**CORONERS COURT**
**OF NEW SOUTH WALES**

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| **Inquest:** | Inquest into the death of Stacey Helen Docherty<br>Inquest into the death of Seth Bonn Docherty |
| **Hearing dates:** | 21 February 2022 – 24 February 2022 |
| **Date of findings:** | 30 March 2022 |
| **Place of findings:** | Coroners Court of NSW, Lidcombe |
| **Findings of:** | Magistrate Harriet Grahame, Deputy State Coroner |
| **Catchwords:** | CORONIAL LAW – mother/child homicide/suicide – Borderline Personality Disorder/complex post-traumatic stress disorder – Alprazolam – child protection – adequacy of handover process between caseworkers |
| **File Number:** | 2017/78718 (Seth Docherty)<br>2017/78755 (Stacey Docherty) |
| **Representation:** | (1) Counsel assisting<br>Mr J Harris of counsel, instructed by Ms C Healey-Nash of Crown Solicitor's Office<br>(2) Department of Communities and Justice, [redacted], [redacted] and [redacted]<br>Mr S Beckett of counsel, instructed by Ms S Cooper and Ms T Moosani of Moray & Agnew<br>(3) Dr Andrew Leon and Dr Jason Kiang<br>Mr C Jackson of counsel, instructed by Ms J Alderson of Avant Law |
| **Findings:** | **Inquest into the death of Stacey Helen Docherty**<br>***Identity***<br>The person who died was Stacey Helen Docherty. |

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| | ***Date of death***<br>She died on 13 March 2017.<br>***Place of death***<br>She died at Hillsdale, NSW.<br>***Cause of death***<br>She died of hanging.<br>***Manner of death***<br>Her death was intentionally self-inflicted.<br><br>**Inquest into the death of Seth Bonn Docherty**<br>***Identity***<br>The person who died was Seth Bonn Docherty.<br>***Date of death***<br>He died on 12 March 2017.<br>***Place of death***<br>He died at Hillsdale, NSW.<br>***Cause of death***<br>He died of undetermined causes.<br>***Manner of death***<br>His death was a homicide, in the context of his mother's mental illness. |
| **Recommendations:** | To the Secretary, Department of Communities and Justice (DCJ):<br>1. That practice advice for DCJ staff, including but not limited to the Mental Health Practice Kit, and any relevant guidance for funded providers, be reviewed by DCJ in consultation with DCJ's Psychological Services with a view to enhancing practitioners' skills to collaborate with mental health providers.<br>2. That DCJ give consideration to a standardised after-hours voicemail message being recorded on caseworkers' mobile phones<br>3. That DCJ incorporate practice guidance about the use of mobile phones into the orientation of new caseworkers, including the use of any standardised after-hours voicemail message.<br>4. That DCJ give consideration to reviewing the existing mandate for transfer of cases between teams with a view to enhancing best practice |

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| | principles for transfer of cases within teams. The review should consider how best to identify the most urgent and high risk concerns and expectations about timescale for the new caseworker meeting the family. |
| **Protective orders:** | <u>Non-publication</u><br>1. Pursuant to section 74(1)(b) of the *Coroners Act 2009* (NSW) the Court orders that there shall be no publication of:<br>(a) the personal contact details of any witnesses or third persons included in the brief of evidence;<br>(b) the names of, and any other information that may identify, the following persons:<br>(i) ████;<br>(ii) ████ and<br>(iii) ████; and<br>(c) the material contained within the bundle of sensitive evidence.<br><u>Access to Coronial File</u><br>2. Pursuant to section 65 of the *Coroners Act 2009* (NSW) the Court orders that there shall be no access to the material contained within the bundle of sensitive material without the approval of the Coroner.<br><u>Pseudonym order</u><br>3. Pursuant to implied power, the Court orders that:<br>(a) ████ be referred to by way of pseudonym, namely “TG”;<br>(b) ████ be referred to by way of pseudonym, namely “NB”; and<br>(c) ████ be referred to by way of pseudonym, namely “EG”.<br><u>Liberty to apply</u><br>4. The Court grants liberty to any party to apply to vary or revoke these orders. |

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## Introduction

1. These inquests concern the tragic deaths of Stacey Docherty and her son, Seth Docherty. The factual circumstances are such that it was appropriate to hold these inquests simultaneously.[1]

2. The inquest in relation to Seth's death is mandatory pursuant to section 27 of the *Coroners Act 2009* (NSW) (the Act).

3. Stacey Docherty was described as a *"firecracker"* of a child. She was gutsy, brave and creative. She had a huge heart, a great sense of humour and a charismatic personality. As an adult, her kindness found expression in her work in aged care and later in her love for her son, Seth. Tragically Stacey also struggled with the effects of the trauma she had suffered as a child. Throughout her life the effect of this trauma led to fractured relationships with her family. They loved her greatly, but day to day contact became impossible. Her death is a tragedy and it is clear that the results of the trauma of her childhood wrought pain on many. I offer my sincere condolences to her family.

4. Seth Docherty was by all accounts a delightful child. Although only three years of age at the time of his death, Seth had already experienced a great deal of fun and joy. His father described him as happy, joyful and engaging. He loved going to the park and beach, had started to skateboard and enjoyed trains, buses and ferries. Whatever the difficulties his mother's declining mental health caused in their lives, it is clear that he was well loved. I offer my sincere condolences to his family and most particularly to his father. I accept Matthew Davis's life will never be the same. I was profoundly moved by his family statement to this court.

## The role of the coroner and the scope of the inquest

5. The role of the coroner is to make findings as to the identity of the nominated persons and in relation to the place and date of their death. The coroner is also to address issues concerning the manner and cause of the person's death.[2] A coroner may also make recommendations, arising from the evidence, in relation to matters that have the capacity to improve public health and safety in the future.[3]

6. In this case there was no dispute in relation to the identity of the deceased or the date or place of death. However, the *medical cause of death* and the *manner* or *circumstances* of the deaths required significant investigation.

[1] For ease of reference I intend to refer to "the inquest" noting that two separate inquests took place.
[2] Section 81 *Coroners Act 2009* (NSW).
[3] Section 82 *Coroners Act 2009* (NSW).

7. As part of these investigations, the court examined Stacey's medical treatment and the care provided to Seth and his family by the Department of Communities and Justice (DCJ), then called Family and Community Services (FaCS). These names were used interchangeably throughout the hearing.

**The evidence**

8. The court took evidence and submissions over four hearing days. The court also received extensive documentary material in an 11 volume brief. This material included witness statements, medical records and expert reports. The court heard oral evidence from the officer in charge of the investigation, doctors involved with the family, community service workers and experts, Associate Professor Andrew Ellis (Psychiatrist), and Ms Bronwen Elliott and Ms Kate Alexander (Social Workers) who had reviewed material for the court.

9. While I am unable to refer specifically to all the available material in detail in my reasons, it has been comprehensively reviewed and assessed.

10. A list of issues was prepared before the proceedings commenced. These questions directed the focus of the evidence presented in court. However, as is often the case, a hearing tends to crystallise the issues which are really at stake. The focus of the inquest centred on understanding the safety systems in place at the time of these tragic deaths and whether there are ways of preventing future tragedies of this sort.

**Background**

11. Counsel assisting provided a detailed review of the evidence before this court in his opening address. I rely on that document to set out the chronology of events and to outline some of the expert evidence received. I accept counsel assisting's summary of the evidence that was tendered as accurate and reproduce much of it below.

12. Stacey was born on 22 April 1978 in New Zealand to parents Angela Bamford and David Docherty. She had an older sister, Kelly, a younger sister, Rebecca, and a younger half-brother, Rory.

13. Stacey's early life was traumatic. There is evidence of neglect, parental substance abuse and housing instability.

14. Her parents separated in about 1981 or 1982, when Stacey was only three or four, with the girls remaining with their mother. The girls were, at times, looked after by different people, including an older family member. That family member sexually abused Stacey. A settlement was later reached and some financial compensation was eventually paid. However it is clear that the consequences of this ongoing childhood abuse were profound, affecting Stacey throughout her whole life.

