CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Pono Wairua Aperahama
Hearing Dates:	26-30 October 2020; 7-8 December 2020
Date of Findings:	21 May 2021
Place of Findings:	Newcastle Local Court
Findings of:	Magistrate Stone, Deputy State Coroner
Catchwords:	CORONIAL LAW – cause of death – cardiac arrythmia during restraint – deceased in care of Department of Communities and Justice – intellectual disability – case management responsibility by Challenge – role each played in overall care – rising levels of agitation – behaviour support – appropriateness of supervision and medication – pool incident
File Number:	2017/00314530
Representation:	Mr J Harris, Counsel Assisting, instructed by Ms L Nash and C Healey-Nash, Crown Solicitor's Office Ms A Cregan for Mr S Henry, instructed by Ms L Lombardo, Gilbert + Tobin Mr I Duane for Challenge Community Services, instructed by Ms N Shepherd, NLS Law Pty Ltd Mr S Beckett for the Department of Communities and Justice, instructed by Ms D Jackman and S Bangash, Department of Communities and Justice Ms G Mahoney for the NSW Commissioner of Police, instructed by Ms E O'Brien, Office of the General Counsel (NSW Police Force)

Ms D Dinnen for Ms J Smith, instructed by Ms S Dow and Ms E Troeger, DLA Piper Australia

Mr K Poh for Dr Babu, Moray & Agnew

Mr J Thompson for Mr C Newman, instructed by Ms V Turner

s. 81(1) of the Coroners Act 2009 (*NSW)(the "Act"*) *requires that when an inquest is held, the Coroner must record in writing his or her findings as to various aspects of the death. These are the findings in the inquest into the death of Pono Wairua Aperahama.*

The court made specific non-publication orders pursuant to sections 65 and 74 of the Coroners Act 2009 (NSW). The orders relate to sections of certain New South Wales Police Force policies, names of children, material provided by the Department of Communities and Justice and certain sensitive footage. The orders are available through the Court Registry.

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Introduction

1. Pono Wairua Aperahama died on 17 October 2017, aged just 17 years. His death followed an incident at Lambton Memorial Swimming Centre ("Lambton Pool"). He had gone to the pool with his carer. As he was preparing to leave, Pono became agitated and aggressive as a result of an interaction with a young person in the pool. Pono was restrained by pool staff and members of the public. NSW Police Force ("NSWPF") and NSW Ambulance were called and various NSWPF officers and paramedics arrived on scene. While being restrained Pono had a cardiac arrest and CPR was commenced. He was conveyed by ambulance to John Hunter Hospital, Newcastle. However, tragically, he could not be revived.

2. As NSWPF officers were in attendance, an inquest is required to be held pursuant to sections 23(1)(c) and 27(1)(b) of the *Coroners Act 2009 (NSW*) ("the Act"). The purpose of this type of inquest is to fully examine the circumstances of the death in which NSWPF officers have been involved in order that the public, the deceased's relatives and the relevant agency can become aware of those circumstances.[1]

3. Section 81(1) of the Act requires a Coroner to make findings as to:

    - the identity of the person who has died;
    - the date and place of the person's death; and
    - the manner and cause of the death.

4. In addition, under s 82 of the Act, the Coroner may make recommendations in relation to matters connected with the death, including matters that may improve public health and safety in the future.

Brief Background

5. In these findings and throughout the hearing I have referred to Pono using his first name. I do not intend any disrespect and it was done with the approval and consent of Pono's father. Annexed and marked Annexure "A" to these findings is an agreed summary of background facts that sets out in considerable detail relevant matters concerning Pono and his background. To provide context, the following information, which I have taken from the opening remarks of Counsel Assisting, Mr Jake Harris (to whom I am indebted), is relevant.

6. Pono was born on 17 January 2000 in Bankstown to parents Mr Steven Henry and Ms Te Rina Abraham. His parents were from New Zealand and like his mother, Pono was Maori.

7. Pono was a happy and energetic child with a passion for sport, including rugby. As a teenager, he was sociable and affectionate and had an affinity with younger children. He was known as a joker and loved pranks. His parents separated when he was a baby, with Mr Henry returning to New Zealand in 2002, and his early life was unsettled. In October 2008, when Pono was eight, he and his siblings were removed from the care of their mother and placed with their maternal grandparents, where they remained for the next five years. In November 2009, final orders were made placing Pono in the shared parental responsibility of the Minister for Family and Community Services (now

[1] See "Wallers Coronial Law and Practice in New South Wales", Paragraph 23.7

the Department of Communities and Justice)[2] (the "Minister") and Pono's maternal grandparents.

8. On 24 September 2013, when aged 13, Pono was involved in a very serious motor vehicle accident. Riding a motorised bicycle, he collided with a car. Unfortunately, he was not wearing a helmet and he suffered an extremely severe traumatic brain injury ("TBI") involving a subdural haematoma and diffuse axonal injuries. He remained at Westmead Children's Hospital for about 10 months and underwent a number of surgeries, including cranioplasty to insert plates into his skull. Increasing pressure in his brain lead to a secondary injury, which required the insertion of a permanent ventricular-peritoneal shunt. As a result of his injuries, Pono suffered a major neurocognitive disorder with behavioural disturbance and memory loss.

9. It was not considered appropriate for Pono to be discharged from hospital into the care of his grandparents and so an alternative placement was sought. Pono's father sought to have Pono placed into his care, although this did not proceed. The Department of Communities and Justice ("DCJ") approached an approved designated agency called Challenge Children's Services ("Challenge") to arrange a residential placement that would meet Pono's needs.

10. Pono was discharged from hospital on 30 July 2014 and placed in various out-of-home care residential placements, ultimately coming to reside in a house in Ashtonfield (near Maitland), where he was the only resident. He remained there until his death. At this placement, Challenge provided Pono with one-on-one, 24-hour care through a team of carers. The carers were supported by a caseworker and manager, and psychologists.

11. In January 2015, final orders were made placing Pono in the sole parental responsibility of the Minister. The Minister held sole parental responsibility for Pono up until the time of his death. DCJ initially also retained case management for Pono, although the day-to-day care was provided by Challenge. On 22 July 2016, case management responsibility for Pono was also transferred to Challenge. As a consequence, Challenge assumed responsibility for most aspects of Pono's care, including case planning, monitoring and review, and planning for his transition out of care as he approached adulthood.

12. Due to his complex needs, Pono's health and support services included a neurologist (Dr Robert Smith), a neuropsychiatrist (Dr Sevegram Umesh Babu), the Paediatric Brain Injury Rehabilitation Team sitting within the Kaleidoscope Paediatric Rehabilitation Service based in Newcastle (including a speech pathologist, an occupational therapist and a physiotherapist), a psychologist (Ms Jacquelin Smith) and a neuropsychologist (Dr Matthew Conroy).

13. These support services were funded by the NSW Lifetime Care and Support Authority ("Lifetime Care") – a statutory corporation whose functions include the provision of care, treatment, rehabilitation and long-term support for persons who have sustained motor accident injuries. From April 2016, Dr Conroy also acted as Pono's caseworker, whereby he coordinated support services and submitted funding applications to Lifetime Care.

[2] To avoid confusion, the current name of this governmental agency will be used, namely the Department of Communities and Justice. Invariably however, where specific references are made to material that uses the acronym FACS, this has not been amended.

14. The management of Pono's behaviour was a significant issue in this inquest, in light of the circumstances which led to his death, one being pharmacological management of Pono's neurological condition through a neuropsychiatrist, Dr Babu, and the other being behavioural support provided by Pono's carers under the guidance of a psychologist.

15. The nature of Pono's cognitive impairment was significant. Dr Conroy assessed Pono in January 2016, aged 16, and found he had a cognitive impairment consistent with a moderate intellectual disability, with an equivalent mental ability of an eight-year-old. The impairment was considered permanent. A feature of his condition was that he experienced behavioural disturbance, problems regulating his emotions and had deficits in his higher-level thinking; he was easily agitated, rapidly escalated into anger, aggression and violence. He had on occasion absconded from his carers and he had difficulties respecting personal space.

16. Behaviour support was provided to Pono by his carers under the guidance of a psychologist, who prepared what is termed a "behaviour support plan" ("BSP"). That describes a model of care which aims to modify behaviour by allowing carers to anticipate and respond to behavioural incidents with the aim of reducing their intensity. A BSP is also a necessary requirement where a child is in out-of-home care and prescribed psychotropic drugs (clause 26 of the *Children and Young Persons (Care and Protection) Regulation 2012*).

17. Initially BSPs were prepared by an internal Challenge psychologist. Unfortunately, staffing changes and a lack of capacity meant that Challenge psychologists were not able to continue providing support for Pono in early 2016 and at that stage funding was sought from Lifetime Care for an external psychologist.

18. Ms Smith, a registered psychologist, was engaged in June 2016 having worked with people with complex disabilities for about 20 years. She revised Pono's BSP in August 2016 and reviewed it every three months until preparing a final plan on 30 August 2017. She also met with Pono on a fortnightly to monthly basis, attended meetings with Challenge staff to provide guidance and training on how to manage Pono's behaviour, received feedback from incidents Pono had been involved in and drew up other guidance for dealing with specific issues. Pono's behaviour nonetheless remained a problem – which is unsurprising given his significant disability and early life trauma. Following Ms Smith's engagement, it appears Pono's behaviour improved, although he was excluded from school on a number of occasions, including an incident to which the NSWPF were called on 21 September 2016.

19. Broadly, Pono's behaviour issues centred around the following key themes:

    I. Pono had poor social skills, but a strong desire to socialise. He could upset people and misinterpret situations, becoming frustrated and upset and perceiving that he was being made fun of.

    II. Pono would self-harm. He would scratch or cut himself, threaten to jump off buildings and, significantly, hit his head or bang it against the wall or ground. This was concerning due to the plates in his skull and his peritoneal shunt. This behaviour resulted in a number of trips to hospital.

    III. Pono's behaviour could escalate quickly, unpredictably. He would sometimes become aggressive and strike out at carers and members of the public. It was

noted however, if given space to calm down, he could also rapidly de-escalate and become remorseful.

20. There appeared to be a pattern of escalating behaviour during the course of 2017, with about 25 incidents recorded by Challenge staff and five reports being made to DCJ. Following an incident in May 2017, Pono was excluded from school. A month later, he damaged property and assaulted a security guard in Green Gill shopping centre, which resulted in criminal charges – ultimately being resolved by a s. 32 order under the *Mental Health (Forensic Provisions) Act 1990*.

21. One very significant matter that impacted Pono in the months preceding his death, was his approaching adulthood (Pono was turning 18 on 17 January 2018) and there was still significant uncertainty around his future care. Various options were canvassed during 2017, including the possibility of moving to or near his family in Queensland, moving to supported Housing NSW accommodation or remaining in the same home with support from Challenge Choices, which is a service for adults with a disability. This last option unfortunately ran into funding problems and could not be progressed. To complicate matters, Challenge's residential care program was going to cease at the end of 2017. As a result, some Challenge staff members began to leave to find employment elsewhere, with their future employment with Challenge not assured. This reduced staff numbers and importantly, had a bearing on the staff that remained who had knowledge of Pono's behaviour and issues.

22. As to behaviour support that Pono received during this period, the inquest focused on two topics in particular:

    a. Firstly, whether in light of Pono's behaviour it was adequate for him to have only one carer while in the community, or whether he ought to have had two. In March 2016, Dr Conroy and others formed the view that as a result of Pono's increasing outbursts, he required two carers at all times, both at home and in the community. That was supported by an occupational therapist and a request was submitted to Lifetime Care for more funding. However, an extra carer was not provided and instead funding was provided for psychological support from Ms Smith with an intention of waiting to see the impact of that before consideration was given to further staff; and

    b. Second, whether further training or guidance could or should have been provided to assist Challenge staff, particularly during community outings, such as during trips to the pool. There had already been two recent incidents proximate to Pono's death where Pono had attended Maitland swimming pool. The first incident occurred on 31 December 2016, when Pono was bothered by a couple of children and he threatened to punch one of them and then pushed a child to the ground. His carer was able to intervene on that occasion and direct members of the public away from Pono, who then left the pool. The second incident occurred on 11 February 2017 and involved Pono repeatedly punching a child in the head, and then assaulting his carer. When he was told to leave and that NSWPF officers would be called, Pono began to headbutt a brick wall. He was then assaulted by a group of children, who pushed him to the ground and kicked his head. Pono was conveyed to hospital for treatment.

23. Following this last incident, Pono's Challenge case manager Ms Lee Armstrong decided that there should be no further trips to the pool until a risk assessment was performed. A draft risk assessment was prepared a couple of days later and this was discussed in a staff meeting on 21 March 2017. Whether that risk assessment was

finalised, what guidance was known to staff and applied on 17 October 2017 will be further considered.

The events of 17 October 2017

24. On the morning of 17 October 2017, Pono's overnight carer Mr Gareth Owen became involved in an incident with him at about 8:15 AM. Pono asked Mr Owen if he could use the computer to type and print a letter to Mr Brendon Bice, the oncoming carer. When he was told that the printer was not working, he became agitated and attempted to punch Mr Owen who left the office to allow Pono to calm down. Pono then took Mr Owen's house keys and threw them down the drain. He remained elevated until Mr Bice arrived on shift, when he calmed down and apologised.

25. The day with Mr Bice appears to have gone relatively well. Mr Bice saw Pono five days a week, so they were very familiar with each other. They went shopping together at Charlestown and Pono bought a ring, although he changed his mind and wanted to return it. He does not appear to have become upset when told he could not do so.

26. At some stage during the day, Pono asked to go to the pool. Mr Bice did not think that was a good idea. He and Pono discussed the issue and Pono agreed it was not a good idea and instead, they agreed to go to the cricket nets. Mr Bice also gave Pono his normal afternoon medication.

27. The oncoming carer, Mr Tyler Bender, arrived at about 2:30 PM and performed a handover with Mr Bice. Mr Bice told Mr Bender about Pono saying he wanted to go to the pool and that they had agreed not to. He also told him about the earlier incident with Mr Owen.

28. Mr Bender had also previously worked with Pono, however in the couple of months prior to his death it appears that Mr Bender only had four to five shifts looking after Pono, and these were mostly sleepovers. While Pono appeared happy and at baseline during Mr Bender's shift, an incident did occur with Mr Bender when Pono asked him for the house keys and these were refused. Pono ordered Mr Bender out of the house. A few minutes later Pono came out and tried to set a catalogue on fire. Mr Bender phoned the Challenge caseworker Mr Luke Hoevers for support. Pono then came outside, calmed down and apologised.

29. Shortly after this, Pono said he had changed his mind about cricket and wanted to go to the pool. Mr Bender agreed. At about 3:40 PM, Mr Bender drove Pono to Woolworths at Jesmond where Pono got a drink and some money. They went to Lambton Pool arriving at about 4:20 PM. At the point of arrival, Pono's mood was said to be baseline and happy.

Events at Lambton Pool

30. Pono first played with a boy and a girl and they did some "bombs" in the pool. This got a bit rowdy, and Mr Bender intervened to warn Pono and the boy to calm down. The boy and girl eventually left and Pono said he was bored, and they decided to leave.

