QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of S**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Rockhampton
FILE NO(s):	2009/942
DELIVERED ON:	22 May 2012
DELIVERED AT:	Rockhampton
HEARING DATE(s):	12 October 2010, 1 December 2010, 28 March 2011, 31 May 2011, 15 August 2011
FINDINGS OF:	AM Hennessy, Coroner
CATCHWORDS:	Death in care, Child in care of Child Safety; Absconding from care; appropriateness of placement of child; Management of conflict with other child placed in the same facility; Communication from service provider to Department; Adequacy of Police search for missing child.

REPRESENTATION:

Counsel Assisting:	Ms Alana Martens and Ms Melinda Zerner
For Next of Kin Mother:	Ms P Morreau i/b by CQ Community Legal Centre
For Next of Kin Father:	In Person
For Kerry Tarren (Carer):	Mr Boe
For Dept of Communities:	Mr R Campbell i/b by Crown Law
For Lifestyle Solutions:	Mr Boe i/b by Boe Williams Lawyers
For Qld Police Service:	Mr W Kelly

These findings seek to explain, as far as possible, how the death of S occurred on 7 February 2009. Consequent on the court hearing the evidence in this matter, where learnings indicate that changes can be made to improve safety and changes to practices and procedures, recommendations may be made with a view to reducing the likelihood of a similar incident occurring in future.

I express my sincere condolences to the family and friends of S for her tragic loss.

THE CORONER'S JURISDICTION

1. The coronial jurisdiction was enlivened in this case due to the death falling within the categories of section 8 of the *Coroners Act 2003* ("the Act") as S's death was a "*violent or unnatural death"* and section 9 of the Act as S was under the guardianship of the Department of Communities (Child Safety) at the time of her death (and so her death is defined as a 'death in care'). A Coroner has jurisdiction to investigate the deaths under section 11(2), to inquire into the cause and the circumstances of a reportable deaths and an inquest can be held pursuant to section 28. Pursuant to section 27 of the Act, an inquest must be held if the coroner considers the death is a death in care and the circumstances of the death raise issues about the deceased's person's care.

2. A Coroner is required under section 45(2) of the Act when investigating a death, to find, if possible:-
   - the identity of the deceased,
   - how, when and where the death occurred, and
   - what caused the death.

3. An inquest is an inquiry into the death of a person and findings in relation to each of the matters referred to in section 45 are delivered by the Coroner. The focus of an inquest is on discovering what happened, informing the family and the public as to how the death occurred, but not on attributing blame or liability to any particular person or entity.

4. The Coroner also has a responsibility to examine the evidence with a view to reducing the likelihood of similar deaths. Section 46(1) of the Act, authorises a Coroner to "*comment on anything connected with a death investigated at an Inquest that relates to – (c) ways to prevent deaths from happening in similar circumstances in the future."* Further, the Act prohibits findings or comments including any statement that a person is guilty of an offence or civilly liable for something.

5. Due to the proceedings in a Coroner's court being by way of inquiry rather than trial, and being focused on fact finding rather than attributing guilt, section 37 of the Act provides that the Court may inform itself in any appropriate way and is not bound by the rules of evidence. The rules of natural justice and procedural fairness apply in an inquest. The civil standard of proof, the balance of probabilities, is applied.

6. All interested parties can be given leave to appear, examine witnesses and be heard in relation to the issues in order to ensure compliance with the rules of natural justice. In this matter, the parents of the child appeared, Department of Communities (Child Safety), Lifestyle Solutions (who provided the contract accommodation), and one of the Carers and the Queensland Police Service were represented at the Inquest.

7. I will summarise the evidence in this matter. All of the evidence presented during the course of the inquest, exhibits tendered and submissions made have been thoroughly considered even though all evidence or submissions may not be specifically commented upon.

8. At approximately 9.10pm on Saturday, 7 February 2009, S, who was 10 years old, was struck by a car on Belmont Road, Rockhampton ('the accident') and suffered fatal injuries. The car which struck S was a white 1991 Ford Laser sedan driven by RJC. S had been subject to a Child Protection Order and was under the care of the Department of Communities (Child Safety), previously known as the Department of Child Safety ('the Department'). On the afternoon of the accident, S had run away from the Rockhampton Lifestyle Solutions (Aust) Ltd ('Lifestyle Solutions') care complex to the north of Rockhampton with a fellow resident, K aged 17 years. K had an intellectual impairment disability and reduced mental capacity. S left the premises after having a series of arguments with another resident, T, during the course of the day. Both girls were lost on Belmont Road north of Rockhampton and were seeking assistance from the Queensland Police Service ('QPS') on the phone at the time when the accident occurred.

ISSUES

The issues investigated during the inquest were:

a. The circumstances in which the Department placed S at Lifestyle Solutions;

b. The considerations made by the Department in relation to the placement;

c. The previous history between S and T;

d. The circumstances in which S and T were placed in the same residence;

e. The action taken by the Department and Lifestyle Solutions to attempt to manage the conflict between T and S; and

f. The initial management of the incident at 298 Greenlakes Road (the Lifestyle Solutions complex).

During the inquest, three further issues were identified:

g. The QPS search for S and K;

h. The experience, supervision and training of S's case manager in the Department; and

i. The contract administration by the Department concerning its agreement with Lifestyle Solutions.

Ms D, S's mother, has stated in submissions that she holds the Department and its officers primarily responsible for placing S in an age-inappropriate centre with another child with whom there had been previous bullying and conflict and then failing to listen to her and her daughter's pleas to remove S from that situation of abuse or even investigate the situation more thoroughly. Further, she considers that there were deficiencies in the management of the escalating conflict by Lifestyle Solutions and an inexcusable failure by that centre to report the detail of S's precarious existence in the weeks leading up to her death to the Department. Ms D was shocked by the revelation during the inquest of the lack of co-ordination and incompetence attaching to the search by the QPS for her daughter. She feels that S's safety was not given appropriate prioritisation.

THE EVIDENCE

Family Situation

9. S was one of eight children of Ms D, her biological father is Mr R and her stepfather is Mr Y. S's family had an extensive history with the Department of Human Services in Victoria due to child protection issues and domestic violence before moving to Queensland in August 2006.

10. The Notification and Concern Reports made to the Department after arriving in Queensland were related to information of ongoing domestic violence, substance misuse, homelessness, poor living conditions, police warrants, minimisation of harm to children, and physical and emotional harm to children. Ms D denies the Victorian history and she appears to downplay the issues which have arisen since moving to Queensland (according to a report made in 2008). Ms D submitted that the situation had improved since 2008. She had a strained relationship with Departmental officers at times but she was an active participant in decisions being made about the children's welfare. She has been frustrated by the events surrounding her daughter's death and this has, in her view, hampered her ability to communicate effectively regarding these issues. Ms D maintains that she had a genuine interest in the wellbeing of the children and an awareness of their needs which she was attempting to advance.

11. S was made subject to a Child Protection Order granting custody to the chief executive of the Department on 30 May 2008 (which was due to expire on 29 May 2009). Prior to the Child Protection Order, S had been in temporary custody of the Department since 14 February 2007.

12. The incident which led to the order was S allegedly dropping her youngest sibling. S felt guilty about this and had later made numerous statements during supervised contact visits of words to the effect "*we could still be at home if I didn't drop bubby*". S was observed by Departmental staff to be domineering and 'parentified' with her younger siblings. S was described as a "very traumatised child" in a Departmental report.

13. Ms D was pregnant with her eighth child at the time of S's death. Four of S's siblings were also in care. Her two older siblings, from Ms D's first marriage) were considered independent adolescents (when the family first came to the attention of the Department) and were therefore not subject to child protection in Queensland.

14. Due to the Child Protection Order that was in place at the time of S's death, the Department had legal responsibility for the care and safety of S. Under section 74 of the *Child Protection Act 1999*, the Chief Executive of the Department was required, so far as reasonably practicable, to ensure that S's rights, as set out in the Charter of Rights for a child (Schedule 1 of the *Child Protection Act 1999*) were complied with. This included her right to a safe living environment. This reflects the paramount principle established by the *Child Protection Act 1999* that her safety, well being and best interests were paramount in all decisions made under this Act and the general principle that she had the right to be protected from harm.

Departmental Involvement

15. The Rockhampton North Child Safety Service Centre ('CSSC') was responsible for S and her siblings. The Centre had three teams, each with a Team Leader. The Manager of the Centre was Karen Abraham. S and her siblings commenced being case managed by the Children Under Orders Team on 6 November 2009. The Team Leader was Kylie Stevens and the Child Safety Officer ('CSO') allocated to S and her siblings were Liana Graham who had been a CSO since April 2008.

16. The Rockhampton South CSSC was responsible for T. T's CSO was Jane Carroll and the Manager of the centre was Julie Cook. The Rockhampton North and South Centres were part of the Central Zone (now called Region). The Zonal Director responsible for the operations of all child protection services across the Central Zone was Peter Smales.

17. From 8 December 2006 to 12 January 2009, S had had 21 foster care placements with 11 different carers. S was described in evidence as a bright, energetic and friendly child but the breakdowns in care arrangements were often due to her behavioural issues, particularly running away to be with her mother. Some carers had described S as very difficult and that she did not cope with some placements. Concerns regarding S's placements began to escalate in January 2009 with four different placements in a two week period.

18. The Out of Home Care Team was primarily responsible for recruitment and training of foster carers and making placement arrangements for children. Jacenta Jeha, a CSO with the Out of Home Care Team, was the acting placement officer assisting the CSO, her Team Leader and the Manager in finding a placement for S. A decision was made to place S at Lifestyle Solutions residential complex from 15 January 2009.

19. At that time, the Department's process concerning placements was in transition, moving from the old system of each CSSC across Queensland having its own arrangements, to setting up Placement Service Units ('PSUs') across the seven regions in Queensland. An Acting Director of the Placement Services Unit, Leanne Donaldson, had been appointed and was in the process of setting up the unit when S was placed at Lifestyle Solutions.

20. The PSUs are now responsible for fostering, kinship care, recruitment, training and retention activities of carers. Further, they take referrals from CCSCs and liaise with agencies to find appropriate matching for children and placements in the region. The PSU Officer receives a standard referral form from a CSO which provides detailed information in relation to a child's need, behaviours and other information required in relation to matching a child in a placement. If there is information missing on the form, the officer consults the state-wide information system and speaks with the relevant CSO before making a decision about an appropriate placement.

21. At the time S was placed at Lifestyle Solutions, there was no evidence that a kinship care arrangement with her older adult siblings had been considered. The *Child Protection Act 1999* sets out priorities to assist families in caring for children and a highly ranked option for that care provision is the placement of the child with kin and/or siblings if that is possible.

22. CSO Laina Graham, and the placement officer CSO Jacenta Jeha, were both aware at the time of the placement of S at Lifestyle Solutions that she had adult siblings. CSO Graham had not made any enquiries about the suitability of that placement for S as she considered it to be the out-of-home care teams' role to do that. The assessment of kinship care is a protracted process. Ms D accepts that there was no time to consider kinship care at the time of S's placement at Lifestyle Solutions, but felt a placement in a family home would have been preferable. Mr Smales gave evidence that the placement with siblings had been considered inappropriate at that time.

23. The evidence from the Department was that had kinship care been considered as a potentially suitable placement option, the process would have taken some time to complete the necessary checks, which include the kin's motivation for caring, their parenting styles, and situations that would impact on their ability to provide care for the young person. The Department had certain difficulties in exploring kinship care options prior

to S's death. After S's death, a kinship care arrangement was assessed for S's younger siblings in May/June 2009 and was not recommended.

24. The Department now have undertaken a kinship care project across the region to check on possible kinship care options to be explored across departmental files. The responsibility for this lies with the CSOs. The policy is in its early days and requires monitoring and ongoing development.

Lifestyle Solutions

25. Lifestyle Solutions is a residential care service providing out of home placements to children subject to statutory child protection intervention. Funding for a residential complex in the Central Queensland region was announced on 7 November 2007 to provide four places for young people aged 12 – 17 years with complex needs in the Rockhampton North and South, Emerald and Gladstone Child Safety Service catchment areas. The service was to provide worker support up to 16 hours per day, seven days per week plus sleepover shifts of eight hours per night. The specific proposed service users included young people with physical, intellectual or multiple disabilities and/or diagnosed mental health conditions including autistic spectrum disorders. Prior to November 2007, Lifestyle Solutions had not previously operated in Queensland. Lifestyle Solutions assert that their contractual obligation was to provide accommodation pursuant to the service agreement and not to assume the Department's responsibility for the child.

26. Jodie Manskie, a former Departmental officer in the area of Out of Home Care, was employed by Lifestyle Solutions in or around April/May 2008 to establish facilities or homes for Lifestyle Solutions in Bundaberg, Gladstone and Rockhampton. This included developing local protocols between Lifestyle Solutions and the individual CCSCs'). The protocols included referrals, liaison meetings, and raising concerns.

27. The Rockhampton Lifestyle Solutions complex was established at 298 Greenlakes Road, Glenlee, about 20 minutes from Rockhampton in a rural area. It is not clear precisely when it commenced operation but it appears to be sometime around September 2008.

28. In January 2009, when S and T were placed at Lifestyle Solutions, the protocols with the Department in Rockhampton had not been completed. However, the Bundaberg protocol was being considered by the Department's officers.

