour by his father. She recalled an incident in 2017 when CJ chased her around the house with a knife. She said he would exert control over her, patting her down at night-time to find her smokes. He would never sleep at night, only during the day.

31. After the knife incident CJ's mother told CJ to get out and she would not tolerate that behaviour at her home. She spoke with Child Safety Services asking for help with CJ's half-brother and

CJ. She felt the Department was trying to keep the boys at home and provide assistance. She said the difficulty was her inability to supervise CJ between midnight and 4:00am when he was awake, but she was asleep.

32. After an episode of deliberate self-harm in December 2017, CJ left his aunt's house and returned to live with his father.

33. After some time, CJ left his father's care and returned to his mother. She told Child Safety Services she could not cope and was unable to manage his behaviours and keep him safe. Despite this he remained living with her while his aunt checked in with the family daily.

34. On 5 January 2018, CJ's mother told Child Safety Services she wanted CJ to go and stay somewhere else and would agree to a Child Protection Assessment Care Agreement. CJ's father would not agree to CJ entering care, stating his preference for CJ to return to his care. On 9 January, CJ's father phoned Child Safety Services telling them CJ said he wanted to remain living with his mother, so he didn't pick him up.

35. On 28 January 2018, Child Safety Services assessed CJ, his sister and his half-brother as children in need of protection from emotional abuse by their mother. The assessment noted CJ was exhibiting behaviours consistent with emotional abuse and emotional instability, engaging in ongoing self-harming and risk-taking behaviours and was considered to have experienced significant emotional harm as a result of CJ's mother regularly using blaming language and speaking about and to CJ in a negative and derogatory way. There was ongoing concern about his exposure to his mother's poor mental health. CJ's mother reported CJ was verbally and physically abusive towards her and she had no control over his behaviour. His mother was assessed as having limited understanding and knowledge in relation to appropriate and positive parenting strategies to respond to the children's behaviours. It was felt a child protection order was not necessary at that time and that intensive in-home support by way of an intervention with parental agreement would meet CJ and his sister's care and protection needs while they remained with their mother.

36. In February 2018. CJ returned to live with his father despite CJ having earlier disclosed he did not want to go to his father's '*because there was DV there'* and because his father *'bashed'* him the last time he lived there. CJ further stated he did not feel safe at his father's. It appears CJ's mother had '*kicked him out*" on 12 February and his father took him in on 20 February and he remained in his father's full-time care. Child Safety Services assessed CJ's father as a willing and able parent, concluding there were no current concerns requiring Child Safety Services to stay involved with the family.

37. Approximately one month later on 12 March 2018, Child Safety Services received further information that CJ had left his father's home and returned to his mother's address because of physical abuse, including allegations that his father '*had thrown him out of a truck and punched him the head'* and '*beat up him and kicked him in the nuts*.' CJ had not engaged in any services while in his father's care and his father had cancelled CJ's paediatrician appointment.

38. Between January – March 2018, CJ moved between living with his mother, his father and self-placing with his best friend's mother Sandra and her partner Cameron.

39. Sandra says CJ would come and visit her son at odd hours of the night and ask to stay for a couple of days because either his mother or his father had kicked him out.

40. In April 2018 CJ's mother told Child Safety Services she was not coping with CJ, he was not sleeping at night, was screaming and not following her directions, searching her to find cigarettes, smoking and drinking, had been suspended from school, had sexualised behaviours and sexually bullied others. She expressed her belief he had been sexually abused by his father. She is documented as saying she was at her '*wits end'* and did not want to continue caring for CJ and wanted him in residential care like his half-brother. She is noted to

have said CJ had mental health issues and was always trying to hang himself, having last tried to hang himself a few months ago. She planned to tell him to sleep on the street because it was Child Safety's problem.

41. CJ was staying with Sandra and Cameron. He had been with them since police dropped him off there in early April after an argument with his mother when he asked her to make him a sandwich. He was suspended from school in early May 2018. When interviewed by Child Safety Services in May, Sandra reported CJ had disclosed his father '*bashes him'* and she observed him to be very distressed, both angry and sad, when he returned from there. Sandra advised she had not seen any self-harming behaviours or suicide threats from CJ and believed this was due to the environment he was in at the time. Sandra confirmed she was willing for CJ to remain with her if Child Safety provided financial support for his basic care needs as he '*has got nothing'*.

42. CJ's sister corroborated her father's physical violence against CJ, telling Child Safety Services '*no one should be near him*.' CJ also confirmed his father's violence. He said he liked living with Sandra and Cameron and wanted to stay there. He did not want to return to his mother's because they would fight, and she would kick him out. He denied any recent thoughts of self-harm or suicidal intent. He said he did not want to go the Child Youth Mental Health Service because he could talk to Sandra.

43. CJ's father told Child Safety Services he was not willing to have CJ '*if he is going to have to keep running away'*. He felt he had tried with CJ and if CJ had to enter care then so be it. He denied physical abuse, admitting only to verbal abuse and said "*I don't care. I'm done with the little arsehole*." He indicated he would prefer not to be updated on what was happening for CJ because he did not want to know and the more he thought about it the more it broke his heart.

