OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of a 13 year old girl (P)**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	2012/1251
DELIVERED ON:	9 October 2015
DELIVERED AT:	Brisbane
HEARING DATE(s):	1 May 2014, 27-28 May 2014, 8 - 10 September 2014, further written submissions October-November 2014.
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, death in care, death in police operations, child absconded in vehicle, restraint, residential care, intergenerational trauma, child protection, mental health services.

REPRESENTATION:

Counsel Assisting:	Mr Simon Hamlyn-Harris
P's mother:	Mr Simon Burgess and Ms Lisa Stewart (ATSILS)
Department of Communities, Child Safety and Disability Services:	Ms Karen Carmody (Instructed by DCCSDS)
Safe Places for Children:	Mr David Grace (Cooper, Grace and Ward)
Commissioner of Police:	Mr Matthew Hickey (Instructed by the Queensland Police Service Solicitor)
Constables Herbert and Elmore:	Mr Troy Schmidt
Mater Health Services and employees:	Ms Jennifer Rosengren (Instructed by Minter Ellison)
Sisters Inside:	Mr Andrew Hoare (Instructed by Kilroy and Callaghan Lawyers)

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Introduction

1. This inquest investigated the death of a 13-year-old Indigenous girl (P) in a motor vehicle accident at Redbank in Queensland at approximately 7:00pm on 11 April 2012.

2. P was born on 27 March 1999. She had been involved in the child protection system since she was an infant. From the age of two to the time of her death, she was the subject of fourteen separate out of home placements. She had already been incarcerated at a youth detention centre on two occasions, the longest being 4 months.

3. At the time of her death P was living at a residential care facility at Collingwood Park run by an organisation known as Safe Places for Children (SPFC), a licensed care service under the *Child Protection Act*.[1] The facility was a modern low set brick home.

4. On 11 April 2012, P was the only child being cared for by rotating pairs of youth workers at the SPFC facility. The cost of these arrangements (described as a transitional placement package) was estimated to be $700,000 - $800,000 per annum.[2]

5. P had previously been cared for by SPFC between June 2011 and October 2011. She was then sentenced to a period of detention. On release from youth detention she was placed with a kinship carer. P was returned to the care of SPFC on 5 March 2012 after that placement broke down.

6. P left in the SPFC vehicle following an extended and violent altercation with her carers. Shortly afterwards she ran off the road approximately 4km away and crashed into trees. P's death was a reportable death because it happened both in the course of police operations and because she was in the custody of the Chief Executive of the Department of Communities, Child Safety and Disability Services (the Department). At the time of death, P was subject to a short-term child protection order granting guardianship to the Chief Executive until 22 February 2013.

7. Section 27(1)(ii) of the *Coroners Act 2003* provides that the coroner investigating a death in care must hold an inquest in circumstances that raise issues about the deceased person's care. Section 27(1)(iii) provides that an inquest must also be held where the death occurred in the course of police operations, unless the coroner is satisfied that the circumstances of the death do not require the holding of an inquest.

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[1] The trading name for Safe Places Community Services Ltd

[2] T3-80

The inquest

Applications for leave to appear

8. A pre-inquest conference under s 34 of the Act was held on 1 May 2014. On that date leave to appear under s 36 was sought by six parties. Leave was granted to the following persons and agencies who fell within s 36(1)(c) of the Act as having a sufficient interest in the inquest:
   - P's mother;
   - Mater Health Services, which provided mental health services for P;
   - The Department;
   - The Commissioner of Police; and
   - Constables Herbert and Elmore.

9. SPFC were granted leave to appear at the commencement of the inquest on 27 May 2014.

10. At the pre-inquest conference leave to appear was also sought by Sisters Inside. Sisters Inside applied for leave on public interest grounds under s 36(1)(c) and s 36(2) of the Act.

11. After considering the written submissions from Sisters Inside, and hearing from those represented at the pre-inquest conference, I ordered that leave to appear at the inquest be granted to Sisters Inside as a person identified in s 36(2) of the Act.[3]

Issues identified for consideration at the inquest

12. At the pre-inquest conference the following issues were identified for consideration at the inquest:

    1. The findings required by s 45 (2) of the Coroners Act 2003; namely the identity of the deceased, when, where and how she died and what caused her death;

    2. The causes of a collision involving a Holden Commodore sedan registration 421 IVJ at Kruger Parade, Redbank Plains on 11 April 2012;

    3. Whether the police officers involved in attempts to intercept the Holden Commodore before the collision complied with QPS policies in place at the time;

    4. The adequacy of the investigation undertaken by police into the circumstances surrounding the death;

    5. The circumstances leading to the deceased taking control of the vehicle, including the actions of her carers;

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[3] I have published separate reasons for that decision.

6. Whether any steps could have been taken to prevent a child in the deceased's position from gaining access to the vehicle and taking it from the residential care facility;

7. The adequacy of care provided to the deceased by the Department of Communities and whether this contributed to the death;

8. The adequacy of the care provided to the deceased by other service providers and whether this contributed to the death; and

9. If there are ways to prevent a similar death occurring in the future, including reforms to the delivery of services for children with highly complex needs.

13. The inquest was conducted in two separate stages. The focus of the first two days was evidence relating to issues one to six. The second three days were primarily concerned with issues seven to nine, relating to the care of, and services provided to P by the Department and other agencies. Evidence was heard from 20 witnesses and over 100 exhibits were admitted into evidence.

14. The inquest heard evidence from the police officers who were involved in the attempt to intercept the vehicle driven by P, those responsible for caring for her on 11 April 2012, officers of the Department, and persons engaged to investigate the death on behalf of the coroner and the Department.

15. The Department produced over 5200 pages of documents to the inquest, which were extracted from its files relating to P. These dated from the time of its first involvement with her family in 1999.

16. Following the conclusion of evidence I was provided with helpful written submissions from counsel assisting and those granted leave to appear at the inquest. These were of great assistance in framing these findings and considering relevant recommendations.

The investigation

17. The QPS Ethical Standards Command (ESC) conducted the coronial investigation and Acting Inspector Timothy Leadbetter prepared a detailed report. Ipswich Police, State Crime Operations Command and Forensic Crash Investigators also provided assistance.

18. ESC investigators conducted disciplinary interviews with Constables Elmore and Herbert, the two officers involved in the attempted interception of the vehicle driven by P. QPS forensic and scenes of crime officers attended the scene and a number of photographs were taken and later tendered at the inquest.

19. Constables Elmore and Herbert consented to a breath test at 10:05pm on 11 April 2012. Detective Inspector Innes of the Corrective Services Investigation Unit, State Crime Operations Command, conducted these and both tests were negative.

20. Interviews were conducted and/or witness statements taken from P's carers and witnesses to P's driving. Investigators obtained the audio recordings of the police radio transmissions made during the incident.

21. I am satisfied that all relevant sources of information in relation to the involvement of the QPS have been accessed and the results effectively collated.

Forensic Crash Investigation findings

22. The vehicle driven by P at the time of her death was a 2005 Holden Commodore sedan with a 6-cylinder engine and automatic transmission.

23. Inspection by forensic crash investigators[4] revealed P had applied the Commodore's handbrake at the time of the accident. This was substantiated by tyre marks that indicated the right rear wheel was locked and sliding when on the road surface. The vehicle was fitted with an 'anti-lock braking system'. The tyre patterns would have indicated if the foot brake had been employed and ABS engaged.