31. As they were preparing to leave Pono became involved in a dispute with a red-haired girl and a boy in a red shirt whom he had met at the pool before. It is unclear why, but shortly thereafter, there was an exchange of insults – Pono stuck his finger up at the girl and called her a "ranga". Pono's behaviour escalated quickly and he told the boy to get out of the pool so he could "smash him". Mr Bender attempted to redirect Pono, but

he was unable to do so. The girl's mother also approached Pono, and Mr Bender asked her to keep a distance, which she did not do. Pono picked up a safety cone and threw it at the boy in the pool, who was continuing to shout at Pono.

32. Mr Bender again attempted to redirect Pono, but he was unable to do so. At about this point in time, the regional manager of the pool Mr Corey Newham approached Pono. He asked Pono to leave and Pono apparently responded by saying he would only leave if the other boy did as well. Mr Newham tried to defuse the situation by getting the boy and girl to move along to the shallow end of the pool, but Pono followed them. Another patron at the pool, Ms Lara Strickland, made the first of four recordings on her mobile telephone at this point, with the first recording beginning at 4:56 PM.

33. The recording shows Pono walking to the shallow end, where he picked up a lane sign and tried to throw it at the boy, which Mr Newham deflected. Pono then tried to punch Mr Newham. Some bystanders approached to help. Mr Bender tried to move Pono away, and Pono then started punching himself in the head. He then entered a disability toilet near the entrance to the pool, where the footage ends.

34. Once inside, loud banging was heard, which caused Mr Newham to open the door and tell Pono not to cause any damage. Pono then sat on a bench outside and for a period of time, appeared to calm down. Some of the bystanders went back to what they were doing, while Mr Newham spoke with Pono on the bench. At this time, Pono's behaviour escalated again. There is some evidence that the boy in the red shirt had continued to provoke him. Pono banged his head against the brick wall behind him and he then smashed a window threatening to harm himself with the glass. He also punched out at Mr Newham.

35. Ms Strickland again commenced recording at 5:08 PM, inadvertently capturing the events that lead to Pono being restrained. At this point, Mr Newham told Pono he would have to leave. As his behaviour escalated, Pono was warned that if he continued, "they" would have to "take him down". There were several people standing around Pono at this point.

36. Shortly after, Mr Mitchell Baird, a water polo coach, approached Pono from behind and put him in a bear hug. Four others (Mr Corey Newham, Mr David Newham, Mr Alex Caldwell and Mr Daniel Robinson) were then involved in moving Pono to the ground.

37. Once on the ground, up to six people were involved in restraining Pono – those that I have mentioned above, as well as Mr Nathan McKelligott. While this was occurring, a staff member, Ms Miranda Griffin, called police. This call is logged in the incident detail at 5:10 PM and it is recorded that she details Pono being restrained on the ground. She declined an ambulance at that stage.

38. Mr Bender called Pono's caseworker, Mr Hoevers, to tell him what was going on. Mr Hoevers told Mr Bender to tell people not to restrain Pono, and that he would attend. However, while on the ground, Pono continued to struggle and kick out. He also banged his head against the concrete ground, so a towel was put underneath him while Mr Newham held his head.

39. Within a short period of time, Pono went limp and appeared to lose consciousness. Mr Newham obtained oxygen and held a mask to Pono's face, after which he was revived. The restraint continued, as Pono continued to be intermittently aggressive,

telling people to let him up. At this point a call was made for an ambulance by another member of staff.

40. Local NSWPF officers had been alerted by Ms Griffin's call and Senior Constables Jennifer Kent and Christopher Lane acknowledged the incident and attended Lambton Pool within a couple of minutes, at 5:15 PM. They had been told that a male was being aggressive, had punched the pool manager and that six people were restraining him.

41. When they arrived, Pono was on his left side and appeared to be fighting against the people holding him down. Senior Constable Lane approached and took hold of Pono's right wrist. He instructed others how to arrange Pono's legs so that they could be controlled. Senior Constable Kent obtained some information about the incident. Mr Bender at this point called Mr Hoevers again, who instructed him to call an ambulance and also to tell police about Pono's head injury, which he did.

42. The first ambulance arrived at 5:28 PM, about 10 minutes after it had been dispatched. Ambulance officers Jason Falkiner, a qualified P1 paramedic, and trainee paramedic Katie Watson on arrival observed Pono still being restrained on the ground, lying more or less facedown. According to paramedic Falkiner, Senior Constable Lane had his hand on Pono's back. Senior Constable Lane maintains that he checked with the paramedics that Pono's position was okay.

43. Paramedic Falkiner obtained a history about Pono which included details regarding his TBI, the medication he was on and that he had banged his head against the wall a short time ago. Due to concerns that Pono had suffered an acute head injury, paramedic Falkiner did not administer any sedation at that point. As a P1 paramedic, paramedic Falkiner was able to administer the sedative Droperidol (as at 2017), however it was contraindicated in circumstances where a patient had a known head injury. Ketamine was the preferred sedative of choice in such circumstances; however this was only able to be administered by an intensive care paramedic ("ICP"), which paramedic Falkiner was not. As such, he asked for ICPs to attend. This call was made at 5:33 PM and while awaiting their arrival, paramedics Falkiner and Watson attempted to assess Pono. They were not able to check his blood pressure or get an accurate oxygen saturation reading, as Pono continued to thrash around. At one point paramedic Falkiner was concerned that Pono's ears were turning blue (an indication that he may have been becoming hypoxic), so he tilted Pono's head back to open the airway and rolled him more onto his side.

44. Mr Hoevers arrived at the pool shortly thereafter to observe Pono being restrained facedown.

45. At 5:43 PM ICPs Jillian Kinna and Angela Rahme arrived. They received a handover from paramedics Falkiner and Watson, and promptly began to assess Pono, discussing various treatment options. ICP Rahme began to draw up Ketamine for sedation. At 5:50 PM, a heart monitor was applied to Pono, which appeared to show sinus rhythm at 72 bpm. At about 5:55 PM, while still restrained and prior to the administration of sedation, Pono appeared to go limp. The heart monitor recorded he was in asystole. Pono was rolled onto his back and the ICPs commenced CPR.

46. Pono was intubated and the ICPs started the cardiac arrest protocol. The NSWPF officers and other bystanders assisted with the CPR. They continued until 6:15 PM when Pono was transferred by ambulance to John Hunter Hospital. Efforts to resuscitate him continued at the hospital for a further 20 minutes, at which time a joint

decision was made to cease all CPR. Tragically, Pono was declared deceased at 6:45 PM.

Post-Mortem Report

47. An autopsy was conducted on 19 October 2017 by Newcastle-based forensic pathologist Dr Brian Beer. He found large cracks in Pono's right skull plate, although no underlying injury, which may have contributed to the death. He found no evidence of excessive force being applied, including to the neck or chest. Although an unequivocal cause of death could not be ascertained, he recorded the death as the combined effects of a self-inflicted head injury and physiologic restraint related cardiac arrhythmia. A neuropathology report provided by Professor Michael Buckland (dated 14 March 2018) notes that Pono's brain showed changes associated with a hypoxic/ischaemic injury and/or raised intracranial pressure, although he noted that this could have been a result of vigorous resuscitation efforts. Professor Buckland was not able to distinguish between these two possibilities.

48. An agreed issues list was prepared with input from all interested parties. As is the ordinary course, the issues list identified the focal points that the inquest examined. It is intended that each issue will be identified and appropriate findings made. Both the oral evidence, as well as the extensive written material encompassing 12 volumes, will be relied upon in making my findings.

Issues

Issue 1: the cause of Pono's death, including the factors contributing to his death.

49. Dr Beer did not give evidence at the inquest. As mentioned above at [47], in his post-mortem report dated 4 May 2018, Dr Beer gave the cause of death as the *"combined features of head injury and physiologic restraint related cardiac arrhythmia"*. In my opinion, the acute head injury that Pono sustained at Lambton Pool, is of lesser significance and played no great role in Pono's death. Aside from the hypoxic/ischaemic injury and/or raised intracranial pressure, Pono's brain showed no clear demonstrable injury on neuropathological examination.

50. In the comments section of Dr Beer's report at [2], he noted that "*sudden death in restraint scenarios is a well-recognised phenomenon*". Importantly he also noted at [5] that:

> "*there was no evidence of excessive force generally having been used during the restraint episode. Neither was there evidence from the history or autopsy of a neck hold which could have potentially obstructed his airway, or excessive chest compression with potential "traumatic asphyxia" having been applied*".

51. Associate Professor Mark Adams, a specialist in cardiology, provided two expert reports: the first dated 13 March 2020 and a supplementary report dated 10 September 2020. When giving oral evidence at the inquest, it was his opinion that the most likely cause of Pono's death was cardiac arrhythmia, being the result of a process arising from Pono's acute physical and mental stress.

52. For the benefit of the court, Associate Professor Adams helpfully described this process in layman's terms. He noted that the electrical circuitry of the heart can become disordered and abnormal during acute physical and mental stress, which can cause loss of cardiac output. This in turn can cause loss of consciousness, heart

failure (left ventricular failure with pulmonary congestion) and shortness of breath. Complete loss of cardiac output can then follow. Associate Professor Adams said it was difficult to be completely certain, as some of the relevant factors may not be apparent during autopsy. Associate Professor Adams formed his view principally because there was no other clear cause of Pono's cardiac arrhythmia that he could see from the autopsy or any of the witness statements that he had read. Pono's stress is likely to have caused a surge of natural hormones (catecholamines), which resulted in Pono developing ventricular tachycardia, followed by ventricular fibrillation, poor cardiac output and cardiac arrest. Associate Professor Adams accepted that this cause of death involves a poorly understood mechanism, but that sudden death in circumstances of restraint is nonetheless observed frequently.

53. Even without restraint, Pono might have gone through this process as a consequence of his agitation. However, it is probable that his restraint had an impact on this process, by increasing and prolonging his stress and agitation, and thereby continuing the catecholamine process. The opinion of Associate Professor Adams is supported by the autopsy and perimortem observations. Pulmonary congestion or oedema observed on autopsy is consistent with Pono developing ventricular tachycardia. Pono also complained of shortness of breath and looked cyanosed at the time of his examination by attendant paramedics. This is also consistent with pulmonary congestion.

54. As I have indicated above at [49], the impact of any acute head injury sustained by Pono at Lambton pool, played an insignificant part. He had already suffered an earlier head injury at some point in the months prior to his death. It is speculative to consider what impact any additional head injury might have had on his behaviour.

55. However, it is probable (on balance) that the TBI Pono suffered in September 2013 had an indirect contribution to the cause of death. As a consequence of that injury, Pono suffered poor emotional control and was more susceptible to a heightened emotional state resulting in an increase in the catecholamine response.

56. I do not accept that Pono's cause of death could be characterised as simply "cardiac arrhythmia". While the physiological process which led to Pono's death could have occurred even without restraint, on balance, I accept A/Professor Adams' oral evidence that it was "probable" that restraint contributed, by increasing and prolonging Pono's stress and agitation. I do not accept that there is sufficient evidence to support a finding, on the balance of probabilities, of an alternative cause of death.

57. I also do not accept the submission made by Mr Henry that Pono's cardiac arrhythmia was triggered by restraint alone.

58. As to manner of death I accept the submission made by counsel for the Commissioner of NSWPF, Ms Gillian Mahoney, at [7] of her first submissions, namely:

> "*The distress, properly understood, is a consequence of the multiple events that occurred at the pool: the initial exchange between Pono and the other young people, Pono's following dysregulation and heightened state, his rapid escalation to significant self-harm and the subsequent restraint initiated by members of the public and staff of the pool."*

The description above relates to the circumstances (or manner) of death, which will be further explored in these findings.

59. On balance, I find that the direct cause of death is cardiac arrhythmia during restraint. Pono's previous TBI also had some indirect contribution.

Issue 2: the nature of Pono's brain injury, intellectual disability and mental health and the impact of these conditions and other matters on his behaviour.

60. It is accepted that Pono suffered a TBI as a result of his tragic accident on 24 September 2013. It is also accepted that as a consequence of that injury, Pono had a cognitive impairment, consistent with a moderate intellectual disability, which affected his executive function and behaviour, including poor emotional control and memory problems (Exhibit 8 at [13]).

61. Notwithstanding the significant injuries that Pono sustained, it is evident that his personality remained joyful. Both Mr Bice and Dr Conroy described Pono as having a playful side and that he loved playing practical jokes. It was readily apparent to the court that Mr Bice and Pono enjoyed a particularly close relationship and that they enjoyed each other's company. My assessment is that Mr Bice, and Dr Conroy, looked after him in a very caring way. No doubt the loss of Pono's weighs heavily on them also.

62. Pono's injury however led him to easily become suspicious or paranoid in social situations, misinterpret social interactions, and it appears that Pono was unable to read social cues and had difficulties understanding personal space. His poor emotional control meant he was quick to anger, often without warning. These factors lead to an escalation in his arousal and dysregulation behaviour, including violence and self-harm. Sadly, as is often the case with persons who have a cognitive impairment, Pono did not look "disabled". Unfortunately, when Pono's behaviour deteriorated in a public setting, members of the public would be unaware of his complex needs, often contributing to further escalation of his behaviour.

63. During his oral evidence, Dr Babu confirmed that Pono's suspicions and paranoia were a frequent cause of his aggression and agitation. Dr Babu also considered that Pono may have had some form of Autism Spectrum Disorder, which might have pre-existed his TBI. However, Dr Babu was not able to confirm this diagnosis, as he did not have sufficient information about Pono's development or family background. From the available evidence, Dr Babu stated that he tried to reach out and obtain access to relevant family medical history through Challenge.

64. On 4 November 2015, Dr Babu asked Mr Hoevers (then Pono's carer) to contact DCJ to arrange for Pono's grandfather to attend the next appointment with him. He referred to this request in his letter dated 11 November 2015, which was copied to Mr Hoevers. There is no evidence as to what occurred after Dr Babu's request, and whether Mr Hoevers did indeed contact DCJ, as this was not explored in evidence. Equally, there is no evidence that a request was ever made to Pono's family. Pono's grandfather did not attend any appointment with Dr Babu. While there may have been an advantage in having information leading to a positive diagnosis of Autism Spectrum Disorder, given that such diagnosis may have impacted on Pono's treatment, it is speculative to consider what impact it may have had. Rather, I am of the opinion that this particular issue reflects on the consistent lack of contact and interaction with Pono's family (which will be further commented on below).

65. Many of Pono's significant behavioural incidents are outlined in the agreed summary of background facts. There was a consistent number of incidents over the years 2016 and 2017, however there was a further deterioration in Pono's behaviour during 2017.

66. Ms Smith, Pono's psychologist, provided two statements and also gave oral evidence at the inquest. Ms Smith agreed that during 2017 the frequency of incidents appeared to intensify. In her BSP of 30 August 2017, she set out the likely trigger points for what she described as "behaviours of concern" which were:

- being asked to do or not to do something by a member of the public;
- not being able to do something he wants to do;
- feeling rejected;
- not feeling heard;
- thinking he's being made fun of; and
- not getting money when he wants it.