44. The school principal told Child Safety Services there were 65 different incident referrals that year involving incidents including CJ making inappropriate sexual comments, swearing, not following directions, smoking and displaying aggressive behaviours towards other students. The school had contacted CJ's mother who was frustrated but didn't know what else to do. CJ had not displayed any sexually reactive behaviours at school.

45. CJ had last engaged with youth worker support in early March 2018. His case was transferred to another area where his father lived but that service had been unable to make contact with CJ or his father.

46. Child Safety Services assessed CJ as having experienced significant emotional harm from both parents, in particular, because both had told CJ they were no longer willing to care for him and he was not able to return to their homes. It was also determined he had been physically abused by both parents. CJ was assessed as needing a Child Protection Order.

47. On 19 June 2018, a Temporary Custody Order was granted for CJ and Sandra and Cameron were approved as his carers. This order expired on 22 June 2018 and was extended for three days. On 25 June 2018, an application was made for a Child Protection Order requesting Long Term Guardianship of CJ to the chief executive until he reached 18 years of age. Neither parent consented the order nor attended the court hearing. CJ's father had said he was not willing to care for CJ and his mother had indicated she would be unwilling to care for him for at least a year.

48. CJ remained living with Sandra and Cameron between August – November 2018. During his time, he was suspended from school multiple times. Sandra says CJ did not demonstrate any poor behaviour at home; it was just at school. CJ told Child Safety Services he felt cared about and important, very safe and was really happy living with Sandra and Cameron.

49. CJ's family contact was self-directed and facilitated between CJ, his carers and his mother. Child Safety Services wrote to CJ's father advising his contact with CJ was refused/suspended and he would need to contact them to discuss re-instating family contact with CJ.

50. In October 2018 CJ's sister reportedly disclosed to her mother that her father had inappropriately touched CJ and raped him and had touched her inappropriately as well. CJ's mother told Child Safety Services CJ had suicidal ideation, had been aggressive, bashing and chopping up animals and felt this behaviour had been modelled by his father. She was concerned CJ was escalating and engaging in self-harm, having suicidal ideation and had started using cannabis.

51. On 19 October 2018, the school made another child protection notification in relation to sexual abuse and physical violence by CJ's father towards him.

52. As at mid-November, CJ's father had sent CJ a letter saying he did not want to see him. CJ was still having contact with his mother but had left early the previous weekend because they had argued.

53. The significant number of school suspensions impacted significantly on CJ's school attendance during 2017 and 2018. His suspensions became more frequent and lengthier due to the increasing complexity of his behaviour at school. He received suspensions for many and serious physical assaults of other students, frequent disruptive behaviours impacting on teaching and learning, frequent inappropriate language directed towards staff and other students including swearing, offensive and sexualised language, bullying other students, truancy, consuming cannabis off school grounds while in school uniform, urinating on the floor in school toilets, mooning while waiting at the school bus stop and skipping class.

54. CJ's disruptive and challenging behaviour at school was quite complex to deal with in the classroom and group settings. However, staff generally continued to be quite fond of him as they understood he had experienced a traumatic childhood and this was having a significant impact on his capacity to behave appropriately at school.

55. CJ's school experienced some difficulty making regular contact with Child Safety Services about CJ as he was assigned three different case officers during 2018.

56. CJ's mother saw him for the last time at a local store about a week or two prior to his death. She spoke with him, telling him she was sorry that his father had done things to him that his sister had told her about, inappropriate really bad things. He laughed and said, "*it's not true*."

CJ's mental health history

57. When CJ returned to live with his mother in September 2016, he was observed to rock back and forth to a point he could not be consoled and made threats to kill himself. He was referred to the Child Youth Mental Health Service on 13 October 2016 but assessed as not meeting the criteria for acceptance to the service.

58. On 27 June 2017, CJ placed a big motor chain around his neck and stood on a chair. When his mother found him, she did not know what to do so she took him to his aunt with whom he was close. He told his mother he had tried to hang himself due to abuse from his father. Child Safety Services worked with CJs mother and developed a safety plan around CJ's suicidal ideation whereby should another incident occur, she was to call 000.

59. CJ was taken to hospital on 5 December 2017 after deliberately cutting his arm and leg. He did not require any stitches. He was referred to the Child Youth Mental Health Service (CYMHS) but refused to engage with the service.

60. CJ had ongoing problems with not being able to sleep and behavioural issues at school resulting in detention or suspensions. When his mother asked him to explain why he was struggling or what he needed, he would tell her *"you'll never understand*".

61. CJ disclosed to Sandra that his father had been physically abusing him. She noticed when he returned from his father he was really distressed, both angry and sad. CJ denied any thoughts of self-harm, refused to engage with CYMHS because he could talk to Sandra if he needed to.

62. As at August 2018, Sandra was concerned about CJ as his behaviours at school were escalating and he wasn't sleeping at night. She thought he might be wetting the bed every night as he putting his sheets in the washing machine before she woke up. Sandra suspected CJ had ADHD as he was unable to concentrate. She wanted to get him on a GP Mental Health Care Plan. She had tried to get a referral to the paediatrician from a general practitioner, but the GP was reluctant to make one given limited information about CJ.

63. In September 2018 Child Safety Services provided Sandra and Cameron with a medical consent letter to provide to CJ's doctors. On 9 October, CJ's general practitioner completed a care plan noting CJ's current problems/concerns as depression and he would benefit from referral for specialist assessment to identify any underlying health problems such as ADHD.