24. The vehicle was estimated to be travelling at 147km per hour when it started to slide on Kruger Parade while attempting to negotiate a right hand bend. The vehicle left the road across a concrete gutter and crashed into trees in adjacent bushland. The extent of the damage to the vehicle was consistent with high-speed impact. The vehicle was mechanically inspected after the crash by the QPS Vehicle Inspection Unit and was found to be in sound mechanical condition.

Child Protection System Reviews

25. At the time of P's death there were two specific statutory provisions for the conduct of reviews in relation to the circumstances of the death of a child in care. I was provided with two review documents relating to P's involvement with the Department of Communities Child Safety and Disability Services:

    - Systems and Practice Review Report[5] dated 26 September 2012 – an internal Departmental review conducted under s 246A of the *Child Protection Act 1999;* and

[4] Exhibit C5, Collision Analysis Report
[5] Exhibit C8

- Child Death Case Review Committee Report[6] – an external review conducted under Chapter 6 of the *Commission for Children and Young People and Child Guardian Act 2000*.

26. The *Child Protection Reform Amendment Act 2014* repealed Chapter 6 of the *Commission for Children and Young People and Child Guardian Act*, which established the Child Death Case Review Committee and provided for the functions of the Committee and the Commissioner in relation to child deaths. The Commission and the Child Death Case Review Committee were abolished by the 2014 Act. The former Commissioner went out of office, as did the members of the Child Death Case Review Committee.

27. Having regard to the former section 140 of the *Commission for Children and Young* People *and Child Guardian Act 2000* and its continuing operation, no member of the former CDCRC (including the former Commissioner) could be called to give evidence at the inquest.

28. Consequently, there was no evidence from any person responsible for the findings contained in the CDCRC report, and limited reliance was placed on that report.

The evidence

Personal history

29. P had two older brothers and one younger sister. The Department's statutory involvement with P and her family dated back to 1993. The Department had recorded thirteen notifications and 7 child concern reports relating to the care of P and her siblings.

30. P was subject to Child Protection Orders from 16 February 2006 to 7 June 2007 (ages 6 to 8) and from 1 December 2008 to her death on 11 April 2012 (ages 9 to 13).

31. One of P's brothers lived with their maternal grandmother. The other brother was subject to Child Protection Orders from 16 February 2006 to 7 June 2007 (ages 10 to 11) and from 1 December 2008 to 1 December 2010 (ages 13 to 15).

32. P's sister was subject to an Intervention with Parental Agreement from the time of her birth in April 2010 until 14 March 2012, when a Temporary Assessment Order was made.

33. Relative to her peers of the same age, P was well over the 97th percentile for height and weight at the time of her death. She weighed 83kg and was 175cm tall.

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[6] Exhibit C7

34. The Systems and Practice Review Report noted that P had experienced emotional and physical harm and neglect, including witnessing significant domestic and family violence. Suspected sexual abuse of P was never fully investigated. She had been diagnosed with ADHD, post-traumatic stress disorder and reactive attachment disorder. She presented with significant hypersensitivity and hyper vigilance.

35. The Systems and Practice Review Report also indicated that P had a history of aggressive and violent behaviours, including throwing furniture, kicking, punching and pushing, resulting in an extensive youth justice system involvement. P displayed an inability to cope with situational stress, crises and problems, which impacted on her functioning in the home and school environment. P was regularly suspended from school due to behaviour and, for the bulk of her education, attended only on a part-time basis. She had a history of absconding from placements.

P takes control of the vehicle

36. On 10 April 2014, the day before her death, P had grabbed car keys, sworn at and assaulted the youth worker caring for her. She was persuaded to return the keys following a promise to obtain credit for her mobile phone. While at the supermarket, she had become abusive and aggressive and threw a bottle of water at a youth worker.

37. On 11 April 2012 two youth workers, Kerry-Anne Makoare and Raymond Murdoch, were rostered to work with P. They were working a 24-hour shift that commenced at 9:00am. Neither had worked with P before the placement at SPFC started on 5 March 2012.

38. That afternoon P was returned to the SPFC facility by her youth justice worker. While her mood was described as “baseline” it appeared that she was unhappy that a planned contact with her mother at the local courthouse did not eventuate earlier that day. P asked to go to the local park with the SPFC workers. Ms Makoare took the car keys from a locked box in the staff area so they could drive to the park in the SPFC Commodore.

39. The evidence at the inquest was that there was some difficulty opening the rear passenger doors. P opened the driver’s side door, reached in and grabbed the keys from the ignition of the Commodore as she and the youth workers were about to leave to go to the park. P then demanded that Ms Makoare leave the vehicle so that she could take it.

40. Ms Makoare and Mr Murdoch attempted to retrieve the keys at the same time as trying to prevent P from getting into the car. In the course of an extended incident over at least 45 minutes, P assaulted Ms Makoare and refused to return the keys until she was eventually able to access the car and drive away.

41. The following chronology of events is confirmed by the records of 000 calls and the records of the Ipswich Police Communications Centre, as summarised by Acting Inspector Leadbetter's Report:[7]

> *1806 hours [First 000 call by Raymond Murdoch:]*
>
> *Call from Raymond Murdoch of 'Safe Places for Children'. Job card details indicate, 'Youth [P], 13 years, has assaulted both care workers on scene. No QAS req. She has taken off with their car keys and has walked off up the road.*
>
> *1814 hours This job was approved by Sgt Byrne.*
>
> *1846 hours [Second 000 call by Raymond Murdoch:]*
>
> *Caller (Murdoch) stated that the youth has returned and is assaulting staff and causing damage to property. Crew dispatched code 2.*
>
> *1853 hours [Third 000 call by Raymond Murdoch:]*
>
> *Caller indicated the youth has now left and driven off with car. Registration number provided. Crew advised to revert to code 3.*
>
> *1854 hours From Goodna 232 (Herbert/Elmore) 'Confirm sighted car. Duncan and Collingwood Drive. At red light. Crew will try and intercept. Crew directly behind. Vehicle then seen to be swerving all over the road. Over 80 km/hr. Down Duncan Street. Last seen heading. Narrowly missed other car. Crew pulled over and did not engage in pursuit'.*
>
> *1857 hours Job log recorded, 'Crew heading to informants location to obtain further details. No other person observed in car'.*
>
> *1900 hours Ipswich Communications contacted Goodna car 232 and 442, and assigned code 2 to Kruger Parade re traffic crash, female possible injuries.*
>
> *1903 430 at scene, car in bush, cannot confirm rego yet.*

42. The prolonged incident at the SPFC home at Collingwood Park, was described in the statements of youth workers Raymond Murdoch[8] and Kerry-Anne Makoare[9] and in their evidence at the inquest.

43. Once P had taken the car keys from the ignition, she set about trying to take control of the vehicle. At one point she was able to lock herself and Ms Makoare in the car using the remote control that was in her possession. P then tried to get Ms Makoare out of the driver's seat by

[7] Exhibit A4, p 17

[8] Exhibit B12

[9] Exhibit B10

repeatedly assaulting her. Mr Murdoch managed to get into the back seat. Ms Makoare said in her statement:

> *"That went on and on and she just kept coming at me. Ray was also in the back seat and trying to stop her hitting me. There were times when she hopped out of the car and would grab something else to hit me with."*

44. As the recording of the 6:06pm call to 000 indicates, Mr Murdoch initially called the police after P had left the SPFC home with the car keys. Ms Makoare's evidence was that P was gone for about 10 to 15 minutes.