15. When Stacey and her sisters were teenagers, they returned to live with their father.

16. In 1999, Stacey and her sisters moved to Australia, followed by Angela in 2002, and later by David. Stacey remained living in Australia for the rest of her life.

17. Stacey trained as an Assistant in Nursing, and she worked for a time at St Vincent's Hospital and in Aged Care facilities.

18. Stacey had started drinking at the age of 12 and commenced experimenting with drugs from about 14 years of age. These became lifelong issues for her. She also suffered from poor mental health. When Stacey drank, she would become unpredictable and aggressive. There are numerous police reports of Stacey assaulting people, including her partner and family members.

19. In about 2006, Stacey formed a relationship with Matthew. They were in a relationship for about five years, separated in 2011, and then resumed a relationship for a period in 2012. Their son, Seth, was born on 4 September 2013.

20. Matthew describes their relationship as "*rocky*" and says they would frequently argue. He says Stacey was physically violent towards him. Nevertheless, even after their separation Matthew stayed in Stacey's life and recounted positive stories about her and her love for their child.

21. Neither Matthew nor her family are aware of Stacey ever having suicidal thoughts.

22. One incident of possible significance occurred in about 2013, prior to Seth's birth. The family dog, Nelson, was old and in poor health. According to Rebecca, Stacey decided to euthanise Nelson. She gave the dog some Valium in its food and then smothered it.

23. As a result of her unpredictable and aggressive behaviour, Stacey was estranged from her family at the time of her death. David and Kelly had not seen her since 2011, her mother last saw her in about 2012, and Rebecca had not spoken to Stacey since February 2014. Only Rebecca had met Seth.

24. On 15 November 2011, Stacey tried to stab Kelly and was taken to Prince of Wales Hospital (POWH) for assessment under the *Mental Health Act 2007.* It was thought she may be suffering a first episode psychosis.

25. Stacey was charged with wield knife in a public place. On 1 March 2012, that charge was dismissed pursuant to section 32 of the *Mental Health (Forensic Provisions) Act 1990.* She was required to attend appointments with a psychiatrist, Dr Andrew Leon, and comply with any treatment regime he proposed, and not to consume illegal drugs or to be intoxicated in a public place.

**Stacey and Seth's early involvement with FaCS**

26. DCJ, which was then called FaCS, became involved with the family because it was reported that Stacey had not engaged in adequate antenatal care prior to Seth's birth. On 3 September 2013, a report was made about this to FaCS. FaCS assessed that report and found it did not meet the threshold for "risk of significant harm" (ROSH). A referral was made to Sydney Day Nursery (SDN) Brighter Futures, a program which provides parenting support. However, Stacey did not take up the referral, and it was closed in January 2014. Nevertheless, for the rest of her life Stacey retained a fear that FaCS could take Seth from her.

27. On 3 April 2015, Seth (aged 18 months) was taken to hospital after an incident where he fell through a glass panel and cut his head. There were concerns raised at the hospital, because there had been a two hour delay presenting Seth to hospital, and because Stacey and Matthew had been drinking and had an altercation at the hospital about who was to blame.

28. A report was made to FaCS about this. It was assessed to be a ROSH. Social workers from the hospital spoke with Stacey and were concerned about her mental health problems. There was a further report a couple of days later, following police attendance at Stacey's home.

29. A few weeks later, on 22 April 2015, Stacey was involved in an argument with her neighbours. Police were called and were concerned because Stacey was in a confused state. A report was again made to FaCS, which again met the standard for ROSH.

30. FaCS decided to refer Stacey to Brighter Futures for a second time. There were attempts to engage Stacey, but she declined help. The referral was closed in June 2015.

31. In December 2015, Stacey signed a tenancy for a privately-rented apartment at Grace Campbell Crescent in Hillsdale.

32. On Christmas day 2015, there was an incident between Stacey and Matthew. Stacey had been drinking vodka and there was an argument. When police attended, Stacey began making bizarre comments, saying "*are you reptiles? I hope not*." Police called paramedics, but Stacey became aggressive and non-compliant. She was restrained and scheduled under the *Mental Health Act 2007* and taken to POWH for assessment. Matthew was asked to look after Seth. Once at hospital, Stacey required sedation and was kept overnight.

33. A report was made to FaCS regarding this incident. It was assessed to require a 10-day response.

34. Caseworkers visited Stacey, Matthew and Seth on 12 January 2016. Stacey agreed to undertake Carbohydrate Deficient Transferrin (CDT) tests, which are intended to detect

long-term high alcohol use. The first result, on 15 January 2016, showed an elevated result (2.5%), although not recent alcohol excess. Two further tests were undertaken in February, showing a reduced level.

35. A safety assessment was conducted, which found Seth to be “Safe” in Stacey’s care. A risk assessment was also conducted, which assessed Seth to be at “Moderate” risk.

36. On 2 February 2016, a caseworker spoke with Stacey’s psychiatrist, Dr Leon by telephone. He told her that he had been seeing Stacey for just over four years and prescribed her medication. He said she had childhood trauma and found it difficult to regulate her emotions. He noted Seth was a *“busy young boy”* but Stacey handled him very well. He did not think Stacey was alcohol dependant, but she drank “*a glass or two and on the odd occasions a bit more*”. It is likely that caseworkers were comforted by Stacey’s long therapeutic relationship with Dr Leon.

37. FaCS referred Stacey back to Brighter Futures for a third time. On 18 March 2016, and with Brighter Futures involved, FaCS closed its file.

38. Thereafter, Brighter Futures did work with Stacey, mainly by arranging playgroups and childcare. Seth was enrolled in childcare at Pumpkin Long Daycare on 28 March 2016, which he attended until August 2016.

39. Brighter Futures caseworkers attempted to provide parenting assistance to Stacey. At a home visit on 21 September 2016, caseworkers had a long discussion about child development, appropriate discipline and parenting courses. However, after this meeting, Stacey told Brighter Futures she had been *“triggered”* by the discussion, and she no longer wanted to speak to the caseworker. On 5 October 2016, she asked Brighter Futures to close its file.

40. Stacey’s contact with FaCS recommenced in November 2016.

**Stacey’s engagement with her General Practitioner**

41. Stacey attended a local General Practitioner (GP) practice in Maroubra. She appears to have seen a number of doctors over the years.

42. Dr Jason Kiang agreed in oral evidence that by 2016 he had become her usual doctor at the practice and remained in that role up until the time of her death.

43. In mid-2016, Stacey had been suffering significant pain from an old fracture to her coccyx and an ongoing shoulder injury. She attended Dr Kiang for treatment and advice. An ultrasound confirmed a fracture to the coccyx. Dr Kiang encouraged consideration of non-pharmacological options such as acupuncture, physiotherapy and stretching. On 15 June 2016, he prescribed Tramadol (an opioid analgesic).

44. Because that is a drug which can lead to dependence and misuse, Dr Kiang appropriately also referred Stacey for specialist help to the Pain Clinic at St Vincent's Hospital. Stacey attended on 12 August 2016. However, a report was not sent back to Dr Kiang until February 2017. Dr Kiang made repeated efforts to contact the clinic for advice and he referred Stacey back there at the beginning of 2017. He told Stacey he would not prescribe her Tramadol after March 2017 without specialist advice. He last prescribed 100 tablets of Tramadol on 6 February 2017, which was the last time he saw her. The drug was detected in her post mortem toxicology.

45. When Dr Kiang took over Stacey's medical care there had already been limited contact between Dr Leon, her treating psychiatrist, and the GP practice. The relationship between Stacey and Dr Leon was by then well established. This may partly explain Dr Kiang's lack of action in relation to finding out more about Stacey's therapeutic progress with Dr Leon.

46. The lack of communication resulted in fractured medical care. It was exacerbated by Stacey's tendency to tightly control the information she gave. While Dr Kiang was aware of some of Stacey's medication, he was not aware of the Alprazolam Dr Leon prescribed. He should have had this information before making a decision to prescribe Tramadol. I note that the lack of communication worked in both directions. Dr Leon had not been officially informed about the Tramadol Dr Kiang prescribed and became aware of it only when Stacey told him.