64. In November 2018, CJ was still experiencing issues at school, was constantly suspended and was on his last warning; if there were any more incidents he would be expelled. His carers could not afford for this to happen because Sandra needed to work, and they couldn't support CJ with transport to attend another school. Sandra had taken him to the doctor who recommended a psychology referral for which Child Safety Services needed to give approval.

65. On 13 November 2018 CJ was discussed at a Complex Case Panel meeting involving school and external staff. It does not appear Child Safety Services participated in this meeting. The meeting discussed CJ's refusal to engage with support services and the difficulty getting him to participate in medical and mental health assessment. The meeting was aware his living arrangements had changed, and he was living with Sandra and Cameron. The school was trying to work collaboratively with CJ's mother and Sandra and various Child Safety Officers to ensure the appropriate referral were in place and CJ actually attended appointments and received the support he needed. An outcome from this meeting was to discuss this issue with CJ's Child Safety Officer, advocate for assistance to support CJ to participate in assessments and consider a referral to EVOLVE (child and youth mental health service).

66. On 20 November, CJ's doctor completed a paediatric referral. The earliest he could be seen by a paediatrician was April 2019.

67. A teleconference meeting of school personnel on 28 November 2018 discussed actions to support CJ. The outcomes of this meeting included a plan to contact his Child Safety Officer to request referral to EVOLVE or the Child Youth Mental Health Service as well as a paediatrician as soon as possible to investigate CJ's mental health and risk taking behaviours with a view to getting treatment happening prior to the following school year. The school was aware of at least three referrals to paediatricians and/or psychologists that CJ had not attended.

68. Sandra took CJ to the local doctor on 4 December 2018 for a GP Mental Health Care Plan and referral to a clinical psychologist. He was scheduled to see the clinical psychologist at 3:00pm on 10 December 2018.

69. CJ's mother was concerned that over the years CJ was subject to domestic and family violence by his father, and this affected his mental health. She felt the children were brainwashed by his father to stay with him. She felt she had tried her best to keep them safe.

Events leading up to CJ's death

70. CJ had been suspended from school for fighting. Following a meeting at school on Wednesday 5 December, concerns were raised that without intervention for CJ, things would not change. At this stage CJ was being supported by a behaviour support teacher, the school guidance officer and the school chaplain. The school provided CJ with uniforms, stationery, lunch and leftover food from the school canteen to take home.

71. During his suspension, CJ was helping Cameron clean up the yard and make a new path.

72. On Friday 7 December 2018, CJ messaged his girlfriend Renee saying "*I am going to hang myself... when everyone is asleep I'm going to do it. I'm not scared of dying*." CJ stated that he had been '*suffering [his] whole life*' and questioned whether anyone cared about him, stating: *'I got bashed by my dad. Is that caring [?]. My mum kicked me out. Wow so much caring going on*.' CJ referred to himself as '*the most violent person'* and stated that *'it's better to go out then to hurt more ppl.*' He told her "*if one more thing went wrong in his life, he would do it*." Renee convinced him not to and went straight over to his carers' home to be with him. She remained there with CJ all weekend.

73. On Sunday evening, 9 December, CJ, Renee and Sandra's son Patrick were in the bedroom CJ shared with Patrick. They were playing on Play station and their mobile phones and tablet devices. Patrick says CJ and Renee were arguing because CJ wanted to know if she was cheating on him. They were going through her Instagram account together. Renee says Patrick yelled at CJ for using his mobile phone. Patrick says this was because CJ was accessing porn on Patrick's mobile phone, threatening to show it to Sandra. CJ left the room at around 2:30am telling the others he was going to the kitchen to heat up some pies in the microwave. Renee and Patrick both fell asleep, not noticing CJ had not returned from the kitchen.

74. At around 6:00am the following morning, Monday 10 December, Sandra woke and went into the lounge room where she found CJ hanging from the rafter by an electrical cord wrapped around his neck. She immediately alerted Cameron to the situation. He lifted CJ down while Sandra removed the cord from around CJ's neck. Cameron commenced CPR. CJ was cold to touch, and his skin was discoloured. Paramedics attended soon afterwards but CJ was unable to be revived.

75. Officers from the Queensland Police Service Child Protection Investigation Unit attended the scene and were satisfied there were no suspicious circumstances. Attending officers observed a cream electrical cord wrapped seven times around an exposed ceiling beam. There was a kitchen chair below the beam. Cameron told police the electrical cord was usually plugged in under a table and was used for the air conditioner.

76. Interrogation of CJs mobile phone confirmed the suicidal message he had sent Renee the previous Friday night.

Mother's concerns

77. CJ's mother expressed concern about Child Safety Services having assessed CJ's father as a parent willing and able to care for CJ despite the domestic violence protection order that prevented him from having contact with CJ without her written permission (which she had not given) and that this decision exposed CJ to abuse from his father.

Department of Child Safety, Youth and Women child death case review outcomes

78. CJ's death triggered a two-tier internal death review process within the Department of Child Safety, Youth and Women under the *Child Protection Act 1999* because he was known to the Department within 12 months preceding his death. This review process focuses on ensuring continuous improvement of service delivery, public accountability and improved outcomes for children.