67. Ms Smith was asked in oral evidence about the relationship between background stressors and the incidents Pono was involved in. She explained:

> "*Again, I don't think the actual triggers changed. He was going through a period of significant uncertainty, he wasn't attending school on a daily basis for part of that year, so there was a lot of boredom, less social interaction, less pleasurable activities, plus the uncertainty around where he was going to live and what his future was going to look like. That – so those circumstances would certainly have contributed to an increase in, I guess, anxiety and concern for him, but in terms of what actually triggered the outbursts themselves, there was no change"*

68. Ms Smith further noted that:

> *"… when Pono became escalated, his ability to think rationally was pretty well non-existent, so with his intellectual disability, with his brain injury, he had significant limitations in being able to assess and understand how to respond in a situation. When people are under stress and particularly for Pono, the fight or flight response comes into play. They then get governed by emotional responses"*

69. During his evidence, Dr Babu described the reasons that he believed were contributing to Pono's deteriorating behaviour in 2017. These included:

- changes in routine (such as being expelled from school);
- Pono requesting certain things and these being denied (Dr Babu was of the view that this type of interaction could be a major trigger for Pono and could be very hard to manage by his care team); and
- Pono's background stress, such as his imminent transition out of care, his desire to move to his grandparent's place, being restricted in his movements and not being allowed to do whatever he wanted.

70. Dr Babu accepted that although "*[Pono's] reactions may have increased in frequency, … they were still the same reactions he was having to stressors or the same triggers previously".*

71. Dr Conroy also gave oral evidence. In his opinion there was more intensity in Pono's behaviour throughout 2017. Mr Hoevers was also of the view that Pono's aggressive outbursts were intensifying over the period from July to September 2017 and this was his reason for writing to Dr Babu seeking additional assistance.

72. Mr Evan Cooper, the Challenge caseworker employed for Pono, had responsibility for Pono from September 2016. He had earlier worked as a support worker in Challenge residential houses and knew Pono from this time He holds a Bachelor of Science, majoring in psychology, as well as a Graduate Diploma in Education. He also has

benefited from workplace specific training. Due to his overall contact with Pono from 2014, it is my opinion that he had very good opportunity to observe Pono over an extended period of time and provide an insight into Pono's behaviour. Mr Cooper did not think Pono's behaviour changed that much over the time he knew him, however he noted that he had periods (particularly as he got older) where his interests changed. Pono had what he described as *"ups and downs dependent on what might be happening for him"*. It was suggested to Mr Cooper that there had been an escalation in incidents in 2017. He did not necessarily agree with this assertion. He conceded there had certainly been incidents throughout 2017, but he did not think they were any greater in number than during other years.

73. Counsel Assisting overall submitted that a finding could be made that there was a deterioration in Pono's behaviour during 2017. With the exception of Mr Cooper, all other persons involved in the care of Pono agreed that there had been an escalation in incidents and behaviour during 2017. On balance, the weight of this evidence, I believe, should be accepted.

74. Professor Leanne Dowse (Professor of Disability Studies within the School of Social Sciences at the University of New South Wales ("UNSW")) provided an expert report to assist the court with this matter. Professor Dowse is a well-respected authority in the area of disability studies and holds various other positions, including as Chair in Intellectual Disability Behaviour Support at UNSW. She was briefed with all of the material relating to Pono's treatment, including various medical reports, day-to-day care matters and statements of all relevant witnesses. She was also provided with Pono's BSPs.

75. Professor Dowse was of the view that Pono's behavioural incidents were not only increasing in frequency, but also in intensity throughout 2017. She opined that Pono's behaviour should have been understood to be *"indicating that perhaps the context is changing"* and *"to be communicative of something"*. She explained that the changes in Pono's behaviour probably had to do with *"a very significant impact on his social settledness and also the changes that were going on within the staff context … as well as his longer term, sort of, transition from care and in the placement itself."*

76. Counsel Assisting submitted at [15] of his closing submissions that there were four interrelated factors which probably resulted in the deterioration in Pono's behaviour during 2017:

    A. Pono was going through adolescence and was also becoming physically larger and stronger. For any teenager it is a time of turmoil and ups and downs in emotions. It was submitted that the impact of his behaviour was likely to be more noticeable.

    B. The incidents at school had resulted in Pono being initially suspended and then ultimately asked not to return physically to the school grounds. As a result, Pono's days were less structured and he replaced school with ad hoc community outings such as shopping trips or visits to the pool. It was submitted that this probably contributed to Pono's boredom and frustration, and it had exposed him to less predictable social interactions.

    C. There was uncertainty around Pono's future – where he might live and who would provide care once he turned 18. He was aware of this uncertainty although how and to what extent this affected him is not clear from the evidence.

D. During 2017 there was less consistency in Pono's carers. This was caused by the uncertainty around Pono's future placement and by the fact that Challenge was no longer going to provide intensive therapeutic care. Some of the staff knew they would not be likely to remain employed with Challenge once Pono was moved and so they were leaving as they obtained other employment. Additionally, some of the staff simply did not want to work with Pono due to his behaviour.

77. It was submitted by counsel for DCJ, Mr Simeon Beckett, (at [39] of DCJ's closing submissions) that the evidence referred to in relation to various factors and triggers underlying Pono's behavioural outbursts, were related to Pono's cognitive impairment. Put differently, Mr Beckett submitted that it was Pono's cognitive impairment which caused the "behaviours of concern". He further noted that Pono was often volatile while in the community, reacting adversely to communication with members of the public in what his treating clinicians considered was an irrational way (but comprehensible to a person who understood him and his cognitive disability). Mr Beckett further submitted that making a causal link between the asserted four factors submitted by Counsel Assisting and Pono's deteriorating behaviour (and ultimately his death), should be avoided.

78. I accept that Pono had complex needs that stemmed from his TBI, yet I am also of the view that it is beneficial to try and group together some of the factors that may have had an impact on Pono's behaviour throughout 2017 and the deterioration of same. Without understanding the reasons behind Pono's deterioration in behaviour, it may not be possible to fully examine what could have been done differently in relation to Pono's care, if relevant. As Mr Harris explained in his submissions in reply, he was merely endeavouring to identify certain matters (as supported by the evidence as a whole) that were the most significant triggers for Pono's behavioural deterioration throughout 2017.

79. In relation to each of the four interrelated factors put forward by Counsel Assisting as contributing to Pono's behavioural deterioration, I find the following:

A. It is possible that adolescence played a part in Pono's behavioural deterioration, however this factor was not comprehensively explored at the inquest and accordingly I have not considered it further.

B. Several witnesses provided evidence that Pono's exclusion from school acted as a significant stressor and contributed to his escalating behaviour in 2017. This change in routine was significant. The case workers found it more difficult to identify structured activities for him to do (T105.33-35) and it appears, no structured plan was made for how Pono's days would be filled. This loss of structure and routine was a stressor for Pono.

School had also brought Pono a large sense of community and offered opportunities for social interaction. Therefore, his exclusion from school likely contributed to an increase in anxiety and concern for Pono.

C. Ms Smith gave evidence that the uncertainty around Pono's transition into adult care was a contributing factor to his escalating behaviour, and certainly *"contributed to an increase in…anxiety and concern for him*".

Mr Cooper gave evidence that he did not know whether Pono was affected by the uncertainty of where he was going to be living after he reached the age of 18. He stated that Pono was entertaining different scenarios at different times.

D. It was rightly accepted by Counsel Assisting that "Pono did generally have a consistent care team, in particular in the form of Mr Bice. … The team minutes and residential daily progress notes show that much of Pono's care was provided by a consistent team of carers during late 2017. …". However, it is also true that some carers who were less familiar with Pono (including Mr Bender), were also providing care to Pono, in particular in the months leading up to his death.

   Several witnesses provided evidence outlining their concern that a lack of consistent care was having on Pono.

   Dr Conroy raised a concern that staff less familiar with Pono would not have capacity or motivation to follow the BSP, in particular by setting limits. Mr Bice observed that casual workers had a negative impact on Pono's behaviour. Dr Babu was also concerned about the impact of high staff turnover on Pono's care.

   Professor Dowse, when asked to comment on the fact that about 90% of Pono's care was being provided by carers who were familiar with him, noted that *"one or two incidences of inappropriate care can have an impact well beyond that one incident"*.

80. Pono suffered a TBI as a result of his accident in 2013. Sadly, this meant that Pono had a range of cognitive impairments, including meeting the criteria for having a moderate intellectual disability. As a result of his TBI, Pono's emotional control (self-monitoring, self-regulation, reasoning and problem-solving) was compromised and could leave him prone to violent outbursts and attempts at self-harm. I find that there was an increase in the frequency of Pono's behavioural incidents throughout 2017 and although Pono's cognitive impairment played a part in this, I find that the factors mentioned in B, C. and D. above at [79] are matters that also had an impact on Pono's behaviour. Yet to what degree these factors played a part in Pono's behavioural deterioration as distinct from his underlying cognitive impairment is difficult to ascertain from the evidence available. Accordingly, I can take this finding no further.

Issue 3. The adequacy of behaviour support provided to Pono by and on behalf of Challenge Community Services in the period prior to his death including the following matters:

A. *Whether the BSP dated 30 August 2017 appropriately addressed Pono's behavioural needs at that time;*

B. *Whether strategies for behaviour management were known to carers and applied in practice, including the response to previous serious behavioural incidents;*

C. *Whether Pono's carers were adequately trained;*

D. *Whether the ratio of carers was adequate in the circumstances;*

E. *The use of psychotropic medication and the process by which this was authorised and reviewed;*

F. Any impact upon the level of support provided to Pono arising from:

I. The funding arrangements for his care; and

II. The fact that Pono was to transition out of the care of Challenge Community Services

81. Before turning to the specific items raised in Issue 3 A – F, it is useful to make some overarching comments regarding behaviour support and what strategies were adopted in relation to Pono. In describing behaviour support and what it involves, Professor Dowse stated:

> *[T[the role involves being a subject matter expert….the model of behaviour support for people who have intellectual disability particularly, but people with disability more generally and the model of behaviour support generally speaking is that approach that's taken by professionals and other supports to a person who has complex and challenging behaviour."*
>
> *"We tend to call that behaviour support rather than behavioural support and it is really a sort of identified and agreed approach, an evidence based approach, would normally be the way it would be described, to providing support for a person whose behaviours tend to be identified as either being potential to harm themselves or harm to others and that are likely to impact on their ability to engage with the community or to themselves come to harm or to be the subject to restricted practices. So it's a model it's an approach to analysing and understanding the precursors to behaviour, the causes of behaviour, the contents(sic) (context) in which behaviour occurs and so certainly there is an assumption in the behaviour support model that behaviours communicate…."*.
>
> *"… [A]ll behaviour occurs in context and so behaviour support, positive behaviour support generally, is identified as a way of understanding the nature of the behaviour in its context and providing a set of strategies which minimises harm and which replaces behaviours that may be dangerous or harmful so that a person can live, sort of, to their best flourishing life"*.

82. Challenge, as the agency with case management responsibility for Pono from 22 July 2016 onwards, had the primary role in providing Pono with behaviour support. Challenge effectively outsourced the role of providing guidance on behaviour support to an external psychologist, Ms Smith. In early 2016, Challenge psychologists who had previously been providing behaviour support were no longer able to do so. Dr Conroy sought advice from Dr David Manchester, a clinical psychologist with expertise in brain injuries, who recommended an increase in the level of psychological support for Pono. Dr Conroy prepared an application to Lifetime Care for funding. Ms Smith was then engaged from June 2016 to provide behaviour support. She had substantial experience in providing behaviour support, including to people with needs similar to Pono's. As at 2016, she was providing behaviour support to between 5 and 10 people at a time. She had undertaken training at the Institute of Applied Behaviour Analysis, and developed her skills, as is common, through experience and mentoring. Ms Smith was an appropriately experienced and competent practitioner for the task.

83. While Challenge might have outsourced the role of guidance on behaviour support to Ms Smith, it still had the obligation to ensure that Pono's behaviour was properly managed, and strategies implemented by its carers in order to discharge its duty in providing Pono's day-to-day care. These obligations arose under its funding deed with DCJ, as well as various other agreements and compliance and management policies that were in place at the time.

84. There was some behaviour support provided on an ad hoc basis by Challenge case workers Mr Cooper and Mr Hoevers, as well as by Dr Babu and Dr Conroy.

85. The funding provided by Lifetime Care was about two hours of psychological support per week, plus travel time. Ms Smith was not able to see Pono more often, due to her own capacity. There is no evidence to suggest that anyone involved in Pono's care raised a concern about the amount of time that was allocated to Pono for psychological support. There were recommendations made by Dr Manchester that Pono receive psychological support two to three days a week for at least a couple of months to learn self-control strategies for high risk situations. Dr Conroy also initially recommended Ms Smith have more intensive input with Pono, however Ms Smith herself did not have the capacity to see Pono as frequently as recommended (T 52.22). Even if she would have had the capacity, Ms Smith's evidence was that Pono himself was not interested in seeing her that frequently and he made this quite clear throughout his engagement with her.

86. I agree with Counsel Assisting's submission that Ms Smith's role was to:

    (1) engage directly with Pono to provide therapy, in particular around the development of social skills;
    (2) formulate BSPs; and
    (3) train carers to implement the BSPs.

87. Ms Smith prioritised the last of these aspects of her role, and Professor Dowse was not critical of that approach.

Engagement with Pono to develop social skills

88. When Ms Smith gave evidence regarding her interaction with Pono (which was supported by her contemporaneous notes), she told the court that

> "*I formed the view that had I tried to see him more often, he may well have chosen to withdraw from contact with me altogether, that he would have – he would have reached a point where he would have come to resent or not enjoy spending his time with me and not being willing to engage at all".*

89. Ms Smith also gave evidence of how difficult it was to engage and interact with Pono. Even when she did attend for home visits and Pono was in good spirits, it was not unusual for him to be unwilling to discuss issues or plans and only want to play Uno. She said sometimes he would be willing for her to stay a whole hour, but it was also common for him to want to end a session early.

90. Ms Smith did not think the issue was with her, but with Pono's unwillingness or inability to engage with the process. While she initially saw him fortnightly, she reduced this to about once a month over time. She did not seek to engage other practitioners, or a different therapist. In Ms Smith's opinion, she thought the problem was with Pono's reluctance to engage in a therapeutic approach, whether that be with her or another practitioner.

91. In response to a question from Mr Henry's legal representative, Ms Anne Cregan querying how often Ms Smith met with Pono in 2017, Ms Smith explained:

> *"By then I think it had mostly reduced [my consultations] to monthly for the reasons I had outlined. So my feeling was, after attempting throughout the half of 2016 to engage with him and to have – to build up some kind of rapport or structure that he would respond to, it*

became quite clear that he wasn't going to, that he wasn't interested in informal social skills training from me or engaging in that kind of structured approach, so I felt that my time and funding was better spent supporting the support workers, supporting the agency, providing the overarching behavioural support and guidance that I'm engaged to do, and I did make a recommendation that a speech pathologist be engaged who might have been able to be introduced and provide structure from the outset in the hope that Pono would engage with the speech pathologist for more targeted structured social skills training."

92. Counsel Assisting submitted at [25] of his closing written submissions that individual therapy was probably of limited use to Pono, as he did not have the capacity to generalise the advice given by Ms Smith into other contexts. He submitted that the approach that was therefore taken, was to develop Pono's social skills through his carers modelling positive behaviours and prompting Pono as needed, under the guidance of by Ms Smith.

93. Counsel Assisting submitted that approach appeared reasonable. Mr Henry's legal representative, Ms Cregan, did not agree. She pointed out that the original recommendation was for intensive individual therapy, which was also supported by the opinions of Professor Dowse and Ms Averill Langtry, who provided a further expert opinion to the court. Ms Cregan noted that given Ms Smith only saw Pono on five or six occasions in total in the period between January to October 2017, this was contrary to the intensive therapeutic approach that was being recommended.

