CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Rachel Anne Martin
Hearing dates:	19- 29 April 2022
Date of findings:	21 October 2022
Place of findings:	Coroners Court, Lidcombe
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	CORONIAL LAW – provision of respite care; carer ratios; carer training; transport related death.
File Number:	2017/00336274
Representation:	Ms G Mahony, Counsel Assisting i/b DCJ Legal (Ms J de Castro Lopo) Ms D Ward SC for the Department of Communities and Justice (i/b Mr Cantrill/ Ms R Davidson, Crown Solicitor's Office) Dr P Dwyer for Special Needs Accommodation Program (SNAP) (i/b Ms N Brown, Meridian Lawyers) Ms C Robertson for Ms Fiona Martin Ms E Elbourne for the National Disability Insurance Agency (i/b Mr L Depares, HWL Ebsworth) Mr R Pietriche for Counsel for the Office of the Children's Guardian (i/b Ms K Kless, Crown Solicitor's Office)
Non publication orders:	Non-publication orders made on behalf of Ms Fiona Martin on 19 April 2022 in relation to certain personal

	information in tendered documents are available from the Court Registry. These orders do not affect matters set out in these Findings.
Findings	**Identity** The person who died was Rachel Anne Martin. **Date of death** She died on 5 November 2017. **Place of death** She died at M1 Pacific Motorway near Cameron Park NSW **Cause of death** She died from multiple injuries sustained when she was hit by a truck on the M1 Pacific Motorway. **Manner of death** Rachel's death occurred while attempting to prevent harm to Riley Shortland. At the time of her death Rachel was an employee of SNAP, an organisation which was providing Riley with respite care. Rachel ran onto the motorway in an attempt to catch Riley who had exited their vehicle.
Recommendations:	**To SNAP Programs Ltd** It is recommended that SNAP: 1. Review, amend, or draft a staffing policy

	addressing hours an employee may work. It is recommended that the policy prevent any employee being rostered on for a period in excess of a double shift. A double shift represents two 8 hour shifts or in the alternative, a sleep over shift (where the sleep hour shift is not more than 4hrs + 8hrs sleep + 4hrs) plus a further 8 hour shift, without a 10 hour break between the double shift and the next shift, or as recommended by an expert in the area. It is understood that such a review would take into account the particular circumstances of staffing levels at camps and allow for exceptional circumstances. 2. To support a comprehensive understanding of any relevant regulations and the above developed staff rostering policy, it is recommended SNAP seek the support of an independent third-party advisor to: a) Deliver a session to the senior executive to understand broader risk implications in relation to staffing levels and related policies, legislative and regulatory requirements; b) Assess the appropriateness of the policy drafted in response to recommendation (1); and c) Deliver a workshop to staff and management to understand the risks around the associated policies and the failure to adhere to them. 3. Develop a policy to address a process for staff to elevate concerns regarding staffing challenges, with such process to be independent of executives and managers;

	4. Ensure that training in the character of PART, or similar training, become a part of a cyclic refresher training program delivered by SNAP to staff and to new employees as soon as practicable after completing their probation period. 5. Update its transport policy to include the following: a) The transport driver should be provided with the details of an available contact person (hereafter referred to as 'support person') who can attend on the vehicle during that period of transport; b) Save for emergencies, a driver transporting a child or young person alone should not exit the vehicle whilst on a motorway, highway, or major public transport corridor. Where there is a need to pull over, such as where a child or young person is presenting a risk to safe driving or is a risk to other persons in the vehicle or themselves, emergency services or a support person should be contacted to assist in the safe access of the child or young person; c) Save for emergencies, whilst on a motorway, highway, or major public transport corridor, a driver transporting a child or young person alone should not open the vehicle's door to access the child or young person. Where there is a need to pull over and obtain access to the child in the vehicle, such as where a child or young person is presenting a risk to safe driving or is a risk to other persons in the vehicle or themselves, emergency services or a support person should be contacted to

	assist in providing safe access the child or young person. d) Where there is a need to pull over and obtain access to the child in the vehicle, such as where a child or young person is presenting a risk to the safe driving, or a risk to other persons in the vehicle or themselves, emergency services or a support person should be contacted to assist in providing safe access the child or young person.