79. The initial Systems and Practice Review outcomes were considered by a Child Death Case Review Panel along with three other reviews relating to adolescent suicide. The Panel identified a number of significant issues relating to the Department's involvement with CJ and his family.

80. There was a five-month delay in commencing an Investigation and Assessment during which time seven additional Notified Concerns were received regarding ongoing concern for CJ and his half-brother in their mother's care including physical abuse, sexualised behaviours displayed by the boys and her inability to manage these behaviours in the context of her own mental health issues.

81. The Panel observed that while CJ had a number of people and supports who were in and out of his life, he never had a strong safety and support network coordinated around him and there was no clear plan developed to meet his ongoing care and protection needs.

82. The Panel expressed concern the Department had not applied a domestic and family violence lens, and a trauma informed practice was absent in the Department's work with CJ and his family. It observed that both CJ's mother and the Department frequently took action to return the children to their father while the domestic violence protection order was in place and as such the Department was complicit in enabling the father to contravene the conditions of the order. On other occasions, the Department was making decisions to return CJ and his half-brother to their mother in contravention of the Family Court order in place.

83. Panel members agreed that where a domestic violence protection order is made which impacts on departmental case planning and decision making regarding the placement of children, it is necessary for the Department to understand the context of the reasons why the domestic violence protection order was sought, specifically whether there was any testing of the evidence and the conditions included on the order, noting that when an application has been made by consent it should not be viewed as an admission of the facts. The Panel considered the Department had an obligation to request a copy of the orders to ensure the facts presented by CJ's parents were an accurate reflection of the court decision and to ensure neither parent was put in a position that caused them to breach the orders in place.

84. The Panel noted that at times CJ's only option was to return to his abusive father for shelter. This was despite CJ voicing his worries about returning to his father's care because of the domestic and family violence in that household and the physical and sexual abuse he endured. His mother's "*destructive parenting*" was presented as an issue but there was limited focus on his father parenting or the impact his pattern of behaviours and how this may have impacted on CJ's mother in her parenting of the children.

85. The Panel was concerned there appeared to be an inconsistent approach to placing CJ with his father when there were serious allegations his father was harming the children. This was a decision that carried high risk and impacted on CJ's immediate safety and wellbeing. The Panel considered that the allegations made against CJ's father were never adequately addressed and the Department failed to gain a complete understanding of the significant trauma CJ experienced in his father's household.

86. The Panel identified the local high school as an important fixture in CJ's safety and support network and held important knowledge and information regarding CJ. The Panel considered there needed to be improved information sharing, consultation and collaboration between the Department and the school and it would have been beneficial for the Department to be proactive in its engagement with the school around CJ's education and to enable child safety officers to strengthen their relationship with him.

87. The Panel noted CJ was displaying multiple high risk factors such as sniffing paint, drinking and attempts to hang himself, and his half-brother was displaying multiple indicators of trauma at only 10 years of age including exposure to domestic and family violence, alleged sexual assault and engaging in impulsive, high risk behaviours.

88. The Panel considered it was clear from CJ's mother's concerns communicated to the Department two months prior to CJ's death and the escalation of his behaviour at school, that further attempts were needed to support and respond to a vulnerable young person who was at chronic suicide risk.

89. The Panel noted similarities between CJ's family circumstances including poor parental capacity to support a high risk adolescent with one of the other cases involving a young female who experienced rejection and physical violence from members of her family household. Both young people were frequently self-placing, neither appeared to meet the criteria for a Child and Youth Mental Health Service and both were lacking engagement with mental health services.

90. The Panel noted the discussion between CJ's child safety officer and Sandra on 15 August 2018 about mental health support for CJ, when Sandra was advised that while EVOLVE services would be beneficial, there was a long waiting list. The Panel expressed concern that Queensland Health including mental health services was '*conspicuously absent'* from the support provided to CJ. Given CJ's mother was reporting CJ was frequently attempting suicide and had made a previous attempt to hang himself, it seemed CJ required a service system that was able to respond to his acute mental health needs and address his significant childhood trauma.

91. The Panel requested that Child Safety and Queensland Health provide a co-ordinated response to its concerns regarding the lack of a definitive response to acute mental health issues experience by young people who are deemed a suicide risk.

92. I am advised by the Department's Chief Practitioner that as at June 2022, the Department's work in meeting the acute mental health needs of children and young people in departmental care is continuing, in many cases in partnership with Queensland Health and other key agencies.

93. The Chief Practitioner advises the Department's response to young people who are deemed a suicide risk include:
    - practice guidance for child safety practitioners through a mental health practice kit, policies and education and development programs
    - a self-harm and suicide risk practice guide and policy for assessing and responding to self-harm and suicide risk
    - use of suicide risk alerts and suicide risk management plans with the young person, their carer and significant others in the young person's life which may include their safety and support network – the alert and risk management plan are accessible to all child safety staff who may come into contact with the young person
    - procedural guidance for child safety practitioners to respond to self-harm behaviour and use of self-harm alerts and self-harm risk management plans.