47. Dr Kiang explained that Stacey shut down any attempts he made at discussing mental health issues. She did not give Dr Kiang permission to discuss her therapy with Dr Leon and in that context it did not strike him as particularly unusual that Dr Leon did not send letters back to the practice about Stacey's care. There is a clear pattern in Stacey's relationship with the professionals in her life. There is little doubt she felt safer or more in control by keeping them apart. She under-reported her psychological distress and described herself as a non-drinker to her GP. Dr Kiang told the court that he was somewhat hampered by Stacey's guarded approach and lack of explicit consent to share information. Dr Kiang explained that ideally he would have preferred *"to communicate with Dr Leon directly, in order to clarify knowing medication…[and] her broader mental health concerns."*[4]

48. I had the opportunity to observe Dr Kiang closely as he gave evidence, in my view he was a caring practitioner who had reflected deeply on his role in Stacey's treatment. I accept that he felt his relationship with Stacey was still developing and that limited the information she was prepared to share with him. I accept that had she lived he may well have tried to tackle Stacey's substance use and other issues as her trust in him grew. I have no doubt the experience has alerted him to the need for obtaining a complete picture of a patient's

[4] 21/2/22 T 47.20.

prescribed medications, including by other practitioners, prior to prescribing a new drug.

**Stacey's engagement with her psychiatrist**

49. On 24 March 2012, Stacey had been formally referred to Dr Leon by her GP at the time, Dr Chan. The referral was for "*alcohol abuse + depression*". Dr Leon saw Stacey frequently over the next five years, sometimes on a weekly basis. He provided her with supportive care, psychotherapy and medication. Dr Leon saw Stacey up until 7 March 2017, five days prior to her death.

50. Dr Leon considered that Stacey had developed Borderline Personality Disorder (BPD) in consequence of her traumatic childhood abuse. That condition results in instability in interpersonal relationships, a poor sense of self and impulsivity. Dr Leon also considered other conditions, notably PTSD, Bipolar 2 Mood Disorder, depression, anxiety and panic disorders.

51. In oral evidence Dr Leon identified Stacey as having complex development trauma, noting that the term BPD can have a pejorative association.

52. Dr Leon prescribed Stacey medication, most significantly Alprazolam, which is a benzodiazepine, and Valproate and later Lamotrigine, which are mood stabilizers. Alprazolam is a Schedule 8 drug because it presents a risk of addiction, and an authority is required from NSW Health to prescribe it. The records show that Dr Leon continued prescribing those drugs to Stacey until the time of her death. The amount of Alprazolam had increased steadily over the course of prescribing.

53. Although initially referred for alcohol abuse and depression, Dr Leon told the court that while he was aware of reported incidents in the community that appeared to involve intoxication, that is not how Stacey presented at her regular appointments. In fact he said that he had never seen her intoxicated or hungover or in an altered state.[5]

54. In oral evidence Dr Leon agreed that in retrospect Stacey became dependent on Alprazolam in 2017.[6] When one reviews the course of Stacey's treatment by Dr Leon, there is minimal explicit engagement with her substance use issues.

55. It is important to note that there are also some real strengths in Dr Leon's care for Stacey. He was able to develop a strong rapport with Stacey that kept her in therapy for five years. He tried to create a safe space for her to commence dealing with some of the complex pain of her past. He also felt he was able to model appropriate caring behaviour with Seth who attended sessions with his mother. Given the severity of her condition, the length of the therapeutic relationship is noteworthy and commendable. I accept Dr Leon's evidence that

[5] 21/2/22 T 79.5.
[6] 21/2/22 T 91.30.

*"not many [psychiatrists] stay with traumatised borderline patients and they get handed on, there are few facilities for them."*[7] In my view the relationship Stacey developed with Dr Leon had positive elements.

56. Associate Professor Andrew Ellis, a forensic psychiatrist, provided the court with an expert review of this case, focussing on Dr Leon's care of Stacey. In his view Stacey experienced substance use disorder at the time of her death. Further he stated that the most likely diagnosis to explain her overall presentation is BPD or complex post traumatic stress disorder. She had clear difficulties with emotional regulation, impulse control and stability in relationships. At times she displayed transient persecutory and self referential ideation. These symptoms were most likely directly related to her experience of childhood sexual abuse. In terms of diagnosis, he agreed largely with Dr Leon.

57. Associate Professor Ellis went on to offer some criticisms of the psychiatric care Stacey received. Before examining those issues it is important to note that Dr Ellis accepted that the cohort of persons with BPD who seek treatment are regarded as difficult to manage effectively. He agreed that finding a psychiatrist willing to take a patient like Stacey on a long term basis would be challenging, and in some areas even impossible.

58. One of the issues Associate Professor Ellis identified in Stacey's care was what he described as *"suboptimal prescribing"*. Drugs were changed quickly with little structured review. There was poor communication between psychiatrist and GP. Not enough attention was given to the fact that Stacey was clearly at risk of developing a substance use disorder once Alprazolam was prescribed. Once commenced, the dose was incrementally increased and other medication was added in without careful planning or review.

59. Associate Professor Ellis questioned the basis for prescribing Alprazolam and Valproate. He was particularly concerned about the long-term prescription of Alprazolam. In his view, a review of Stacey's medication regime should have occurred, in particular following an incident in October 2016.

60. Associate Professor Ellis also noted that, because Stacey's condition was not improving with the medication or the support Dr Leon was providing, it would have been appropriate for him to seek a second opinion, or a referral to another specialist, in particular for substance abuse issues. I accept his evidence in relation to the shortcomings of Dr Leon's prescribing and in relation to his management of Stacey's substance use issues.

61. Associate Professor Ellis was also concerned that the clinical service provided to Stacey did not amount to an evidence-based psychotherapy for BPD or related conditions. He was concerned that the sessions were not frequent enough, that Seth was usually in attendance

[7] 22/2/22 T 23.49.

and that Stacey was routinely prescribed benzodiazepines which would have affected her ability to participate effectively in the treatment. I accept his view, noting however that finding an alternative suitable practitioner for Stacey would have been extremely difficult.

62. Dr Leon was clearly very affected by the deaths of Stacey and Seth. He described it as *"the most shocking experience in my long medical career."*[8] He clearly cared very deeply for both Seth and Stacey and I accept he had always acted in good faith and had done everything, within his skill set, to support them. It is commendable that having faced such a professional tragedy Dr Leon was able to reflect deeply on the therapeutic relationship that had developed.

63. Dr Leon accepted in hindsight that his prescribing was sub-optimal. The level of Alprazolam had been steadily increasing. Dr Leon conceded in oral evidence, that by May 2016 Stacey was receiving more than the authorised dose. It may be that Dr Leon had lost control of the situation. He certainly conceded, and it is evident in his notes, that he had begun to realise it was an issue in the lead up to Stacey's death.

64. Dr Leon told the court that he is now very careful to monitor and assess whether prescribing medication is affecting the growth of the therapeutic relationship. He stated that if *"medication is a problem they should see a general psychiatrist to deal with those issues and just deal with the therapy with me."*[9] He spoke of a new openness to separate those aspects of care if it is necessary to preserve the integrity of the therapy he could offer.

65. He also accepted that more communication with Stacey's GP should have occurred. He told the court that this was his usual practice and he was unable to say why it did not occur in this case. It is clear that Stacey told people different things and limited the information she gave those professionals working with her so that nobody had the complete picture. She was not always a reliable historian. In these circumstances open communication between the referring GP and psychiatrist is essential. Dr Leon saw his relationship with Stacey's caseworker as more complex and told the court that without Stacey's permission he would always be limited in what he could say. Nevertheless he appeared to accept that he could possibly have obtained further information from the caseworker that could have informed his practice.

66. In my view Dr Leon has shown a willingness to appropriately reflect on what occurred and on the criticisms offered by Associate Professor Ellis. He accepts the major criticism in relation to the sub-optimal prescribing of Alprazolam and has devised a strategy to protect against a recurrence of that issue in future treatment.