29. At the time of S's death the only formal meetings held between Lifestyle Solutions and the Department were the quarterly service reviews which were a mandatory meeting for Child Safety funded services. There were no liaison meetings occurring with the specific CCSCs. Any day to day liaison in relation to children was to be undertaken by the Lifestyle Solutions Team Leader.

30. A placement agreement meeting was supposed to occur within a few days of a child being placed in a Lifestyle Solutions complex but this would often not occur for three to four weeks. The purpose of the meeting was to discuss the behaviours of the child, the child's strengths and needs, family contact, and who is to do what in relation to appointments, etc. Placement plans were to be developed by the Department after these meetings and provided to Lifestyle Solutions. A placement agreement meeting for S's placement had not occurred prior to her death.

31. Staffing problems were being experienced in the Rockhampton Lifestyle Solutions complex at around the time of S's death. Lifestyle Solutions found it difficult to attract and then retain part time staff skilled in this area of work as there were a number of agencies in the area who were all competing for the same pool of staff.

32. When Lifestyle Solutions was first established in Central Queensland it ran a four day training program. However, with the high staff turnover, such training was not possible in each case and a buddy system was introduced where a new worker would be buddied for a minimum of six shifts with a senior worker who had been through the training to learn, so that the junior member learned the practicalities of how the system worked. Further, new staff were provided an opportunity to read the policies and procedures.

33. There were three primary sets of documentation used by Lifestyle Solutions. These included a communications notebook, progress notes for the individual child, and the incident report book. The progress notes were to be filled out at least at the end of each shift. The communication book was also to be filled out at the end of each shift and contained information about what was happening in the house and communication between staff. As well as the communication book, a verbal handover was given to staff coming on each shift. Incident reports were to be completed following any incident and forwarded to the Lifestyle Solutions supervisor by fax or email and it was then for the supervisor to provide a copy to the Department.

Analysis of the Issues

A. Circumstances surrounding the placement of S at Lifestyle Solutions

The Department

34. On 12 January 2009 a case conference/discussion was held between CSO Liana Graham and Ms D. The meeting was about a number of issues, including the family circumstances, access visits and the reason for breakdown of the last placement.

35. Due to the difficulties in placing S, a placement referral form was completed on 12 January 2009 by her case manager, CSO Liana Graham. The form states:

"*S's behaviour is an area that requires support due to recurring placement breakdowns resulting from challenging behaviours. The behaviours include defiance, lying and attention-seeking behaviours (ie. lying about doing chores/breaking things, telling frightening lies to younger children in placements, yelling to be centre of attention during visits, not listening to instructions and challenging adults about instructions they give). S tends to interact better in placements without other children.*

S exhibits a level of resilience, however she is in need of support to understand complex events that have occurred in her life. These include: abuse, separation from family and siblings, self blame for causing the event that initiated the Department to take all the children into care, and recurring placement breakdowns. S is also re-defining her role within the family unit at present, as she had previously assumed a parenting role towards her younger siblings."

36. The placement of S was a difficult, urgent and complex task for the Department.

37. An internal Department email from Jacenta Jeha, the Acting Placement Officer, was sent to Anglicare detailing that urgent placement was required for S as all departmental carers had been exhausted. Anglicare was a service provider supplying accommodation services to the Department. They would advise what options were available with their service and then she would refer these to the CSO for decision by the CCSC as to where the child would be placed.

38. Anglicare advised that Colleen Daniels was the only carer available. S had previously been placed with Ms Daniels but had become unhappy and ran away. As there were no other options, S was returned to placement at Ms Daniels on the night of 12 January 2009 but again absconded and was returned by QPS the next morning. Ms Daniels remained happy to have S back. She stated S had said she wanted to stay at her home but her mother kept telling her to run away. Ms D denies Ms Daniels evidence that Ms D encouraged S to run away and submits that it could be inferred from the evidence that S was telling different people what she thought they wanted to hear.

39. On 13 January 2009, Jacenta Jeha emailed CSO Graham advising there were no general foster care placements for S and proposing possible placement at Lifestyle Solutions. The email states: "*Lifestyle Solutions are funded for children aged 12-17 who fall within the Complex category. As S falls outside the age category, and at first glance doesn't present as having Complex needs, we will need the Zonal Director's approval in order to progress this."*

40. Later on 13 January 2009, CSO Graham completed a child information form. The details concerning behaviour and emotional stability were the same as documented on the placement referral form completed the previous day. This information was taken from the needs assessment which was completed in September 2008 and did not include S's absconding behaviour. CSO Graham stated that this oversight was likely due to the form being filled out quickly to get the placement happening.

41. Additionally on 13 January 2009 an email was sent between Jacenta Jeha and CSO Graham regarding the possibility of S staying at a foster placement at Wowan, 80km from Rockhampton. This was not thought appropriate by the CSO for a number of reasons including the distance from Rockhampton and because the placement was very short term. Another option was commercial accommodation in a motel room or caravan park supervised by a youth worker or a transitional placement which is a fee for service, rostered youth worker arrangement where the child is primarily isolated from others.

42. On or around 14 January 2009 discussions occurred between CSO Graham, Team Leader Kylie Stevens, Jacenta Jeha, the Acting Regional Placement Coordinator, Michelle Powell and the Manager of the Rockhampton North CSSC, Karen Abrahams in relation to considering appropriate placement options for S other than seeking a placement at the Lifestyle Solutions complex. It was agreed a referral would be made to Lifestyle Solutions after other funded residential facilities were considered. Anglicare LIFE program was identified as a suitable option however there were no vacancies. The LIFE program was a residential complex targeted to 12 to 17 year old children with a therapeutic focus utilising an employed psychologist. That program was not further considered for S at that time. It was agreed it would be unsuitable to move S to a different area within the zone due to sibling and parental contact.

43. Anglicare staff indicated in the review after S's death that it would have been beneficial for them to have had a round table with CSOs, Anglicare staff, and the foster carers to develop a placement plan to try and stabilise S before she was placed at Lifestyle Solutions. Jacenta Jeha said this was not common practice but felt it would have been helpful in this situation.

Lifestyle Solutions

44. Jodie Manskie, the Area Manager from Lifestyle Solutions explained the process of referral to Lifestyle Solutions. A CSO would initially contact her by phone to discuss the possible referral. If the referral was appropriate, a formal referral was filled out by the caseworker and forwarded to her for consideration. She would make an assessment against Lifestyle's criteria, which included matters such as the child's age, specific needs of the child, Lifestyle's capacity to take the child, the

duration of the placement and the personalities and needs of the other children in the house. Further, Lifestyle Solutions had a document for the 'matching' process which she would complete. Ms Manskie has advised she does not have a specific recollection of the conversations or processes she undertook concerning S's referral, however, she does recall speaking with the CSO from the Department and expressed a concern about the risk of S running away from the property which was located in a rural setting.

45. Ms Manskie advised because S was only 10 and outside Lifestyle Solution's service agreement, she would not accept a referral until she received written confirmation from the Department's regional manager that he approved the placement. Further, the Department's Community Support Team (who oversaw the funding and licensing of Lifestyle Solutions) had to be notified that Lifestyle Solutions was being asked to accommodate a child outside their service agreement. After consultation with the general manager of Lifestyle Solutions, a decision was taken to accept the referral.

46. The General Manager of Lifestyle Solutions accepted S's referral based on the knowledge the reason they got the referral was that the Department had gone through the placement principle steps, that being there were no other options available.

Conclusion

47. S had behavioural issues and due to exhausting the pool of foster carers in the region, the Department was having difficulty in finding a suitable placement for her. The Department seems to have been focused on the placement issue rather than attempting to address S's behavioural issues. For example, a case conference involving all stakeholders (including her parents) was not held to discuss the future management of S and what possible strategies could have been put in place prior to resorting to residential care. There was evidence however that stability of placement was required before therapeutic interventions to address behavioural and other issues could be put in place.

48. Due to the urgency of finding a suitable placement for S, Lifestyle Solutions was accepted as an appropriate option despite S being outside of the service agreement.

B. Considerations made by the Department in relation to the placement

49. Peter Smales and Kylie Stevens confirmed the placement of a child outside of a service agreement was not common (this had only occurred on one or two occasions over the last couple of years).

50. In considering a placement at Lifestyle Solutions, Jacenta Jeha said she would have been provided with some information verbally from Ms

Manskie about Lifestyle Solutions and the children already in care there however she did not recall the details. Unless a child was being placed with a Departmental carer there was no capability to search the ICMS (the Department's internal database) for other children in care with agency carers or residential complexes. It was an informal practice to give information to a carer in some form, usually verbally.

51. The Department's view is that the residential facility managers have the capacity to decline a placement for reasons including the inability to manage a child's behaviour.

52. No witnesses were able to recall any specific discussions about T already being placed at Lifestyle Solutions. Whilst both children were managed by the Department, at the time there was reliance on the external organisation to provide information to the Department in relation to the compatibility of the children being placed with them.

53. After consultation with the placement co-ordinator, CSO Graham sent a request to Mr Smales on 14 January 2009 seeking approval for S to be placed at Lifestyle Solutions. In the request, S's challenging behaviours were listed to include behaviours intended to deliberately breakdown a placement (e.g. repeated absconding including attempts to "shake off" staff in order to abscond), persistent lying (telling frightening lies to other children in care), defiance and inappropriate attention-seeking. S's behaviours had been assessed by CSO Graham as complex. There was no documented risk assessment in relation to S's absconding behaviour.

54. In oral evidence Jacenta Jeha said she saw Lifestyle Solutions as a primary placement for three to six months and it was contingent on how S progressed. It was suggested this was different to what was expressed in her email request to Peter Smales in reference to Lifestyle Solutions "*which will only be seen as a short-term measure until a suitable alternative placement can be sourced*". She then conceded that what she wrote in her email was her intention at the time.

55. On 14 January 2009, Mr Smales supported the placement on the basis of Michelle Powell and Leanne Donaldson's advice. Karen Abrahams said in her statement: "*It was identified that although not ideal, there were no other appropriate placement options for S other than seeking a placement option at Lifestyle Solutions*."

56. Leanne Donaldson says she was aware of the difficulties concerning the placement of S and contributed to the decision making process in placing S temporarily at Lifestyle Solutions. She was of the opinion that with the assistance from staff, S could work towards modifying her behaviour from complex to high needs and then be placed once again in foster care.

57. The placement of S at the Lifestyle Solutions complex was legislatively catered for pursuant to section 82(1)(f) of the *Child Protection Act 1999.*

The provision addresses the options available to the chief executive when placing a child. It provides options that fall outside the usual regime of approved kinship or foster care entities conducting a departmental care service, licensed services and provisionally approved carers. The Child Safety Practice Manual - third release (in place at the time of S's death) required the CSO to ensure the care provided was consistent with the statement of standards and other key provisions in the *Child Protection Act 1999*.

58. In oral evidence, Mr Smales said he saw his role in relation to the placement of S at Lifestyle Solutions to be around the contract arrangements rather than making a decision according to section 82(1)(f) of the *Child Protection Act 1999*. He confirmed Karen Abrahams had the delegated authority to make the placement decision under the legislation. However, he did say he not only turned his mind to the contractual issues but also safety issues around the child. Mr Smales confirmed he relied on the information provided by his staff and did not make any independent enquiries.

59. Mr Smales indicated he saw the vacancy at Lifestyle Solutions as an opportunity to be utilised. He said it was the first time he could recall in the region that after they had set up a residential facility, there were only two girls residing in the facility as they were usually filled with young males.

60. On 15 January 2009, Karen Abrahams signed an authority permitting Lifestyle Solutions to care for S from 15 January 2009 until 15 April 2009. Lifestyle Solutions accepted the referral for S. S was transported to Lifestyle Solutions by CSO Graham on 15 January 2009. She was introduced to staff and settled in. Regular phone contact with S's parents was arranged. CSO Graham telephoned S's parents to advise them of the arrangements. On 20 January 2009 Karen Abrahams wrote to Ms D and Mr R advising of S's placement and outlined their review and appeals rights in relation to the placement decision.

Conclusion

61. The Department was presented with a difficult and urgent situation regarding S's placement needs. S needed a placement where she could be settled and stabilised before consideration could be given to therapeutic interventions for her behavioural issues and a longer term placement.

62. It was an unusual circumstance for the zone to place a child outside of a service agreement into residential care. As such, additional safeguards and precautions were required. Mr Smales gave the final approval for the placement and he relied on information from his staff in making the decision.

63. Whilst it is appreciated the Department needed to find a placement urgently for S, the short-term placement option (with the foster carer at

Wowan) may have bought some additional time to fully investigate the suitability of Lifestyle Solutions or to source another foster placement after consultation with all stakeholders. On the other hand, the logic of attempting to find a longer term stable placement for S which Lifestyle Solutions offered is understandable in the circumstances. The placement was also located close to Rockhampton which would assist in the facilitation of family contact with S. Karen Abrahams and Peter Smales both say, even with the benefit of hindsight they consider the decision to place S at Lifestyle Solutions was the appropriate decision in the circumstances.

64. The speed in which the referral and subsequent acceptance of S by Lifestyle Solutions occurred potentially led to less information about and active management of S's issues being identified to Lifestyle Solutions than was ideal. Whilst Ms Manskie admitted in evidence she was aware S had previously absconded, this was not included on the placement referral form completed by CSO Graham. Ms Manskie's knowledge (which was fortuitous) meant that the omission in the Departmental information to Lifestyle Solutions was without consequence. However, if Ms Manskie did not happen to have that knowledge, the Department's omission could have been critical.