94. Professor Dowse was of the opinion that it was *very* likely that Pono would have benefited from additional one-on-one psychological support. However as Professor Dowse explained, given the limited hours available to Ms Smith, her priority was being directed towards supporting Pono's care staff, due to the difficulties they experienced in engaging with Pono. This view is consistent with Ms Smith's evidence.

95. I adopt Mr Henry's submission in this regard. I am of the view that Ms Smith should have informed other members of Pono's care team, who were responsible for his behaviour and therapeutic support (such as Challenge and Dr Conroy), that Pono needed more intensive psychological care. This would then have given Challenge an opportunity to make representations regarding whether further support should or could have been made available. In light of the seriousness of the incidents throughout 2016 and 2017 involving Pono (including interactions with members of the public, which involved violence), in my opinion, it was important to review what was occurring and to at least look at other interventions and/or therapies. This did not happen.

96. While I have concluded Ms Smith ought to have informed Pono's care team that he needed more intensive psychological care, as I have noted above, Challenge had the ultimate responsibility for Pono's behaviour support. When his behaviour deteriorated during 2017, this ought to have caused Challenge to review what was happening and to look at other options.

Pono's routine

97. From all of the evidence it was clear that there was an advantage in attempting to structure Pono's day, so that his activities were predictable and manageable. Ms Smith identified the need for structure in the BSP, however she considered it to be the role of the carers and caseworkers to identify particular activities.

98. This issue is relevant to what happened on the day of Pono's death. Pono initially wanted to go to the pool, was persuaded to go to the cricket nets and then changed his mind. Had there been a structured activity for Pono to do that day, this type of

discussion may not have arisen. Mr Bice knew that it was better for Pono to have a routine yet could not explain why there was no plan for Pono on 17 October 2017. Dr Conroy had been attempting to engage Pono in Challenge Choices day programs, a vocational training program called Mai-Wei and a social support group called Headstart. Mr Cooper, whose role as caseworker included guiding carers in relation to Pono's routine, said there were attempts to engage Pono in structured activities, but this was sometimes thwarted by Pono's desire to do other things, such as go shopping. Pono was not forced to do things he did not want to do, so his routine was largely directed by what he wanted. Overall these factors made it difficult to identify appropriate activities. When Pono was asked not to attend school from June 2017, this left him with a large amount of unstructured time, and this clearly presented a challenge for his carers.

99. Ms Smith was asked about providing structure and the activities available for Pono on a daily basis, she stated: –

> *"They were limited. He wasn't engaged, he didn't have friendships, he didn't have friends he could catch up with and spend time with, he –there weren't very much (sic) disability specific social groups, sporting groups, that he could engage in or was interested in engaging in. Exploration had been made regarding other disability services, work options. They hadn't been entirely successful. So there had been repeated attempts to find options for Pono but they were very limited and his interest was in going to the pool, going to the shopping centre, going to where there were going to be other people he could interact with….He wasn't interested particularly in engaging with other people with a disability….[W]e knew that he needed more structure, knew we needed more activities, but finding activities that were suitable that he would agree to was very difficult."*

100. Despite these difficulties, I find that there was limited effort being made by Challenge to find alternative options for activities for Pono. While those who cared for Pono knew he needed "more structure", there doesn't appear to have been any structure in his day-to-day routine. On the evidence it appears that it was quite "ad hoc."

Issues 3A–B: whether the BSP dated 30 August 2017 was adequate and behaviour management strategies were known to carers

101. The BSP for Pono was an important document. It was considered a primary tool for managing Pono's behaviour, so as to prevent and respond to behaviours of concern. Ms Smith's approach to the creation of BSP's was to make them functional, in terms of being easily understood by Pono's carers, containing necessary rather than comprehensive information. Pono's carers had given feedback that previous plans had been difficult to follow and Ms Smith considered that there was a tension between an easy-to-use BSP, which the carers would read, and a more detailed and comprehensive BSP, which they may not.

102. Ms Smith said that she did make reference to Pono's previous history in her BSPs, so that carers would know that previous plans existed and could see more detailed information if they chose to seek such further information, or felt there was a need to. She was asked by Counsel Assisting whether she thought it was realistic to put the burden on carers to seek out this information (by looking back at previous plans). Her answer in my view legitimately expressed the tension that existed:

> *"I find it difficult to answer "was it realistic that they may go back and review those plans". If directed to do so I would hope that they would have, if their manager or case manager identified there was a need to gain that further understanding, but likewise, my experience*

is putting a lot of information into a behaviour assessment and support plan, it is not realistic to expect that they're actually going to read and take that on-board either".

103. Ms Smith also provided a conversation checklist and guidelines concerning personal space and promoting a healthy diet. She met with the carers on a monthly basis. Accordingly, she had some appreciation of their skill level and their understanding, and one of her primary aims was to make the plan more usable by the carers.

104. Mr Cooper agreed that there was a balance between making Pono's BSP a readable document which could be understood by everyone, and a "thesis" which may make it hard to get information from quickly. Ms Smith's BSPs were, in his view, very easy to understand and captured the important information as it related to Pono. Mr Bice also endorsed the fact that a BSP can contain too many details and become hard to manage.

105. Professor Dowse's view was that a BSP ought to be a "central repository for all of the strategies"; she considered this to be best practice. While she endorsed the creation of other guidelines and checklists, she considered that there should not be a disconnect between what is in those guidelines and what is in the BSP. Guidelines could provide an accessible strategy taken from the BSP, but not additional or different ones. Part of her reasoning was, that where there is a high turnover of staff, having guidance in separate documents and emails may result in information being missed.

106. A consequence of Ms Smith's approach was that not all information about Pono's background in behaviour was contained in the BSP. The BSP explicitly referred carers to previous versions of the BSP. Ms Langtry did not criticise this approach however she assumed that staff would have had access to earlier BSPs. In fact, only the most recent BSP was kept in the house, to avoid confusion, and while staff could use a shared drive on the computer (called the "S:" drive) in order to access old plans, there is no evidence that they did so.

107. The BSPs Ms Smith prepared did not change substantially over time. Ms Smith stated that this was because the triggers of Pono's behaviour remained the same, and accordingly so did the strategies to predict or respond to his behaviour. Further, she felt that the factors which lead to an intensifying in Pono's behaviour in 2017 were not within her capacity to modify.

108. Professor Dowse pointed out that a significant change in Pono's life was that he stopped attending school in mid-2017 and as a result had more unstructured outings. She would have expected the BSP to be updated to take this change of context into account.

109. In hindsight, it would have been desirable for Ms Smith to have included more information in the BSP regarding Pono's background and also for it to have been updated to reflect his changing context. However, the tension described between an easy to follow BSP and a comprehensive one is apparent. In light of the different opinions expressed in the evidence about this topic, I agree with Counsel Assisting's submission that it would be appropriate for the relevant agency's policy (in this case Challenge's Policy on 'Behaviour Support'), as it relates to BSPs, to stipulate which approach is to be preferred.

110. Whether it was a separate guideline or contained in the BSP, what was missing in Pono's case was clear guidance for his carers about community outings, as they became more frequent in mid-2017. Ms Smith recognised the need to provide such a

guideline in mid-to-late 2017. She stated that there were lots of discussions and meetings around developing a guideline about community outings, and she believed that caseworkers had created a variety of other guidelines and plans for Pono as a result. She could not offer an explanation however as to why she did not develop a specific guideline, other than the fact that identifying the best approach was difficult.

111. Ms Smith also said there were discussions about restricting Pono's access to the community where large numbers of people could be present, including for example, shopping centres and swimming pools. However, these did not advance prior to the time of Pono's death. One of the real issues were Pono's trips to the pool. Overall there were three incidents at Maitland pool; two incidents proximate to Pono's death on 31 December 2016 and 11 February 2017, and one further removed in time, on 25 November 2015. Why the pool presented a particular risk for Pono is unclear. Nonetheless after the December 2016 incident, Mr Cooper sent some guidance to carers. After the February 2017 incident, Ms Armstrong directed that Pono should not attend the pool until a risk assessment was completed. Mr Cooper prepared a risk assessment and sought Ms Smith's views on it. She concurred with his assessment.

112. That risk assessment contained some useful advice to carers about how to assess, plan and manage trips to the pool. The risk assessment was then discussed in carer meetings. Unfortunately, it does not appear that the risk assessment was ever in fact finalised. The version in the brief of evidence is unsigned and Ms Armstrong could not recall if it had been. Mr Cooper understood it had, but also believed that carers were required to sign off before they took Pono to the pool, and there is no evidence that this occurred. It seems unlikely that an incomplete risk assessment would have been placed in Pono's house folder, and in any event, there is no evidence that it was. Mr Bender was not aware of the pool risk assessment, or the advice it contained. This is precisely the risk that was identified by Professor Dowse in not having all relevant information contained in the BSP.

113. Ms Smith did not include similar guidance for carers in the BSP or create a specific guideline about pool trips or community outings. The BSP did not provide guidance to the effect that busy periods at the pool or shopping centres should be avoided; or how to assess, plan and manage a community outing; or how to anticipate problems and prepare Pono with strategies. Ms Smith accepted that it may have assisted carers if she had included such guidance in the BSP. Such guidance might also have included advice on how to respond to members of the public who sought to become involved when Pono's behaviour escalated – though this was a difficult topic to advise on.

114. The monthly team meetings between Pono's carers and Ms Smith were the primary method for providing training and guidance in behaviour support for Pono. In addition, issues could be raised on an ad hoc basis by the caseworkers and carers. The meeting records show that Ms Smith engaged in significant discussion around behaviour support issues, providing feedback and suggesting strategies to respond to Pono's behaviour. Overall, Professor Dowse considered that Ms Smith took a comprehensive approach to incident review and debrief, and modelling, coaching, feedback and support.

115. The meetings were not always well attended, and not all carers got the benefit of Ms Smith's advice. There was not a reliable system for updating the carers who did not attend meetings about issues discussed. Carers would usually be sent the meeting notes and asked to sign them and the last meeting notes would be kept in the house folder. The material available does not demonstrate that the minutes were always read by each carer.

116. There was also no reliable system for ensuring carers accessed and reviewed all available guidance, including previous versions of the BSP. As I have described above at [106], previous versions of the BSP could be accessed by carers via the "S:" drive, although there is no evidence that they did. Other "ad hoc" guidance was kept in a house folder, but again there is no evidence that carers were required to review it. If the intention was to provide appropriate guidance for Pono in multiple documents, a robust system to ensure carers were directed to that guidance ought to have been in place.

117. I find that the BSP dated 30 August 2017, which was in use at the time of Pono's death, did not contain sufficient guidance on how to assess, plan or manage community outings for Pono. The failure to provide such guidance to carers in the BSP was a missed opportunity. Had such guidance been available, it might have caused Mr Bender to carefully consider the appropriateness of a trip to the pool, or to have planned it more fully. However, assessing the impact of guidance that was never created is speculative. It is also speculative to posit how effective any such guidance would have been. In any event, as Ms Smith observed, once Pono became escalated to a certain level of arousal or distress, he was not able to recall or follow strategies for dealing with such issues.

Issue 3C. Training and experience of carers

118. The training records of Pono's carers were available for the inquest. Mr Bice had a Certificate IV in Disability, which he considered relevant to his work with Pono. He also appears to have had the most experience in caring for Pono. He rarely experienced difficulties with Pono's behaviour, which he put down to the fact that he was the first worker to care for Pono, he was a constant presence in Pono's life, they had mutual respect and he knew what made Pono tick. He also tended to use humour with Pono as a method for keeping him calm.

119. Mr Bender had a Certificate III in Disability. He was generally experienced in working with children with trauma-based behaviours or cognitive issues, and not physical disabilities. He had worked with Pono on and off over three years. The records show that he did four shifts in the weeks prior to Pono's death, but none in the months prior to that. He did not recall doing a "buddy shift" to reintroduce himself into Pono's routine, which might have been an advantage. He attended only one team meeting on 9 October 2017. There is no evidence he read previous team minutes, given he had recommenced working with Pono in late 2017. He felt he had enough training to deal with Pono.

120. Challenge carers all received Therapeutic Crisis Intervention training. Professor Dowse notes that this training is widely accepted and appropriate. Notably, it includes specific guidance on physical restraint and positional asphyxia, including to monitor the position of the child, skin colour, respiration, level of consciousness and agitation. Mr Bender, who had done that training, was not able to recall this in evidence.

121. Professor Dowse stated that the absence of formal additional disability training for carers was notable and would have been beneficial. Some carers had Certificates III or IV in Disability. However, in Professor Dowse's view, it was not education that was required, but more disability-specific training. In particular, she was of the view that a greater understanding of the impact impairment can have on a young person, their capacity to follow instructions, their memory and language processing was vital. This would have facilitated a greater appreciation of the inherent limitations of a person with Pono's needs. She did not identify a particular course, although considered it ought to

be a mandatory requirement for carers working with people with intellectual disability. Existing Challenge policy provides for specialised training of carers when required, but the need was not identified in Pono's case.

122. Ms Smith was also of the view that a higher level of training would have been an advantage. She was more familiar with carers being clinically trained (i.e. nurses) who may have a greater understanding of the reasons for a person's presentation. While she agreed that it was part of her role to educate the carers about Pono's needs, she agreed that a higher level of training would be an advantage.

123. In addition, a worker such as Mr Bender, who was returning to work with Pono after not being involved in his care for some time, needed to be retrained or updated about strategies for Pono, possibly via a "buddy shift". It was not sufficient to expect a carer to go searching for important guidance on the "S:" drive. The evidence shows Mr Bender did attend one team meeting and he did receive the August 2017 BSP, although he did not sign it. He may also have had discussions with Mr Hoevers about Pono's care needs, but there was little, if any, additional training.

124. Given that evidence, a recommendation about the need for specific training would be desirable. It is noted, however, from submissions received from Challenge that additional training will be incorporated into their carers' policy having regard to the tragedy concerning Pono. Nevertheless, an area where the policy could be improved is to ensure workers in Mr Bender's situation are adequately trained and prepared for their role, in particular after periods of absence.

125. In this matter I find there is no specific evidence that Mr Bender was aware of any concerns or discussions about the development of guidelines for community outings such as attending the pool. There is no evidence of why Mr Bender did not participate in a "buddy shift". There was evidence that attendance at team meetings was not compulsory. If a person did not attend the team meetings, they were required to read the team meeting notes and indicate they had done so by signing the sign off sheet. On the evidence, these appear to have been the only mechanisms put in place by Challenge to ensure attendance at these important meetings and to ensure information discussed at team meetings was available to Pono's carers who did not attend. In hindsight it would have been prudent for Challenge to conduct some form of audit to ensure all carers had knowledge of the most up-to-date information concerning the person they were looking after.

Issue 3D: carer ratios for Pono

126. Prior to Pono being placed with Challenge, his needs were assessed the South Western Sydney Child and Family District Unit with the Child Assessment Tool ("CAT"). The CAT was reviewed and updated in February 2015, when Pono was in the care of Challenge. While Mr Brown was critical of the sufficiency of that tool to capture all of Pono's needs, it nonetheless identified that he would require intensive therapeutic care, the highest level of care. This was appropriate. Fulltime 1:1 support and supervision was recommended.

127. In early 2016, prior to the transfer of case management from DCJ to Challenge, there had been discussions about whether Pono should have a second carer allocated to him for community activities. These discussions are described in the summary of background facts.