94. The Chief Practitioner explained that in circumstances where an immediate acute mental health response is needed, child safety practitioners facilitate access to mental health assessment by contacting 1300 MHCALL for advice, and support and/or facilitate a young

person's presentation to an emergency department or Child and Youth Mental Health Services. Following acute mental health presentations, child safety practitioners make referrals to Child and Youth Mental Health Services, EVOLVE, Headspace or other relevant non-government organisations. Where child safety practitioners perceive a young person's acute mental health needs are not being met, there are escalation processes and additional departmental supports including Regional Practice Leaders, Specialist Services Clinicians, the Mental Health Practice Leader and complex case clinics which can be accessed to review and support the child's mental health needs.

95. I am advised the Department continues to invest in programs and services focussed on improving intervention, prevention, health and wellbeing outcomes for children and young people in its care including a Specialist Practice team within the Office of the Chief Practitioner to provide practice support and guidance to child safety staff across the state to respond to the complex needs of young people in care, three Practice Leaders focused on statewide capability development and practice support in the areas of mental health, domestic and family violence and First Nations cultural practices and 12 Child Safety Health Liaison Officers across the State designed to improve information sharing and rapid response when health professionals have concerns about the safety of a child or young person in care.

96. The Chief Practitioner also refers to the Department's ongoing work in partnership with other government and non-government agencies to provide young people in care with access to comprehensive health assessments, mental health assessment and intervention through initiatives including Evolve Therapeutic Services and the Navigate Your Health and the Strengthening Health Assessments Pathways programs.

Domestic and Family Violence Death Review Unit review

97. The Coroners Court of Queensland Domestic and Family Violence Death Review Unit (DFVDRU) provided advice about the domestic and family violence and child protection issues relating to CJ's family.

98. DFVDRU agreed there was an absence of a domestic and family violence informed lens across CJ's involvement with Child Safety Services which may have represented a missed opportunity for Child Safety to appropriately assess and respond to the risk to him from his exposure to domestic and family violence and child abuse, including possible sexual abuse by his father. DFVDRU also identified the apparent failure by Child Safety Services to take action in response to its knowledge of CJ's suicidal ideation and self-harming behaviours in the months preceding his death.

99. However, DFVDRU considered the Department of Child Safety, Youth and Women two-tier death review process did not address all the concerns regarding the Department's involvement with CJ and his family and did not entirely address the lack of a domestic and family violence lens in the child protection practice in this case. More specifically, DFVDRU identified:
    - there was an almost exclusive focus on CJ's mother's parenting and capacity to care for CJ, despite significant and ongoing allegations of domestic and family violence and possible child sexual abuse perpetrated by his father toward CJ;

    - allegations of domestic and family violence and child abuse perpetrated by CJ's father toward CJ appeared to have been minimised. For example, allegations of physical assault were often referred to as '*excessive physical discipline'* or '*physical altercations*;'
    - there was an apparent failure by Child Safety Services to appropriately assess and respond to repeated reports that CJ was exhibiting sexually inappropriate or aggressive behaviour toward his mother and his siblings and the risk posed to other family members in this context; and

- broadly speaking, reports of child harm were treated in isolation, rather as an accumulation of adverse experiences or a pattern of cumulative harm or trauma that required comprehensive and holistic intervention.

Independent expert systemic review

100. Dr Silke Meyer, Deputy Director of the Monash Gender & Family Violence Prevention Centre reviewed the coronial investigation material and provided an opinion as to whether there may have been a missed opportunity for early intervention or to have prevented CJ's death. Dr Meyer is a recognised expert and had published extensively on child protection responses to domestic and family violence.

101. Dr Meyer's review identified the lack of a domestic and family violence and trauma-informed lens from the service response to CJ and his family as representing a significant 'failed opportunity' to:
    - protect CJ from harm by his father;
    - support and empower CJ's mother towards increased parenting capacity;
    - facilitate recovery support for both CJ and his mother for their respective underlying trauma histories; and
    - support CJ's mother across her life course and multiple help-seeking attempts to protect CJ.

102. Dr Meyer observed that despite extensive references in the family's child safety records to CJ's experiences of parental domestic and family violence (along with his experience of child abuse and child sexual abuse), his father's parenting choices and his perpetration of domestic and family violence and the significant impact this seemed to have on CJ (and to some extent his siblings) remained mostly unacknowledged throughout Child Safety's investigations and interventions. Dr Meyer described CJ's father as being "*..invisible in the vast majority of investigations and interventions when concerns regarding the children's harm were raised or was seen as a parent willing and able to care for [CJ] and his siblings when [his mother's] parenting behaviours raised child welfare concerns*."

103. Dr Meyer observed that CJ's father was repeatedly identified as willing and able to care for and protect CJ from harm until after he refused to care for CJ any longer. This was later than May 2018 when Sandra told CJ's Child Safety Officer he had returned distressed after staying with his father who had a known and ongoing history of abusive behaviours. Dr Meyer noted that when Sandra stated "*who will take him if I don't?",* the Child Safety Officer's responded by saying she would check with CJ's father whether he was willing to care for CJ. This was despite CJ and his sister having been interviewed the previous day by the same Child Safety Officer and disclosing their experiences of abuse and ongoing safety concerns.