65. Further, there was no evidence of a risk assessment being undertaken by the Department of Lifestyle Solutions concerning S's history of absconding. Had this been properly considered, strategies may have been able to be put in place, or at least the staff at Lifestyle Solutions fully briefed on the issue prior to S's arrival to Lifestyle Solutions. Mr Smales considered that the rural location of the Lifestyle Solutions property amounted to a disincentive and a physical barrier to absconding.

66. There is also no evidence a genuine consideration of the suitability of the children S would be residing with at Lifestyle Solutions was undertaken. Peter Smales and Karen Abrahams (the decision makers) were not aware of who the other children were, including a 17 year old with an intellectual impairment and an 11 year old with a history of violence and aggression (who had been placed at Lifestyle Solutions but had not yet arrived at the placement). Both Mr Smales and Ms Abrahams were reliant on the information provided to them by others.

67. Due to the short time frame in which the placement was negotiated, the placement being outside the service agreement, and the fact S was being placed with older children in a non-foster care arrangement, the Department should have negotiated a management plan with Lifestyle Solutions at the outset. This could have included the Department closely monitoring how S was settling in and assessing whether the placement was indeed appropriate for a 10 year old. The Department did not address in evidence whether this desirable course was overlooked or rather was not possible or practical to achieve in the circumstances of the matter.

68. Initially S was quite happy at Lifestyle Solutions indicating that the Departmental decision on the basis of stabilising S in the placement was at least initially correct.

C & D. The previous history between S and T and the circumstances in which they were placed in the same residence

69. T and the other resident K, who resided at Lifestyle Solutions, were managed by the Rockhampton South CSSC. S was managed by the Rockhampton North CSSC.

70. T, who was then 11 years of age, arrived at the Lifestyle Solutions on 21 January 2009 (six days after S). The placement decision was taken on 8 January 2009 following the breakdown of a kinship placement with T's aunt in Brisbane which commenced in November 2008. The Department file note indicates T had been in five placements (the changes were predominantly due to carers not being able to meet T's challenging behaviours), one night in the watch house, and two nights in mental health since 14 October 2008 when T entered the Department's care. It was decided residential care would be the most suitable option for her. The Placement Referral Form states that T "*experienced difficulties interacting with peers…is easily agitated…on some occasions…displaying aggressive, physical behaviours…can be withdrawn and anxious on occasions…self-harms, and is aggressive to children, peers and adults*." According to Departmental records, T also had Attention Deficit Disorder, Autism and Defiant Disorder. Lifestyle Solutions management were confident that they were able to manage those sorts of dynamics.

71. On the day T was picked up from the airport by the carers from Lifestyle Solutions, S told K she went to the same school as T and said she was a big bully and S was afraid of her. A couple of days after T had settled in, K told the team leader at the time, Jarred, there were problems between T and S.

72. Whilst S was placed with Colleen Daniels in the last quarter of 2008, T was also placed there between 29 October and 2 November 2008. There is no evidence S and T had met prior to this placement. Ms Daniels had taken in another five children during the night before as an emergency placement. She was already caring for S, T and another child.

73. On 2 November 2008, T ran away from Ms Daniels' place on two separate occasions. Ms Daniels took T for psychiatric assessment at Rockhampton Hospital for risk of self harm. Ms Daniels indicated she had concerns for the other children in her care if T was returned to her care that evening. T was admitted to hospital over night.

74. On that night, Ms Daniels described T as 'losing the plot' in that she was self harming and smacking herself into walls. Ms Daniels says she removed S from her home to her neighbors place as it was 'pretty horrible'. Ms Daniels said S was quite distressed over that incident as she was a little bit frightened of T because of the behaviour and as T was a bigger child. T's behaviour was not directed to S and there was no direct problem between them during the placement other than what Ms Daniel's describes as "*normal, little niggly 10 year old stuff*".

75. On 3 November 2008, Ms Daniels refused to have T returned to her residence as she was concerned T may self-harm. Ms Daniels said she thought no child should have been placed with T because of her problematic behaviour. However, there was no information provided to the Department that there was this previous relationship between S and T, and therefore there was no flag to the CSO or others to warn of potential future conflict between the two girls.

76. On 9 January 2009 S advised CSO Graham that she wanted to change schools because she was being bullied at her current school. On 27 January 2009, CSO Graham attempted to locate a new school for S. S's parents and Lifestyle Solutions were to be consulted before a decision was made. CSO Graham said she did not recall making any enquiries as to who was bullying S at school. In oral evidence Team Leader Kylie Stevens said she would have expected further investigations to be undertaken, including clarifying who was bullying S.

77. The PSU now takes full responsibility for the placement management and the associated systems and processes for all new children and young people referred, and those with the current out of home care service system in Central Queensland.

78. Leanne Donaldson advised if there had been a serious incident between children and a decision made they were not to be placed together, there would be alerts placed in the information system around placement where records and documents can be attached. She confirmed placement unit officers would be looking at any alerts in place and having a look at the relationships between children. However, her evidence is contradictory on this point to the effect that there is no provision for alerts on the ICMS for recording conflict between children due to privacy concerns.

79. The circumstance of S being apprehensive about T's previous behaviour was not a fact which in itself would have precluded the subsequent placement of the two children with the same carer according to the evidence of Mr Smales. Julie Cook advised that where there are ongoing issues identified between children in care, and where their respective cases were being managed by separate offices, officers from the different offices will meet to discuss the case and to develop appropriate strategies jointly for the children.

80. Danielle Roff, the Lifestyle Solutions Team Leader, says she was not advised of the history between S and T and only became aware of it through the children. The general manager, Gary Christensen, said had they been made aware of a prior conflict between T and S before S was placed at Lifestyle Solutions, they would have had some serious reservations about placing the two young people together. Whilst it may not have changed the fact they were placed, he said it would have heightened their awareness and reservations about placing them together. He said they could have approached the Department for funding for an individualised worker for T or S.

81. Following lessons learned from S's situation, the PSU is now said to be across the needs and requirements of all children placed in the region. Six weekly meetings are held with funded residential services to check on the progress of children, and in some services there is discussion about new referrals and joint decisions are made between the service and the Department about accepting a child.

82. Ms Daniels considered she was not provided with enough information from the Department concerning the children she was caring for. She advised if she was provided with information concerning a history of sexualised behaviours and violence etc of a child it might be easier to care for the child. She confirmed she considered she was not provided with sufficient information about S before S was placed with her.

83. Further, Ms Daniels considered it would be helpful for carers to provide feedback to the Department when a placement ended. She thought it would be helpful if this feedback was provided by email directly to the child's CSO. Ms Daniels thought it was Department policy to fill out an end of placement agreement but she was never provided with the forms. She is not sure if they still exist but has filled out only a couple over the years despite having had hundreds of placements. Ms Daniels confirmed there was no policy on reporting on positive and negative interactions between children in care during a placement.

Conclusion

84. There was no evidence of actual conflict between T and S whilst S was placed with Ms Daniels. S was witness to T's aggressive outburst and behaviour which warranted the admission of T to the Rockhampton Base Hospital for psychiatric assessment which was frightening to S. Whilst T's CSO was aware of the outburst, there is no mechanism in place to notify the CSOs of any other children in the same placement who are witness to such an incident. This would be valuable so the children can be followed up by their CSO and treatment provided if necessary and the incident recorded for consideration in relation to future placements.

85. Prior to S's placement at Lifestyle Solutions, S notified CSO Graham that she was being bullied at school. This was not investigated and no enquiry was made as to who was bullying S. S had told K that she had known T at The Hall State School and that "she's a big bully" but there

was no evidence produced to the inquest that T bullied S. K has an intellectual impairment and her evidence was given 2 and a half years after the incident without having given a statement closer to the time of the incident. Her reliability despite her obvious honesty is a little questionable given the lapse of time and the lack of an aide memoir for her. There were also some conflicts between some evidence that K gave and evidence of other witnesses, especially in relation to the 000 call, which cast some doubt on her reliability.

86. Had T been identified on the system as a person in conflict with S, S may or may not have been placed at Lifestyle Solutions. The evidence was not clear as to whether there was in fact conflict between the girls prior to the placement other than what has already been described. The lack of certainty in the position is an indication of the need for improved notation of these issues in the Departmental records. Both Department and Lifestyle Solutions officers gave evidence that conflict between the girls would not necessarily have resulted in the termination of the placement of either child.

87. Ms Manskie gave evidence that she accepted the referral to place S at Lifestyle Solutions with an awareness that T had already been placed there and she did so with an understanding of T's aggressive physical behaviours. To that extent Lifestyle Solutions was positioned to act under their service agreement regardless of any deficit in the Departmental information with respect to either of the girls. Certainly, if the issue of potential conflict between the two girls had been noted, appropriate strategies could have been put in place at the outset. Besides recording this type of issue in the case notes, there is currently no mechanism for flagging that a child is in conflict with another child in ICMS.

88. There is a high level of confidence by Departmental officers in the PSU and it is considered within the Department that the initiative will facilitate the matching of children in placements such that the situation in this instance is unlikely to reoccur.

89. Whilst the establishment of the PSU is a positive initiative, there is no ability to flag on ICMS information of prior conflicts between children, or between children and carers other than by attaching documents. The placement assessment is reliant on the information provided by the CSO from his or her knowledge and a review of the ICMS case notes. If there is an inexperienced CSO, a new CSO to the child, or the conflict was some time ago, it seems highly unlikely the conflict would be routinely identified and provided to the PSU.

90. If any history of conflict is able to be recorded in a dedicated area which must be checked prior to a placement it would be less likely to be overlooked. Obviously it is still dependant on foster carers reporting incidents of concern, CSOs investigating issues of conflict, and the CSO recording the details in the dedicated area on the ICMS.

91. To assist in the identification of conflict issues and future placements, it would be helpful to obtain a feedback report from carers on the positive and negative aspects of the placement which could be used in future placement decisions and to inform new carers of specific issues concerning the child.

E. Action taken by the Department and Lifestyle Solutions to attempt to manage the conflict between T and S

92. S commenced living at Lifestyle Solutions on 15 January 2009. According to the Lifestyle Solutions file, only minimal admission and assessment details had been completed. There is no record in the Initial Assessment Form of any consideration of interactions with current or proposed residents. S was reported to be happy and pleased to be at Lifestyle Solutions prior to the arrival of T.

93. Lifestyle Solutions management accepted in evidence that it was the role of the facility to facilitate the care of the children with challenging behaviours. Both T and S fell outside the age range in the service agreement. Mr Christensen said that it was not unusual for Lifestyle Solutions before or since this incident to take children outside the age range with the consent of the Department and to take children with complex behaviours.

94. Ms Roff explained that the incomplete and blank Lifestyle Solutions assessment forms in S's file may have been started and on the computer but she was unable to confirm if this had actually occurred. Mr Christensen said a risk assessment should have been completed more quickly. Further, he thought given the circumstances, the Incident Prevention and Response Plan (IPRP) should have been completed for staff to follow. Mr Christensen confirmed he completed an IT search of Lifestyle Solutions' computers and did not locate any documents/assessment forms for S which he confirmed suggested they had not been started in hard copy or electronically.

95. Ms Manskie advised that during her visits to the Rockhampton complex she got to know the three girls placed there. She says she was aware of the events and personalities in the complex and the tensions and conflicts between the girls through calls from the Lifestyle Solutions Community Support Workers ('CSW'). Ms Roff worked onsite at the complex and observed and interacted with the children daily.

96. Ms Roff said whilst there were outbursts and moments of aggression she observed the three girls generally interacting well together. She said the girls did not clash all the time and there is always some level of conflict between residents in such environments. S and T clashed more because they were of similar ages and there seemed to be a power struggle between them. Management of the girls' behaviour was a day to day process. She was coaching CSW's in managing challenging behaviours on a daily basis and would have case discussions after every

incident to evaluate the CSW's response to the situation and discussed how the situation might have been managed better. They discussed different ideas and strategies and scenarios, to see how the CSW would respond to that situation. In oral evidence Ms Roff estimated the children got along probably about 50 percent of the time.

Incident Reports

97. T commenced residing at Lifestyle Solutions on 21 January 2009 (S had been there for 6 days). From 24 January 2009 to prior to S's death on 7 February 2009, there were eight incident reports concerning S. A description of the incident and action taken as documented on each incident form is set out:

1. 24 January 2009, 1.35pm
Description: "*T asked S to move away and S said no and T then hit S on the head and was sitting down when she struck her. She then hopped up and started to hit S, twice more* (sic) *pick up her belongings and then hit S on the head as she went past*";
Immediate action taken: "*Steve Smith rang Jodie 3-3.30pm to notify her*".

2. 24 January 2009, 3.30pm
Description: "*T through* (sic) *a small dart at S and called her a slut…T said S had said things in the shed…T had shove* (sic) *S against the wall in the shed, T was trying to continually intimidate S…At 9.15pm….T started arguing with S, K came down to tell the careers* (sic), *I saw T jump on top of S, she punched her in the nose, and grabbed her around the throat, and attempted to strangle S, I ran to the room and lifted my voice and instructed T to LEAVE THE ROOM she observed, and said that S had called her a nigger. S had finger marks around her neck and started vomiting; she said that she did not call T any names. 9.30pm trying to get girls to bed. S is now on the roof as she says that is the only place T cannot get her. I said we cannot keep her safe up on the roof, however S is refusing to come down*".
Immediate action taken: "…*call to the area manager at 9.30pm who told me as the department was not open till Tuesday we needed to contain the situation*".