128. There were also specific situations where Pono did have a second carer or worker present, for example: during “buddy” shifts and changeovers, during trips to Queensland, and during structured activities such as school or Mai Wei.

129. In mid-2017, when Pono’s behaviour began deteriorating, the possibility of a second carer being allocated to Pono was raised again. Ms Smith recalled there had been discussions about increasing the number of carers, as well as restricting Pono’s access to the community. A meeting record from 4 September 2017, notes Ms Smith’s recommendation to include a second staff member on community outings particularly to large major events such as football games. However, the record suggests that this recommendation would be made as part of a future review of Pono’s BSP.

130. Ms Armstrong recalled discussions about this issue, about the need for a second carer in “high stress situations”, although she did not recall how these discussions progressed. Mr Bice recalled that there had been discussions about a second staff member, although he did not recall exactly when these were. He had been told there was not enough funding for two staff members. Mr Hoevers was confident that a second staff member had been mentioned, and that there was also some discussion about restricting Pono’s access to the community, following the assault that had occurred at Green Hills shopping centre, although neither proposal progressed. Mr Cooper recalled discussions in around September 2017 about specific situations where Pono might have needed an extra carer, such as at large events. He also felt, in hindsight, that it would have been an advantage for Pono to have a second carer on trips to the pool. Mr Henry’s evidence was that Mr Cooper told him during Pono’s trip to Queensland in July 2017 that a second carer was being considered for all social outings, although Mr Cooper did not recall that conversation. Dr Conroy believes there were ongoing discussions about the need for a second carer.

131. Mr Brown initially stated that a search of Challenge records had not revealed any suggestion or request to increase the number of carers in the period leading up to Pono’s death. However, in oral evidence he too could recall that there had been discussion about this issue. He was not aware of the outcome.

132. Ms Nicola Jeffers, Executive District Director South Western Sydney, DCJ, also believed there was some conversation with DCJ, at some stage, relating to a second carer, although no application for exceptional funding was made.

133. As correctly identified by Counsel Assisting, the outcome of any of these discussions about a second carer in 2017 is unsatisfactory. Effectively there was no decision made at all, one way or the other about a second carer. No funding application was ever proposed either to Lifetime Care or DCJ. In light of Ms Smith’s recommendation, there ought to have been, at least, a decision made by Challenge about whether or not to provide Pono with a second carer.

134. Counsel Assisting suggested that the focus that was being placed on arrangements regarding Pono’s transition out of care may have distracted from the issue of, and need for, a second carer. However, I am of the view that there is no evidence about that suggested distraction.

135. It is debatable whether a second carer would have made an impact and would have improved control of Pono’s behaviour. While the use of two carers had been successfully trialled during Pono’s trips to visit his family in Queensland in 2017, there had been no trial of a second carer during Pono’s daily routine. An advantage of having two carers could have been that if Pono had become escalated, one carer

could have focused on Pono and the other on members of the public who were present; or the two carers could have acted as a "tag team", allowing one carer to have a break from active care. This strategy might have helped Mr Bender as the incident escalated at the pool on 17 October 2017. However, as Mr Bender pointed out, two carers are not always effective in practice and there would need to be a trial and error process regarding same with any particular client. For example, Pono may have reacted against having two carers because of the stigma.

136. Mr Bice, the carer most experienced in looking after Pono, said that he did not personally think it was necessary or desirable to have a second carer as he was "always comfortable taking Pono out into the community". Mr Bender was unable to support the proposal either way because in his experience there would be some children for whom two carers would be beneficial for, and others for whom it would not. Pono's case manager, and the supervisor of Mr Bice and Mr Bender, Mr Cooper, did not form the view as at September 2017 that Pono required a second carer while in the community.

137. Counsel Assisting refers to there being a "missed opportunity" to bring matters to a head on this. I accept this submission. It would have been desirable for Challenge to formalise whether it considered that a second carer was necessary, given the disparity in opinion between Ms Smith and Dr Conroy on the one hand and the direct carers and case managers on the other. I accept the evidence implies that the case for a second carer was not so compelling that Challenge managers considered there was a need to make a decision on the issue as a matter of priority. Really however there is force in Mr Henry's submission that Challenge ought to have at least trialled the use of a second carer. Mr Bender said that such a trial would be necessary, given in his experience that the strategy did not always work.

138. It is not appropriate in the context of an inquest to consider whether Challenge or DCJ breached any duty of care they held towards Pono. It is not part of the statutory exercise required by s. 81 of the Act.

139. I find Pono's problematic behaviours and increasing incidents and the successful, albeit infrequent use of a second carer (e.g. during trips to Queensland to see family), were matters that warranted further investigation regarding the feasibility and trial of a second carer. Challenge should have explored this option with more rigor.

140. It is speculative to consider what impact a second carer might have had on 17 October 2017. A second carer could indeed have explained the need for the other boy to move away at the pool, assisted to de-escalate Pono, managed community members and explained Pono's needs, but none of those strategies were certain to subdue Pono or avoid the involvement of others – it is simply impossible to hypothesise about the effect of a second carer on that day.

Issue 3E: the use of psychotropic medication

141. Dr Babu was consulted as a private neuropsychiatrist to advise on Pono's care, including medication. He did not see himself as the lead in a multidisciplinary team, but as providing advice to Pono's coordinator or behaviour support practitioner. Dr Babu's evidence was to the effect that medication was necessary, but not on its own sufficient; it was to be used as an aspect of managing Pono's behaviour. Medication was used to facilitate Pono's engagement in the BSP. Dr Babu sought to manage Pono's anxiety, brain injury and aggressive behaviour, and to reduce Pono's "flight or fight" reflex and his "suspicion and paranoia" to a normal level. Dr Babu was clear that medication

alone would not resolve Pono's behavioural problems and he stated this on a number of occasions to Pono's carers.

142. There is no evidence that the medication prescribed to Pono was anything but appropriate nor is there any evidence that it contributed either to the intensifying of his behaviour or to his death.

143. Pono's medication had significant side-effects (weight gain, risk of diabetes, acanthosis, nigricans, reduced alertness) which Dr Babu wanted to avoid. Some medication, in particular risperidone, appeared to have only a short-term effect. Dr Babu, to some extent, accommodated the concerns of carers, for example in continuing medication for its "placebo" effect, because it gave carers confidence to manage Pono's behaviour.

144. On 21 September 2017, Mr Hoevers sent an email to Dr Babu hoping he might provide any *"interim recommendations/ suggestions/changes [to Pono's medication regime] prior to the [next] consultation"*. A prior consultation in August 2017 had been cancelled, because Pono did not want to attend and as a result, Dr Babu had not reviewed Pono since May 2017. Mr Hoevers, however, noted that he understood that "*medication is a delicate science and not a full solution to Pono's emotional stability"*. This is consistent with the approach Dr Babu was taking with the medication. Dr Babu did not review Pono at the time as he was on leave, but he agreed to recommence risperidone and increase Abilify. There is no evidence that risperidone was actually dispensed prior to Pono's death (it does not appear in any Challenge medication charts or in the toxicology report). Despite having ceased this medication previously, Dr Babu prescribed it to reduce Pono's outbursts in the short term, anticipating that its effect would wear off in the longer term. Its impact on Pono's attention was also less of a problem while Pono was not at school. There can be no criticism of Dr Babu's approach, and given the medication was not in fact commenced, it has no bearing on the cause of death.

145. The use of psychotropic medication requires authorisation as a restricted practice and requires its administration to be taken into account in a BSP. The last authorisation had been endorsed by Mr Chris Brown, the Principal Officer of Challenge, on 1 June 2017 and was intended to be reviewed every three months, but was not reviewed prior to Pono's death. After the missed appointment with Dr Babu in August 2017, no further consideration appears to have been given to medication until Mr Hoevers' email on 21 September 2017. However, Pono's medication was taken into account in the BSP dated 30 August 2017.

146. I find that although the documentation regarding Pono's medication was not reviewed as anticipated, there is no evidence that the medication he was prescribed contributed to the manner or cause of Pono's death.

Issues 3F(i) - (ii): Funding arrangements and leaving care plans

147. The steps taken by Challenge to prepare for Pono's transition out of care is outlined in the summary of background facts. It appears to have commenced prior to his case management transfer to Challenge, with a leaving care plan authored by DCJ in February 2016.

148. The leaving care plan prepared by Challenge on 17 February 2017 identified that a number of options were under consideration, namely: moving Pono to be with or near his family in Queensland; obtaining supported accommodation through Housing NSW;

or transitioning Pono to the adult Challenge program, Challenge Choices. The plan however did not have any involvement of or input from Mr Henry or other relatives living in Queensland.

149. The preferred option by Challenge (and arguably DCJ) was for Pono to remain in his current accommodation and be transitioned to Challenge Choices, which would ensure continuity of care. Nonetheless, there was some parallel planning undertaken, in particular for alternative accommodation. By about May 2017, a Housing NSW application was submitted for Pono. This required a lot of supporting documentation to be obtained. Pono was on a waitlist for priority housing by October 2017, when Challenge regional manager Ms Samantha Gribble wrote to Housing NSW to advocate for Pono.

150. Funding for Pono's future care was complex, where his funding was obtained partly from DCJ, which would cease when he turned 18, and partly from Lifetime Care. By May 2017 it was appreciated by Challenge that NDIS funding was not going to be available for Pono, and that Lifetime Care would be the main source of funding in the future.

151. In June 2017, Dr Conroy submitted a "My Plan funding application" to Lifetime Care. That funding would expire in November 2017, and it did not represent a commitment that funding would continue after that date. Nonetheless, Dr Conroy had no reason to believe that funding from Lifetime Care would cease after Pono turned 18, and he understood it would continue at approximately the same rate. His main priority was to secure clarity regarding where Pono would live, who would provide funding for this accommodation and which agency would provide care. Dr Conroy understood that Lifetime Care generally did not fund accommodation, but rather only funded the carers that would go with that accommodation. He saw Challenge or DCJ as primarily responsible for finding accommodation for Pono. Dr Conroy would then act as a "go-between" to source funding from Lifetime Care for whatever health and attendant care needs Pono required as part of that accommodation or placement.

152. Casework manager Ms Armstrong was the person within Challenge driving the transition process for Pono, although she said she was not determining or negotiating the funding arrangements. On 16 June 2017, she emailed Challenge Choices regarding Pono's transition, and set out a proposal about how he would transition, including remaining in his current accommodation with staff being offered to transition to Challenge Choices.

153. On 9 August 2017, Ms Gribble emailed Challenge Choices regarding the possibility of three children, including Pono being transitioned into their care. On 15 August 2017, Ms Armstrong emailed Challenge Choices again, expressing some frustration, seeking an outcome and noting she had initially been in contact 12 months prior, and not much progress had been made since then. Ms Armstrong was still awaiting a formal quote from Challenge Choices on 7 September 2017, when she sent her own estimate to Dr Conroy, which he forwarded to Lifetime Care. Ms Gribble sent an update to Mr Brown on 20 September 2017, noting that the leaving care plan had "stalled"; in evidence he recalled having some conversations with his counterpart, the State Manager of Challenge Choices, regarding the transfer. The quote from Challenge Choices did not arrive until 21 September 2017.

154. Dr Conroy noted that Challenge Choices operated according to NDIS rates and that Lifetime Care had different rates and expenses. He attempted to arrange a meeting

between Lifetime Care and Challenge Choices to resolve this disconnect, which Lifetime Care declined, as it required a formal quote to be submitted.

155. Matters came to a head on 12 October 2017 when Lifetime Care advised it would not approve Challenge Choices and would approach a different agency, Allambi Care. This decision was a surprise to Challenge, as staff appear to have assumed the transition would occur. The tenor of Ms Armstrong's email to Regional Manager, Ms Gribble on 12 October 2017 suggested that the placement was in imminent danger of breaking down completely.

156. Due to Pono's complex needs, the transition process was going to take time to work out. Ms Jeffers stated that she would have hoped that this process would have been done sooner. But it was not. In my view, it commenced too late and took too long to progress. Challenge, through its managers, ought to have considered what funding was needed for Pono's transition to Challenge Choices at an earlier stage. Mr Brown agreed that transition planning should have commenced earlier, when Pono was 15 or 16, and that Challenge had to accept responsibility for the fact that his transition was not identified by October 2017. There was no particular policy regarding this issue produced to the inquest.

157. The fact that there was uncertainty about Pono's placement in October 2017, may have had a direct impact on his behaviour. The uncertainty around the future of his placement also had an indirect impact, because his carers did not know if they could remain with Pono and may have looked for work elsewhere. This compounded the problem which had arisen in March 2017, when Challenge was informed it was no longer going to provide intensive therapeutic care to Pono, and probably also resulted in further staff leaving.

158. As a result, less regular carers, such as Mr Bender, became involved in Pono's care. Dr Conroy's observation by 9 October 2017 was that current staff were doing "*minimal prompting/structure as they will be leaving Challenge at [the] end of the year and [were] unlikely to keep working with Pono".* Professor Dowse noted that although the majority of Pono's care was still provided by regular carers, such as Mr Bice, the care provided by less regular carers could have had a destabilising impact on Pono.

159. It may be the case that an independent advocate for Pono would have advanced this transition process. Mr Brown agreed with this possibility. There were systems in place within Challenge for the appointment of an independent advocate at the time of Pono's death, but these were not used.

160. Challenge was responsible for the process of planning the transition for when Pono turned 18 years of age. Challenge submits that the leaving care process commenced in February 2016 prior to Challenge having responsibility for case management. In my opinion that is a poor attempt at deflecting responsibility. Challenge had case management responsibility for Pono from 22 July 2016. The February 2017 case plan identifies Challenge Choices as the care body which would take over care of Pono as an adult, but there is no other information about what the post-transition care plan would comprise, and no such plan was in evidence. The preliminary accommodation application that was made to Housing NSW in May 2017, was missing considerable documentation needed for long-term accommodation funding for a person with Pono's care needs. On 11 October 2017, a Senior Client Service Officer in Housing Services at DCJ, Ms Kerin Neely advised Mr Hoevers that the application was still not complete. Mr Brown told the inquest he did not consider that the urgency of the need for

accommodation was something he should or would raise with his counterpart at the DCJ Hunter New England District Office.

161. The submission of DCJ in my opinion has great weight: –

> "*The critical part of any transition arrangement was finding and locking in the funding for care. Somewhat surprisingly it appears that Dr Conroy was the main liaison person between Challenge and LTCS [Lifetime Care]. This was clearly inappropriate. Dr Conroy is a well credentialled neuro-psychologist but he is not a person with sufficient financial expertise or experience to negotiate a complex funding arrangement. That obligation sat with the Regional Manager, overseen by the then State Manager Mr Brown. Funding was a matter for those who dealt with financial services within Challenge".*

162. In addition, on 8 September 2017, Dr Conroy's contact at Lifetime Care indicated that it usually used its "panel providers" and would have to exhaust them before it could consider Challenge Choices, which was not listed as a provider on the relevant panel. Dr Conroy was also told that Challenge Choices rates were "considerably higher" than Lifetime Care panel providers. No substantial steps were taken to obtain funding for Pono until 21 September 2017 when Mr John Harries, Manager Performance and Strategy at Challenge provided a draft quote to Dr Conroy. The quote was for the substantial sum of $528,081 per annum and was provided to Lifetime Care by 29 September 2017. The quote was rejected on about 12 October 2017, because not only was Challenge Choices not on the panel and the rates too high, but no arrangements had been made to transition Pono's care staff over to Challenge Choices.