104. Dr Meyer commented she has very rarely seen a domestic violence protection order as specific as the one granted to CJ's mother which clearly listed what form of contact was permitted or prohibited for CJ's father and each individual child victim. This order was designed to protect CJ and his siblings from his father's ongoing abuse and set very clear standards for CJ's contact with his father; Child Safety encouraging CJ to stay with his father or encouraging his father to allow CJ to live with him violated that order. Dr Meyer considered that any consideration of CJ being cared for by his father by the time the domestic violence protection order was in place should have involved either a variation of the order agreed to by his mother or a child protection order that overrode the domestic violence protection order, although this would have been equally problematic given the extensive history of abuse perpetrated by CJ's father against him, his siblings, CJ's mother and the father's subsequent partner.

105. Dr Meyer identified the following main concerns about CJ's historical and more recent child safety involvement:

Worker inconsistencies

106. Dr Meyer observed CJ and his family were well known to the Department and experienced high levels of worker inconsistencies. Over the final 12 months of CJ's involvement with the Department, there were 20 different Child Safety Officers and 14 different Senior Team Leaders in his case management and departmental decision making/approval processes. A number of external stakeholders including CJ's perceived different workers at the time to be underinformed about CJ, with school personnel describing Child Safety as unresponsive and questioned whether some of the workers they had contact with in relation to CJ had even met him.

107. Dr Meyer commented this unfortunately is not an uncommon experience for young people and their families subject to child safety interventions due to the high staff turnover in the child safety system, which is not unique to the Queensland child safety system.

Absence of a domestic and family violence and trauma-informed lens

108. Dr Meyer identified the lack of trauma-informed responses that would address the family's complex experiences and support needs more holistically as a missed opportunity.

109. Dr Meyer observed CJ had regular child safety involvement since he was born, initially due to notifications relating to his older siblings and then due to notifications about his own immediate welfare concerns. Initially, child safety contact was regularly marked by his mother's help-seeking behaviour and her willingness to engage with the Department. However, the child safety responses to CJ and his family (primarily his mother) were always reactive and symptomatic. Dr Meyer noted that CJ's mother, notifiers, extended family and later CJ, his siblings and other carers repeatedly voiced CJ's experiences of severe physical abuse beyond hitting, smacking and pushing - including dragging him by the hair, force feeding him, shoving his head down the toilet, throwing him out of a not moving truck, punching him in the belly with a closed fist – along with suspicions of sexual abuse. Dr Meyer's report cites multiple references documenting the long-lasting effects of domestic and family violence and/or child abuse on children's social, emotional and physical wellbeing. Despite this, the various child safety responses to CJ and his family repeatedly lacked a trauma-informed and domestic and family informed lens; all investigations and interventions focussed predominantly on either CJ's mother's or CJ's problem behaviours and despite his father appearing to be the driver of underlying trauma in the family including for CJ's mother and CJ, trauma recovery support did not feature in any of the child safety interventions.

110. Dr Meyer identified the following examples of a lack of trauma-informed responses by the agencies involved with CJ and his family:
    - the use of 'safety plans' in response to his mother help seeking and CJ's behaviours including his alleged sexual abuse of his younger brother – Dr Meyer expressed concern there was no consideration of the underlying trauma that likely contributed to CJ's behaviours and the related recovery needs for CJ; nor was there any apparent consideration of the support needs for his half-brother as a victim-survivor of childhood sexual abuse – as a result CJ and his half-brother's respective behaviours escalated over time while their support needs remained unmet and his mother was held accountable for preventing sexual behaviours between the children by ensure they slept in separate bedrooms.

- the use of 'safety plans' in response to his mother's help-seeking for CJ's suicide attempts and suicidal ideation – Dr Meyer observed the service response (telling CJ's mother she should call an ambulance if she observed future suicidal ideation or another attempt) did not address her concerns around CJ's underlying trauma and support needs and CJ's actual risk and needs remained invisible in the service response.

- A reference to EVOLVE during CJ's final year of life was considered to assist CJ in managing his '*problematic behaviours'*, namely his aggression at school and at home); it did not appear to be framed around recovery support for his extensive underlying trauma history. This was followed by statements such as '*this may be useful but they have a long waitlist*' and did not lead to any meaningful engagement.

  Dr Meyer considered this likely a reflection of the constraints experienced by Child Safety Officers who identify certain support needs, but referral pathways are limited by lack of wider system capacity. Dr Meyer referenced recent studies confirming the limited availability of support services for young people affected by domestic and family violence, noting this forms a key priority area of the next National Plan to End Violence Against Women and Children. Dr Meyer commented that while the lack of adequate and warm referrals for CJ raises concerns regarding trauma-informed responses to identifying young people's support and recovery needs, it equally highlights the need for better resourcing of a specialist sector that is equipped to address the needs of young people affected by domestic and family violence in a timely manner.

- Child Safety records frequently referenced CJ's mother's underlying trauma, including her own experiences of child abuse and neglect along with childhood sexual abuse which were known to the Department at the time in addition to her subsequent experiences of domestic and family violence while involved with the Department around her own children. However, none of the child safety interventions reflected a domestic and family violence or trauma-informed approach and lacked proactive initiation of suitable recovery services; instead, the focus on CJ's mother throughout the records takes a '*victim-blaming lens'* and missed the opportunity to empower her through recovery support to address any identified parenting concerns. Dr Meyer noted that while CJ's mother appeared to be willing and able to protect her children in the beginning, this seemed to decrease over the years, likely due to the accumulation of issues arising from her unaddressed underlying trauma, the emerging behaviours displayed by her children particularly CJ and his half-brother, and the lack of meaningful support received whenever she did seek help and engaged with Child Safety Services.