3. 25 January 2009, 9.40pm
Description: "*S had bread and butter knife trying to break window of company car so she could drive it to her mums. Rang on call (Jodie), wasn't much we could do except try defuse situation, and monitor her while she was outside, because she is scared of the dark I knew she wouldn't go too far away from the house, which did happen*"
Immediate action taken: "*Steven Smith and Jodie Manskie*".

4. 31 January 2009, 5.15pm
Incident: "*We were driving home from out bush when half way home the girls started fighting. T had spate (sic) at S and had started punching her. The spit had landed on K so K responded by jumping over S and*

starting to punch T. We then pulled over on the highway. K then jump out an walked up the road while S an T were still fighting so we calmed S and T down then went an pick up K. We then got in to town an K jumped out an ran away when we got to a set of stop lights. When we got home S went for a shower".
Immediate action taken: (only page 1 of the incident report is available)

5. 31 January 20009, 6.30pm
Description: "*As T was walking around still very angry and when S got out of the shower T walked up to her an (sic) punched her in the ear*".
Immediate action taken: "*Rang Jodie Manskie, (Area Manager) Daniel (Team Leader). 9.20pm – Rm & TL phoned CSAH (Kylie) with update and reported K missing*".

6. 2 February 2009, 4.30pm
Description: *"I was standing at the desk of the police station when S came over to me and told me that she was going to go to her mother. I said "I don't want to hear it".*
Immediate action taken: "*Rang Danielle*".

7. 5 February 2009, 8.45pm
Description: "*Whilst I was chatting to T in her room, S walked to T's door from bathroom with towel wrapped around her, nothing else. I told S to go and put some clothes on and said is very inappropriate. S not complying straight away, she then kept grabbing her towel at the top pretending to flash herself. Told S its not right to behave in that manner around anyone, especially when we have male workers on shifts. After she went to put clothes on in her room*".
Immediate action taken: "*On shift was Adel, so I informed Adel of what S did, and filled out incident report*".

98. Further, there was an incident on 29 January 2009 where S had created a mess in the bathroom and T and K made her clean it up. S called T a derogatory name and T hit S. The progress notes say see incident report but an incident report has not been located.

99. Ms Roff provided evidence concerning the incident reports. In relation to the incident reports being passed on to the Area Manager, it was usual practice for a report to be prepared for the Department on a daily basis. The incident reports were all signed by Ms Manskie as the designated manager and the usual practice was that a copy would be sent to the Department. In this case it seems only one incident report was faxed to the Department.

100. Ms Manskie confirmed she received the incident reports on the day of the incident and actioned them accordingly but that often she did not sign the incident reports until she was next at the complex. Level 1 incident reports were to be sent to the Department within 24 hours and level 2 reports were to be sent within 48 hours. In addition, the on-call person (Ms Manskie at the time) would notify Child Safety After Hours

Service of the incident. Further, the internal Lifestyle Solutions incident spreadsheet should have indicated when the incident reports were forwarded to the Department.

101. The spreadsheet was an internal document which was forwarded to the general manager so he could see what was occurring across a region for the month. In S's case, Ms Manskie advised she sent the incident reports to CSO Graham. CSO Graham says she did not receive the reports.

102. Since the incident, Lifestyle Solutions no longer have level 1 and level 2 incident reports. All incidents are now to be reported to the Department within 24 hours.

103. The evidence did not show any double check procedure of whether reports were sent and received by the Department at Lifestyle Solutions or Departmental ends. There is no system for identifying the number of incident reports being received from a particular facility and that the Department is reliant on the facility providing the reports to the Department when an incident occurs. In the absence of the notification by the Incident Reports, the system seems dependant on the individual CSO who has direct contact with the child and the facility to identify any concerns.

104. Had the Department received the incident reports ledger 84 – 85 (24 January 2009) and ledger 86 (24 January 2009) the placement for all children in care at Lifestyle Solutions would have been questioned according to Mr Smales, and there would be some separation of the three children and based on the previous incident between S and T, an individual placement would have been found.

Notification to the Department

105. On Wednesday 28 January 2009 Lifestyle Solutions reported some difficulties to the Department as S was refusing to attend school. CSO Graham spoke with S. S said she was going to walk to her mother's place. Further on the same day, S reported to Child Safety Support Officer, Narrelle Kenny that another girl at the placement, T, had been sitting on her and the carer's were not doing anything about it. As a result a placement meeting was scheduled for 4 February 2009 to discuss the concerns.

106. On Saturday 31 January 2009, QPS contacted the Department After Hour's Service because a complaint had been made by Ms D that S was being bullied and had an earring ripped out. The After Hours CSO contacted the CSW at Lifestyle Solutions. The CSW advised there had been an argument and physical altercation between S and T and K had absconded. T was upset and threatened to kill herself. QPS had advised Lifestyle Solutions to bring the children to the police station as T was likely to be charged as it was her third assault on S in two weeks.

107. On Monday 2 February 2009, CSO Graham spoke by telephone with Ms D regarding the incident with T on 31 January 2009. CSO Graham advised Ms D that she would speak with the carers about protecting S from bullying by the other girl in placement. CSO Graham then spoke by telephone to Lifestyle Solutions about the incident. She was advised Lifestyle Solutions were concerned because S regularly stated she wanted to go to her mother's and tries to shake off carers. Further, CSO Graham was advised that S and T had been previously placed together and hated each other.

108. Team Leader Kylie Stevens said in oral evidence she did not have any concern with CSO Graham's management of the case following the incident of 31 January 2009. CSO Graham had made contact with Ms D and there was a plan to manage the girls.

109. Later on 2 February 2009 at 5.20pm, Lifestyle Solutions advised the Department After Hours Service that S had absconded from the police station at approximately 4.30pm. Sometime later, QPS advised the After Hours CSO that S had been located at Ms D's residence and that S refused to return to Lifestyle Solutions as she was being bullied and assaulted by another resident. QPS were not prepared to forcibly remove S.

110. On Tuesday 3 February 2009, CSO Graham contacted Ms D who advised that S did not want to return to Lifestyle Solutions if T was there and she would keep running away. Ms D agreed to bring S to the Department. CSO Graham advised Lifestyle Solutions that S had been located. Lifestyle Solutions advised CSO Graham that T was aggressive and tended to pick on S however S would stir T.

111. Later on 3 February 2009 CSO Graham and Team Leader Karen Tomlinson met with Ms D and S. S advised she did not want to stay at Lifestyle Solutions as she was sick of T bashing her. S was advised she could not live with Ms D and she could not keep running away as it was dangerous. CSO Graham asked S to notify them when she is not happy before running away.

112. Following this, a meeting occurred at Lifestyle Solutions between CSO Graham, S, Ms Manskie and Ms Roff on 3 February 2009. The dangers of running away were discussed with S. In response S raised the following concerns: T hitting her, that she was not allowed to go horse riding and she was not seeing her family enough. Further, there was a discussion regarding S's behaviour i.e. defiance, smashing property, not getting up for school in the mornings, stirring T (by using an electronic device to send messages to K knowing it left T out) and climbing on the roof with T. A number of strategies and outcomes were developed. These included:

1. S using a code word (red) when threatened or uncomfortable in order for staff to respond to provide assistance and intervene as necessary without aggravating T;

2. a ban on children entering each other's rooms;

3. S notifying carers when she needs time out and one on one time could be organised;

4. Not climbing on the roof and finding somewhere else in the yard for time out;

5. Respecting staff by not swearing at them and doing as she was asked;

6. An earlier bedtime so she could get up earlier without being tired;

7. Investigating whether horsemanship classes could be arranged;

8. Investigating further activities.

113. S was reported as being happy to be at Lifestyle Solutions at the conclusion of the meeting. It was agreed the placement meeting which due to be held on Wednesday 4 February 2009 would be postponed to the following week in order to give time to trial the strategies before a review of the placement occurred. CSO Graham said in oral evidence even if she had been aware of the previous incidents she would not have been of a different opinion as to what had been put in place because she considered the meeting with Lifestyle Solutions had been successful.

114. CSO Graham did not make any contact with T's CSO after the meeting or when she was first advised of the conflict to find out more about T. CSO Graham conceded this could have been helpful. She said she never had any discussions with Rockhampton South CSSC and was not advised by the team leaders to do so. She said it was kind of viewed as a separate department. She agreed she assumed the information about T would have been provided to T's CSO.

115. Ms Roff said the plan would have been communicated to staff verbally and the document outlining the strategies could have been made available to staff once it was completed (it had not been completed at the time of S's death). Further she advised it would form part of the Incident Prevention and Response Plan for S but as S's file was empty it could have been in the process of being developed.

116. It would appear that neither of the CSW's caring for the children on the day of S's death were aware of the meeting between the Department and Lifestyle Solutions and the strategies that were to be adopted. In particular, neither CSW looking after S on the day of her death were

aware of her code word to alert them that S was concerned about the behaviour of T.

117. Ms Manskie provided evidence that she had considered moving S to the Lifestyle Solutions residence in Gladstone rather than T as S was a better mix for the children already in care in Gladstone. She was unable to confirm when she suggested Gladstone as an option but thought it may have been around 31 January 2009 but it was an emergency overnight scenario. Ms Manskie had a conversation with CSO Graham prior to the meeting of 3 February 2009 as to whether Lifestyle Solutions was the best environment for S to return to.

118. Ms Abrahams indicated in her statement that had the incident not occurred on 7 February 2009, it is likely discussions would have been held between Rockhampton North and South CSSC's to collaboratively case manage the conflict and behavioural issues of T, K and S residing together at Lifestyle Solutions. It was considered with ongoing support from the Department and Lifestyle Solutions given time, appropriate intervention and appropriate behavioural and support plans, the conflict between the girls would have gradually dissipated.

119. Since August 2010 a regularly monthly meeting is convened between a number of stake holders in the Rockhampton region to collaborate in planning, developing and delivering an integrated out of home care (placement) service system responsive to the support needs of children and young people in care or entering care. The initiative is called the Rockhampton Options for Collaborative Caring Initiatives ('ROCCI').

Behaviour Management

120. Ms Roff confirmed the behaviour was not simply limited to T bullying S. S was considered to "niggle" T and they were agitating each other. An example was that S would call T a "nigger" which T was particularly sensitive to.

121. Ms Manskie advised in evidence she was often contacted when T's behaviour escalated. She had discussions with Ms Roff about strategies which could be put in place to address the conflict between T and S. These included trying to keep the two girls separate and having two staff present at all times, with one CSW to look after S and one CSW to look after T. Ms Manskie said it was her expectation these strategies would have been communicated to staff.

122. Ms Roff confirmed that besides verbal communication there was no system in place for the Team Leader to communicate with Lifestyle Solutions staff any specific issues concerning a child; this was particularly relevant to communicating to weekend staff who she did not see. Since S's death, there is now a section in the communication books for the Team Leader to communicate with staff. It was an expectation of a CSW's role to be aware of the progress of the children by regularly

consulting their progress notes, the communication book and incident reports.

123. There was a reported fear on the part of CSW's of physically intervening between children. They were concerned about having their Blue Card cancelled if a complaint is made regarding physical contact if the complaint is substantiated. Lifestyle Solutions currently addresses this through induction and whilst they have a hands-off policy for everyday interactions, advice is provided to staff that they are to use as much force as reasonable to remove a child from physically hurting another child but then let them go (and adopt the PART principles - Predict, Assess, Respond, To aggressive behaviour). If there was an incident and a worker did not intervene this would be addressed when the incident was reviewed. At the time of S's placement they had not adopted PART.

Conclusion

124. There was a clear breakdown in communication between Lifestyle Solutions and the Department, and between Lifestyle Solutions and its employees. The Department did not receive the incident reports concerning S and T, and was therefore not aware of the extent of the conflict. The assault on 24 January 2009 which left S with marks on her neck and vomiting is particularly concerning. The Deprtment was entitled to a reasonable expectation to be promptly informed by Lifestyle Solutions of any matters and concerns affecting the care of S and communication from Lifestyle Solutions was simply inadequate.

125. Compounding this issue was that the Department's system (where there was a lack of incident reporting from a facility) was reliant on the individual CSO to identify issues of concern. It took a telephone call from Ms D to the police on Saturday 31 January 2009 for the Department to be aware of the significant issues between T and S. Even then the history of the previous assaults or the extent of the animosity between the children was not fully disclosed, nor did the Department investigate the issue to any extent, for example, visiting S on Monday, 2 February 2009.

125. It seems arguable had action been taken at the time and strategies appropriately communicated to all staff at Lifestyle Solutions, S may not have run away from the police station to her mother's house later that afternoon.

126. The staff caring for S on the day of her death were not aware of the strategies developed by the Department and Lifestyle Solutions to manage the conflict between S and T at the meeting on 3 February 2009. There was a clear failure by Lifestyle Solutions to communicate the strategies to their staff and to ensure their staff had the skills to manage the behavioural issues between S and T.

127. Further, Lifestyle Solutions' policies and procedures were lacking. The assessment and admission paperwork for S was incomplete and the training of its staff was limited at best. In addition, its internal communication strategies were flawed. The combination of all of these issues meant the staff caring for S would have often been ill informed and less well equipped than they might have been to manage the high conflict situation which was developing between S and T.