45. When P returned she got back into the car and punched Ms Makoare in the nose. She then left the car, came around the other side and hit her in the nose again. P had a lighter and was burning the door of the car. She then burnt Ms Makoare's arm with the lighter. Ms Makoare and Mr Murdoch managed to get the lighter from her. Ms Makoare said that at one point she and Mr Murdoch were able to swap over because P moved away from the car.

46. Ms Makoare then went into the house to tend to her burnt arm. P followed Ms Makoare into the house and continued the assault with punches and kicks. Ms Makoare tried to get back to the front door to get out. She had dropped a mobile phone in the struggle. She said in her statement:

> *"I was able to get her arms behind her back at one stage and was walking her to the door.*
>
> *I made it to the door and she was trying to kick me and I grabbed her leg. I put her leg down. I was able to get the door open and she punched me in the head and my head went into the wall and left a hole in the wall."*

47. After Ms Makoare managed to get out of the house P began hitting her with a mop. Ms Makoare thought P was doing this so that Mr Murdoch would get out of the car to help her. Ms Makoare ran off, and called to Mr Murdoch that the phone was inside the house and to ring the police. She and P both ran down the street.

48. According to Mr Murdoch's statement he waited for them to get to the end of the street and got out of the car. He then went inside to retrieve the work phone but while he was inside, P returned and got into the car. P was able to return to the car while it was briefly unattended and get into the driver's seat. She was then able to start the car and drive off.

49. The evidence of Ms Makoare and Mr Murdoch shows the determination with which P acted throughout this incident. As Mr Murdoch said in evidence:

> *"All she was focussed on was she had the keys and she wanted to take the car at that time.*

…

she had a firm grip on the keys… she just had it on her person where none of us could retrieve it without, I guess, physical restraint… Hence the reason that led into calling the police for assistance…"

50. Later in his evidence, Mr Murdoch said that he considered physical restraint would "escalate the incident… to a high level". The strategy instead was for one of them to try to stay in the car for as long as possible to try to see if they could de-escalate the incident and get the keys back.

51. It was clear from Ms Makoare's evidence that she was concerned that her actions in getting P's arms behind her back, when she was trying to get away from her and in an effort to restrain her, were contrary to the policies of Safe Places for Children. She said that it was "against what I was trained to do". However:

    "I couldn't take it and I had to try even if I got reprimanded for it. I had to try and stop her."

    "I would have been just trying to get out and get her to stop hitting me."

52. When asked if she thought anything could have been done by way of training that would have made it better or easier for her to deal with P, Ms Makoare said that the only thing she could think of would be some form of self-defence:

    "Because she knew she could do that and she could get away with whatever and there was nothing really that we could do to stop her."

Was physical restraint an option?

53. Mr Keith Mason, Quality and Systems General Manager for SPFC, gave evidence at the inquest. He said that SPFC staff were not trained in physical restraint. As to whether physical restraint might be considered in the situation confronting Ms Makoare and Mr Murdoch, he said:

    "In this particular case, even if the staff was extremely highly skilled in - in physical restraint, in my opinion, I would say most definitely not. I think it would still be too high risk to restrain [P] for a number of reasons… I don't think that they could have restrained [P] safely. If it would have failed then the immediate danger would have been that she would have got in the vehicle, so in that particular situation, even with extremely highly skilled staff that are trained in - in restraint, I would still say that it was too high risk in my opinion."

54. Mr Mason said that planned physical restraint – "a specific plan in place just in case a particular person acts in a particular way" – was not permissible. However, there was a distinction between that and what would be classified in terms of the Department's positive behaviour support policy as a reactive response.

55. Ms Alicia Matthews, Senior Practitioner for SPFC, confirmed that physical restraint of a young person was not part of Safe Places training or part of its accepted policy, and confirmed that the policy makes a distinction between planned physical restraint which is not permitted, and reactive responses, which might include temporary physical restraint.

56. Under the heading "Reactive responses", the Department's Positive Behaviour Support policy[10] states in part:

> *"When responding to unsafe behaviour of children and young people, carers and direct care staff may be required to intervene with reasonable force to protect the child, themselves, and others. Reasonable force is defined as the minimum force necessary to protect the child, oneself, and others from injury or harm…*
>
> *Reactive responses may only be used where there is a high risk of immediate harm to the child or others should intervention be withheld. Where reactive responses are used, paramount consideration must be given to the best interests of the child or young person."*

57. Ms Matthews said in relation to this policy:

> *"What is in our policy… is very similar to the information that is in this document, in that we talk about a reactive response and what that is, and that there may be a situation where minimal force to restrict the movement of a child might need to be used by a youth worker to keep a situation safe. And that is, to keep the child or other members of the community safe."*

58. Ms Matthews said this policy was found in the Safe Places youth worker policy booklet, and she believed it would have been made clear to Mr Murdoch and Ms Makoare during their training. However, neither worker had been trained in the use of physical restraint or was aware that it was an option that could be employed in the circumstances they confronted on 11 April 2012.

59. Both workers had considerable experience working with young people in residential care in New Zealand. While Ms Makoare had a Diploma in Youth Work and a Certificate IV in Juvenile Justice, Mr Murdoch had no formal qualifications at all. At the relevant time SPFC required prospective youth workers to have at least 6 months experience in youth work. SPFC provided 3 days of youth worker induction training and 3 days therapeutic crisis intervention (TCI) training.

60. In addition, workers were required to work a number of "shadow shifts" where a youth worker observed their skills and aptitude for the role. Mr Mason's evidence was that up to 25% of youth workers did not pass this stage in the recruitment process.

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[10] Exhibit B21.26

61. As noted above, the evidence from the Department was that reactive physical restraint was permitted in accordance with its Positive Behaviour Support policy.

62. After the Department became aware during the first stage of this inquest that that SPFC may not have been employing restraint in circumstances where it was warranted, it moved to reinforce the expectation that all funded service providers would comply with the Positive Behaviour Support policy, and to ensure that TCI including physical restraint based on the reactive response model which was used by SPFC.

63. Evidence to that effect was given by Ms Majella Ryan, the Department's Assistant Executive Director, Strategic Policy and Programs. Ms Ryan explained that once the Department became aware that Safe Places did not have a practice of restraining children in appropriate circumstances steps were taken to rectify that situation. She referred to a meeting with Safe Places managers and indicated that the issue had been resolved.

64. Despite the apparent consensus between the Department and SPFC it appears from the submissions provided on behalf of SPFC that it considers that restraint can only be used in situations where a child is in imminent danger, for example "about to step out in front of a truck, bus or train".

65. My reading of the Positive Behaviour Support Policy is that "*high risk of immediate harm to the child or others should intervention be withheld"* would encompass a wider range of situations; including where a child was attempting abscond in a motor vehicle. This indicates that the policy requires clarification. I also consider that the policy should comprehensively deal with the risks of harm, including further traumatisation, associated with restraint.

Conclusions with respect to the actions of the SPFC Youth Workers

66. It was clear from Ms Makoare's evidence at the inquest that she was profoundly distressed by the events on the day of P's death. Ms Makoare and Mr Murdoch's efforts were primarily directed at preventing P from accessing the car with the keys before the police arrived.