- CJ's mother received little if any holistic, wraparound support for the complex issues with which the family was presenting. Dr Meyer identified this an example of why adult victim-survivors with complex needs and extensive trauma histories can become reluctant to repeatedly engage with new services providers or practitioners. Dr Meyer advised that a trauma-informed lens would assist practitioners in understanding why adult survivors may present as '*unwilling to engage'* and in developing strategies to work with highly vulnerable families. Further, Dr Meyer identified a domestic and family violence informed lens as critical to understand, identify and address the impact of domestic and family violence on different family members and their recovery and support needs.

Deficit focused service responses

111. Dr Meyer expressed concern that child safety responses to CJ and his mother appeared to be primarily victim-blaming and deficit focused, and the responses to welfare concerns relating to CJ appeared to be highly gendered.

112. Dr Meyer observed that multiple child safety responses to CJ focused on his '*problem behaviours'* including the use of violence and aggression at school and/or at home, causing problems at school, displaying sexually reactive behaviours, underage drinking and alleged cannabis use despite all of these being well-established warning signs of historical trauma in children. Dr Meyer located only one child safety record that noted CJ's problematic behaviours while also acknowledging much of this was likely the result of his underlying trauma; yet no trauma-informed, recovery focused intervention eventuated from that either.

113. Dr Meyer observed a similar pattern in the child safety service responses to CJ's mother. Despite her documented childhood trauma history of adult domestic and family violence victimisation, the focus across the child safety interventions was predominantly on her parenting failures and her lack of parenting capacity with no consideration for the role her underlying trauma experiences and unaddressed support needs likely played in her decreasing parental capacity over the years. This was despite it being well-established that experiences of domestic and family violence can undermine a mother's parenting capacity, and wider reforms implemented by the Queensland child safety system since 2016 around partnering with mothers and empowering parenting capacity by recognising and addressing the potential impacts of domestic and family violence with underlying trauma.

114. Dr Meyer acknowledged the Queensland child safety system has undergone substantial reform to make fathers visible more broadly and to hold them accountable for the child welfare concerns they create, particularly in the context of domestic and family violence. Dr Meyer cites recent research demonstrating that identifying and responding to men's use of domestic and family violence has become core business in child practitioners' practice. These research findings highlight the benefits of Queensland Child Safety's substantial investment into domestic and family violence practice reforms over recent years, but Dr Meyer observed the same body of research also showed that reform progress varies across service centre locations; unfortunately the reforms were not reflected in the service responses to CJ and his family. Dr Meyer considers this highlights the need for consistent reform work across child safety service centre locations and ongoing investment in upskilling frontline practitioners along with leadership staff around domestic and family violence and trauma informed practice in child protection work.

Concerns around CJ's suicidal ideation

115. Dr Meyer observed that Child Safety, along with CJ's single mental health contact seemed to be satisfied he was at low to moderate risk because CJ would assure them he currently had no suicidal thoughts or ideation. His involvement with these services seemed to be marked by denial, which Dr Meyer noted as not uncommon for young people with complex experiences and support needs. Dr Meyer considered that even if CJ denied suicidal ideation whenever asked about it by Child Safety, his known trauma history should have triggered a greater level of support and ongoing monitoring of risk.

Schooling

116. Dr Meyer noted CJ's schooling was marked by instability across his education and by 2018, he was largely disengaged from school with 116 days absent of which 76 were due to suspension. Dr Meyer acknowledged it can be difficult for education providers to respond effectively to young people with extensive trauma histories and high levels of home

instability (being constantly moved back and forth between different family/carer arrangements). She considered CJ would have benefitted from holistic support through a partnership between Child Safety, his family/carers and other relevant support services such as mental health. This did not occur with the school focussing primarily on his mother including when CJ was living with his father or Sandra and Cameron; CJ's father remaining completely invisible to any intervention; Child Safety not liaising effectively with the school and the school not being invited to the Family Group Meeting when one was eventually considered in August 2018. Dr Meyer identified this as a common example of multiple service providers being involved in the life of a young person/family with complex needs, but the service responses remain siloed and deficit-focussed rather than holistic and strength-based.

Action taken by the Department of Children, Youth Justice and Multicultural Affairs to enhance its application of a domestic and family violence lens to child protection practice since CJ's death

117. I note the Department continues to partner with the Safe and Together Institute to strengthen domestic and family violence informed child protection practice. I am advised the Department:
    - has partnered with the domestic and family violence sector to deliver training child safety staff and non-government partners
    - has led the Walking with Dads program since 2016 to hold fathers accountable for their behaviours as parents and reduce the risk they pose to adult and child victim/survivors and support multiagency work across the sector to create safety by intervening with the person using violence
    - incorporates domestic and family violence modules in its learning and development program for child safety practitioners including about the impact of violent and coercive behaviours on children
    - provides practice guidance to its practitioners through a domestic and family violence practice kit incorporated in its Child Safety Practice Manual
    - employs three Practice Leaders within the Office of the Chief Practitioner focussed on statewide capability development and practice support in areas including domestic and family violence; and
    - continues to partner with non-government organisations by investing in secondary support services to provide early intervention including Family and Child Connect and Intensive Family Support services which each have specialist domestic and family violence case workers.