67. I have no doubt that Stacey's relationship with Dr Leon was deep and significant. In my view

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[8] 21/2/22 T 85.19.
[9] 21/2/22 T 84.27.

it clearly went beyond a connection aimed only at the supply of drugs. There was no need for Stacey to attend regularly for years just to obtain medication. In my view she obtained some benefit from the safe haven his therapy offered. She would not have been an easy patient and Dr Leon provided stability and genuine support.

**The escalation of events from mid 2016 and the role of Stacey's caseworkers**

68. From mid-2016, Stacey had a dispute with her neighbours about some second hand goods Stacey was storing in her garage. There were a number of minor incidents and complaints. Matters came to a head on 7 October 2016. Stacey received an email telling her to remove her belongings from the garage. Stacey is alleged to have gone out into the street and damaged cars with a cricket bat, and then tried to hit one of her neighbours. She had left Seth asleep and unattended in her home. Police were called. Stacey was charged with malicious damage and assault. She was scheduled by police and taken to POWH for assessment.

69. Stacey's bizarre behaviour continued in hospital. She said she would contact Donald Trump to sue people. She obtained some alcohol wipes, washed her feet with them, and then ate the wipes. She was given a sedative.

70. The following morning, she was reviewed by a psychiatric registrar, Dr Shelley Xia. Stacey could not recall the incident and was shocked when she was told about it. The doctor took a history and found no evidence of psychosis or other disturbance. Her impression was that Stacey's behaviour was due to alcohol. Stacey confirmed that she had an appointment to see Dr Leon on 11 October 2016. A nurse also spoke with Matthew. Dr Xia did not consider Stacey met the criteria for involuntary admission and she was discharged home.

71. The community mental health Acute Care Team made contact with Stacey the next day, but she declined their involvement. The team also contacted Dr Leon's rooms to advise him of the incident and checked that Stacey had attended her appointment. There is little doubt that Stacey's record of attendance with Dr Leon may have given other providers a somewhat false sense of security.

72. A report was again made to FaCS about this incident, which was assessed as meeting the ROSH threshold and requiring a 10-day response. In fact, Stacey was not seen until about a month later. This delay is troubling and difficult to understand on the evidence now available. I accept Ms Elliott's view that the delay was significant, given that FaCS was already aware that Stacey had not benefitted from the Brighter Futures Program.

73. On 9 November 2016, the case was allocated to caseworker NB. She was then in the Response Team at Eastern Sydney Community Services Centre. She attended a Pre-Assessment Consultation (PAC) with another caseworker, her manager and the caseworker

who had worked with Stacey at the beginning of the year. An initial response plan was discussed.

74. The next day, 10 November 2016, NB and another caseworker visited Stacey. Stacey told them she had stopped taking her mood stabiliser medication prior to the incident on 7 October 2016. She said she was only drinking twice a week, but agreed to do further CDT testing. They also discussed her mental health, Matthew's involvement, and other aspects of her life. NB gave Stacey her contact details including her mobile number.

75. After this meeting, NB completed a safety assessment, concluding that Seth was "Safe". She later conducted a risk assessment, which found the risk level to be "High".

76. Stacey undertook the CDT testing, which initially showed 2.8%, indicating heavy alcohol use over the past couple of weeks.

77. A second home visit occurred on 21 November 2016. Among other things, Stacey told caseworkers about having problems with her sleep, that she was having night terrors. She was also worried about the end of her lease, which was due to expire in December. NB offered to contact the real estate to advocate on her behalf, which she did. On 24 November 2016, the real estate gave Stacey extended notice to move out, by March 2017.

78. On 22 November 2016, police attended Stacey's home following a report that Stacey had verbally abused her neighbour. They found Stacey unconscious in bed, intoxicated. Matthew was present and said he would take care of her.

79. On 23 November 2016, NB phoned Dr Leon. This was the second contact made between FaCS and Dr Leon, and there were no further contacts prior to the deaths. According to NB, Dr Leon did not appear to be aware of FaCS involvement, or that Stacey had been scheduled to hospital, or all of the medications Stacey had been prescribed. Dr Leon said he thought Stacey's alcohol consumption was *"not ideal"* but at the lower end of a serious drinking problem. She asked Dr Leon if Stacey needed more mental health support, and he said he would have to think about it. There was no further contact.

80. On 1 December 2016, a case planning meeting was held with Stacey. Matthew attended but did not participate. Dr Leon was not formally invited to attend the meeting, but I accept NB may have told Stacey to mention it to him. A case plan was developed, including a plan that Stacey would undergo ongoing CDT testing, attempt to reduce her drinking and have alcohol and drug counselling. She would apply for housing and engage with a family support service. The caseworkers were to consult with Dr Leon and an internal psychologist about Stacey's mental health.

81. Caseworkers also intended to engage with Matthew, who they considered capable of supporting Stacey. However, that did not occur. Indeed, little progress was made with any

of the case plan outcomes prior to the deaths. The ongoing failure of caseworkers to properly engage with Seth's father, Matthew is clearly a missed opportunity and one that is difficult to understand in all the circumstances.

82. On 12 December 2016, caseworkers visited Stacey. Among other things, she told them she wanted to see a new psychiatrist because she was not happy with Dr Leon, though she was willing to keep seeing him for the time being. No specific action was taken by FaCS in response.

83. On 13 December 2016, Stacey appeared in court on charges arising from the 7 October incident. The matter was adjourned. An application to dismiss the charges pursuant to section 32 of the *Mental Health (Forensic Provisions) Act 1990* was not successful. Those charges were still outstanding at the time of the deaths. Stacey was concerned she would go to prison and lose Seth.

84. NB sent Stacey information about the Waverley Drug and Alcohol Centre (Waverley Centre) around this time. Stacey said she was going to make an appointment. However, this never occurred. On 4 January 2017 Stacey told NB that she did not want to go to the Waverly Centre, as she had seen a woman in the waiting room who was drug-affected. This turned out to be false; it appears Stacey did not like the image on the front of the brochure. She later told caseworkers that she was willing to reschedule an appointment. Whatever the real reason for her non-attendance her reluctance to engage with drug and alcohol treatment needed to be better understood and pursued.

85. There was a further home visit on 11 January 2017. NB says she was becoming concerned about Stacey's mental health and raised this with her manager, EG.

86. On 30 January 2017, NB called Stacey. Stacey was worried she was pregnant. She had met a man, Lee Barber, on a train at the end of 2016 and they were in a relationship. At NB's suggestion, Stacey attended Dr Kiang on 6 February 2017 and took a pregnancy test, which was negative.

87. Nonetheless, it appears that Stacey continued to worry about being pregnant. It also appears that, because of this, she stopped taking her mood stabiliser medication, Lamotrigine, because of concerns it could cause birth defects. At some stage she must have taken it, because the drug was detected on post mortem toxicology. In any event, I note that Associate Professor Ellis told the court that stopping that drug was likely to have been of limited significance, given the other medications she was also taking.[10]

88. A CDT test taken on 1 February 2017 showed 4.5%, indicating probable excessive alcohol intake. On 13 February 2017, NB called Stacey about this result. Stacey was stressed, and

[10] 23/2/22 T 61.20.

overwhelmed about her impending court hearing, worried about the eviction, and had not gone back to the Waverley Centre. However, it is noteworthy that she told NB she was not feeling suicidal.

89. Unfortunately, given Stacey's escalating stressors, NB was moving to a new role at that point. The case was therefore transferred to a new caseworker, TG.

90. The court was keen to understand the nature of the handover between NB and TG. I accept that NB had become increasingly concerned about Stacey, in particular in relation to her mental health. NB believed that she had developed a good relationship with Stacey, and she well understood the stressors in her life: the alcohol use, housing instability, pregnancy, mental health and relationship issues.

91. NB, told the court that because her move to the Out of Home Care (OOHC) team was sudden there was no time to have a handover meeting. She stated that she was told by her manager, EG, that she (EG) was *"across the case"* and would be able to deliver a handover to TG who would be taking over as the new caseworker. NB remained concerned so she prepared an email with handover notes which she sent to her manager on 9 February 2017.[11]

92. NB gave evidence before me and impressed as a caring and conscientious caseworker. I accept that she had genuine concerns about Stacey's wellbeing at the time she was moved to a new team and that she tried to convey these concerns to her manager. I accept the fact that there was no formal handover has stuck firmly in her memory.