67. They tried to work together to deal with P's aggressive behaviour while at the same time keeping her from the car. However, it appeared that despite their training and prior experience in working with young people in care, they were completely overwhelmed by the situation.

68. When P succeeded in getting possession of the car, police were already on their way and it is likely they would have arrived within minutes. At the time of the incident, Ms Makoare and Mr Murdoch could not have

anticipated the tragic outcome of the incident or whether, if they tried to physically restrain her, they might have prevented her death.

69. In the circumstances, they had to exercise their own judgement (within the limits of their training) as to how to manage a very difficult situation. I am unable to conclude, with the benefit of hindsight, that the outcome would have changed had they acted differently.

70. I also consider that the decision to call the police was appropriate on this occasion. The workers were confronted with violent behaviour and faced the additional challenge of trying to prevent P from taking the car. Ultimately, they were not successful, but not because of any failings on their part.

Vehicle immobilisation

71. Ms Alicia Matthews conducted a review of the circumstances of P's death for Safe Places, and prepared a report entitled: "[P] - Internal Review 5/6/12".[11] As set out in the report, the review resulted in a number of recommendations. In particular, the review recommended: "Install Future Fleet vehicle tracking devices into high risk placements".

72. Safe Places has fitted over 70% of vehicles with future fleet tracking devices, which allow a vehicle to be tracked and immobilised when required. All zonal managers have been trained to implement this. Safe Places is using these vehicles in cases considered to be high risk. This is assessed by the zonal manager at the start of a placement.

73. Safe Places has also introduced a PIN Immobiliser system, which requires a PIN number to be entered before a car engine can start notwithstanding that the key has been inserted. I consider that the combination of the tracking immobilisers and the PIN Immobilisers together provide an effective means of preventing young persons from accessing and taking control of vehicles belonging to organisations such as SPFC.

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[11] Exhibit C28

The Police Response

74. Constables David Herbert and Bernard Elmore were the crew in car 232 from the Goodna Police Station on 11 April 2012. They were on the way to the SPFC facility after being allocated a job by Ipswich Police Communications Centre (PCC) Coordinator Sergeant Byrne in response to Mr Murdoch's second 000 call at 6:46pm which related to P's assaults on staff.

75. Police crews had not been dispatched immediately in response to Mr Murdoch's first 000 call at 6:06pm as none were available and a number of priority jobs were being delegated.

76. Unit 232 was given priority code 2 to attend this location. Code 2 is for urgent matters involving injury or current threat of injury to a person or property. En route the crew of unit 232 was given the warnings (flags) listed on QPS databases in relation to P. The flags included issues such as P having previously been violent to police and attempting to remove a firearm from a police officer, her mental health history and bail conditions.

77. Before they arrived at the SPFC home the crew of unit 232 were informed that P had driven off in the Commodore. As a result the call was downgraded to a code 3 – routine matters. At approximately 6:54pm, unit 232 saw the Commodore in Collingwood Drive and advised PCC that the vehicle appeared to have been driven safely at that time.

78. Unit 232 attempted to intercept the Commodore after it stopped at red traffic lights at the intersection of Collingwood Drive and Duncan Street. Unit 232 activated its lights after the light turned green. However, the Commodore accelerated rapidly away and narrowly missed another vehicle at the intersection.

79. Constables Herbert and Elmore did not attempt a pursuit because of the circumstances and in particular their awareness that the driver was a 13-year-old child. The crash site was one kilometre from that intersection, along Duncan Street, which then becomes Kruger Parade.

80. After the attempted intercept, the crew of unit 232 pulled the police vehicle over and advised PCC of what occurred. The crew further advised PCC that the Commodore had overtaken another vehicle on the left and was seen driving on Duncan Street.

81. At 6:57pm, the crew of unit 232 advised PCC they were returning to the address of the SPFC home at Collingwood Park in order to make enquiries at that location.

82. Mr Michael Gesler finished work at Redbank Plains at about 6:50pm on 11 April 2012 and proceeded to travel to his home. His evidence at the inquest was that he was travelling along Namatjira Drive and approached the intersection with Kruger Parade, with the intention of turning left at Kruger Parade. At this time he saw the Commodore being driven by P to his right on Duncan Street, about one hundred metres away from him.

83. Mr Gesler turned left onto Kruger Parade. He looked in his rear view mirror and saw the Commodore about one to two car lengths from him. He estimated that it was travelling at about 100 km per hour. The Commodore overtook Mr Gesler's vehicle near Goodna Creek, swerved back into the left lane and accelerated away. Mr Gesler stated that as the Commodore went past the bend into Kruger Parade, it hit the gutter and lost control. He saw the car fly across the road into bushes, spin a few times hitting trees and then resting about 50 metres into the bushland.

84. Mr Gesler made a call to 000 seconds after the accident which was recorded as being made at 6:56pm on his mobile phone. Mr Gesler stated there were no other vehicles on the road at the time. About 10 - 20 seconds after the accident he saw several cars on Kruger Parade travelling from the opposite direction. At no time did he see a police vehicle, see police vehicle lights activated or hear a police siren.

Conclusions with respect to the actions of QPS officers

85. Those aspects of the QPS pursuit policy that were in force in April 2012 and relevant to this matter are considered below. The principles underpinning the policy were outlined in the Operational Procedures Manual (OPM). Those of particular relevance to this case are:

(i) Pursuit driving is inherently dangerous. In most cases the risk of the pursuit will outweigh the benefits.
(ii) Pursuits should only be commenced or continued where the benefit to the community of apprehending the offender outweighs the risks.
(iii) If in doubt about commencing or continuing a pursuit, don't.

86. Officers have to conduct a risk assessment before starting a pursuit. The risk assessment must consider a range of factors, including the seriousness of the offences the person fleeing may have committed and the strength of the evidence indicating they have committed those offences. In this balancing exercise, issues of safety are paramount.

87. The policy defines "*pursuit*" as the continued attempt to intercept a vehicle that has failed to comply with a direction to stop where it is believed on reasonable grounds the driver of the other vehicle is attempting to evade police.

88. "*Intercept*" means the period from deciding to direct the driver of a vehicle to stop until either the driver stops or fails to stop. It includes the period when the police vehicle closes on the subject vehicle in order to give the driver a direction to stop.

89. The policy prohibits the commencement of a pursuit for a "non-pursuit matter". These include licence and vehicle checks, random breath tests and traffic offences, including exceeding the speed limit.

90. An attempted intercept must be abandoned if a pursuit is not justified. Where a pursuit that had initially been justified becomes one where either the officer, the occupants of the pursued vehicle or members of the public are exposed to unjustifiable risk, it must be abandoned. In such cases the officer must turn off the flashing lights and siren, pull over and stop the police vehicle at the first available safe position and provide details to the local police communications centre.

91. Acting Inspector Leadbetter's report examined the conduct of the police involved in the events surrounding the crash. His report concluded, "there is no evidence to suggest police pursued the vehicle at any time".

92. I am also satisfied that there was no pursuit in this case. This conclusion is consistent with the evidence at the inquest that unit 232 pulled over after the Commodore driven by P failed to stop in response to the activation of the lights on the police vehicle. The witnesses who saw or heard the crash all said that they did not see any police vehicles in the area at the time or in the immediately ensuing period.

93. I am satisfied that Constables Herbert and Elmore complied with QPS policies in place at the time, and acted professionally and reasonably in the circumstances.