F. The initial management of the incident at Lifestyle Solutions on 7 February 2009

Lifestyle Solutions

128. There were two carers on duty at Lifestyle Solutions on the day S died, Lorna Bounghi and Kerry Tarran.

129. Lorna Bounghi did not receive orientation when she started with Lifestyle Solutions in September 2008 and prior to the incident the only training she received was first aid training. Lorna said whilst she was aware of bickering between S and T she was not aware of any previous physical alterations.

130. Kerry Tarran also did not receive any training when she started working for Lifestyle Solutions and was not provided with any orientation concerning the complex and how it was to operate. She was aware there was a folder for each child and a communication book which was to keep a record of everything that occurred but she was not provided direction on their use. She also advised she had been told a handover or debrief was to occur between the person on the pervious shift and herself. Incident reports were for a significant event and the usual process was to complete it before the shift finished and given to the Team Leader.

131. Kerry Tarran was not told very much about the children and why they were at the Lifestyle Solutions complex. She knew K had previously left the property but she did not know S had left the supervision of carers at the police station on 2 February 2009. She was not aware of what had been occurring between T and S on the day of S's death and the issue had not been discussed at staff meetings. Kerry Tarran said she was aware there was some animosity between S and T and that S was scared of T because T bullied S a number of times.

132. On the day in question, T was angry and S asked Kerry to take her to her mother's house because she did not feel safe. Kerry advised S she could not do that but she offered to call Jodie or Danielle to see about alternate accommodation but at the time K was using the phone. S told Kerry "*T's going to kill me*" and that she was visibly upset. Whilst Kerry Tarran was attending to S, she thought T was packing her bag. T then came with her suitcase and said she had to leave otherwise she was going to kill S. Kerry advised she did not think T was going to physically

try and kill S, just that she was angry and was going to do something to S (following T accusing S of tearing up one of her photographs).

133. K noticed S in the food cupboard and told her to go into her room on the ground floor (S's room was upstairs). K then made some popcorn and took it into her room where S had gone and shut the door. Lorna says whilst T was arguing with Kerry about providing her with phone numbers in order to leave the facility, K and S walked off to the main gate at the front. She says she followed them out and asked where they were going. K said '*we're going to see the horses*' and Lorna responded '*Ok, stay together and be careful*'. Lorna said she watched as they walked to the horse paddock and said it was quite common for the girls to go to the paddock. She says this would have been approximately ten past three and it was the last time she saw S.

134. Lorna felt that there were no house rules concerning the girls visiting the horses, nor how long they could stay down with the horses. The carers were able to see the horses from the house.

135. K said in oral evidence that at no time that afternoon did S go down to the horses. K says S went into her room after the photograph incident then climbed out her window and escaped. K says she rang S on S's mobile and S said *"I'm more than halfway down the road*" so K cut through the paddock when the carers could not see her to go to S. Later in evidence K said she was in the yard playing basketball by herself when she got the call from S. Again later in evidence K said she told the carer she was going down to the horses and should be five minutes. She could not see S and then she cut through the paddock. Lorna's evidence about the girls leaving the house is more reliable than K's multiple versions.

136. K said Ms D's mother had given S a mobile so she could keep in touch with her family. K said one of the carers knew S had a mobile phone. She said that after they left, the police passed her and S on the road (on their way to the complex) and it was daylight at the time.

137. Lorna says she was looking out through the blinds of the office window and could not see S and K so she went down to the paddock. She walked around the paddock calling out for the girls. She could not see the horses either so she thought the girls were further in the paddock, out of sight, with the horse. Lorna says as she walking to another area of the paddock she heard a loud scream come from the house so ran straight back to the house to see what was happening.

138. While Kerry was in the office considering ringing Danielle and Jodie, T came in and was demanding the black box which held all the contact details. Kerry advised T she could not give it to her but would make a telephone call for her. T was screaming and wiped everything off the desk. Kerry became frightened for her own safety. Lorna went into the office as T was leaving. Kerry shut the door to tell Lorna what was going

on and then T starting banging on the other side of the door. At this time Kerry does not recall where S and K were and denies having a conversation with Lorna about them.

139. As T was continuing to bang on the door, Kerry went to open it to try and calm T down but realised the door would not open because T had hit the door so hard, the barrel in the door jammed. Kerry phoned Jodie Manskie to tell her they were stuck in the office and could not get the door open. T then came around to the veranda and opened the office window; she was screaming and was still demanding the black box. She reached through the window and pushed the fax machine off the cabinet. She had a stick in her hand and was trying to come through the window. Kerry said she was really scared by this stage and she tried to calm her down by writing some numbers down for T and while T was screaming she called the police. She called the Child Protection and Investigation Unit ('CPIU') not '000', she thinks probably due to nerves.

140. At approximately 4.40pm, Plain Clothes Constable Whitmee (of the Rockhampton CPIU) received a call from Kerry Tarran advising that T had jammed the door shut so the carers were unable to open the door and was threatening to assault the other children at the address and damage property. Plain Clothes Constable Whitmee attended the Rockhampton Police Communications Centre and advised Communications Officer Scott of the information provided by Kerry Tarran. As a result a job card for a first response unit to attend the address was commenced.

141. At approximately 4.43pm a request was made for police to attend a disturbance at 298 Greenlakes Road. Acting Sergeant Gary Mabb authorised a crew to proceed Code 2 (lights and sirens) to the address. He also authorised a second crew to attend and the District Duty Officer ('DDO'), Sergeant Burgoyne (Acting Senior Sergeant at the time) to proceed as Code 3 (no lights and sirens).

142. Sergeant Burgoyne, on his way to the scene, asked for Queensland Fire and Rescue and the Queensland Ambulance Service to attend the scene. He also advised the crew which had arrived at the scene to remove any ancillary persons from the area so T could not see them and be distracted by them. Sergeant Burgoyne says he also asked that Sergeant Kerry Duffy, the negotiating coordinator, be contacted to make someone available.

143. Constables Collins and Warby arrived at the residence approximately 13 minutes after being tasked (i.e. 4.56pm). Upon their arrival, they observed two carers at the front of the residence and T who was by then standing on the roof. Constable Warby began to speak to T to talk her down from the roof. T was very emotional and yelling and screaming about wanting to kill herself. Constable Collins provided information to Rockhampton Communications and then spoke with the two carers. At

about 5.11pm Constables Tonkin and Wilkinson arrived and provided an update to Rockhampton Communications.

144. Lorna Bounghi says the police were very concerned that T was on the roof but she and Kerry were trying to suggest to the police this happened all the time. However, the police took over and they were told to get out of the way as the police thought T's behaviour was linked to them. Kerry said she had a conversation with police when they arrived, she mentioned there were two other children and said that Lorna told her the girls had gone for a walk.

145. When Sergeant Burgoyne arrived at the scene at 5.27pm he took over command of the scene. Constable Tonkin advised Sergeant Burgoyne of the situation upon his arrival. Sergeant Burgoyne asked for contact details for T's mother and arranged for her to be brought to the scene. Sergeant Burgoyne did not receive any direct information from T from what she said or what she did that gave him an indication she was threatening to harm herself. He said at the time the focus was on T and he was not aware of any other children residing at the residence.

146. Police Liaison Officer's Asse and Bowman were working that afternoon. They heard the surname that both K and T shared (although they were not related) broadcast over the police radio and assumed K was on the roof. They attended K's parents' residence to get them to assist by attending 298 Greenlakes Road. Before they left, they then heard a radio broadcast indicating it was T, not K on the roof. They left K's parents residence and commenced travelling towards 298 Greenlakes Road to provide assistance. They got as far as the turn off to Greenlakes Road from the highway when Sergeant Burgoyne requested no further cars were to attend the scene.

147. Senior Constables McKean and McWilliam arrived at approximately 5.30pm and took up position at the front gate. Further, at 5.30pm, Constables Richardson and Rose were tasked to attend T's mother's residence to bring her mother to 298 Greenlakes Road.

148. T stayed on the roof, threatening to jump off and hurt herself. T was screaming and saying she wanted her mum.

149. Lorna said the children found it easy to get on to the roof and frequently did so. She confirmed they went on to the roof to get away from everyone and not as a threat to themselves. Kerry confirmed it was a regular occurrence for the children to get on the roof, perhaps even on every shift. Kerry said the house has a sloped roof and it was easy to climb on the veranda rail and then roof. Danielle Roff said besides a general conversation about safety, no measures were taken to keep the children off the roof. It was seen as a self imposed time out space for the children. The property was leased and there was no consideration given to making an application to the owner for physical alterations like guardrails or some other sort of barricade to stop access to the roof.

150. The negotiator contacted Sergeant Burgoyne to say she was coming to the scene in her own vehicle. By that stage QAS and QFRS had turned up and were parked near a shed just outside the property. Just before the negotiator arrived at 5.42pm, the police had been able to talk T off the roof. After T came off the roof, she told Constable Warby she and S had a fight and S had run off and as a result T had got on the roof.

151. Constables Richardson and Rose and T's mother arrived at 298 Greenlakes Road at 6pm.

152. It was decided T required a mental health assessment and her mother accompanied T to hospital with the QAS. Constable White and Plain Clothes Constable Whitmee arrived at 298 Greenlakes Road at 615pm. They were tasked with following the QAS with T in it, to the Rockhampton Base Hospital to complete an Emergency Examination Order.

153. The police claim they were not informed about S and K not being at the facility until after the incident with T had settled down. Sergeant Burgoyne said as the ambulance left, the carers advised him the other two children, S and K had gone missing. According to the IMS job sheet this was at 5.55pm. Sergeant Burgoyne says he reported the outcome of the incident concerning T and the evolving case regarding the missing girls to Inspector Somerville.

154. Lorna admits at the time she was focused on T as she thought she was going to harm herself and it was not until after the ambulance and fire brigade had left that she told Kerry who then immediately advised the police. While T was still on the roof, a preliminary search was undertaken by the carers to locate S and K. Kerry said they worked out they had been missing for about 45 minutes before the police arrived.

155. Kerry Tarran advised she called Jodie Manskie (the person on call that day) and told her about the police being at the complex dealing with T and that S and K were missing. Kerry says she was instructed to get police to leave and to find the girls. Kerry told police this but they said they were in charge and they were looking for the two girls.

156. Jodie Manskie said in evidence she does not recall telling Kerry or Lorna to get rid of the police but admits to becoming frustrated and raising her voice as she had to tell them to stop and listen to what she was saying. Jodie says she instructed the staff to try and locate S and K as the police were dealing with T.

157. Lorna and Kerry gave police a missing person report for S and K. Some of the police walked down to the dam and she and Kerry walked right around the paddock but could not find the girls. It was then they realised they were not on the property. Lorna estimates this was at about

6.15pm. She says she and Kerry gave the police a description of the girls and then the police left.

Conclusion

158. In the first instance it is obvious Lifestyle Solutions was not managing the children climbing on to the roof. There was no clear policy in place in relation to this frequent activity undertaken by the children who resided at the facility.

159. The Lifestyle Solutions internal communication processes were poor with the carers not being aware of S's history of escapes and the level of conflict which existed between S and T prior to the incident with T. The carers did employ some strategies to manage T but were faced with an explosive aggression from her and nothing was likely to work on that day.

160. Whilst Lifestyle Solutions carers did not have any clear strategy in place when T's behaviour began to escalate, it is acknowledged, it would have been a difficult and highly charged situation. It appears the incident with T was beyond her normal behaviour with Lorna Bounghi concerned T would harm herself. One can see how the immediate focus would have been on T but it is unfortunate that after police arrived the carers did not turn their attention to attempt to locate S and K.

161. Access to the roof was regarded by carers more as a safety valve than anything else. It gave the children the opportunity to be away from carers and other children in a time out of own choosing fashion. It arguably offered carers a mechanism with which to manage children with entrenched behaviours. Climbing onto the roof from the high rear slope was not inherently dangerous but access to the front of the roof and the two storey drop was. The Department submits Lifestyle Solutions was not managing the activity but it seems they were tolerating it so that the safety issues were not pushed.

162. The Department argues that the final fateful absconding on 7 February can only be understood against the background of S's fraught relationship with T and her habitual absconding behaviour. The Department further submits that the evidence shows that S was not scared when leaving Lifestyle Solutions, was calm when walking to the horses, the earlier incident with the photo had been resolved, she was not leaving as direct response to aggression by T although T's aggression in general and on that day was probably a factor. She had her bag packed the night before probably so she could abscond when the opportunity arose which the incident between T and the carers afforded.

163. The initial police response appears to have been appropriate in the circumstances. They had a child who was reportedly threatening to jump from the roof, and they were not informed until after the incident of the missing girls.

G. The QPS Search for K and S

164. Sergeant Burgoyne was the relieving District Duty Office ('DDO') on 7 February 2009. His supervisor was Inspector Darren Somerville. Sergeant Burgoyne was relieving in the position of DDO for two weeks and had been in the role since the previous Monday. He had not acted in the role previously but had undertaken a similar role as an On-Road Supervisor. Sergeant Burgoyne had worked as a police officer in Rockhampton for 19 years and had lived in Rockhampton all his life.

165. Inspector Somerville had been an Inspector since March 2006 and had been in the Rockhampton area since 2004. His supervisor was Superintendent Wockner, the District Officer. There are four inspectors in the region who are rotationally on call. Inspector Somerville was on call the night of S's death.