93. EG, NB's manager at the time, had a very different recollection of events. She recalled attending a handover meeting with NB and TG, the new caseworker. She stated *"although I cannot recall precisely what was discussed during the meeting, it was my invariable practice to go through the case review, the history of the case and outlined next steps."*[12] She acknowledged that it was her responsibility to enter a record of this meeting on the system and that there was no such record. In oral evidence she confirmed the handover meeting occurred in her office and that she had a distinct memory of it.[13]

94. TG did not give evidence before me, but her written statement confirms she has some memory of a meeting where files were handed over, including Seth and Stacey's file.[14] She was unable to recall a date for the meeting or find a record of what was discussed.

95. Having reviewed all the evidence I am confident that there was no *proper* handover. The fact that there is no record of the meeting is suggestive that a formal meeting did not occur.

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[11] Vol 6, Tab 93, NB-43.
[12] Statement of EG, Vol 6, Tab 95, [51].
[13] 23/2/22 T 41.30.
[14] Statement of TG, Vol 6, Tab 94, [15].

Given EG's evidence it is certainly possible that some kind of informal meeting may have happened where files were transferred to TG. However I do not accept that NB participated in a full handover where she had an opportunity to set out her concerns in a formal and detailed manner. In my view, given her involvement in the matter, she would certainly remember if that had occurred. The result of there not having been a proper handover is that it is likely that TG could not have fully understood the complexities and urgency of the situation facing Stacey and Seth at that time.

96. On 14 February 2017, there was a brief meeting of about 15 minutes between Stacey and EG, at the Community Services Centre. Stacey collected some forms for housing. She appeared to EG to be very talkative and Seth appeared well. In oral evidence EG stated that she remembered Stacey *"being in very high spirits. I remember Seth very clearly…sitting in his pram…I recall her being very enthusiastic and very happy."*[15]

97. Nevertheless, EG accepted in oral evidence that the situation at that time *"demanded more intense casework support"* than was provided in that short meeting.[16]

98. The first time TG spoke to Stacey was a phone call on 24 February 2017. I have some sympathy for TG who had not been properly introduced and yet was tasked to provide sensitive support to the family. Quite properly TG wanted to arrange a home visit. Stacey told her that she was concerned about her alcohol consumption and was waiting for a call back from the Waverley Centre. TG herself attempted to call the Waverly Centre, but was unable to make contact. Stacey was also worried about her eviction, pregnancy, and housing situation, and stated that she was thinking about moving to the Gold Coast. TG sent her some information from Link2Home, which provides temporary accommodation.

99. At the end of February 2017, Stacey did spend a couple of nights in temporary accommodation in Edgecliff, before returning to her apartment in Hillsdale. Her real estate agreed to give her some further time to move out.

100. TG tried to contact Stacey a few times on 28 February and 1 March 2017, but was unable to make contact. She states that she did not think this was unusual, as it was not uncommon for parents to be difficult to contact. In my view this should have been a warning sign and escalated the need to get in touch. TG did manage to speak to Stacey on 2 March 2017, and arranged a home visit for 9 March 2017. Stacey said she was pregnant and was considering an abortion. There is no objective evidence that she was pregnant. There was a picture of a positive pregnancy test on her phone on 20 February 2017, but there were no indications she was pregnant at the time of the autopsy.

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[15] 23/2/22 T 44.34.
[16] 23/2/22 T 44.46.

101. A report was made to FaCS on 3 March 2017, after Stacey attended a Housing NSW office. A further report was made on 4 March 2017, raising concerns that Stacey had an intellectual disability and could not look after herself. Those reports were not considered to meet the ROSH threshold. Nevertheless they demonstrate a possible decline in Stacey's ability to function in the community.

102. On 7 March 2017, TG completed a Risk Re-assessment Decision Report,[17] finding that Seth was at "Very High Risk". It appears that this process was undertaken to meet a mandated deadline. In my view, given that there had been no home visit and that TG had never met Stacey and Seth face-to-face the review was necessarily superficial. It is perfectly clear that someone from FaCS needed to visit them to understand the urgency of their situation.

103. The next step in these circumstances would have been for the case to be discussed at the Weekly Allocation Meeting (WAM), scheduled for the next day, to consider allocating the case to a child protection team. However, that did not occur. EG wanted the home visit to go ahead on 9 March 2017, to allow TG to update her assessment of the family circumstances, and present the case to the WAM the following week. Tragically Stacey and Seth died before that could occur.

104. On 9 March 2017, Stacey called TG and cancelled the home visit, saying she was in pain, was scared about being pregnant, had to leave her home by 13 March 2017, and had run out of mood stabilisers. She also said Seth was doing well and they were going to the beach. Nevertheless, it should have been clear that her difficulties were escalating. Her reluctance to engage at this point should have been another red flag.

105. That is the last time anyone from FaCS spoke with Stacey.

106. On 10 March 2017, Stacey left a voicemail message for her former caseworker, NB. She said:

> *"Hi ████ it's Stacey. I don't have the phone number for you guys at all. I was contacted yesterday and I wasn't well. Basically they want to come over and see me, and I have had so much pressure and um I just can't get hold of you guys. Can you get someone to call me? You're supposed to be helping me, I just don't understand why I don't have your numbers, you call off unknown numbers. Please ████, I am still sick from the medication I am coming off, can you please give me a number to call?"*

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[17] Statement of TG, Vol 6, Tab 94, [33], TG-13.

107. That message was left at 5.16pm on a Friday. NB was on a plane at the time. She did not receive it until the Monday morning and did not listen to it until after the deaths had been reported. This was the last contact Stacey made with DCJ prior to killing Seth and herself.

108. The court carefully examined the role DCJ played in supporting Seth and Stacey in the lead up to their tragic deaths. While I do not single out any particular worker for individual criticism, there were systemic issues which created missed opportunities to provide this family with adequate support. I accept all the workers involved found Seth and Stacey's deaths extremely distressing and I acknowledge the difficulty of the work they do.

109. I was particularly impressed with NB. She was a relatively new caseworker when she came into contact with the family. Nevertheless, her statement demonstrates the conscientious efforts she made to offer Stacey support. Even more impressive was her ability to reflect on her practice and with hindsight identify things she could have done differently, including engaging with Seth's father and following up Stacey's medications more rigorously.

110. After Seth's death FaCS conducted its own internal review. An Internal Child Death Review Report[18] is prepared to assist in identifying systemic and practice issues following the death of a child. The review in this case found that although there was a case plan in place by December 2016, there was minimal targeted activity to coordinate the interventions needed as the months rolled on. FaCS did not adequately engage with Stacey's psychiatrist or Seth's father, Matthew in case planning and the change in caseworkers in February 2017 was unfortunate and poorly timed. Put simply, at the time of their deaths, FaCS did not know enough about what was going on in Stacey and Seth's lives. It was thus unable to offer the intensive support needed. There is a sense that in trying to *"solve"* Stacey's problems, workers may have neglected to keep Seth's safety at the centre of the equation.

111. The conduct of the department was also reviewed more recently by Kate Alexander, Senior Practitioner of the Office of the Senior Practitioner (OSP) in DCJ. The OSP was established in 2013 to lead, support and improve DCJ's practice of working with vulnerable children through in depth practice reviews, development of practice advice, consultation, training, coaching and mentoring. I accept it continues to have a positive effect on the department and to improve practice on an ongoing basis.