94. Consistent with the Forensic Crash Unit report and the evidence of Mr Gesler, I conclude that no other person or vehicles were involved in the collision involving the Commodore driven by P.

P's involvement with the Child Protection System

95. The Systems and Practice Review Report (SPR Report) contains many references to the fact that P was a child with complex needs who had experienced significant trauma and harm as a result of the actions and inactions of her parents. The evidence at the inquest was that she experienced significant family violence and trauma from a very early age.

96. It is possible that early intervention at that time by skilled support agencies may have changed the outcomes for P. However, a fundamental principle of the child protection system is that the Department had no authority to intervene and provide services unless there is notification of it under the *Child Protection Act 1999*, and a child is found to be in need of protection. A child in need of protection is a child who "has suffered significant harm, is suffering significant harm, or is at unacceptable risk of suffering significant harm".

97. A notification received on 16 June 1999 was investigated by the Department. A visit was made to P's home, and it was recorded that "the house was very clean and hygienic looking" and the children "looked well-presented and clean". The outcome of an assessment was "unsubstantiated neglect".[12]

98. The next matter of significance appears to have been a notification on 15 April 2001 after P's mother was incarcerated. The records note that she had been in contact with W who was happy to take P and her brother who had been in her care previously.[13] A voluntary placement was agreed to.

99. The next matters of significance were notifications in 2005. A notification on 22 November 2005 resulted in child protection orders being in place until they were revoked on 7 June 2007.

The Systems and Practice Review Report

100. The Systems and Practice Review Report (SPR Report) identified the following four key practice issues, which it considered to have significantly impacted on service delivery to P:

- investigation of child protection concerns;
- effectively meeting the therapeutic needs of the subject child;
- appropriateness of placements for the subject child; and
- reunification and permanency planning.

101. Dr Fotina Hardy, the independent reviewer who headed the Systems and Practice Review Team, gave evidence at the inquest about the four identified issues, as did Ms Lejana Howard, Team Leader at the Inala Child Safety Service Centre.

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[12] Exhibit C10 - Departmental records, pages 3-10.

[13] Exhibit C12 – Departmental records, pages 25-26

Investigation of child protection concerns

102. The Systems and Practice Review Report found that the analysis of the concerns received "did not sufficiently consider the impact of cumulative harm and the pattern of concerns that indicated an escalation of issues". The report considered that the assessment of concerns appeared to be incident focused rather than considering P's ongoing vulnerability, particularly given her high level of emotional needs. Dr Hardy's evidence was that:

> "*As the service that is there to protect children,.. being responsive is quite often what ends up happening. Yes, you're responsive and reactive to a particular situation, a placement breakdown or whatever, but if we were – the suggestion would be that by considering, I guess, the bigger picture and considering what was happening to P in a much more holistic way, which involves having the services and resources available to do that and the time for departmental workers to be able to do that, I might add, you know, were there other – was there an opportunity to be able to provide a greater level of support to both P and to her family, I guess, by looking at, I guess, the bigger picture and not just responding to discrete events.*" [14]

103. However, Dr Hardy also acknowledged that the ideal services in terms of the resourcing of departmental workers to be able to do the job to the level that they would like to do, and also the types of supports that were available, were not ideal.

104. While Ms Howard agreed that cumulative harm may have been insufficiently considered she considered that P's caseworkers were very much aware of P's needs and the child protection concerns. She did not believe consideration in an overall sense would have made any difference to P's care.

Effectively meeting the therapeutic needs of the child

105. The second key practice issue identified in the SPR Report was concerned with the fragmented nature of the mental health services provided to P. It found that she received no mental health services for significant periods of time, despite having ongoing complex therapeutic needs, and that "this impacted on every aspect of her life, including ability to engage with education, relationships, and her concept of self."

106. At the inquest Dr Hardy said that a continuous relationship with the service provider would be the best solution. However, she recognised that that became very difficult, particularly given that there was the instability around placements and that it had taken so long for that relationship to develop.

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[14] T4-65, L20-30.

107. Dr Hardy's evidence was that a therapeutic relationship takes a great deal of time - trust that has to be established and you cannot just change from one person to another and especially for a young person with attachment issues.[15]

Appropriateness of placements

108. The SPR Report was also concerned that P was given many short-term placements. It considered that she required placements that could meet her ongoing complex therapeutic needs, as evidenced by her escalation in behaviour and absconding. The complexity of her needs also suggested that ongoing respite was required for her carers.

109. P's placement history was summarised in the Systems and Practice Review Report[16]. The report states that from the age of six until her death at age 13, P experienced 14 different placements, not including two periods of incarceration at the Detention Centre.

110. This number of placements is indicative of the instability in P's life. However, to the extent that the number gives the impression that the child protection system lacked consistency and coherence in her care, it is somewhat misleading.

111. Five of the placements were with kinship carer, W, who also cared for P's brother and P was first placed with her in a voluntary care arrangement in 2001 when she was aged 2 years, and from 22 November 2005 to 16 May 2006.

112. After a domestic and family violence incident resulting in their mother being hospitalised, P and her brother then returned to the care of W from 26 May 2008 to 18 December 2008.[17] This broke down because of P's behaviour. She was then placed with foster carers for two weeks from 18 December 2008 to 2 January 2009 before she returned to W for 12 days from 2 – 14 January 2009 for respite until another placement was found.

113. Upon her release from youth detention in December 2011, P placed herself with W until 5 March 2012. This placement broke down on 5 March 2012, and on the same day she was expelled from Beaudesert State High School. This necessitated P's urgent placement with Safe Places for Children from 5 March 2012 until her death on 11 April 2012.

114. In relation to the appropriateness of placements, Dr Hardy was asked whether, given what the department was dealing with, it could realistically have done much better. She replied:

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15 T4-68 L40 – T4-69 L45.

16 Exhibit C8 at pages 55-56.

17 The evidence suggested that P's brother was eventually successfully reunified with the family.

"In the circumstances, with what they had, I don't know that they could have. The issue is about the models of care that are available and the fact that attempts had been made to refer her to a therapeutic residential care service, that wasn't successful, the limited number of therapeutic residential care services available. So the models of care – and that's what the report tries to highlight that the models of care where you have 24-hour youth workers [referring to the roster system like that at Safe Places for Children] as opposed to a therapeutic setting was not the most ideal."[18]

115. Dr Hardy said that her understanding is that there were only a very limited number of therapeutic residential care services in Queensland at the time. Towards the end of 2011, another referral was made for a therapeutic residential care placement for P but it was understood that she did not meet the referral criteria.

116. Dr Hardy described the type of therapeutic residential facility that she envisaged in the following terms:

"So a therapeutic residential facility would have a greater focus on being able to work with a child from a really strong therapeutic perspective, which means having qualified staff with the relevant sorts of qualifications, whether that's psychology, social work or what it might be, to be able to provide a safe, secure and containing environment where the model of care would not be – where the staff would have qualifications and experience to be able to work with a child that has high needs such as reactive attachment disorder, post-traumatic stress disorder.