166. The Rockhampton communications centre was managed by the officer in charge, Senior Sergeant Shane Thomas. The Communications Coordinator ('Comco') on shift was Sergeant Mabb. The operator who took the 000 phone call from K was a civilian radio operator ('CRO') Steven Barry. At the time of the call Steven Barry had been employed as a CRO for 12 years in the Rockhampton communications centre.

167. The details of the QPS involvement are recorded on the Incident Management System ('IMS') job card which is completed by the communications centre in relation to a job that comes in for detailing to crews. The information recorded is received by phone and radio. It is a running sheet of a job as it evolves.

168. The QPS has various policies and procedures relevant to searches. These include Operational Procedure Manual sections on Major Incidents, Search and Rescue and Missing person occurrence; Rockhampton Police District Standard Operating Procedure ('SOP') Missing persons and attempted abductions; and SOP Search and Rescue.

169. Initially Sergeant Burgoyne said in oral evidence he had been operating on the assumption the girls had gone missing at around the time T went on the roof and was not aware they may have left the property earlier. On being recalled to provide further oral evidence Sergeant Burgoyne confirmed he had a conversation with Senior Constable Mabb at the communications centre and in that conversation he said S and K had been missing for an hour, maybe two hours. By this time, the girls had the opportunity to travel quite a distance from Lifestyle Solutions and it seems likely from the evidence that they had crossed the Bruce Highway before the police attendance at Lifestyle Solutions property. The distance that the girls had traveled before the police became aware that they were missing was a major factor adversely affecting the prospects of them being located before dark.

170. Sergeant Burgoyne explained in a missing person case a risk assessment is undertaken of the incident. The risk is assessed as low, medium or high depending on the circumstances. In a low risk situation initial inquiries are made with friends and relatives, in a medium risk situation a number of crews will be tasked to conduct patrols, and in a high risk situation a structured land or marine search is coordinated by Search and Rescue Mission Coordination ('SARMAC'). The reporting officer (i.e. the officer completing the missing persons report) is responsible for completing the risk assessment. Sergeant Burgoyne said he did not complete a risk assessment document but assessed the situation with S and K as a medium risk.

171. On the day in question Sergeant Burgoyne asked Constable Tonkin to start taking details for a missing person report (which would later be logged into the computer system). Whilst Constable Tonkin obtained information from the carers, Constable Wilkinson started driving down the road using the microphone to call for the girls.

172. Once Sergeant Burgoyne advised the communications room that K and S were missing, Senior Constable Mabb and Sergeant Burgoyne organised a search of the immediate area. A "Be on look out for" ('BOLF') was issued including a description of the girls and was broadcast on the police radio at 6.09pm. The BOLF was not broadcast again. There are many situations where police officers for various reasons would not hear radio transmissions from Comms or between crews if only one broadcast is made.

173. Senior Constable Mabb prioritised the search over all of the other incidents received by the police communications room. Sergeant Burgoyne said taxi drivers had been asked at 6.38pm to keep an eye out. Sergeant Burgoyne said he had asked for the Capricorn Helicopter to assist in the search but it was out of service. Sergeant Burgoyne said this was the first time he was aware that children had been reported missing from a care facility in a rural area. Senior Constables McKean and McWilliam searched the dam on the property.

174. Sergeant Burgoyne then requested Constables Tonkin and Wilkinson to start patrolling for the missing girls. It was assumed by the police that the girls were likely to be travelling towards Rockhampton. They patrolled down Greenlakes Road, Olive Estate and Greenlakes Road to the Bruce Highway and Bruce Highway back to Glenmore shopping area. They used a microphone to call out for K and S and to advise they were not in trouble in case they were hiding from police.

175. Senior Constables McKean and McWilliam were told to commence patrols of Greenlakes Road, Olive Estate and Bruce Highway areas towards the city. They had not been formally tasked to the job but were attending of their own initiative in case they could assist. They had no identifying information about the girls. Senior Constable McKean said he had lived in Rockhampton for the last 16 years and was aware there

were three ways to get into Rockhampton from the Lifestyle Solution location. They were not provided with any instructions (apart from it was likely the children were heading back into Rockhampton) from Sergeant Burgoyne and they were sent out to patrol the area.

176. Sergeant Burgoyne told Constables Richardson and Rose to commence patrols. They conducted patrols of Greenlakes Road and the immediate bushland adjacent to the road, Perrott Drive, Constance Avenue, Sheldon Road, Mildura Road and returned to the Bruce Highway. They ceased searching at 7pm when they were tasked to another job.

177. Constable Richardson was provided with a description of the girls and what they were wearing. She was instructed by Sergeant Burgoyne to start conducting patrols in the area around Greenlakes Road, the house and the immediate vicinity around the house. She did not recall being advised how long the children had been missing but made an assumption it was when the incident involving T on the roof began. They had been advised the children were possibly heading for Rockhampton. Constable Richardson had lived in the local area for 12 years and knew there were three routes back to Rockhampton. She said she had a discussion with her partner about moving to patrol the Dawson Road/Belmont Road way into Rockhampton just before they were assigned to another job by Comms at 7.20pm. They did not have a discussion with Sergeant Burgoyne before being tasked to the next job which concerned a domestic dispute.

178. Police Liaison Officers ('PLO') Asse and Bowman had been heading out to the Greenlakes Road when they were advised no further cars were required. They decided to return to town however they drove down Belmont Road to satisfy their curiosity as neither had ever travelled down the road and it was one potential route for the girls to have taken. They drove down Belmont Road for approximately 2kms while it was still daylight. PLO Bowman stated they had not been tasked to the search and were just keeping a look out as part of their regular patrols.

179. Sergeant Burgoyne stated that there was no grid search or allocation of specific areas for the search but rather that the idea was that the patrols would overlap as they were looking for the girls, in contrast to a SARMAC search with a topographical map marking off areas as they were searched.

180. Sergeant Burgoyne stated there were three routes from Lifestyle Solutions by road and two which could have been taken by foot. He said he was aware of the three routes by road at the time of the incident but has subsequently identified the two routes by foot. He confirmed he did not give any specific instructions to his officers of what roads to search on. Most of the officers searching were not that familiar with the area and only knew one way back to Rockhampton (along Greenlakes Road to the highway).

181. There was evidence that a search involves the officer being instructed on the area to search and when that is exhausted they seek further instruction. There was no evidence of any officer seeking further instruction from Sergeant Burgoyne.

182. Sergeant Burgoyne left the scene and drove to a location nearby in case S and K were watching the house. As it was getting close on dark and the police had not located S and K as they thought they would, Sergeant Burgoyne contacted Senior Constable Gawne of SARMAC at around 7.24pm to get his advice as to what should happen including whether a land search should be undertaken. It was considered this would not be feasible as it was getting dark. Senior Constable Gawne suggested to Sergeant Burgoyne that he contact Constable Williams, the Assistant SARMAC as he was more experienced with land searches.

183. Sergeant Burgoyne says he spoke with Constable Williams and sought his advice about locating the children. He suggested 4 kilometre boundaries for the search based on the time they had been advised the girls had been missing. The SARMAC officers both suggested SES be activated in vehicles (not a foot search) to get some more eyes on the road. Sergeant Burgoyne relayed the information to Inspector Somerville.

184. At 7.07pm Sergeant Burgoyne sought approval from Inspector Somerville to deploy the SES. Whilst this was initially agreed to, Inspector Somerville changed the approval decision on the basis that at the time he did not believe the SES would be effective (on the basis that a foot search was not viable in the dark). He said in his mind the children were not lost but had run away and on previous occasions they had turned up at their parents house. He thought they did not want to be found because of the patrols they had already made around the area. Inspector Somerville briefed his supervisor, Superintendent Wockner, about the case and discussed the deployment of the SES but Superintendent Wockner agreed that the SES would not be effective in the circumstances relayed to him.

185. Constable Tonkin contacted Ms D to advise her S was missing and to enquire if she had seen S. Ms D indicated she would check the park near the Southside pool. Ms D was asked to contact the police if S arrived. Constable Tonkin also attended the residence and spoke with K's mother who did not know the location of the girls.

186. At 7.15pm, Senior Constables McKean and McWilliam attended K's parents' residence and spoke with her mother and father. In doing so they patrolled the Bruce highway back into town. K's parents advised neither S nor K had been at the residence and they were unable to provide a contact number for either S or K as K had just got a new number. They returned to the station as they were due to finish their shift at 8pm.

187. Sergeant Burgoyne said enquires were made with the carers at Lifestyle Solutions to obtain contact phone numbers for the girls but none were known. Sergeant Burgoyne intended on following this up on his return to the station with a QPrime check which was the only practical search available to the police in the circumstances.

188. Senior Constable Mabb said "*I recall that this search was continuing for about an hour probably without success. During that time other calls for assistance were being received in the Police Communications Room, and at some point I had to start prioritising crews to attend those jobs as well*." He confirmed he was not keeping a track of the search and advised if the DDO is in charge of an incident including search co-ordination and requests for more resources.

189. Sergeant Burgoyne said there was no record in the IMS as to when the search vehicles stopped searching. He knew that essentially he was the last car at the scene but later said he thought Constables Wilkinson and Tonkin were still patrolling the area until the traffic accident with S occurred. However, Constables Wilkinson and Tonkin had returned to the station at 8.30pm to start writing up the missing persons report.

190. Sergeant Burgoyne had not been advised by the communications centre that the crews who had been tasked to search were assigned to other jobs and he had not been made aware Constables Wilkinson and Tonkin had returned to the station. In effect, he thought the search was still underway when in fact it was not. Sergeant Burgoyne was not aware of this until he was giving evidence at the inquest many months after the events.

191. Senior Sergeant Graham Patterson, the officer in charge of the Rockhampton communications centre at the time of the incident, said when the officers stopped searching they should have informed the communications centre and Sergeant Burgoyne. Sergeant Burgoyne said the Comco (Senior Constable Mabb) should have spoken to him before allocating the officers assigned to the search to any other jobs as he was in charge of the incident. He advised there is no formal handover to oncoming staff and that the Comco will advise of any BOLFs and major incidents but will not provide an update status of all jobs still open. Senior Constable Mabb confirmed it was possible Sergeant Burgoyne would not have known the units had stopped searching or had been tasked to other jobs if he had not been listening to the radio at the particular time they were tasked to that other job, or booked off.

192. Sergeant Burgoyne advised as well as managing this incident he was still responsible for his DDO duties and was taking calls concerning other incidents. Sergeant Burgoyne said he had not had any training in incident command training prior to the day S died. He confirmed he was operating on limited experience as a Sergeant of police and the induction package he had read in relation to the DDO duties. He said he

was used to investigating incidents rather than managing an incident. He has subsequently completed the Incident Command training.

193. At around 9pm the Mental Health Unit at Rockhampton Base Hospital released T and Constables White and Whitmee returned T to Greenlakes Road.

194. Stephen Barry was working the 8pm to 4am shift. He recalls being aware of the job concerning S and K and a number of actions had already been taken to try and locate them. The actions included SES being involved and a number of police units including CPIU also being involved. He obtained this information from his quick review of the IMS job sheet when he started his shift. It was a very busy night so the handover was brief. His recollection was that he thought the search had ceased because it had become dark.

195. On receipt of the telephone call from K at 9.07pm, Stephen Barry realised she was one of the missing children and attempted to establish their location. Whilst he was talking to K he immediately sent a message to CPIU and Senior Constable (Acting Detective Sergeant) Michael Logan came down and sat with him for a short time. Whilst Senior Constable Logan was there, Mr Barry says he used his UBD to attempt to establish their location. Sergeant Burgoyne says he was made aware of the call from K and he tasked Senior Constable Logan to deal with the call. Mr Barry says K advised they had left Lifestyle Solutions a few hours ago so he was suggesting a few different landmarks in the area as he says he knew the area slightly. Senior Constable Logan provided oral evidence that if the location of the girls had been able to be identified he would have attended the scene to pick the girls up but he was not responsible for tasking crews to the job. Senior Constable Logan said at the time the call came in, he was under the belief there were crews still searching for the girls.

196. The 000 call was taped and later transcribed. Mr Barry spent a large portion of the phone call attempting to locate the girls with no success. When K indicated a car was approaching, Mr Barry instructed her to stand on the side of the road and wave the car down. S was struck on the road by a vehicle travelling in the opposite direction to the vehicle that K was attempting to wave down.

197. At 9.17pm a 000 call was received from Heather Porter advising a child had been hit by a car. At 9.31pm, Constables Williams and Winslade arrived at the scene of the accident. S was declared deceased by QAS paramedics.

198. The driver of the vehicle that struck S was traveling along Belmont Road which was not lit. He told police that without warning a person appeared on the road in front of his vehicle and there was no time for evasive action. Numerous witnesses observed the driver of the vehicle being overwhelmingly upset after the incident. Ms D accepts the decision of

the police that no charges were to be laid against the driver over the incident.

QPS Policy and Procedures

199. Despite many references to a search for S and K, the operation was not approached as a "search" according to section 17.5 (search and rescue) of the Operating Procedure Manual ('OPM'). The procedure states "*Only officers appointed as a Search and Rescue Co-ordinator (SARMC), Assistant Search and Rescue Mission Coordinator (ASARMC) or Field Search Coordinator (FSC) are to coordinate search and/or rescue operations on behalf of the Service and activate volunteer rescue organizations in consultation with the relevant district officer or RDO*".