163. As no firm plan had been devised by Challenge Choices nor its funding agreed to by October 2017, it is not surprising that none of the staff who cared for Pono had been approached to transition with him to Challenge Choices. If Challenge Choices had been confirmed as the preferred carer much earlier, then staff arrangements could have been made much earlier, and Pono's transition would have been more predictable and certainly smoother.

164. Professor Dowse's opinion was, if it was accepted that the first mention of Allambi Care as a potential care provider was about 12 October 2017, then that was very late in the piece and it was "a terrible state of affairs to be honest."

165. Mr Henry fairly points out that the "preferred option" of Pono moving to Challenge Choices was a preference expressed by Challenge, not him. He refers to the advantages for Pono of being placed with his family. He challenges the suggestion that Pono's family would have lacked skills to care for him. This apparently was a concern, but really it was never appropriately investigated or discussed with Mr Henry. The records show that the focus (such as there was any focus) was on moving Pono to Challenge Choices, and that the lack of progress to that end was a contributing factor in Pono's destabilisation. Essentially a resolution of Pono's future placement and him having some certainty as to where he was heading would have been of benefit to Pono. Excluding Pono's family from his adult care arrangements is most regrettable.

166. On my finding, there was a significant level of disorganisation and lack of impetus regarding Pono's transition out of the care of Challenge. In particular no one at Challenge appeared to be taking control nor overseeing, in a sufficient manner, an effective transition plan for Pono. Challenge were far too late in implementing their proposed placement plan, particularly in light of Pono's complex disabilities. It was assumed that Challenge would be able to transition Pono to their Challenge Choices program. Challenge failed to explore other options for Pono including moving to or residing near his father in Queensland. Challenge failed to take the necessary steps to

secure funding for Pono's transition and when the application for funding was rejected by Lifetime Care on 12 October 2017, three months before Pono turned 18, there were no arrangements for where Pono would live and who would provide support to him.

167. I also accept that DCJ had an oversight role with respect to Pono's transition planning and similarly they ought to have taken further steps to question and support Challenge in its task (this is addressed further below).

Issue 4: Oversight by DCJ

168. DCJ transferred Pono's case management to Challenge on 22 July 2016. From that time, the primary method of oversight of Pono's placement by DCJ was through the three-monthly District Review Panel meetings, although there was also a regular contact as required between Challenge and the relevant part of DCJ, the Child and Family District Unit ("CFDU"). Separate to this, there was the process for reporting risk of significant harm.

Risk of significant harm ("ROSH") reports

169. Reports were made to DCJ about Pono by mandatory reporters, pursuant to s. 27 of the *Children and Young Persons (Care and Protection) Act 1998*. There were eight such reports from July 2016 through to Pono's death, but none were considered to meet the threshold of "risk of significant harm" ("ROSH"), in part because Pono was in Challenge's care.

170. ROSH reporting is a process devised primarily for the receipt of information about risk of significant harm to a child in New South Wales. It is not a central part of the oversight mechanism provided by DCJ to designated agencies such as Challenge for the provision of out of home care. That role was provided by the District Review Panels, the CFDU and the contract management meetings. The place for review of the ROSH reports, even where they did not reach the ROSH threshold was at the District Review Panel meetings. This happened in two ways. First, Challenge provided a written report to DCJ on (approximately) a three-monthly basis via the District Review Panel. Those reports were in evidence and were detailed. The reports provided Challenge with an opportunity to report on incidents of concern and how they were being addressed. Second, at the three-monthly District Review Panel meetings, there was an opportunity for DCJ (including CFDU staff) to raise any concerns they may have had arising out of any ROSH reports received or from the designated agency's report. Many incidents involving Pono were the subject of Challenge's reports to the District Review Panel.

171. Ms Jeffers who gave evidence at the inquest, provided a very genuine and heartfelt apology on behalf of DCJ to the family of Pono. Her evidence was forthright and candid.

172. It was acknowledged that DCJ maintained its parental responsibility for Pono and that it also had an oversight role. DCJ was responsible for, amongst other things, responding to ROSH reports, for consent to marriage, and for any decisions around residency outside of New South Wales. They would also be responsible for applications for passports and birth certificates and for consent to life. In addition, their oversight role encompassed:

    - The regular reporting by Challenge to, and review by, the District Review Panel for the Hunter New England District Office. The District Review Panel was later

renamed the High Needs Penal, the Complex Care Review Panel, and then the High Needs Kids and Complex Cases Panel.

- The provision of services via the Hunter New England CFDU members, of which some also sat on District Review Panel meetings. The CFDU provided a point of contact for Challenge, which was a "designated agency". Challenge was required to advise CFDU of any change in placement, anything the Minister needed to approve (such as travel outside the state) and if there were any incidents or issues.

- Monthly contract management meetings with the commissioning and planning team of the Hunter New England District.

173. Ms Jeffers accepted that DCJ's response to Pono's escalating violence was less than adequate and that there was a missed opportunity to look at those reports collectively or cumulatively and to enhance Pono safety and well-being.

174. In the submissions of Mr Beckett for DCJ at [16] it was said that:

> *"DCJ takes every death of a child in its care very seriously indeed. Departmental procedures require that a thorough review is completed of the Department's involvement in the care of a child who has died. The office of the Senior Practitioner: Serious Care Review unit of FACS (later DCJ) undertook an Internal Child Death Review, the report of which was delivered in February 2020. The report is in evidence. The review made a number of criticisms of FACS' care of Pono as well as his brothers and sisters over the period during which they were in the Minister's care. Those findings are summarised by Counsel Assisting at [95] (of counsel assisting's submissions)".*

175. I adopt DCJ's submission and find:

> *"In particular, it is acknowledged that there were missed opportunities in the areas of oversight by the District Review Panels such as transition planning for Pono's care, assisting the coordination of agencies and funding needed for Pono's care and reviewing risk of significant harm (ROSH) reports with Challenge. In particular, DCJ regretted failing to work together with ("partnering with") Pono's family, especially his father Mr Henry. In the Internal Child Death Review it concluded that FACS needed to ensure that Pono's leaving care plan included strategies for him to strengthen his relationships with family, friends and other support people. It is those adverse findings in the Internal Child Death Review which then guided DCJ's response to the inquest…"*

176. It was submitted by Counsel Assisting that the system of mandatory reporting would not appear to offer a reliable method of oversight for a placement such as Pono's. I agree with this submission. Escalating reports indicating behavioural and violence issues are indicative of a problem that ought to be investigated. It was submitted by counsel assisting that dealing with Pono's behaviours by way of the mandatory reporting system is a reactive process and what was needed was a proactive process for monitoring Pono's placement such as through the District Review or Complex Care Review Panels (which are considered below).

177. Since Pono's death there have been efforts to improve responses. There has been a group supervision session by the DCJ South Western Sydney Complex Needs Panel, which amongst other things looked at how to respond to such reports more holistically. There also now exists a program called LINKS Trauma Healing Service, a multidisciplinary team which provides services to placements at risk of breakdown. This, of course, is a welcome addition to DCJ's oversight and service provisions.

District Review Panels

178. There were five District Review, or Complex Care Review, Panel meetings between transfer of case management to Challenge in July 2016 and Pono's death. In preparation for the panel meetings, Challenge caseworker Mr Cooper would prepare a report which was then the focus of discussions at the meetings. Following the discussions, the panel was to provide its recommendations.

179. The February 2017 panel meeting recorded that Challenge was "working on [Pono's] after-care plan currently", and that there was consideration of moving Pono into the Challenge Choices program. The report prepared by Mr Cooper for the May 2017 panel meeting recorded that Pono's support team "*continue[d] to work towards finding suitable accommodation for after Pono turns 18*" and that there "*continue[d] to be some uncertainty about what funding Pono will be eligible for*". The report prepared by Mr Cooper for the August 2017 panel meeting noted that Pono's team would "*continue to work towards Pono transitioning into Challenge's Choices Program" but that "Lifetime Care funding arrangements still needed to be finalised and agreed upon for this to occur*". The panel meeting notes of August 2017 stated: "*waiting to hear back from Choices – the goal is to transition by December"* and that "*after-care planning will start this month*".

180. As submitted by Counsel Assisting, the reports do not provide confidence that Pono's transition was being progressed in a timely way or indeed was proceeding smoothly and he was fast approaching his 18th birthday. There is no record of the panel giving any significant directional recommendations to Challenge during this period. Again, this was a missed opportunity for DCJ to ask questions and provide guidance for Challenge. Equally there was no evidence that Challenge raised a concern at the meetings or sought particular assistance from DCJ.

181. As submitted by Counsel Assisting, and with which I agree, "*Ms Jeffers in evidence referred to a number of other missed opportunities, on the part of [DCJ], in the process of oversight of Pono's placement, reflecting the conclusions of the Serious Case Review*".

182. It is accepted, and I find, that:

    A. DCJ ought to have done more regarding a transition plan for Pono in its February 2016 case plan;
    B. DCJ should have referred to the possible issue of a second carer, at the time of the case management transfer;
    C. DCJ could have been more "curious and proactive" around the transition plan at the time of the case management transfer;
    D. DCJ could have assisted in coordinating the agencies involved in Pono's care; and
    E. DCJ did not "partner" very well with Mr Henry nor did they provide an appropriate level of communication with him. As mentioned earlier, the latter is most regrettable.

183. While one has to be careful about criticism and the advantage of hindsight in an inquest, it is very disappointing, in my opinion, that as part of DCJ's oversight role, it did not do more in facilitating contact between Pono and his family. DCJ should have ensured that this happened. Pono's father and his partner were assessed as suitable to care for Pono in December 2014, yet the decision was made not to support Pono in

residing with his father. That decision was not well communicated, nor from the evidence do I find any serious justification for this decision. DCJ failed to inform the family of serious incidents that Pono had been involved in and were poor in updating the family in relation to the arrangements for his transition out of care**.**

184. As has been indicated, Ms Jeffers admitted there were a number of areas where DCJ oversight was inadequate. It is regrettable that they did not effectively engage with the family in key decisions. One has a feeling that the family were being treated indifferently and thoughtlessly.

185. It is accepted by DCJ, and I find, that there was a missed opportunity for oversight of transition arrangements at the August 2017 meeting of the District Review Panel. Challenge's transition arrangements were well behind and while Challenge might have been representing to DCJ at panel meetings that they were "working towards transitioning Pono" and that "funding still needs to be finalised". It is accepted by DCJ, and I find, that it did not proactively question these matters at the meeting and did not offer to assist with coordinating relevant agencies. Again, Challenge also did not seek assistance from DCJ either.

186. There is currently a review into High Needs Kids and Complex Case Panels, which was due to report to the DCJ Executive in April 2021. It is noted that DCJ accepts there is merit in the review considering matters such as the appropriate oversight mechanisms for children in residential Out of Home Care with respect to behaviour support, ROSH reports and leaving care plans.

187. Ms Jeffers noted a number of other improvements to DCJ processes since the time of Pono's death, including: the creation of Permanency Coordinators, whose functions include working alongside case managers in behaviour support and after-care planning; changes to leaving care processes; and the creation of a new case management system (Child Story,) which allows information to be shared more easily between DCJ, designated agencies and other government agencies.

188. Mr Henry submitted that the ROSH reports provided to DCJ did not mention specific assaults nor provide detail of the actual amount of aggressive conduct that Pono was engaging in. As submitted by Mr Beckett for DCJ, and which I adopt, many of the child protection reports were made by Challenge. The witnesses from Challenge did not confirm whether Pono's aggressive conduct was discussed at the meetings, including when a child protection report was made to the DCJ Helpline. DCJ officials who attended those meetings were not called to give evidence in that respect. Mr Henry says that DCJ did not respond, or make any efforts, to ensure Pono's escalating violence was addressed and therefore did "not discharge their residual parental risk responsibility to oversee". However I am of the view that the management of Pono's escalating violence was primarily a matter for Challenge and it was dealt with by them, through Challenge's contractual and policy obligations, and by Pono's many clinicians including Ms Smith and Dr Conroy (and ultimately by DCJ through the District Review Panel meetings).

189. There were a number of recommendations proposed by Mr Henry in relation to DCJ. I attach at Annexure 'B' a schedule provided by DCJ, detailing these proposals and the response to each by DCJ. While I have considered these proposals carefully, I am not persuaded that it is necessary or desirable to make such recommendations in the circumstances of this case.

Issue 5: The decision to take Pono to the pool

190. As was referred to in the background section at [26] - [29] above, Pono wanted to go to the pool on 17 October 2017, but initially Mr Bice dissuaded him. They discussed a previous issue that had occurred at a pool the week before. There is no report about an incident at the pool in that timescale. Nonetheless Mr Bice believed an incident had occurred. Mr Bice also knew that the pool was a "trigger" for Pono and that being amongst crowds presented a risk. Mr Bice's evidence that an incident occurred the week before may not be accurate. He is relying on his memory of an event that occurred over three years ago and where there is no evidence in any written record of a particular incident. He was taken to a number of records that indicated that Pono had been to the pool on 29 September 2017 and 11 October 2017, where each occasion is recorded in a positive light. Despite this, Mr Bice says he is "fairly certain" there was an incident. He has no recollection of the incident and it's not in the records. Although Mr Bice was a credible witness, I think he is mistaken on this point. Mr Bender, who also gave evidence regarding an incident with Pono at the pool, has no recollection that this incident was discussed in the changeover between Mr Bice and himself that day.

191. Mr Bender also did not recall being told more generally of the risk of going to the pool with Pono by Mr Bice, although he accepted he had no reason to doubt what Mr Bice said. Importantly there was already significant discussion occurring about trips to the pool before this trip occurred. In January 2017, in response to an incident at Maitland pool on 31 December 2016, Mr Cooper developed guidelines for when Pono attended the pool. The guidelines contained strategies for his attendance. In March 2017, Ms Armstrong directed that all pool visits were to cease until a risk assessment was completed for Pono. Ms Armstrong emailed Mr Cooper, Pono's caseworker, on 21 March 2017 and asked Mr Cooper to have a roundtable at the next staff meeting on "what… a successful visit [to the pool] looks like for Pono including location, environment (including other people), and preparation etc."

192. I think that because management of Pono during pool visits was being discussed by those in a more senior role at Challenge, it is more likely than not that the relevant information regarding pool visits had filtered down to the care workers working with Pono. I am satisfied that the care workers that were working with Pono, one way or another, had knowledge that there had been previous incidents during attendances at the pool and that there was a potential risk. I am satisfied on balance that something was said by Mr Bice to Mr Bender about Pono wanting to go to the pool earlier that day and him redirecting him away from that request.

193. Mr Bender's evidence was that he could recall that when he arrived to take over from Mr Bice that Pono was at "baseline", which he described as "happy, not angry, in a good mood, wanting to do things". Shortly after Mr Bender arrived, there was an incident where Pono told Mr Bender to leave the house. Mr Bender described it as Pono being a bit angry and that he wanted a bit of space. He calmed down quickly and was back at baseline not long after. Counsel Assisting's submission was that "Pono's escalation was difficult to predict, and the fact of a prior incident does not appear to have been a predictor of any further escalation", with which I agree.