…

The ideal model involves consistency of staffing, having sort of therapeutic treatment plans that work with the child and engaging with the child from that sort of more therapeutic perspective, whereas with the – just a normal residential care service, …the staff have minimal qualifications, they go through training, but it hasn't been set up as a safe therapeutic environment, and a therapeutic service tends to have, you know, more of a multidisciplinary team approach and has that stronger focus and understanding on the fact that when a child is acting out or a child's behaviour escalates, it's actually quite pain-based behaviour that they're seeing, as opposed to being a naughty girl..."[19]

117. When asked what the difference between what she envisaged as ideal and, for example, the Safe Places facility where P lived, Dr Hardy replied:

"Having staff that have more than a minimum qualification of a cert III, having staff that have been through a more robust and ongoing training and higher qualifications to understand that a young child

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18 T4-71 L40 – T4-72 L5.

19 L4-72 L20-40.

who might be escalating in their behaviour is not just being a difficult child, but that they're responding and reacting to something that has triggered them.

… I would be envisaging a therapeutic residential service that has appropriately skilled and well-skilled and qualified practitioners from a multidisciplinary team that are there to provide support to the child and support to other workers that are working with the children.

… That's not taking away from what residential care workers do or any of the residential care services – and I'm not doing that, I guess I'm talking about at a systemic level – if we were going to have services that were truly responsive to the needs of children, that we would have services that had the appropriately-qualified people in them."[20]

118. The evidence of Departmental officers, including Ms Howard, was that SPFC was identified as a suitable placement for P because it had a successful track record in achieving good outcomes for young people. Ms Howard considered that SPFC was "the best service we could provide for her due to their commitment to her needs and willingness to work with stakeholders to finally gain consistency".

119. Similarly, the Director of Placement and Support Services in the Brisbane Region, Ms Celia Lenaghan, noted:

> *"We considered Safe Places to be appropriate because they had been caring for P and that they had a knowledge and a history with her. Safe Places have always been an agency that will place young people with needs such as P and other complex people, young people. We've always experienced that they would work with the department flexibly and that they are open to input from other stakeholders, and will work in a collaborative way with other stakeholders around children and young people. I guess another factor would have been that the organisation was known to P, so that whilst the direct care staff may not have been a care team that she had worked with previously, that the organisation was known to her. And often, where possible, Safe Places would always work with us to try and staff with staff that young people knew or, you know, had a relationship with. I do know, though, that that is often challenging, because they are staffing across many homes across the State."*[21]

Lack of permanency planning

120. The last of the key practice issues in the SPR Report was identified as "lack of permanency planning resulted in short term placement options leading to ongoing instability for the subject child".

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20 T4-73 L5 – T4-74 L5.

21 T3-83

121. Dr Hardy referred to the fact that the nature of P's residential care placements were that they were intended only to be short term. She made these observations:

> *"… if we're talking about P specifically and if I think about what her needs were, and having a really well supported therapeutic service, if that had been available – and we don't know what would have happened – but it's about being able to provide the right service to the child as opposed to trying to fit a child into existing services and the Departmental officers were only able to use whatever services and resources were provided to them and this is what was provided to her. Ideally, any child requires stability and so, if it's re-unification – if re-unification is the plan, then obviously being able to keep a child in the one placement until re-unification occurs. If it's permanency planning, then, it's being able to keep a child in the one placement on a long-term basis."*[22]

122. P was referred to Complex Care from November 2010 to February 2011. Complex Care is a private agency that provides support and consultancy services specifically tailored to respond to the needs of children with complex behaviours. At the end of that period, Complex Care provided a report, which recommended reunification with P's family was not reasonable or achievable at that time, although it did recommend that she continue to have contact with her family. It appears that it was not until this assessment and report by Complex Care that it was clearly established that reunification was no longer a realistic goal.

123. However, when the child protection order then in place expired at the end of 2011, a decision was still made by the Department to ask for another short-term guardianship order. This was said to be in order to minimise the upset that a long-term order would cause to P.

124. When asked whether she would accept that this was a reasonable decision to make at that time, Dr Hardy replied *"Yes, I would, and I know, in talking with the staff about their decision, they made the decision because they felt it was in the best interests of P."*[23]

125. Ms Howard did not agree with the SPR Report's conclusion that "lack of permanency planning resulted in short-term placement options". She believed that it was a result of P's behaviour that each placement became short-term, rather than part of a conscious plan by the Department. Ms Howard also noted that there were continual immediate needs to be addressed with P, and those had to be prioritised for her "immediate safety and her immediate needs that were evolving constantly".

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22 T4-75
23 T4-76 L 35.

Recognised Entities

126. Ms Leslie Williams was engaged as a cultural consultant for the SPR. Her evidence was that her role was to consider whether service delivery to P was culturally appropriate. This would primarily occur through engagement with a recognised entity. Workers from the recognised entity would ideally accompany Departmental officers when they engaged with P and her family.

127. However, Ms Williams noted from her involvement as cultural consultant in reviews under the legislation that the recognised entities were "very short on resources, not enough people on the ground to actually go out and do all this work".

The CDCRC Report

128. The CDCRC report contained a number of specific criticisms of the child protection system. Most significantly, the report concluded that P may not have died if the Department had discharged its obligations:

> *"In considering all these factors, the Committee was compelled to find that the actions and inactions of the service system were linked to the child's death.*
>
> *The Committee's identification of a link between the child's death and the action and inaction of the service system in the case highlights the need for urgent review and reform of the child protection interventions available for children suffering trauma and mental health issues resulting from abuse and neglect."*

129. Having regard to this conclusion, it was relevant for the inquest to independently examine whether the service system was "linked to" or contributed to P's death. The CDCRC Report stated:

> *"The Committee suggests that the Department's inadequate assessment of cumulative harm and an unwavering commitment to the reunification of the child to her family was detrimental to the child's long term stability and her emotional well-being."*

130. As noted above, a similar point about insufficient attention to the impact of cumulative harm was identified in the SPR Report and Dr Hardy's evidence confirmed that the Department was often limited to reactive responses.

131. While Dr Hardy acknowledged that a more effective response involved "having the services and resources available to do that and the time for departmental workers to be able to do that", she also acknowledged that ideal services were not available.

132. The CDCRC Report also made nine recommendations covering matters such as improved mechanisms to engage senior officers in decision-making in complex cases, staff training, mandatory qualifications for residential care workers and responding to trauma. I am satisfied from the evidence of Ms Kirstin Hall that each has been implemented by the Department.[24]

Trauma-based Therapy

133. Ms Lisa Hillan, Program Director of the Aboriginal and Torres Strait Islander Healing Foundation, explained the relevance of "trauma-based therapy" for children who have been exposed to trauma early in life:

> "… *trauma-based therapy is really about attachment and the attachment disorder that people actually end up with as a result of trauma, be that an attachment to their individual family, be that an attachment to their community, be that an attachment to even their cultural self. Trauma interrupts and disconnects people from a sense of who they are and their safety in their world and their safety in relating to others.*

134. Ms Hillan's evidence was that a child's strongest attachment forms between birth and one year of age. Attachment disorder also begins very early, especially where there are high levels of violence and children exposed to high levels of fear and terror. The long-term neurocognitive impacts of disrupted attachment are now well understood.[25]

135. Ms Hillan's evidence was that a comprehensive investigation of P's circumstances would ideally have been part of trauma-based therapy:

> *"I think trauma-based therapy would have been relevant to P and her entire family, and I would say that one of the things that probably for me is missing is an understanding of the intergenerational trauma that was located in this family as an Aboriginal family*
>
> *… So we know that because of past policies in Australia nearly every Aboriginal family has a Stolen Generations past, that they've had family removed as a result of government policy where Aboriginal children were to be assimilated, and that was fairly widespread and fairly significant in Queensland, and particularly was enacted through the missions as well, so things like Cherbourg and Mornington and Doomadgee, all of those places also removed children from their parents, put them in dormitories, did not allow their parents to have any decent sort of parenting experiences, or children to have that, and children were harmed often in those experiences. We know that not understanding that, then we don't actually understand for P and her family what their history of removal was, what the impact of trauma on her own parents was, and then how that played out in their own domestic*

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24 Exhibit B19

25 T5-32 L45 – T5-33 L15

and family violence and their own drinking and alcohol. So there doesn't seem to be that historical sense in the file."[26]

"If there had have been a comprehensive assessment done of this family, and we understood also the entire history of both her mother and father's sense of removal and what had happened in the generations, there could have been a very comprehensive plan put around P and her kinship carer to support that effectively at that point."[27]

136. Ms Hillan agreed that Queensland does not have good quality residential treatment services. Like Dr Hardy, she said that a quality residential treatment service which employed a trauma-based approach would have enabled P to have access to psychiatrists, psychologists, social workers, highly trained residential care workers, educational assessment, occupational therapists and speech therapists. Together, these professionals could have undertaken a more comprehensive evaluation of what was happening.

Mental Health Services

137. The inquest heard evidence that a considerable range of mental health services were provided or offered to P. As noted in the statement of Dr Lydia Rusch, Consultant Psychiatrist at Evolve Therapy Services, P had been under the care of Logan Child and Youth Mental Health Services (CYMHS) between 8 November 2008 and 7 September 2010, a period of almost two years.

138. During that time she attended individual therapy with psychologist Olivia Donaghey and medical reviews with Dr Sue Miller. Initially her engagement was noted to be quite good but it deteriorated over time to the extent that she refused to attend monthly appointments.[28]

139. The Discharge Summary of Logan CYMHS[29] sets out the following reason for referral:

P.. is an Aboriginal girl aged 11 years who was referred to CYMHS in Sept 2008 by the Dept Child Safety. This was a few months after being removed from the care of her natural parents for her own protection. Initial presentation included nightmares and uncontained emotional states that led to aggressive and destructive behaviours such as physical and verbal aggression to carers and pets, threats of self harm, destruction of property. P's school and carers reported hyperactivity and poor concentration. These behaviours occurred in a child with a prejudicial background where she witnessed severe violence between her parents who both abused alcohol and was allegedly subject to emotional and physical abuse and neglect.

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[26] T5-35 L10-35.
[27] T5-37 L45.
[28] Exhibit B25, paragraphs 35-36.
[29] Exhibit B25.5

Prior to intervention by the Dept Child Safety at age 9, P was frequently placed by her parents in care of family and friends throughout her childhood. A family friend of P's mother, Aunty W, looked after P at various times since her infancy and was P's initial foster carer when removed by Child Safety and a good historian in relation to P's social emotional wellbeing."

140. The following diagnoses were noted in the discharge summary:
    1. Reactive Attachment Disorder
    2. ADHD
    3. Post-Traumatic Stress Disorder
    4. Problems relating to alleged frightening experiences in childhood
    5. Problems relating to alleged physical abuse

141. P was then under the care of Inala CYMHS from 23 September 2010 to 25 May 2011. A letter from Inala CYMHS dated 7 October 2010 stated that the main goal of mental health services at that time was to promote stability in P's placement, and individual therapy was not recommended at that time because of the lack of stability in her current circumstances. Dr Rusch supported this approach, noting

> *"In my experience there is little clinical benefit, and indeed it can be counter-productive – to engage a child with such complex needs in individual therapy for a short period of time. It usually takes a significant period of time to build rapport and trust between the child and the therapist, which are important features of a therapeutic relationship."*

142. P was accepted into the Evolve Therapy Services Program in late October 2011, but because of her detention and the resignation of her Child Safety Officer, commencement with the program was delayed. Psychologist, Dr Kiran Sangha, was allocated as P's case manager, but the first opportunity for her to meet P was not until the beginning of February 2012. Dr Rusch saw P for the first time on 14 February 2012.[30]

143. According to Dr Sangha's statement, the plan was for P's mental health assessment to take between 3 and 4 months. Dr Sangha's statement sets out details of various meeting with Child Safety Officers, stakeholder meetings and home visits that took place before P's death on 11 April 2012.

144. Her last home visit with P was on 5 April 2012, when Dr Sangha noted that P engaged with her to a greater degree than she had in the past. As Dr Sangha said:

> "*My preliminary view, recorded in my working draft assessment plan, was that P's principal diagnosis was likely classified as 'other mixed*

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30 Exhibit B25, paragraphs 27-31.

disorders of conduct and emotions' together with a 'disinhibited attachment disorder of childhood'. This was only my preliminary conditional diagnosis and was yet to be discussed and reviewed."

145. The evidence of Dr Rusch and Dr Sangha, and the records, clearly show that because of the instability in P's life, together with P's reluctance to engage with therapy, the point was never reached where a therapeutic relationship could be established so that she could be engaged in individual therapy. Nor was the point reached where a comprehensive diagnosis could be made by Evolve Therapy Services.

146. It is apparent from Dr Rusch's statement that a number of improvements to the services offered by Evolve Therapy Services have subsequently been made:

    (i) The Mater and Queensland Health have collaborated to develop a comprehensive training and education program specifically directed at child and youth trauma attachment issues. The program is directed at DOCS child safety staff and residential care workers.

    (ii) A complex case discussion group has been established to obtain broader input from senior and very experienced clinicians. The discussion group is comprised of the Director of the Mater Mental Health Services, the Executive Manager of Mater CYMHS, a consultant child and adolescent psychiatrist, members of the child's treating team and representatives of other stakeholders who may be able to provide input to the discussion.

    (iii) ETS has become more proactive in providing ongoing services to any child who has been approved for ETS services and who is subsequently placed in detention.

    (iv) ETS has commenced engaging the Child and Youth Forensic Outreach Service to provide forensic assessments of clients, which assist in ETS' clinical treatment of the clients.

CONCLUSIONS ON CHILD PROTECTION SYSTEM INVOLVEMENT

147. The evidence does not support the conclusion reached in the CDCRC Report that "the actions and inactions of the service system were linked to the child's death".

148. I consider that the Department made appropriate use of the services that were available to it at the time, including SPFC and mental health services, in responding to P's needs. The services were selected following appropriate consideration of their capacity to assist P.

149. The opportunities for the Department to intervene were limited up until 2005, when P was aged 6 years. However, the evidence at the inquest suggested that P and her family would have benefited from more comprehensive services (if such services had existed) and highlights the importance of investment in early intervention.

150. As demonstrated by this case, the consequence of the system's lack of capacity to meet needs of children like P in a timely way is a response that, of necessity, becomes crisis driven, reactive and extremely costly. It also sees too many young people move from the child safety system to the criminal justice system. With her background, it was almost certain that P would have eventually entered the adult criminal justice system.[31]

151. The evidence in relation to the service system confirmed a number of the deficiencies in the system that were identified in the 2013 report of the Queensland Child Protection Commission of Inquiry (the Carmody Report).

152. If comprehensive and culturally appropriate services had been available, P's family are likely to have accessed them. If the child protection system envisaged by the Carmody Report had existed during P's lifetime, it would be expected that P's family would have been provided with comprehensive services and support commencing before she was born. Ideally, she would not have been exposed to the trauma and family violence that she experienced from an early age. However, it is impossible to conclude with certainty that the difficulties P encountered throughout her life would have been avoided.