112. Ms Alexander brought fresh eyes to the original review and was able to update the court on many changes that had been made in the lengthy period before this inquest commenced. I do not intend to repeat her detailed evidence here, nor can I refer to each of the policies and guidelines she made available to the court. In short I accept that in the five years since Seth and Stacey died, DCJ has implemented a number of significant changes that should increase the knowledge, skills and resources provided to caseworkers. I accept that many

[18] Vol 5, Tab 88.

of these changes, as carefully outlined by Ms Alexander, represent a shift in the approach DCJ would take in similar circumstances today. Ms Alexander notes that a more collaborative approach to supporting Stacey and Seth would now involve more proactive attempts to engage with Seth's father and Stacey's family. She also suggests that today there would be a more holistic approach when identifying supports and identifying risks. More proactive steps to engage Stacey's health care providers might be taken. The group supervision that has been introduced also supports skill development in caseworkers, allowing them to grow professionally under the guidance of a casework specialist.

113. In assessing the role of DCJ caseworkers it is also necessary to acknowledge that Stacey was a strong and charismatic woman who would have been challenging to work with. She was protective about personal information for fear of losing Seth. She provided different versions to different professionals and it is clear that no professional had the full story. Unfortunately, as we have seen FaCS did not adequately engage with the one person who probably knew the most. Failing to engage with Matthew, Seth's father was, in my view, a critical missed opportunity. His relationship with Stacey was turbulent and there is evidence she feared the possibility that he would seek formalised contact with Seth, nevertheless it was Matthew who was there assisting, as best he could, at the end when Stacey's life was veering out of control. I acknowledge that involving Matthew might have been complicated for Stacey, given her fear of losing Seth. Nevertheless he was very motivated to provide positive support in Seth's life right up until his final tragic hours and he should have been properly consulted.

114. Whether or not FaCS engaging with Matthew could have changed Seth's trajectory is of course unknown, but it should have been investigated. I was heartened by Ms Alexander's evidence on this issue. She conceded *"the father was there and he was present and he should have been front and centre as someone we assess and as someone who we relied on to increase Seth's safety."*[19] She outlined for the court the changes DCJ has made to address this issue, in particular the approach outlined in the practice mandate "Working with fathers to keep children safe."[20] Ms Elliott, the independent expert told the court that she had noticed that there has been a real shift in the approach taken by DCJ towards fathers in recent years. There is *"more consistency in the engagement of fathers and more effort in looking for fathers who weren't immediately involved."*[21]

115. There was another missed opportunity in not trying harder to develop a rapport with Stacey's psychiatrist, Dr Leon. He had a lengthy relationship with Stacey and enjoyed an amount of trust with her. Leaving aside the issues Dr Leon raised about patient confidentiality, more

[19] 23/2/22 T 94.30.
[20] Vol 8, Tab 95.1, KA-20.
[21] 23/2/22 T 97.16.

effort could have been put into inviting his participation in a case conference. I was heartened by Ms Alexander's evidence about the Mental Health Practice Kit and accept that it provides caseworkers support that was not available at the time of these deaths. I also accept her evidence that a cautious approach is called for as one must be careful not to threaten a positive therapeutic relationship between a treating practitioner and patient.

116. As an agency FaCS seemed to misjudge the urgency the case required. The case plan which had been developed may have been appropriate but not enough was achieved in a timely manner. Even when NB communicated her concerns about Stacey's mental health, when she was about to move teams, the urgency of her concern was somehow lost. The effects of Stacey's past trauma may not have been fully understood across the team. I have had the chance to review a large quantity of DCJ material and I note that the "Understanding trauma and resistance" practice advice which was published in December 2016 offers many relevant insights. I accept that this and other support now available to caseworkers is likely to strengthen the assistance they can provide.

**Discovery and cause of death**

117. The events of the weekend before the tragic deaths were tumultuous. The police investigation was able to piece together many of the details, relying on witness statements, CCTV, phone and transport records. Also, Matthew had begun to record his calls, so there are transcripts of calls between him, Stacey and Lee over the weekend.

118. These calls show that Matthew and Stacey were in dispute about him spending time with Seth and about Child Support. Matthew had not seen Seth since the beginning of the year. He was in the process of seeking legal advice about spending time with Seth and told Stacey this.

119. On 9 March 2017, Lee was at Stacey's home helping her to move. Stacey discovered Lee had failed to attend a probation appointment. They argued and apparently ended their relationship. As a result, Stacey was left with no-one to help her move. There is little doubt that Stacey's relationship with Lee was damaging and toxic.

120. On Friday 10 March 2017, despite their difficulties and disagreements, Matthew went to Stacey's home to help her out and to help with her car, which wouldn't start. That evening, he tried to charge Stacey's car battery, and he also cooked a meal for Seth. He slept in Seth's bed while Seth slept with Stacey.

121. The next day, Saturday 11 March 2017, Matthew had his first day at a new job at Bunnings at Eastgardens. After work, he returned to Stacey's home. She was quite emotional about Lee. Matthew tried to fit the battery into Stacey's car, although it had not charged. At 5.30pm, Matthew, Stacey and Seth went shopping at Woolworths, and got some food at Dominos. There is CCTV footage of this shopping trip, which also shows Stacey buying

some ginger wine at BWS. According to Matthew, Stacey was a bit inebriated that evening but was *"mellow"*.

122. The next morning, Sunday 12 March 2017, Lee and Stacey exchanged some texts, which were initially hostile. Lee called Stacey at 7.30am. He apologised to her and asked to come over. Matthew decided to leave. When Lee arrived, Stacey called Matthew, offering to discuss him seeing Seth. This call was recorded. Lee can be heard on this call. Matthew offered to come over again after work at 1pm the following day to help Stacey move.

123. Following this call, Lee and Stacey went to bed. Lee wanted to have sex, and he bit Stacey three times on the legs. He later told police about this, although he said that he had not intended to be aggressive. However, Stacey slapped him and told him to leave.

124. Stacey phoned Matthew and told him about this at 11.14am. She repeatedly told Matthew that Lee bit her, and how upset she was. She was very distressed but did not want to call the police, because she was worried FaCS would take Seth away from her if she did. She said she might go and show Lee's friends the bite marks.

125. I have no doubt that Lee's abusive behaviour towards Stacey in a sexual context triggered a trauma reaction and contributed to her increasingly unstable state of mind.

126. There were further hostile messages between Stacey and Lee. That afternoon, Lee also called Matthew and they discussed the problems they had each had with Stacey.

127. At about 3pm, Stacey left the home with Seth and went to Maroubra beach.

128. At about 4pm Stacey and Seth went to the Maroubra Bay Hotel. She ordered a bottle of wine. Lee then attended the hotel. Stacey became intoxicated and disruptive. She accused Lee of having an affair with another woman who was sitting nearby.

129. At about 5.15pm, the hotel owner, Brendan Devlin, asked Stacey to leave. Lee left first, with Seth in the pram, and Stacey followed afterwards, throwing a chair into the corner of the room. These events were captured on CCTV. Outside the hotel, Stacey confronted Mr Devlin, as if spoiling for a fight. She then punched Lee in the face, and he left.

130. At 6.20pm Lee made a couple of calls to Matthew, telling him Stacey had had a few drinks and that she had "*lost the plot*". Matthew was at North Bondi Golf Club, watching a friend's band. Matthew was concerned about Seth, and he called Stacey at 6.38pm. He tried to reason with her saying, "*do you want our son to be taken into custody*" to which Stacey replied, "*Yes, it's going to happen*". This was an ongoing fear for Stacey. Matthew told her to go home and settle down. He tried to call and text Stacey repeatedly after this, and thought about going to her house, but then went to his home at Bellevue Hill instead. Neither Matthew, nor anyone else, called police about Stacey that evening.

131. Meanwhile, Lee, Stacey and Seth boarded a bus together at Maroubra. Lee then travelled

on to Martin Place, where he spent the night sleeping rough at the King Street Court complex. That has been confirmed by police with CCTV footage. Stacey boarded another bus and went home with Seth.

132. There were some further messages and calls from Lee to Stacey. At about 7.30pm, Stacey called Lee's mother (Lois Barber) although she was not coherent. She later left a message saying, "*You will be sorry, you won't go to heaven, you will go to hell".*

133. Stacey arrived home sometime around 8pm. Her landlord drove past at about 9pm and saw lights on inside the unit.

134. Police later canvassed Stacey's neighbours and examined other evidence to piece together what happened after Stacey and Seth arrived home. There was a sighting by a neighbour of a woman in a nearby park, but this was thought not to be relevant. Several neighbours also recall hearing an argument between a man and a woman during the night, but this does not appear to be related to Stacey either. The police investigation has demonstrated, by CCTV and phone cell locations, that neither Matthew nor Lee were with Stacey at this time, and there is no evidence that any other person was present in the home.