194. When Pono decided he wanted to go to the pool instead of the cricket nets (as had been the plan he had discussed with Mr Bice), Mr Bender did not attempt to dissuade him, though he knew that he could. He understood that Pono was fine to go into the community, provided he was not heightened. Although he could not recall taking Pono to the pool before, he had no concerns about it. Mr Bender says that he telephoned

Mr Bice to tell him they were attending the pool. That gives some force to the argument that Mr Bender would not have done that unless there had been a conversation with him and Mr Bice about efforts to redirect Pono earlier in the day away from going to the pool (and to the cricket nets instead), and the risk associated with taking Pono to the pool.

195. From Mr Bender's evidence, he appears to have been fairly casual about thinking through the risks of outings with Pono. It was a hot day and the pool was likely to be busy. Mr Bender had to balance any issues that may have arisen from refusing to take Pono to the pool (which might have escalated his behaviour) against those that may have arisen by taking him to the pool. However as was seen by Mr Bice's interaction with Pono earlier in the day, Mr Bice was able to redirect Pono that morning in relation to an attendance at a jewellery store and then redirect him again when Pono raised the possibility of going to the pool. It was therefore entirely possible for Mr Bice to redirect Pono and to not accede to his every wish, particularly in circumstances where a known risk was present.

196. Dr Conroy's view was that a less consistent team of carers, who were not as familiar with Pono, would have less capacity and motivation to follow the BSP and set limits with Pono, in particular out of fear of Pono's outbursts and aggression. This observation by Dr Conroy, in my opinion, reflects Mr Bender's approach to the decision to take Pono to the pool on 17 October 2017.

197. Mr Bender gave evidence that he was not aware of the partially completed risk assessment authored by Mr Cooper. This notwithstanding, Ms Smith gave evidence that attending locations when they were likely to be busy was inadvisable and that this had been discussed in team meetings. However, Mr Bender had only attended one team meeting, on 9 October 2017.

198. While Mr Bender gave evidence that he checked the BSP, and that it was his practice to do so before every shift, there was no clear guidance in the BSP (or elsewhere) to assist Mr Bender on how to assess, plan and manage a community outing, including a trip to the pool.

199. Given the risks that outings in the community posed, more importantly the heightened risk that the pool evidently posed (in particular on a hot day), specific guidance should have been created and listed in the BSP. If Challenge had finalised the risk assessment relating to the pool (and thereby finalised appropriate guidelines for taking Pono to the pool), and if those guidelines had been readily available to care staff, then perhaps Mr Bender may well have made a different decision on that fateful day. It is accepted that this is a speculative comment. However accepting Mr Bender's evidence that he read the BSP before each shift, had any guidelines been itemised in Pono's BSP, it is likely that he would have taken these guidelines into account, and it follows that it seems likely that he would have attempted to divert Pono away from wanting to visit the pool, given the known risk associated with such a visit.

200. I find that as Ms Armstrong had given a direction on 2 March 2017 that all pool visits were to cease until a risk assessment was completed for Pono and although Mr Cooper prepared a draft and sent it to Ms Armstrong and Ms Smith for comment, it was not, on the evidence, finalised. Importantly, it does not appear to have been effectively communicated to Mr Bender that there were elevated risks that needed consideration when visiting the pool. Accordingly, Mr Bender should have been directed that Pono could not attend the pool. That this did not occur, is a significant oversight by Challenge.

Issue 6: Mr Bender's actions at the pool

201. As is readily accepted by all parties, Mr Bender was on his own with Pono at Lambton Pool. The issue of having a second carer is set out and discussed above at [126] – [140]. Leaving aside that particular issue, Mr Bender's actions and his alone are the main focus to be reviewed during an examination of this particular issue.

202. When Pono became agitated at the pool, I am of the view that Mr Bender attempted to de-escalate him. On the evidence from witnesses in their statements, video evidence and evidence at the inquest, I am satisfied that Mr Bender took the following action. He:

    A. attempted to redirect Pono, telling him it was time to go to organise dinner;
    B. stood between Pono and the boy he was arguing with, and tried to direct Pono away;
    C. apologised to the woman involved in the argument and asked her to keep her distance;
    D. told the pool manager, Mr Newham, that Pono should be given space;
    E. tried to distract Pono and "shepherd" him out of the pool;
    F. attempted to stop Pono throwing the poolside laneway sign, and tried to deflect Pono's punches from hitting Mr Newham;
    G. told people not to restrain Pono, prior to the time when he called case worker Mr Hoevers;
    H. called Mr Hoevers for advice once Pono had been taken to ground and was rolled on his front, and called him again later during the restraint; and
    I. told people present that Pono had a brain injury, a shunt and was on medication, and that restraining him could be dangerous.

203. These actions, as set out above, are indicative of an approach that is reflective of what was itemised in the relevant BSP in relation to managing Pono's behaviour. However, by the time Pono entered the disability toilet, he was in an intensely agitated state, to an extent that Mr Bender had not seen before. It is likely that Pono's behaviour was beyond Mr Bender's capacity to control, even with the training, experience and knowledge that Mr Bender had in dealing with Pono previously. The fact that a large number of members of the public also became involved did not assist Mr Bender in trying to regain control over the situation. It would have on balance increased Pono's agitation and anxiety.

204. There is an obvious tension between Challenge's "No restraint policy" and the scene that was unfolding in front of Mr Bender at the pool. Mr Bender knew of Pono's medical issues and tried to communicate that problem to various people as their interaction with him was occurring. While Mr Bender was seeking to avoid physical restraint and was wanting others to follow that course as well, when Pono commenced to physically harm himself and others, Mr Bender was placed in a very difficult situation for which he was not trained or experienced enough to handle.

205. It was submitted by Ms Cregan on Mr Henry's behalf that there was an inadequate system for information sharing by Challenge and an absence of specific guidelines for community visits in the BSP, and because of that it failed both Pono and Mr Bender. With the benefit of hindsight maybe other things could have been done, such as enlisting the assistance of a second carer, had one been available at the pool. On my review of the video evidence however, I am of the view that on balance this was unlikely to have been of any great assistance, in view of the agitated state Pono had

worked himself into. Even with better training and/or knowledge I cannot be satisfied that the situation would have been any different.

206. Dr Babu had already given evidence that BSP's were to be provided to care workers to help guide their interactions with Pono on a day-to-day basis. The care worker would build up a degree of history with Pono in implementing the BSP. From that interaction, the care worker could provide feedback to the creator of the BSP, which in the latter period of Pono's life was Ms Smith, as to what worked and what didn't work. Dr Babu accepted the view that it is on that basis *"that garnering of experience by care workers allows them to develop good judgement in terms of picking trigger points, for example, for a particular person such as Pono"*.

207. Professor Dowse gave evidence about Mr Bender's actions at the pool and whether he was following the BSP by stating:

> *"[C]ertainly in both the written accounts and in the footage that I viewed it appears that Mr Bender was doing his absolute best. According to the behaviour support plan, Mr Bender's role was to talk to Pono, to divert him, to identify a clearing, you know, "Let's just get your stuff and go" kind of approach, which he appears to be doing in the video, in video number 3, I think it is, where, you know there were a large number of members of the public and the situation has escalated into something that is… well and truly outside of Mr Bender's control… things escalated and Mr Bender was in a very difficult position… from his account it appears he was instructing the men about Pono's shunt and to be careful about all those sorts of things, but I understand he wasn't able to physically intervene to prevent the intervention of the members of the public…*
>
> *I also note in the video number 3… Mr Bender… withdraws himself and takes out his mobile telephone and makes a phone call and I'm assuming according to the written accounts… he is calling Mr Hoevers… it appears that Mr Bender was able to do what was required, which was really not to do a whole lot of physical intervention, but I feel as though the events themselves overtook Mr Bender's responsibility or capacity once the whole number of members of the public became involved*".

208. On the basis of what I have outlined above, I am not critical of Mr Bender's actions at the pool. I find that Mr Bender's actions were reasonable and appropriate in the circumstances, and in accordance with the BSP in place for Pono. However, as highlighted already, the absence of information relating to the risk that the pool posed for Pono in the BSP was an oversight by senior personnel at Challenge and by Ms Smith, as the author of the BSP.

Issue 7: The restraint of Pono at Lambton Pool

209. I do not think it is possible to make a finding in particular terms about the restraint of Pono by the civilians (i.e. pool staff and other pool goers), who initially restrained him. Witnesses gave differing accounts and in view of the evidence as to the cause of Pono's death (cardiac arrhythmia), it is not necessary to make findings about his exact position during the restraint. I am satisfied that all of the witnesses that provided their observations of the restraint undertaken by the civilians attempted to do so truthfully. From all of the evidence I am satisfied on balance that there was no heavy downward pressure being applied to Pono at any stage which might have been relevant to asphyxia.

210. Some witnesses indicated Pono was lying face down, on his stomach, with his head turned to the side and other witnesses, including Mr Steven Brinkley, a retired NSW paramedic, observed Pono being taken to ground carefully and eased onto his back

initially. Mr Brinkley stated that he was "quite sure it was the lifeguard's voice who said let's roll him over." He then observed Pono being moved into a lateral position, a position he described as "a common patient position which allows for a good airway and respiratory function".

211. I am satisfied that there is no evidence to support a heavy restraint of Pono by one or more persons. Pono became highly agitated and was at risk of causing himself or others harm. Immediately prior to the restraint he had hit his head repeatedly on a brick wall and was threatening to put his head through a broken glass window. I find it was reasonable for Mr Newham and others to restrain him in order to prevent Pono harming himself or others.

212. Mr Bender in evidence said his recollection was that Pono was initially lying face down on the concrete and remained in that position. That evidence is inconsistent with others and I do not accept that he remained in that position, because at some stage he was rolled on his side, particularly when police officers arrived. Both Mr Newham and Mr Baird said that Pono initially ended up on top of Mr Baird facing upwards and then from there he was rolled off Mr Baird and placed onto the ground with Mr Baird "spooning" Pono.

213. By the time Pono became very heightened, and had thrown the pool laneway sign, the chances of avoiding public involvement appeared unlikely. While Mr Bender did make efforts to allow Pono to have more space, his chances of avoiding the involvement of civilians were overtaken by the events themselves and Mr Newham's decision to restrain Pono. The decision by Mr Newham to restrain Pono so as to prevent him from harming himself could not be criticised and indeed was reasonable in the circumstances.

214. Mr Brinkley described Pono's position as "left lateral" when police arrived. Mr Newham took up a position at Pono's head cradling it, Mr McKelligott was holding one arm and Mr Baird the other, and Mr Robinson was holding his legs. Pono was initially struggling and thrashing about and head-butting the ground and telling people to "get off [him]". During this time, the men who were holding Pono, were doing so forcefully and Mr Caldwell placed his body weight across Pono's hips to stop him kicking out. Mr Baird says that he initially placed his own chest in contact with Pono's upper rib cage, just below his shoulder, to prevent Pono from getting up and to control him better. He did so for a minute or two and released his weight when Pono started to calm down.

215. A towel was obtained and placed under Pono's head, as he was hitting his head against the concrete. Pono tried to bite Mr Newham and in response he put his hand at the back of Pono's head to prevent him doing so. The men were telling Pono to calm down and as he did so, Mr Baird took his weight off him and moved onto his knees and held onto Pono's wrist with his right hand and with his left forearm across Pono's shoulder. Pono continued to tell people to get off him and also said "I can't breathe".

216. Pono then lost consciousness and went limp. Mr Newham told the other men to release Pono at this point. An oxygen mask had been obtained and was placed near Pono's face, and his pulse was checked. He revived and began thrashing about again and the men continued to hold his arms and legs.

217. When NSWPF officers arrived, they observed Pono to be lying on his left side, facing towards the direction where the NSWPF officers were coming from, so that the whole

of the side of his body was in view in a position similar to the recovery position. This is consistent with the evidence of the men involved in the restraint.

218. Pono had areas of grazed skin on his legs (including his thighs) and/or knees. It was submitted by Mr Henry that this was evidence of "forceful downward pressure" or "heavy restraint" being applied to Pono. There can be no doubt that Pono's knees more likely than not came into contact with the ground, but it does not necessarily follow that this was as a result of forceful downward pressure or heavy restraint. It could just as likely have occurred as a result of Pono struggling and lashing about, which the witnesses clearly gave evidence about. On balance, I consider that these injuries were likely occasioned by his efforts in struggling rather than any forceful downward pressure.

219. As to the period of time he was restrained, the evidence would suggest that Pono was taken hold of by Mr Baird in a "bear hug" at around 5:00 PM. Ms Griffin in her statement says that she thought the time of the call to police was 5:02 PM and which was confirmed in the statement of Ms Grace Williamson. Ms Strickland stated that she "*recommenced video recording what was occurring with the male in the white T-shirt… I can see that I recommenced recording at 5:08 PM*". She said she stopped recording when the men in the area restrained Pono and they put him to ground. The recording was one minute and 10 seconds in length (that would make the time a little past 5:09 PM).

220. In my opinion that is the best evidence as to when Pono was taken to ground. Mr Hoevers in his statement said that he received a call from Mr Bender at 5:09 PM in which he was informed that Pono had lost control.

221. Overall, during this initial period of restraint, I find that Pono was restrained for approximately five to seven minutes by five members of the public, as well as the pool manager Mr Newham. During this period of restraint, I find that Pono was restrained by his arms and legs, with Mr Newham holding his head. I also find that at one point early in the restraint, pressure was applied to Pono's midsection to try and stop him kicking and moving. While Pono may have initially been restrained face down on his stomach, he was moved onto his side, although he was continuing to move around. From all of the evidence, I am satisfied and find that Pono was taken to ground carefully. I accept the evidence of Mr Caldwell, who recalls Mr Newham saying they should be gentle because Pono had a brain injury. I find there is no evidence of forceful downward pressure being applied to Pono's neck or chest.

Issue 8: Action taken by police

222. The NSWPF CAD records indicate that the incident was recorded by NSWPF dispatch at 5:10 PM, assigned at 5:12 PM and that NSWPF officers were on scene at 5:15 PM. This appears to be the best evidence as to when NSWPF officers arrived.

223. The triple 000 transcript records a call from 5:10 PM to 5:14 PM in which the person reporting says that Pono was in a recovery position and it was shortly thereafter that the police are reported to have arrived.

224. As Senior Constable Lane and Senior Constable Kent entered Lambton pool, both observed Mr Newham holding an oxygen mask to Pono's face. Senior Constable Lane became involved in the restraint and his colleague Senior Constable Kent spoke to witnesses and made contact with police radio. Senior Constable Lane took hold of Pono's right arm. Other witnesses observed him placing his left hand in the middle of

Pono's back between the shoulder blades, in what look like an arm lock, although he did not recall this. He also repositioned Pono's legs to make it less fatiguing to hold them, although he denied this was a "leg lock". Pono then remained approximately in the same position on his side until paramedics arrived.

225. It was submitted by Mr Henry that Senior Constable Lane was "applying something approximate to an 'arm lock' during the restraint." There was no specific evidence about what an "arm lock" was or what the mechanism is to put someone in an "arm lock". Senior Constable Lane explicitly denied using an "arm lock". He said he was just holding Pono's forearm or wrist area to stop him from lashing out. I accept that some lay witnesses used the term "arm lock".

226. Mr Bender gave evidence that Senior Constable Lane had Pono's arm out flat on the ground and held Pono's wrist with one hand and had his other hand on Pono's shoulder. Paramedic Falkiner reported observing Pono's hands being held down by his side, with Senior Constable Lane holding the right arm and having one hand in the middle of Pono's back. Paramedic Watson observed Senior Constable Lane having hold of one of Pono's arms. During oral evidence, Senior Constable Lane was asked by Counsel Assisting whether he was applying something approximate to an "arm bar" or "arm lock" to Pono, whilst he was under restraint, although he was no asked what he believed constituted an arm lock. In any event, Senior Constable Lane replied no. Based on all of the evidence, I am not satisfied that an "arm lock" was applied by Senior Constable Lane.