118. The Department's Chief Practitioner also refers to Child Safety's involvement in the eight multiagency High Risk Teams now operating across Queensland established with the aim of using common risk and safety frameworks and validated tools to provide integrated, culturally responsive risk assessment and safety management planning for women and their children assessed as high risk of harm or death.

Action taken by the Department of Children, Youth Justice and Multicultural Affairs to enhance its application of a trauma-informed lens to child protection practice since CJ's death

119. The Chief Practitioner advises the Department is continuing to work towards enhancing practice in relation to integrated trauma-informed positive behaviour support approaches. Its learning and development program incorporates trauma-informed practice modules including about identifying and assessing complex trauma and cumulative harm. It is also

partnering with Evolve Therapeutic Services to provide training for child safety practitioners and carers on topics including trauma informed care and managing the impacts of childhood trauma for children and young people in care.

120. I am advised the Department has revised its Positive Behaviour Support and Managing High Risk Behaviour policies and developed a new Positive Behaviour Support and Managing High Risk Practice Guide highlighting the importance of understanding a child's behaviour in the context of their trauma with a focus on ensuring that responses to their behaviour does not cause the child further harm. The Department has provided statewide Community of Practice workshops for child safety practitioner working with young people who demonstrate high risk behaviours.

121. I note the Department supports these specific initiatives more broadly through the Specialist Practice team established within the Office of the Chief Practitioner in 2018 to provide practice support and guidance to staff across the state in responding to the complex need of children and young people.

Findings required by s.45

Identity of the deceased – [deidenitifed]

How he died – CJ died from hanging with the intention of taking his own life. He did so in the context of having been exposed to significant and enduring domestic and family violence and child abuse primarily perpetrated by his father. There had been extensive child safety involvement with CJ and his family since before he was born, culminating in the making of a temporary protection order under the *Child Protection Act 1999* placing CJ in the care of the chief executive of the then Department of Child Safety, Youth and Women approximately six months prior to his death. Despite extensive references in the family's child safety records to CJ's experiences of parental domestic and family violence and his own experiences of child abuse and alleged child sexual abuse, all but one of the child safety practitioners involved with CJ and his family failed to identify CJ's increasingly challenging behaviours and self-harm episodes, and his mother's inability to cope with them, as stemming from the family's underlying complex trauma driven largely by CJ's father. Instead, the child safety response focussed predominantly on CJ's problematic behaviours and his mother's parenting deficiencies with next to no acknowledgement of his father's violence and lack of parenting capacity.

The lack of trauma-informed child protection practice and the lack of a domestic and family violence lens in the child safety response to CJ and his family led to multiple and significant missed opportunities for CJ to have accessed appropriate supports through a strong safety and support network coordinated around him and a clear plan to meet his complex ongoing care and protection needs.

CJ's life story is heartbreaking. It is evident his mother tried to keep him and his siblings safe but had limited capacity to do so given her own underlying trauma and mental health issues. She was help-seeking and trying to work with Child Safety services but could not cope with the increasingly challenging behaviours of both her sons. CJ's escalating behaviours and concern for his mental health were recognised and reported to child safety practitioners not only by his mother but also his school and in the months preceding his death, by his approved foster carer. I accept Dr Meyer's opinion that even if CJ denied suicidal ideation whenever asked about it by child safety officers, his known trauma history should have triggered a greater level of support and ongoing monitoring of his risk of self-harm or suicide. In the final months of his life, both his school and his foster carer were actively trying to arrange referrals for specialist assessment to investigate CJ's mental health and risk-taking behaviours. Child safety practitioners were largely absent from these efforts; they

needed to have done much more to work with the school and the carer to support and respond to CJ's mental health needs.

At the time CJ took his life, he had found a place where he felt safe, cared about and was really happy living with his approved foster carers. However, he was experiencing rejection in multiple aspects of his life. He was aware neither of his parents were prepared to have him live with them; his father had sent him a letter telling him he did not want to see him, and he had recently argued with his mother. He was yet again suspended from school and on his last warning; expulsion potentially threatened the ability of his carers to support his access to schooling. He was yet to engage with specialist paediatric and mental health services. On the weekend preceding his death, he expressed despair about his family life and the violent person he believed he had become. He told his girlfriend "*if one more thing went wrong with his life, he would do it*." It is possible that thinking his girlfriend was cheating on him was that one thing, but this will never be known.

There have been substantial reforms to Queensland's child protection system since 2016 but as observed by Dr Meyer, the reforms implemented at the time of CJ's death were not reflected in the service responses to CJ and his family. Systemic continues with significant investment in domestic and family violence practice reforms in recent years. CJ's life story and the circumstances in which he took his own life at 14 years of age highlights the need for consistent reform implementation and ongoing investment in enhancing the capacity of Queensland child safety system to deliver trauma informed practice and apply a domestic and family violence lens in working with vulnerable children and young people and their families.

Place of death – [deidentified]

Date of death– 10/12/2018

Cause of death – 1(a) Hanging

I close the investigation.

Ainslie Kirkegaard
A/Coroner
CORONERS COURT OF QUEENSLAND
17 June 2022