153. It is reasonable to conclude that the trauma and family breakdown that P experienced from an early age contributed to her complex mental health issues and behaviour. However, experience suggests that the underlying issues including the deep-seated inter-generational trauma that affects Indigenous communities referred to in the evidence of Ms Hillan are not amenable to easy solutions.

154. Based on the evidence heard at this inquest, and the continued overrepresentation of Aboriginal and Torres Strait Islander children in the child protection system, I encourage the Queensland Government to approach the implementation of all of the recommendations of the Carmody Report informed by an appreciation of the ongoing impact inter-generational trauma has on Indigenous communities.

155. While I am concerned that P appeared to "drift" in the care of the Department, and that she had 14 placements during her life, there was some level of consistency in those placements. In particular, a number of these placements were with her kinship carer, W.

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[31] Livingston et al, Understanding Juvenile Offending Trajectories, *Australian & New Zealand Journal of Criminology* December 2008 41: 345-363

156. The records of the Department, and the evidence of Child Safety officers indicate that the Department made considerable efforts to accommodate P's cultural needs and to continue contact with her family. For most of the time that P was in care, the goal pursued by the Department was reunification with her family.

157. Having regard to the policy framework in place at the time, this was not unreasonable, notwithstanding that it could not be finally achieved. The relationship between P's parents was unstable and she was ambivalent about whether she wanted to live with them. However, the evidence was clear that she had a very strong bond with her family, which she wished to maintain.

158. P's attachment to her kinship carer, W, was also strong. These bonds were respected and accommodated by the Department. As a kinship carer, W was provided with limited support and would have benefited if more comprehensive support services had been available to her that might have enabled P's placement to be sustained.

159. As noted above, it appears that it did not become apparent until around early 2011 when the Complex Care report[32] was received that the goal of reunification with family was unlikely to be achieved. However, the evidence does not support the conclusion that, until then, it was inappropriate for the Department to pursue reunification as the ultimate goal for P.

160. It is relevant that P's brother could be reunited with the family. This suggests that P's needs were not identical to those of her siblings. The response of the child protection system necessarily had to be responsive to P's unique circumstances as they presented throughout her life. Unfortunately, the service system was unable to respond to the behaviours that she exhibited which inevitably led to the breakdown of a number of placements.

Autopsy results

161. Experienced Forensic Pathologist Dr Beng Ong completed a post mortem examination of P's body on 14 April 2012. Dr Ong completed a report which was in evidence at the inquest. The post mortem examination identified extensive injuries to the right side of P's face, both internal and external.

162. Significant injuries were detected to the right side of the torso including multiple rib fractures. There was also evidence of trauma to the heart as well as ruptured right atrium. Significant fractures were detected on the right side of the pelvis.

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[32] Exhibit B25.16

163. Dr Ong's opinion was that the injuries were extensive and non-survivable and he stated the death was immediate. The injuries were consistent with a high energy impact. Dr Ong stated the cause of death was "due to multiple injuries as a consequence of a motor vehicle accident (driver)".

164. Analysis of chest cavity blood, urine and a specimen of vitreous humour found no drugs, alcohol or other volatile substances.

Findings required by s. 45

Identity of the deceased –	P
How she died –	P died when a motor vehicle that she took to abscond from a residential care facility at Collingwood Park failed to negotiate a bend and spun out of control into bushland before crashing into trees.
Place of death –	Kruger Parade, Redbank, Queensland
Date of death–	11 April 2012
Cause of death –	Multiple injuries, due to, or as a consequence of a motor vehicle accident.

Comments and recommendations

165. Section 46 of the *Coroners Act*, insofar as it is relevant to this matter, provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice, or ways to prevent deaths from happening in similar circumstances in the future.

166. Those who were represented at the inquest submitted that I should make recommendations in relation to a range of matters such as:

- the qualifications and training of carers of complex needs children, including a requirement for tertiary qualifications;
- earlier intervention and mental health care;
- support services for children and families;
- continuity of therapeutic care across placements; and
- the availability of therapeutic residential care facilities.

167. While these matters would fall within the scope of comments that could be made under s 46, I do not consider that it was the function of this inquest to duplicate the comprehensive investigations carried out over more than a year by the Queensland Child Protection Commission of Inquiry. The Carmody Report made 121 recommendations of which 115 were

accepted in full by the Queensland Government (six were accepted in principle). I consider that the scope of those recommendations encompasses each of the matters identified in paragraph 166.

168. However, it is appropriate to acknowledge that many deficiencies in the child protection system that were relevant to P's life circumstances were identified in the Carmody Report. The evidence of Dr Hardy, Ms Williams and Ms Hillan was consistent with the overall recommendations of that Report. The Report stated:

The evidence provided to the Commission has been strongly in favour of a shift in funding from statutory services to those focused on prevention and early intervention. The Aboriginal and Torres Strait Islander Healing Foundation states:

> *'Children and their families need to be supported from the very beginning to prevent abuse and neglect and eliminate the need to separate children from their families and culture. Despite this being acknowledged by most service providers and government departments, expenditure on out-of home care continues to increase. It is vital for a shift to occur from expenditure on reactive child protection services to a focus on expenditure of family support services and child and family wellbeing.'*[33]

169. In particular, I note that the Carmody Report was critical of the practice adopted by some residential care services of routinely calling the Queensland Police Service in response to challenging behaviours. The evidence from the Department at this inquest was that its expectation is that this should only occur as a last resort.[34] However, the Carmody Report noted "contact with police is a common experience for young people living in residential care". It found that, as at 30 June 2012, 27.6 per cent of children in licensed care services had been charged with "placement-related offending" - criminal offences as a result of residential care staff making complaints regarding behaviour.[35]

170. In contrast to the use of police to manage behaviour, the Report noted that therapeutic responses to challenging behaviours are informed by "an understanding of trauma, damaged attachment and developmental needs", and that residential care facilities with a strong therapeutic focus "attend to children's needs and emotions, instead of simply responding to children's behaviour". Recommendation 8.7 was as follows:

> *That the Department of Communities, Child Safety and Disability Services partner with non-government service providers to develop and adopt a trauma-based therapeutic framework for residential care*

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33 Carmody Report, page 75.
34 Exhibit B28
35 Carmody Report, page 265

facilities, supported by joint training programs and professional development initiatives.

171. I make the following specific recommendations:

1. That the Department of Communities Child Safety and Disability Services work with licensed care services to implement policies and procedures, including the introduction of technology such as tracking and PIN immobilisers, to ensure that children in care with complex needs are not able to take control of vehicles.

2. That in implementing recommendation 8.7 of the Carmody Report, the extent to which licensed care services should engage the QPS to respond to placement related behaviours be reviewed, and consideration be given to an audit tool to monitor this practice and outcomes for young people in care in terms of entry to the criminal justice system.

3. That the Department of Communities Child Safety and Disability Services review its Positive Behaviour Support policy to ensure that it provides more guidance in relation to the circumstances in which reactive restraint can be used, and the types of restraint permitted. The policy should also highlight the significant risks, including asphyxiation, posed to the wellbeing of persons being restrained by inappropriate restraint techniques.

I close the inquest.

Terry Ryan
State Coroner
BRISBANE
9 October 2015