227. Sergeant William Watt, a Senior Operational Safety Instructor with NSWPF, considered that the position that Senior Constable Lane took when he initially took control of Pono's arm did not appear to be specifically taught, but appeared to be akin to an "arm bar". However, Sergeant Watt considered that the technique certainly fell within what would be considered acceptable when measured against training, policy and practice employed by the NSWPF.

228. Senior Constable Lane said he did give consideration to moving Pono into a different position or releasing him. His evidence was that when Pono was struggling less, he decided to try to sit him up, but that Pono lashed out and spat at him and so the restraint was resumed. He accepted that there may not have been any discussion about this, although that was his intention. Sergeant Watt noted that keeping Pono on his side was consistent with police training and policy. Mr Henry submitted that Senior Constable Lane ought to have attempted other restraint techniques including handcuffing Pono.

229. Senior Constable Lane gave the following evidence:

> "*I guess I felt that handcuffing him due to his state of mind and unable to really comprehend directions that handcuffing him might've agitated him more, given that it now wasn't a criminal thing, it was more of a medical/mental health incident if you like; and it was more comfortable, I thought it was just more comfortable being held legs and arms as opposed to having handcuffs."*

230. On the option of handcuffing, Sergeant Watt pointed out that this may not have immobilised Pono sufficiently, and handcuffs could have been used as a weapon, including as a means of harming oneself. I do not accept that handcuffing was a viable option based on the evidence.

231. Senior Constable Kent also gave evidence about the possibility of getting or sitting Pono up into a more upright position. Her answer:

> *"At one stage when restraints were released, Pono started head-butting the concrete ground, and that was one of the times that it was attempted to allow him a bit more movement, and he started head-butting the ground. So I asked the pool staff if there was anything that we could use to cushion the area"*

232. Sergeant Watt considered that the action taken by Senior Constable Lane was appropriate and in accordance with NSWPF policy. This is within a context where the NSWPF operational aim is to control the person concerned. Sergeant Watt was asked about NSWPF officers using other options, including releasing Pono or "tactically disengaging", an option which allows officers to move back from a situation to gain an advantage or to "avoid pushing a bad position". Sergeant Watt found it exceptionally difficult to offer an opinion on a hypothetical basis, about whether the risk of restraint might become so great that NSWPF officers should withdraw.

233. Sergeant Watt placed emphasis on the ability of a NSWPF officer involved in a restraint to make a judgement about the risks, based on what was occurring. Reducing restraint might result in a prolongation of the altercation or expose those present to other risks. The correctness of the judgement is clearly situation specific and involves a difficult balance to be struck. It is therefore difficult to make a specific finding that NSWPF officers should have attempted some other technique to restrain Pono or to consider another type of position of restraint.

234. Relevant NSWPF policy and training material was produced to the inquest. Amongst other things, the policies identify risk factors associated with positional asphyxia, the need to roll the subject onto their side or upright as soon as possible, not to leave them lying prone and to monitor signs of breathing. It was submitted by Mr Henry that the restraint of Pono satisfied five of the seven risk factors for positional asphyxia. However as submitted by Counsel for the Commissioner (a submission which I accept), Pono did not satisfy the requirement that the person subject of the restraint present as *"(a) wild, threatening, bizarre behaviour with possible mania or psychosis, (d) restraint of the individual in a prone, face down position, while handcuffed or (e) drug and alcohol used by the individual"* and by the time NSWPF officers arrived, he was not engaged in *"(c) violent behaviour generally*".

235. There is no specific evidence that Pono lost consciousness after NSWPF officers arrived on scene. Senior Constable Lane said that he was unaware of Pono losing consciousness prior to the paramedics arriving and that he was monitoring Pono's level of responsiveness. He did this

> *"by talking to him and just still reassuring him and asking him to calm down and he would be still grunting and groaning and fighting, and struggling against us, and every now and then he was saying "can I get up now", but – so just my observations of him".*

236. I do not accept the submission made by Mr Henry that during the period of restraint Senior Constable Lane did not appear to closely monitor or assess Pono's breathing as required under the NSW Police Close Quarter Control policy.

237. While it is likely that Senior Constable Lane did place his hand between Pono's shoulder blades, there is no evidence that any forceful downward pressure was applied to Pono's chest or neck at any time during the time NSWPF officers were in attendance. That is also consistent with the observations of Dr Beer at post-mortem.

238. Overall the actions taken by Senior Constables Lane and Kent appear to be in accordance with NSWPF policy. Senior Constable Lane was aware of the risks associated with restraint and did attempt to release Pono or move him to a more upright position. Pono was presenting in a highly agitated and disordered state and releasing him from restraint would have likely exposed both him and others to risk.

239. I find that the actions of both NSWPF officers were reasonable and appropriate to the circumstances, and within the parameters of relevant NSWPF policies. There is no criticism of either NSWPF officer either in respect of their actions once they attended Lambton Pool that day, or during the restraint of Pono by Senior Constable Lane.

240. I note that the NSWPF policy on positional asphyxia is an area currently under review. It is hoped that the findings in this inquest and the scenario that occurred on the day may be useful in informing that process. The evidence of Sergeant Watt is that NSWPF policy on positional asphyxia will take into account the matters leading to Pono's death, will involve both medical and legal advice and that the review intends to better identify the risk factors for death during an arrest. It is hoped that this updated policy will develop tactics to minimise those risks and will inform future actions to the extent that they are considered relevant.

Action taken by paramedics

241. While not identified explicitly as an issue, the inquest also heard evidence from two of the four paramedics who attended Lambton Pool, paramedic Falkiner and ICP Kenna, and it is appropriate to comment briefly on their actions on the day.

242. On his arrival, paramedic Falkiner described Pono as being in the "prone" position with his chest to the ground and his head turned to the right side. Paramedic Falkiner maintained this description of Pono's position during his oral evidence, although he accepted the possibility that because Pono was thrashing about, he could have been moving his chest off the ground. His colleague, trainee paramedic Watson, believed Pono's chest was raised off the ground slightly at an angle.

243. That evidence is not entirely consistent with the evidence of the other people present, who said that Pono was in the recovery position, though turned more to his front. Paramedic Falkiner said he asked for Pono to be moved more onto his side, because he was concerned about Pono becoming hypoxic, and this was done, probably within a few minutes of the paramedics' arrival. Paramedic Falkiner believed that Pono remained in this position and did not go back onto his chest.

244. ICP Kenna arrived and observed Pono to be in a "prone" position upon her arrival, although in evidence she clarified that he was in a "semi-left lateral" position with his chest off the ground. I accept Counsel Assisting's submission that as Pono was struggling, his position was changing and that his chest was at times on or close to the ground. None of the paramedics observed any forceful pressure being applied to Pono's torso at any time.

Administration of sedatives

245. Paramedic Falkiner considered that a sedative was appropriate for Pono, yet he did not administer one. He explained that he was concerned that Pono may have suffered an acute head injury, and as a P1 paramedic, he could only administer Droperidol. The relevant NSW Ambulance policy in place at the time stated that Droperidol was contraindicated where the patient had an acute head injury. Accordingly, he

appropriately sought assistance from an ICP, who was able to administer a greater range of sedatives, including Ketamine (which paramedic Falkiner was not qualified to administer).

246. Since Pono's death (and partly in consequence of his death), the relevant NSW Ambulance policy has been amended so that Droperidol may now be administered by P1 paramedics in cases where an acute head injury has been sustained. Ketamine remains the preferred sedative agent and this can still only be administered by an ICP.

247. Given that paramedic Falkiner acted in accordance with relevant NSW Ambulance policy, in effect there is no criticism of his conduct or of any other ambulance officer.

Conclusion and remarks

"Hindsight is not only clearer than perception-in-the-moment, but also unfair to those who actually lived through the moment" – Edwin S. Shneidman

248. It would be easy to make adverse criticism of others about what happened and why it happened on the day of Pono's untimely death. However, it is impossible to discern what could have happened to Pono had he been accompanied by a second carer, and whether or not that would have made a difference. In one sense, the decision to take him to the pool, in hindsight, was a poor one – it was a poor one because it proved to be fatal. Pono liked going to the pool – it was one way that he had some form of social interaction with others. His carers knew that he could be difficult and volatile but made a decision that they thought was in his best interests at the time. It is entirely possible that he could have had a similar episode to the one that he had at Lambton Pool in a shopping centre, his school or some other area where there were large numbers of people congregating.

249. The key risk for Pono's behaviour escalating was during outings with him in a public setting. No one in the evidence said that Pono should be kept in his home for 24 hours a day. No one suggested Pono should not have community interaction of some type. Whether he had two carers or more than two in a public setting, is not the real issue. It is my suspicion that he could still have found himself being restrained by others who were concerned about the risk of injury to him or to other members of the public, had he had a similar episode in another public setting. The laypeople at the pool, before NSWPF officers arrived, were doing their best to try and restrain Pono, so that he did not hurt himself or others. They thought they were doing the right thing. There is no criticism that could be in any way directed towards them. In a different setting, with the same scenario, it could easily be a situation where the same result occurred – we will never know. Looking back at the situation, we want to suggest other ways of managing what occurred yet those that "lived through the moment" all thought, I believe, they were doing the right thing. I include NSWPF officers, attending paramedics and Mr Bender in that statement.

250. I have not referred to all of the suggested findings and recommendations urged by Mr Henry. I have instead addressed the core issues, mindful that I am obliged to keep within the confines of the evidence and not stray into areas outside this inquest. For example, I accept there might be an advantage to have certain studies done and to have various government agencies study the impact of restraint and positional asphyxia and cardiac arrhythmia. However, in my opinion, such recommendations do not fall within the Coroner's ambit in this matter.

251. I also accept from my review of this matter, that an independent person appointed as Pono's advocate may well have been an advantage for his overall care and the decision making surrounding it. Someone who knows the person they are advocating for and the processes which govern that person's care, may well assist in giving a person the best care outcomes possible. When this decision is read by those within DCJ, I am hopeful that my comments may provide some impetus to look at that issue.

252. What does stand out clearly from the evidence, is that there were a lot of meetings between Challenge, its senior staff and the medical professionals looking after Pono. There were also meetings between Challenge and DCJ, yet they appear to have been routine and not effective in bringing about change for Pono that assisted him in a positive way. No one appears to have advocated in a stronger or a more effective way to bring about a change for Pono. It appears to me that for the large part, the care was centred on Pono's day-to day living and trying to manage a young man who could be volatile and troublesome. There did not appear to be a holistic approach by all of those involved in his care. In particular, and most regrettably, Mr Henry was not given an opportunity to help or given an opportunity to have input into long-term goals for Pono. His lack of training apparently was a factor, yet if he had been given more opportunity to be with Pono, he would have learned what was needed – as much as Pono's carers did – and probably more, given his overarching love for his son.

253. I have already remarked how I and those in court on the last day of evidence were moved by Mr Henry's words. He spoke with a sincere dignity about a number of matters, but importantly about how life had changed for him since the tragedy. Again, in hindsight, he accepted and wished that things had been different – better for Pono and himself in the early days of Pono's life. The most profound point was his strength to move on and to help others in a positive way. He is helping others who are experiencing turmoil in their own lives. He acknowledged he had gained significant insight through the process of this inquest as to how things had unfolded for Pono. It is hoped that it has helped not only Mr Henry but also Pono's mother, Ms Abraham, when she reads this decision, as well as other members of Pono's family.

254. Finally, I pass on my sincere condolences to Mr Henry and Ms Abraham and other close members of Pono's family, for the loss that they have sustained and the tragedy of losing a much loved child at the young age of 17 years. I do not know your pain, yet I hope it does lesson over time.

255. All of the legal representatives and counsel in this matter that appeared have shown a great sensitivity in the way in which they conducted themselves throughout the inquest. They were all doing their best in the interests of their clients, but still remained focused, to ensure, in the presence of Pono's family, that matters were dealt with sympathetically and appropriately. For that I am truly thankful and very appreciative. Counsel Assisting together with solicitors Ms Lena Nash and Ms Caitlin Healey-Nash from the Crown Solicitor's Office have spent many many hours working on this matter and in particular assisting with the preparation of this decision. I acknowledge their hard work and their empathy for wanting to obtain a just and appropriate outcome. I am indebted to them for all that they have done. To the Officer-in-Charge of the coronial investigation, Detective Inspector Paul Laksa, I am also thankful for his hard work and efforts.

256. Below I record my formal findings regarding this inquest, as required by the Act. I am of the view that the evidence supports that recommendations are appropriate to be made in relation to Pono's death and outline these also below.

257. I close this inquest.

Formal Findings

Pono Wairua Aperahama died on 17 October 2017 at John Hunter Hospital, New Lambton Heights, NSW.

Cause of death

Direct cause – cardiac arrhythmia during restraint.
A condition that had significant contribution – previous traumatic brain injury.

Manner of death

Pono died as a consequence of multiple events that occurred at Lambton Pool. Following an exchange between Pono and other young people, Pono became dysregulated and heightened, rapidly escalating to aggression and self-harm. He was restrained by members of the public and subsequently by police officers. He suffered a cardiac arrest during the restraint.

Recommendations

To the Chief Executive Officer, Challenge Community Services

1. Consider whether all guidance relating to a person in their care be contained in a single Behaviour Support Plan, rather than separate documents.

2. Consider reviewing the policy regarding Behaviour Support Plans to include the following elements:

    a. Appropriate methods for distributing Behaviour Support Plans and other guidance to carers, including the expectations on carers to access and review such guidance; and

    b. Appropriate methods for training a carer on a client's current behaviour support needs, where that carer is not regularly involved in the client's care

3. Consider providing specific disability training to all carers of clients with an intellectual disability, in particular regarding the needs and capacity of such clients and appropriate forms of communication.

4. Consider developing a policy regarding the process by which clients leave residential care, or transition from child to adult services, to ensure this process is undertaken at the earliest opportunity and with sufficient time to ensure a planned and smooth transition.

To the Secretary, Department of Communities and Justice

1. Consider, as part of the state-wide review of Complex Care Review Panels, whether there are adequate mechanisms for oversight of residential out-of-home care placements, including:

a. the adequacy of behaviour support;

b. review of risk of significant harm reports; and

c. the adequacy and implementation of leaving care plans.

2. Consider whether it is appropriate to revise Department and Communities and Justice behaviour support policy as follows:

    a. with respect to children who have a cognitive impairment, to achieve harmony with behaviour support policy adopted under the National Disability Insurance Scheme; and

    b. to recommend that all guidance should be contained in a single Behaviour Support Plan, rather than separate documents.

To the Commissioner, NSW Police Force

1. Consider the evidence and findings in this inquest as part of the current review of NSW Police Force policy and guidance relating to positional asphyxia and related causes of death during restraint, and in particular consider:

    a. Whether guidance should be amended regarding the description of the possible causes and risk factors involved in sudden death during restraint;

    b. Whether further guidance can be given to NSW Police Force officers involved in restraint, as to the circumstances where restraint should be modified or ceased;

    c. Whether further guidance can be given to police officers involved in restraint, to better assist them to recognise warning signs that a person's condition is deteriorating.