200. According to section 12.5 (missing person occurrence) of the OPM, a person with a physical or intellectual disability and a child are classified as 'known vulnerability'. The procedure says "*where the missing person occurrence involves known vulnerability, the local search and rescue mission coordinator or officer trained to coordinate search operations is advised*". Further the procedure states "*if a search is necessary; see s 17.5: 'Search and rescue' of this Manual*".

201. Appendix 12.2 is the Risk Assessment Guidelines for Missing Persons ('the Guidelines'). It states "*Officers receiving a missing persons report are to conduct a risk assessment upon receipt of each case. When making an assessment, the information that leads to the determination of the level of risk must be recorded*". The Measure of Consequence or Impact ranges from:

    1. level 1 (LOW RISK) – Kept under review (no apparent threat of danger to either missing person and/or the public);

    2. level 2 (MEDIUM RISK – Active and measured response (missing person and/or public possibly facing some danger);

    3. level 3 (HIGH RISK) – Immediate deployment of police resources (risk posed is immediate and there are substantial grounds for believing that the missing person and/or the public is in danger).

202. The Guidelines set out a number of indicators for consideration but there is no weighting to the considerations as to what constitutes a particular risk. It is left to the assessing officer's discretion.

203. The Rockhampton Police District Standing Operating Procedures ('SOP') for Search and Rescue says the SOP should be read in conjunction with section 17.5 Search and Rescue of the OPM but then is contradictory as it states "*ADVISE Search and Rescue Mission Coordinator (SARMC) for the area in which the search is to be instigated*." Further, it states: "*LOCATE all available maps of search area; ARRANGE Police searchers if required from rostered personnel*".

Conclusion

204. The Department has submitted that the QPS responded very promptly and in numbers significantly over and above the usual deployment in an operation to search for two absconding children. Further, that the QPS officers conducted the search on the correct assumption that the girls had absconded and did not want to be found. The evening in question was a Saturday night and was busy with many operational demands across the Rockhampton area (38 jobs between the callout to Lifestyle Solutions and the death of S).

205. It is quite clear from the evidence that the police response to the Lifestyle Solutions callout was immediate and sufficient in terms of resources. The situation with T was resolved quickly and safely. The search operation was initially hindered by factors beyond the control of the QPS (the lack of notification) and the search was conducted with the best of intentions.

206. Whilst the children were reported as missing and a missing person report was completed, Sergeant Burgoyne did not manage the incident as a 'Search and rescue'. Instead he proceeded on the assumption the girls had run away and did not want to be located. This assumption meant the policies and procedures for a 'Search and rescue' were not fully implemented. There was no accurate assessment of time since the girls had been missing and no calculation of the distances that might have been covered by them to instruct the search parameters.

207. In response to the report by the Lifestyle Solutions staff that the girls were missing, Sergeant Burgoyne says he informally completed the missing persons risk assessment which was not documented despite the requirements of section 12.5.1 of the OPM.

208. The OPM sets out a number of factors for consideration in completing a risk assessment, including whether the person is vulnerable due to age, whether the person has mental health issues, whether there was a reason prompting the persons' leaving, but there is no weighting of these factors. Sergeant Burgoyne classified the risk as medium despite the missing persons being of 'known vulnerability' (S was 10 years old and K had an intellectual impairment), the approaching darkness, and the rural setting of Lifestyle Solutions. It seems likely the known history of the children escaping and returning to their parents was an influencing factor.

209. Whilst Sergeant Burgoyne says he assessed the risk in accordance with the Risk Assessment Guidelines for Missing Persons, he did not implement OPM section 17.5 'Search and rescue' which flows from section 12.5 Missing Person Occurrence. The procedure states "*if a search is necessary; see s17.5: 'Search and rescue' of this Manual*". Had this procedure been implemented only a qualified search and rescue officer would have been responsible for co-ordinating the search.

210. The contradiction between the regional Rockhampton Search and Rescue SOP and section 17.5 of the OPM may have impacted on how Sergeant Burgoyne approached the incident as he did not consider the SARMC was required despite sections 17.5 and 12.5 of the OPM indicating if a search is required, SARMC are to coordinate it. Putting this aside, Sergeant Burgoyne's coordination of the patrols (he says it was not a formal search) was poor. A map was not consulted. There was evidence some of the officers were not familiar with the area and therefore did not know where they should have been looking. Further, there was little to no direction provided to the officers as to where to patrol and to report back after they had completed their patrol and therefore virtually no co-ordination of the areas being searched. There was no follow up with the patrolling crews.

211. It is acknowledged that it would be difficult for the OPM to provide a guideline for all possible scenarios in which a search might be considered necessary. QPS have submitted that the OPM is founded on the National Search and Rescue guidelines. The guidelines which are contained in the OPM provide 16 points which an officer should use in assessing the measure of risk which should be allocated to a missing person.

212. QPS have submitted that the OPM supplies the guiding principles for any officer to follow. The local SOPs are developed with the local geography and conditions in mind. It is clear however, that in this case, the SOP needs to be more consistent with the OPM as the guiding principle.

213. Even if Sergeant Burgoyne did not consider a 'Search and rescue' was necessary in the initial circumstances, the fact the girls were not located after the preliminary patrols suggests section 17.5 'Search and rescue' of the OPM should have then been implemented. Further, even if Sergeant Burgoyne's initial assessment of medium risk for the missing girls was correct, arguably it should have been escalated to high when the girls were not located after the first patrols were completed and it became dark.

214. Counsel for Ms D has submitted that if Sergeant Burgoyne had the skills to properly conduct even a medium risk level search then it is likely that S would be alive today and that his actions amounted to police misconduct for which a referral should be made under section 48 of the Act.

215. It is clear on the evidence that Sergeant Burgoyne attempted to escalate the matter by contacting Inspector Somerville to request the SES become involved and by seeking advice from the SARMC and the Assistant SARMC. Inspector Somerville seemed to be influenced by the known history of the girls escaping and was working from the assumption the girls were not lost but did not want to be found. It is suggested that it was at this time that the SARMC or the Assistance

SARMC could have taken charge of the situation (despite acting as the DDO, Sergeant Burgoyne had not had any training in Incident Command). Sergeant Burgoyne has taken appropriate action in this respect of the situation. I do not consider that it is necessary or appropriate to make a referral for misconduct against Sergeant Burgoyne.

216. Incident command training would preferably be undertaken by all officers before taking on Acting or full time positions as DDOs. The submission received from the QPS has indicated that it would not be possible for this training to be undertaken by such officers. The submission indicates that incident command training falls under the control of Education and Training at the Queensland Police Academy in Brisbane, is two weeks in duration (10 days) and is residential. The course is a compulsory component for Senior Sergeants to attend and is part of the qualifying process for the participants to be eligible for promotion to the next rank. As of 1 December 2011 there were 2,381 Sergeants serving in the QPS. It would not be practical to offer the training to all of those officers, even over a couple of years. Sergeants are the most likely officers to relieve in DDO positions.

217. However, in addition to face to face training, the QPS conducts courses which can be undertaken online, some of which are compulsory to complete before undertaking incident command training. The online courses are Competency Acquisition Program ('CAP'). A CAP exists as a preparatory step to the incident command training which, once completed, would be sufficient training for any Sergeant to relieve in the position as DDO.

218. During the period of the search, Sergeant Burgoyne still had to meet the other obligations of the DDO and was receiving calls about other incidents during the whole period.

219. This case has demonstrated a number of deficiencies in locating children who are missing in care where in the initial instance a full scale 'Search and rescue' is not deemed necessary. A full review of the relevant procedures (including the risk management guidelines) and their integration with each other would be appropriate. Further, if it is decided a search (or patrol as Sergeant Burgoyne referred to it) is required for a missing person at medium risk, that is, section 17.5 'Search and rescue' of the OPM is not necessary, some guidelines or an intermediary procedure should be provided to officers coordinating patrols to ensure a coordinated approach is implemented and examples of such incidents should be included in the incident command training (if it is not already provided).

220. The communication processes between the DDO and the Comco in the search/patrol operation was lacking. Neither Sergeant Burgoyne nor Senior Constable Mabb knew what was happening in relation to who was patrolling where and for how long they were patrolling. There should

be consultation with the DDO in circumstances such as these before allocating resources to other incidents. QPS submit that this was a failing on the part of Sergeant Burgoyne who admitted in evidence that he was not aware of the location of each crew or that some crews were directed to other jobs. He further agreed that he could have contacted the Comco to check on the progress of the crews and the status of other jobs.

221. It was further submitted by QPS that in 2010 the QPS conducted a review of communications centers around the State. This review was conducted by the Inspectorate and Evaluation Branch attached to Ethical Standards Command and developed the *Police Communications Centres Quality Assurance Standing Operating Procedure*. The purpose of the Standing Operating Procedure is to detail the requirements of the QPS for quality assurance of the provision of call taking, job tasking and radio communications by police communication centres as a risk management strategy. These new quality assurance strategies for police communication centres were further expanded on 1 March 2011 to include a checklist form for staff performing duties as a radio operator. A further quality assurance process for Comco duties was also commenced on this date to include a checklist form.

222. In addition to the SOP's that were developed, the Inspection and Evaluation Branch made five recommendations where it was identified inconsistencies in work practices within each centre. Those recommendations included: the necessity for standardisation of training courses for communication centre staff across the State; the use of standard operating procedures that are both current and relevant to PCCs; all Assistant Commissioners with responsibility for a police communication centre ensure SOPs are current, relevant to their centres, and deal with the role of a call taker, a radio operator and a Comco; SOPs address priority policing, negotiated response, triple O, management and the initial recording of domestic violence incidents; all Assistant Commissioners with responsibility for a police communication centres ensure risk management and business continuity plans are current and relevant to their centres; the Assistant Commissioner develop a standard methodology for quality assurance and performance management for police communication centres. As at 7 March 2011 the three communication centres located in Central Region had reviewed their SOPs in respect to the recommendations and had applied them. In addition to the above review of communication centres the Queensland Police Service has now introduced a new Computer Aided Dispatch system for the State. The first roll out of the system commenced on 7th December 2011 to be rolled out across the communication centres around the State within the following twelve months.

223. Despite evidence that if an officer was distracted or out of the car, he or she would not hear the announcement, the BOLF was only broadcast once. As the children were not located, it would be reasonable to consider that it should have been regularly repeated until the lost girls

were located. QPS submitted that this was not practical in busy centres if a specific time frame was put on the calls, which would unnecessarily tie up the police channels. Further, QPS submitted that the Missing Person report was available online to all officers through QPrime. It was the evidence in this case that the task of entering the Missing Person report onto QPrime was not commenced until around 8pm, long after the search was underway and this would not have been practically available to officers before that time. More broadcasts of the BOLF should have been possible and may have assisted, if in nothing else then to draw to the attention of the patrolling officers that the girls were still missing and there was a need to continue searching.

224. The lack of coordination of the patrols, not escalating the patrols to a 'Search and rescue,' and the poor internal police communication contributed to the QPS not locating the girls in a timely manner. Had officers been allocated to patrol Belmont Rd (one of the three roads back to town), it is possible the girls would have been located shortly after the "search" commenced. This of course is on the basis the girls did not attempt to evade police.

225. In addition to an Ethical Standards investigation which occurred in this case, police have a system of reviewing operational issues in the context of major incidents. The Significant Event Review Panel is chaired by the Chief Superintendent who is the operational coordinator for the district. It has the jurisdiction to look into the operational issue of the coordination of the search and the conduct of the 000 call. There is no evidence the Significant Event Review Panel considered the incident involving S.

226. The QPS Ethical Standards Investigation did not reveal the issues concerning the search for the girls and/or refer the matter to the Significant Event Review Panel to consider the operational issues in this case. It would have been of assistance for a review of this nature to have been carried out shortly after the death of S rather than waiting for the outcome of the coronial inquest held months or years after the incident. It is clear form the oral evidence of Sergeant Burgoyne and Inspector Somerville that they were not aware of the operational issues until they were providing their evidence at inquest. Apart from informing the QPS of potential areas of procedural change (which in this context would improve public safety), a review would have informed the coroner's investigation.

227. QPS submitted that in 2010 the QPS conducted an internal review of the Significant Event Review System. As a result of that review, 17 recommendations were made, of which 16 are being implemented. The modified policy is expected to be finalised early in 2012. The new policy recognises that some criminal, coronial, and/or workplace investigations of significant event matters will be protracted and the results of such investigations may not be finalised or available for some time, and commencement of a Significant Event Review should not be delayed for this reason alone.

H. Experience, Supervision and Training of Case Manager

228. S's Department case manager at the time of her death was Liana Graham. Ms Graham became a CSO in April 2008 and took over the management of S and her siblings on 6 November 2008. Prior to this, S and her siblings were being case managed by the Intake and Intervention with Parental Agreement Team. CSO Courtney McKenna was the case manager from 4 April 2008 to 24 October 2008.

229. At the time of taking over S and her siblings, CSO Graham was managing between 20 and 25 children. She advised she was able to regularly check in with the children if everything was running smoothly but if a crisis arose with one specific child this would mean she could not check in with the others as frequently.

230. CSO Graham had received a handover from the previous CSO concerning S and her family. The handover involved discussing the case with the previous CSO and her team leader, reviewing the current case plan and a brief summary of what had happened up until that time. She had the opportunity to read fairly thoroughly the files and the information available. She had supervision with her team leader, Kylie Stevens, probably once a week or fortnight. This gave her an opportunity to raise any concerns she had and was not sure of how to address. Further, she advised if she required immediate assistance she would consult her team leader as needed.