135. The most reliable account of what occurred is probably to be found in Stacey's phone records, including some video footage later found on her phone.

136. It appears that, at some stage between about 8pm and 10.30pm, Stacey caused Seth's death. A recording at 10.32pm shows Seth in bed, apparently deceased, with Stacey by his side. Her anguish and desperation at this moment is hard to imagine.

137. At 1.28am on 13 March 2017, Stacey recorded a video on her phone describing her funeral arrangements. Shortly after she talked about hanging herself. At 1.51am, Stacey began to search the internet on her phone for methods to kill herself.

138. At about 6.00am, Matthew attended outside Stacey's home. He had got to work slightly early and walked around to Stacey's home to check on her. He saw the light was on in the laundry and assumed that Stacey and Seth had made it home. He made a couple of calls to Stacey, and left messages saying he was going to come over after work, at about 1pm, and that he wanted an explanation from her. He asked her to let him come up.

139. While this was occurring, Stacey was searching methods to kill herself. At 6.22am, Stacey called Lifeline, but only for 7 seconds.

140. At 9.10am, Stacey sent Matthew a message, "*U come over 1 door opena*", to which he replied, "*I finish at 1*". The last activity on Stacey's phone was a call to her voicemail inbox made at 10.37am.

**Discovery of the deaths**

141. At 1pm on 13 March 2017, Matthew finished work. He attended Stacey's home and knocked. He saw Seth's sunhat and wipes outside. He called Stacey's number, and could hear the phone ring inside. He was concerned.

142. At 1.16pm, he called Constable Radoski at Mascot police station. Matthew reported that he could smell gas at the home. The incident was broadcast as an urgent job at 1.20pm.

143. Police arrived promptly at 1.23pm. The fire service attended shortly afterwards, and isolated the gas supply. A meter reading showed no gas, and so the fire service forced entry. Police then entered the home and discovered the bodies. Matthew was informed of the deaths shortly afterwards.

144. Seth was found deceased on a bed in the lounge room, with two rings on his chest and what resembled a shrine of other items around him. His face, hair and towels underneath him were wet.

145. Stacey was located partially suspended by her neck from an electrical cord, which had been looped over a hinge behind the front door. A child's chair was located nearby.

146. The scene inside the home was shocking. There was writing on most of the walls in the home, in blood and red texta, with bizarre messages, including "*Hello from the other side", "SD Pray 4 my son Seth"* and referring to the conspiracy theory *"Pizzagate".* There was blood in a bowl, which matched Stacey's, and blood in the bath, which was full of water. There were butane gas cannisters, one of which had its seal broken, and plastic bags with packaging tape and strands of hair attached which matched Stacey's DNA.

**Autopsies and subsequent expert investigation**

147. An autopsy was conducted for Seth by Dr Van Vuuren on 15 March 2017. The cause of his death was undetermined. He had no suspicious injuries, although he did have some cuts and bruises. Drowning, strangulation or suffocation could not be confirmed or excluded.

148. Toxicology detected a low level of alcohol (0.015g/100mL) and Alprazolam (0.02mg/L). A report by toxicologist Professor Alison Jones opines that the alcohol was post-mortem production by natural processes. She states that Alprazolam is likely to have caused Seth drowsiness and possibly some toxic effects. The lethal level of that drug in children is not known, and there is no clear evidence that Alprazolam is the sole cause of Seth's death.

149. I have carefully considered the evidence and am of the view that the exact cause of Seth's death remains unknown. The toxicological results suggest that it is likely that he was drowsy or unconscious shortly before death.

150. An autopsy was conducted for Stacey on 16 March 2017. The cause of her death was also recorded as undetermined. She had a single ligature mark around her neck and a fracture of the right superior horn of the thyroid cartilage. Those features and others are in keeping with hanging. She had superficial incisions on her upper arms and wrists. She also had multiple bruises, mainly to her limbs. She was not pregnant.

151. Toxicology revealed Alprazolam at between the toxic and lethal range (0.32mg/L). Stacey had a range of drugs in her system at non-toxic levels, including codeine, Lamotrigine and Tramadol. Stacey also had a moderate level of coronary atherosclerosis. Dr Van Vuuren recommended that first degree relatives should be assessed for premature atherosclerosis.

152. I have carefully considered all the information before me and find on balance that Stacey's death was caused by hanging. It is likely she was significantly affected by drugs at the time of death.

**Could these deaths have been prevented?**

153. Stacey's decision to end Seth's life was shocking to all who knew her. Seth's father, Matthew while concerned about Stacey and his son, never expected that Stacey would kill Seth.

154. Dr Leon told the court that in the five years he saw Stacey, she had made no *"suicidal threats, gestures or attempts and did not self-harm."*[22] He told the court that he never saw any reason to think she would harm Seth. He described her as a loving and caring mother. She told him *"she would protect him with all her capacity, all her ability, especially having been abused herself."*[23] His view was shared by Dr Kiang, her GP.

155. In his review, Associate Professor Ellis makes clear that Stacey had a significant history of psychiatric treatment from her teenage years and that her symptoms and function remained somewhat resistant to the treatment she got.[24] Her ability to function appears to have gradually declined over many years. Nevertheless Associate Professor Ellis told the court these deaths could not have been foreseen. He stated that *"homicide-suicide is a very rare event, and less common for females to engage in. It would not have been possible for any clinician to predict this as an outcome."*[25] I accept his view. While Stacey presented with a number of risk factors associated with suicide, these had been present for many years. She had frequently been exposed to stressful events and survived. The actions she took in March 2017 could not have been predicted.

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[22] Report of Dr Leon, Vol 11, Tab 119, [18].
[23] 22/2/22 T 24.43.
[24] Report of Associate Professor Ellis, Vol 11, Tab 126, page 8.
[25] Report of Associate Professor Ellis, Vol 11, Tab 126, page 18.

**The need for change and recommendations**

156. In listening to the evidence I was struck by the need for further services and support for those who experience complex trauma after childhood sexual abuse, whether or not they accept a diagnosis of BPD.

157. Associate Professor Ellis referenced Project Air, a specialist personality disorder unit based at University of Wollongong which could have provided clinical advice in the public sector. He agreed that public resources in this area are scarce and that finding skilled private psychiatrists willing to work on Medicare would be almost impossible. This is undoubtedly true. NSW Health was not represented at this inquest and accordingly I make no formal recommendations in this regard, however it is clearly an issue that needs to be addressed.

158. Counsel assisting put forward a number of specific recommendations for the court's consideration which were directed at DCJ and which arose directly from the evidence before the court.

159. Section 82 of the Act confers on a coroner the power to make recommendations that he or she may consider necessary or desirable in relation to any matter connected with the death with which the inquest is concerned. It is essential that a coroner keeps in mind the limited nature of the evidence that is presented and focuses on the specific lessons that may be learnt from the circumstances of each death.

160. I intend to deal with each of the proposed recommendations in turn.

**Draft recommendations proposed by Counsel assisting the Coroner**

*To the Secretary, Department of Communities and Justice:*

1. *That training for DCJ staff and funded providers, including but not limited to the Mental Health Practice Kit, be reviewed with a view to enhancing practitioners' skills to collaborate with mental health providers.*

161. This recommendation grew out of evidence disclosing the potential difficulties faced by caseworkers in establishing strong communication channels with mental health providers, specifically arising from the facts of this case where it appeared that information sharing between Stacey's caseworkers and Dr Leon could have potentially provided her with greater support. However, the complexities involved in establishing communication without harming a therapeutic relationship were evident and the need for a skilled and nuanced approach appeared clear. Enhanced training support for caseworkers in navigating these complex relationships is called for.