231. Kylie Stevens explained that supervision is provided to CSOs formally and informally. Formal supervision was for two hours each fortnight and involved a meeting in her office with the door closed so that it was uninterrupted time. She explained the time was broken down into a range of different components which includes how the worker is traveling themselves and the worker's educational development. The educational development is an opportunity to reflect on the cases the worker is working on and to consider what worked well and what could be improved in the future. Then the meeting may move to discuss certain issues that need to be addressed on certain files with timeframes set for the CSO to meet those issues. In terms of informal supervision, Kylie Stevens explained this occurred on a day to day basis with staff able to access her as needed. She advised informal supervision could also happen with other staff members within the office.

232. CSO Graham felt that supervision for CSO's needed to occur more regularly than what was provided when she was at the Department.

233. Kylie Stevens said there were role requirements in relation to supervision and they were being met. She acknowledged the work is complex and agreed that it would be nice perhaps to get extra guidance, but that she was certain there was always someone available to assist CSO Graham whether it was her or other staff members.

234. There is significant training and support provided to CSO's built into the formal training program of the Department. CSO Graham had completed her three week mandatory training and had progressed through other training prior to S's death. Kylie Stevens did not have any concerns regarding CSO Graham's performance.

Conclusion

235. Despite CSO Graham's inexperience, the evidence was she had completed the relevant training and had supervision with her Team Leader. Further, there was evidence there were other resources within the centre CSO Graham could have utilised if she had any questions concerning her case management.

I. Contract Administration

236. Following the government approving money for residential complexes in 2008, a state-wide tender process was undertaken. Whilst there was a state-wide service for bigger picture issues, the regional community support team was responsible for assessing the applications and making recommendations back to the Minister. It was Mr Smales' responsibility to ensure all the processes are properly followed and to make the final recommendation.

237. Mr Smales said the Department usually allowed some kind of lead in time to provide the service. Mr Smales confirmed he had a couple of meetings with the Directors of Lifestyle Solutions before they commenced operation. The purpose of these meetings was to touch base and establish communication lines with the Department.

238. Mr Smales said he thought there was day to day monitoring of Lifestyle Solutions on a number of levels, including at CSO level and the community support team.

239. As part of the licensing requirements a service provider was required to have a report undertaken by an independent party on their performance. If their performance meets the requirements of the Department and all other requirements have been met, a three year license may be granted. In the case of Lifestyle Solutions the first independent review was due to be undertaken on 9 February 2009 but was postponed because of S's death.

240. Mr Smales advised that the quarterly service agreement meetings were convened by the community support team and the service provider. The purpose of the meetings was to review the operations of the service since the previous review, to assess whether the service provider was meeting the benchmarks in the agreement. Annual reviews are also undertaken. Once an organisation had met the rigorous licensing requirements the Department expects very high standards.

241. Apart from the quarterly reviews there are no systems in place to monitor any issues with a residential facility. The system is reliant on the

residential facility keeping the Department advised and the CSO being aware of any issues with any child they are supervising who lives at the facility. There are a number of other mechanisms that sit outside of the Department including the Children's Commission and Official Visitors.

Conclusion

242. Mr Smales clearly thought there was more communication occurring between Lifestyle Solutions and the Department than what was occurring. Lifestyle Solutions was a new start up organisation for the Department and as such attracted a potentially greater risk than a known organisation. On his evidence, if an organisation is not reporting incidents, the Department is dependant on the individual CSO identifying any issues but there are no guidelines as to the requirements of a CSO in such circumstances as these. In this case, it was not only a new start up organisation but also a child had been placed in a residential facility outside of the service agreement.

243. The Department had an obligation to ensure the service standards were being met and a quarterly meeting prior to a license being granted seems somewhat inadequate. It is acknowledged the licensing process is rigorous and the review by the independent body before granting a licence is appropriate but there is a gap between when the independent review occurs and when the facility commences operation. The monthly stakeholder meetings which now occur between the CSSC's and the residential complexes are an improvement but arguably more is required. Whilst it seems the quarterly review meeting occurs on site of the residential facility, a documented review process of the facility is required.

244. The Department does not accept the submission that the quarterly review process is inadequate or there is a gap between the independent review stage and the commencement of residental operations.

Reviews of Incident and changes since

Ethical Standards QPS Investigations

245. An investigation of the police conduct in the matter was undertaken by Senior Sergeant Hawkins of the QPS Ethical Standards Command. The report concluded that the effectiveness of the QPS search was hampered by the rural setting and the circumstances of the situation; the decision making of senior officers was sound; the search for the girls was duly diligent albeit unsuccessful; and the officer conducting the 000 call acted appropriately.

246. The report does not make any specific conclusions concerning the actions of the driver of the car. However, it does note Ricky Conrad's breath test was negative for alcohol, his car was not deemed to have any defects, and witnesses considered Ricky Conrad would not have seen S, or if he did, he would not have had time to stop prior to hitting her.

Department Review

247. The Department undertook an investigation in relation to the service delivery to S. It was conducted by an external and two internal reviewers in accordance with chapter 7A of the *Child Protection Act 1999*.

248. The review identified three factors which hindered service delivery to S:

    1. The distribution of workload between the new and inexperienced Investigation and Assessment workers and workload pressures caused delay in commencing the Investigation and Assessment for the notification 14 September 2006;

    2. An insufficient safety assessment caused the development of an insufficient Safety Plan for the children when they returned home after being placed in voluntary care on 12 December 2006; and

    3. Lack of age-appropriate placement options with trained carers caused the placement of the Subject Child in a residential facility which did not sufficiently met (sic) her care needs.

249. It was noted an area for practice improvement was the assessment of S's therapeutic needs. It established that the CSO's were instead focusing on stabilising placements. Further, the review found the residential facility operated through an adolescent framework and this did not assist S when she was bullied and assaulted by another resident. The review concluded the placement proved to be unsafe and not a positive living environment for S.

250. The review report was to be provided to all staff involved, PSUs and the regional director. The recommendations were implemented on 6 August 2009.

251. The review was considered by the Child Death Case Review Committee ('the Committee'). The Committee found that whilst the review found no risk factors relevant to S's death, it considered her high risk behaviours – absconding was a risk factor. Further, the Committee identified two service systems issues which included: assessment of intakes received in relation to the subject child while in foster care in 2008; and disclosure of sexual abuse in May 2008 not referred under s14(2) of the *Child Protection Act 1999.* The Committee found the recommendations made in the review were appropriate and no further action was required by the Department in terms of the sufficiency of the original review.

252. The Department has submitted that the Committee were informed by the available evidence as at August 2009 and did not have the capacity to forensically test the evidence presented in the same manner as to the inquest. A critical part of the evidential foundation of the Review Report has been undermined by the evidence given at the inquest and to that extent the analysis and conclusions of the Review Committee are in retorspect misconceived, for instance the conclusion reached by the

Committee that the placement proved unsafe and was not a positive living environment. Some crucial pieces of information presented to the review were incorrect, for instance that T arrived at Lifestyle Soloutions before S, there was a "history" between them, constant bullying and assualts at Lifestyle Solutions, S had to change schools due to T, history of bullying and its impact on S's safety was more than likely unknown at the time of the placement. The evidence at the inquest was to the contrary. This does not impact on the integrity of the review or the thoroughness of the Committee which conducted its business on the basis of the evidence placed before it.

Lifestyle Solutions Review

253. Lifestyle Solutions undertook a review of the circumstances leading up to S's death. As a result of discussions at a Senior Executive Team meeting a number of actions were implemented. These included:

1. The residential care services being moved from the rural setting to a house in town;

2. A review of staff training was conducted and all staff at the service were trained in PART (Predict, Assess, Respond, To aggressive behaviour);

3. The licensing action plan was reviewed and monitored monthly by the National General Manager Operations & Program Development to ensure staff were meeting the action plan within specified time lines;

4. A local Lifestyle Solutions office was opened in Rockhampton to ensure the Area Manager had a local base to support and supervise staff;

5. All staff were trained in Positive Behaviour Support; and

6. The reporting lines for the Area Manager were reviewed and changed to the Operations Manager in South East Queensland to ensure the position has more localised support and supervision.

External Review of Lifestyle Solutions

254. An independent external assessment of Lifestyle Solutions Rockhampton Residential was undertaken by Community Link in March/April 2009. The assessment was in accordance with the *Child Protection Act 1999* which requires an independent external assessment of a license holder every three years. The purpose of the assessment was to provide independent advice to the Director-General of the Department about compliance against the Minimum Service Standards in child protection placement services in order to consider granting the licence. The assessment found that Lifestyle Solutions was meeting or close to meeting five of the eleven Standards.

255. In October 2009, Lifestyle Solutions received notification it was unsuccessful in its application for a care service licence under the *Child Protection Act 1999* in the Rockhampton Out of Home Care (Residential) service. The reason for the decision included concerns related to training in behaviour support, reactive responses, and appropriate reporting of incidents.

256. In February 2010, Lifestyle Solutions received notification from the Director General of the Department that the Minister for Child Safety had approved the decision to refuse to make further payments of the grant to Lifestyle Solutions for the Rockhampton Residential Care Service.

257. Lifestyle Solutions have confirmed there have been some learnings from setting up in Queensland. They now put a project team on the ground for an extended period of time to make sure they have the necessary infrastructure and experienced resources on the ground. It is not left to one or two people to set up and manage. Lifestyle Solutions have now set up using this approach in Alice Springs, Darwin and Western Australia.

Findings required by section 45

258. In accordance with section 45 of the Act, a coroner who is investigating a suspected death must, if possible, make certain findings.

259. On the basis of the evidence presented at the inquest, I find that:

1. the identity of the deceased persons - the deceased person is S;

2. how the deceased persons died - S died as a result of being struck by a car after she had run away from the Rockhampton Lifestyle Solutions residential complex;

3. date of death - S died on 7 February 2009.

4. place of death - S died on Belmont Road, Rockhampton;

5. cause of death – S died as a result of a consequence of injuries suffered in the accident, or of the injuries themselves.

Recommendations

260. Section 46 of the Act provides that a coroner may comment on anything connected with a death that relates to: public health and safety; the administration of justice; or ways to prevent deaths from happening in similar circumstances in the future.

261. Based on the evidence received, I propose to make comment on some matters in an effort to avoid similar deaths occurring in the future.

I RECOMMEND THAT:

1. **The Department review its processes in placing a child in residential care outside of a service agreement, including that a management plan be developed between the Department and residential care facility to closely monitor the child's progress especially during the period before the first Departmental review of the placement and that be put in place prior to the placement of the child.**

2. **The Department develop a field in ICMS which records any past conflict/relationship issues between other children and/or past carers which is easily accessible by CSOs and PSUs for reasons including placement decisions.**

3. **The Department review its processes concerning seeking feedback from carers following a placement and implement a mechanism of feedback by providing carers with a feedback sheet which is stored in a place easily accessible for staff to relay information to future carers and in order to take that information into account for future placements of the child.**

4. **The Department review its processes concerning reporting requirements by both home based carers and care facilities as to events occurring throughout the placement and reporting processes be streamlined in both instances.**

   In particular for care facilities, in addition to the initial phase of operations there should be regular audits by the Department of the existence of appropriate policies and procedures and compliance with best practice models for internal communications, communications with the Department and staff training to deal with complex behaviours and critical incidents.

5. **The Department ensure that as part of their supervision of CSOs, team leaders or other appropriate personnel must review investigations undertaken of kinship care options and the timeframes set for renewed enquiries in that regard.**

6. **Lifestyle Solutions ensure that it has in place monitoring and internal review processes to ensure the existence of appropriate policies and procedures in all its centres, and compliance with best practice models for internal communications, communications with the Department and staff training to deal with complex behaviours and critical incidents.**

7. **The QPS ensure all officers acting as DDO or equivalent have completed Incident Command Training prior to acting in such positions if possible but at least that officers have completed the SAP module preparatory to such training.**

8. **The QPS revise OPM sections 12.5 and 17.5 (including the Risk Assessment Guidelines) and map the Rockhampton Search and Rescue SOP against it to ensure:**

   (i) the management of medium risk incidents are more clearly articulated, including when an incident should be escalated to a high risk;
   (ii) the relevant procedures are consistent with each other (SOPs with the OPMs); and
   (iii) the relevant QPS officers responsible for managing patrols to locate a missing person rather than a full scale search, have the necessary training to coordinate the patrols and manage the incident in an efficient and effective manner.

9. **QPS consider obtaining a facility to permit 000 calls to be monitored, and, if appropriate, be joined by persons other than the call taker.**

10. **The QPS revise its communication procedures between the DDO and Comco to ensure each know the status of the job, including the areas being patrolled and the areas to be patrolled, and requiring the Comco to consult with the DDO before re-allocating resources from an incident managed by the DDO to another job.**

11. **QPS increase the frequency of the broadcasts of BOLFs in searches for missing persons who are classed as 'known vulnerability' such that broadcasts are sufficient in the circumstances to inform the greatest possible number of officers of the information.**

12. **The Department consider developing an audit tool for examining policies and procedures, internal communication, communication with the Department and staff training of a start up organisation which could be used by the CTMS in the initial phases of the commencement of a residential facility (e.g. monthly site visits to conduct an audit by CTMS until the review of the license application is undertaken by the independent assessor).**

I close this inquest.

A M Hennessy
Coroner
Rockhampton
22 May 2012