162. It is important to bear in mind that the circumstances leading up to these tragic deaths occurred some years ago and the court readily accepts Ms Alexander's detailed evidence of the extensive changes in caseworker training since 2016. The court acknowledges that

the Caseworker Development Program, which was revised in 2020 and now includes a specific module on mental health as well as broader content about the importance of collaboration with other professionals including medical professionals is likely to offer stronger guidance to caseworkers on these issues than was previously available. The court was taken to the practical advice currently offered to staff working with parents and families with mental health issues and accepts it encourages collaboration and information sharing between professionals. In oral evidence Ms Alexander, stated that the recent focus on mental health in the new Caseworker Development Program greatly improved the training offered to caseworkers, but agreed *"the more knowledge we can impart to caseworkers the better."* She appeared at least open to reviewing the available material to see if it could be improved.

163. In final submissions DCJ did not support a recommendation directed to *"funded providers"* as well as DCJ staff, given that DCJ Practice Learning within the OSP does not have direct responsibility for providing training to funded or non-government organisations. However, in my view, given that DCJ provides the online learning program "Change Together", there does appear to be some utility in reviewing its content with respect to this issue.

164. Having given the matter some thought I am persuaded to make an amended recommendation which will call for the review of resources for DCJ caseworkers and also for any relevant guidance that can be made available to funded providers in this area.

*2. That consideration be given to:*

*(a) providing an emergency contact number, such as the Helpline, Lifeline or Parentline number, in the unavailable voicemail message recorded on a caseworker's work landlines and mobile phones; and*

*(b) that practice guidance about the use of mobile phones be incorporated into the orientation of new caseworkers.*

165. This recommendation grew directly out of the tragic factual circumstances before the court. It was clear that in the period shortly before her death, Stacey reached out to her former caseworker for support. Unfortunately that caseworker, for reasons the court understands, was unavailable. It appears that Stacey was left feeling that she had no way of contacting someone from DCJ who could help her.

166. The court heard that mobile telephones are the primary means of communication between caseworkers and those they are working with. Individual caseworkers may currently leave different messages on the message bank of their telephones. Depending on the message left it may be that there is no guidance, for those seeking help, about where to turn at a moment of crisis.

167. I note that DCJ accepts that a standardised message should be developed for after-hours calls and that it is appropriate to review the most appropriate content. I accept that the content of the message is something that should be reviewed by DCJ under the guidance of the OSP.

*3. That consideration be given to developing written guidance relating to the handover of cases between caseworkers in the same team, including the importance of identifying urgent tasks and expectations about the timescale for the new caseworker meeting the family.*

168. The court was concerned about the sub-optimal handover which appears to have occurred. Counsel for DCJ submitted, on the basis of evidence given by Ms Alexander, that additional written guidance relating to handover of cases would not necessarily have made a difference in the factual circumstances of this case.

169. I accept Ms Alexander's view that there can be a tendency to think more policies and more mandates will be the solution, when in fact they can overload caseworkers. She identified the problem as broader than just the casework handover. She noted that the risk re-assessment which took place, probably because it was due, but without a face-to-face meeting with Stacey was superficial. Had that re-assessment been a more robust process, the urgency of Stacey and Seth's circumstance is likely to have been revealed.

170. I accept Ms Alexander's evidence about the critical role of good leadership and her opinion that careful consideration of the issues may have meant management recognised that it was not a good time to transfer this case.

171. The court had the opportunity to review the current casework mandate regarding transfer of a child or family between teams.[26] It specifies, among other things, the need to identify where the most urgent and high risk concerns lie. Tragically in Stacey and Seth's case, while NB had identified some urgency in Seth and Stacey's situation, this did not translate into immediate action on transfer.

172. I would welcome further review of this issue and intend to make a modified recommendation in this regard.

**Recommendation made by the Officer in Charge**

173. An important recommendation was also raised by the Officer in Charge, Detective Sergeant Andrew Pincham at the end of proceedings. He drew the court's attention to the call made from Stacey's telephone to Lifeline in the early hours of the morning of 13 March 2017. The call lasted only six seconds and it may not have been picked up.

[26] "Transfer of a child or family between teams, CSCs and JCPRP", Vol 7, Tab 95.1, KA-11, page 2406.

174. It is likely that Seth was already dead at the time of the call and that Stacey was in a state of enormous distress. Nevertheless it appears that at least for a few seconds she was reaching for assistance.

175. Detective Sergeant Pincham raised the possibility of a technological response to this kind of call, either a callback, a text message or an automatic referral to police for a welfare check. Lifeline was not represented at this inquest and the court had no evidence of how many short or inadvertent calls might be made to the agency or any expert evidence about whether a response of this sort could or should be contemplated. Nevertheless it seems an important issue and one I intend to bring to the attention of Lifeline in correspondence for their consideration.

**Findings in relation to Stacey Helen Docherty**

176. The findings I make under section 81(1) of the *Coroners Act 2009* (NSW) are:

***Identity***

The person who died was Stacey Helen Docherty.

***Date of death***

She died on 13 March 2017.

***Place of death***

She died at Hillsdale, NSW.

***Cause of death***

She died of hanging.

***Manner of death***

Her death was intentionally self-inflicted.

**Findings in relation to Seth Bonn Docherty**

177. The findings I make under section 81(1) of the *Coroners Act 2009* (NSW) are:

***Identity***

The person who died was Seth Bonn Docherty.

***Date of death***

He died on 12 March 2017.

***Place of death***

He died at Hillsdale, NSW

***Cause of death***

He died of undetermined causes.

***Manner of death***

His death was a homicide, in the context of his mother's mental illness.

**Recommendations pursuant to section 82 *Coroners Act 2009***

178. For the reasons stated above, I make the following recommendations to the Secretary, DCJ:

1. That practice advice for DCJ staff, including but not limited to the Mental Health Practice Kit, and any relevant guidance for funded providers, be reviewed by DCJ in consultation with DCJ's Psychological Services with a view to enhancing practitioners' skills to collaborate with mental health providers.
2. That DCJ give consideration to a standardised after-hours voicemail message being recorded on caseworkers' mobile phones
3. That DCJ incorporate practice guidance about the use of mobile phones into the orientation of new caseworkers, including the use of any standardised after-hours voicemail message.
4. That DCJ give consideration to reviewing the existing mandate for transfer of cases between teams with a view to enhancing best practice principles for transfer of cases within teams. The review should consider how best to identify the most urgent and high risk concerns and expectations about timescale for the new caseworker meeting the family.

179. I also intend to write to the CEO of Lifeline, enclosing a copy of these findings and raising the issue of Stacey's last call to Lifeline for their information and review.

**Conclusion**

180. This inquest offers no simple solutions. Childhood sexual abuse causes enormous pain and lasting trauma for many in the community. Stacey's mental health and her capacity to parent Seth was directly impacted by her complex trauma. Treating those with complex trauma or BPD is extremely difficult, especially when substance use disorder is also involved.

181. That Stacey would kill Seth and then herself could not have been predicted. Nevertheless it is clear that with the benefit of hindsight, the support offered to the family could have been strengthened in the months leading up to the tragedy. It was in Stacey's interest to deflect any consideration of the real risks to Seth as her mental health deteriorated, because despite her trauma she loved him and wanted him with her. At this critical juncture FaCS needed to maintain closer contact with that family to understand more of what was going on even when Stacey resisted.

182. Finally, once again I offer my sincere condolences to Seth and Stacey's family. I acknowledge that the pain of losing a loved one in these circumstances is profound.

183. I greatly respect their decisions to participate in these difficult proceedings and acknowledge their ongoing sorrow and grief. The family statements were profoundly moving and I thank all those in court for sharing their personal memories of this remarkable mother and son. They are not forgotten.

184. I offer my sincere thanks to counsel assisting, Jake Harris and his instructing solicitor Caitlin Healey-Nash for their hard work and enormous commitment in the preparation and conduct of this inquest. I also thank Detective Sergeant Pincham, the officer in charge of the investigation for his assistance.

185. I close this inquest.

Magistrate Harriet Grahame
Deputy State Coroner
30 March 2022
NSW State Coroner's Court, Lidcombe