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Introduction

1. This inquest concerns the death of Rachel Anne Martin. Rachel was just 28 years of age at the time of her death. She was looking forward to the future and was pregnant with her first child. Her family described her as funny, smart, kind and giving. She was always willing to help those less fortunate than herself and was passionate about her work assisting those in need.[1]

2. At the time of her death Rachel worked in respite care for an organisation called SNAP. On 5 November 2017, she was caring for a young boy named Riley Shortland. When Riley ran towards traffic on a busy motorway, Rachel did not hesitate to follow him in a courageous attempt to catch him and prevent terrible harm. It is important to acknowledge that Rachel died trying to save Riley Shortland's life. Tragically both Rachel and Riley were hit by an oncoming vehicle and died at the scene.

3. Rachel's employer described her as a skilled and dedicated worker. She was described as very caring in her support for the children she worked with. Ms Ford stated "*She was just beautiful*" and she told the court that Rachel's death had been devastating for the entire organisation.[2]

4. Rachel's family is severely affected by her sudden and shocking death. Their pain is profound and ongoing.

5. I record my utmost respect for Ms Amanda Martin, Rachel's sister, who attended and participated in these confronting proceedings. I acknowledge her great sorrow for the loss of her sister and friend and I send my sincere condolences to Rachel's entire family and former colleagues.

The role of the coroner and the scope of the inquest

6. The role of the coroner is to make findings as to the identity of the nominated person 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.[3] A coroner may make recommendations, arising from the evidence, in relation to

[1] The Martin family statement is attached to the court file.
[2] Transcript 20 April 2022 p. 41 L40
[3] Section 81 *Coroners Act 2009* (NSW).

matters that have the capacity to improve public health and safety in the future.[4]

The evidence

7. The court took evidence over eight hearing days[5]. The court also received extensive documentary material in three volumes. This material included witness statements from agency staff, experts and executive level officers, respite and other child placement policies and procedural documents from the agencies involved in the matter. The court also received extensive records concerning Riley Shortland's history and care arrangements and selected material from the SafeWork NSW prosecution proceedings against SNAP and the Department of Communities and Justice.

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

9. A list of issues was prepared before the proceedings commenced. These issues guided the investigation. It is important to note that because Rachel's death occurred in the context of her employment with SNAP Programs, as a carer for Riley Shortland, who died in related circumstances, much of the information considered in the investigation into Riley's death is also applicable to Rachel. Their inquests were held simultaneously for this reason.

10. The issues were:

    a) The manner of Riley and Rachel's deaths, including the factors contributing to their deaths.

    b) The adequacy of support, including funding and respite arrangements, provided to Riley Shortland and his foster mother by and on behalf of the Department of Communities and Justice (DCJ) in the period prior to his death, and whether his care was impacted by the fact that Riley's care was in the process of being transitioned to another agency.

    c) Whether the involvement of multiple agencies resulted in important issues and certain responsibilities being overlooked in the care provided to Riley.

    d) Whether Rachel was provided with sufficient information in respect of Riley to ensure both her safety and Riley's safety.

[4] Section 82 *Coroners Act 2009* (NSW).
[5] Three inquests were held together and some evidence was applicable to each inquest. In total the court sat for 8 days.

e) For high needs children who receive short term respite care, should there be a policy regarding certain information which must accompany all children on all respite care arrangements?

Fact finding

11. This inquest took place following Safework NSW proceedings in the District Court where many of the circumstances surrounding Rachel's death were closely examined.[6] Those matters are regarded as established. Prior to commencing the inquest, a summary of facts taken from the extensive available material, including the District Court decision, was circulated. This document was agreed to by the parties and is annexed at Appendix A. It accurately sets out a chronology of events and for this reason I do not intend to repeat all those details in the body of these reasons.

12. Further information was received in oral evidence. Counsel Assisting also summarised much of that material in her comprehensive written submissions. I regard her submissions as accurate and, as will be evident, I rely on that document to set out further chronological details and aspects of the evidence in these reasons, where appropriate incorporating her words. The interested parties' written submissions have also been considered carefully.

Cause of death

13. There was no dispute in relation to the medical cause of Rachel's tragic death. The impact from the vehicle that hit her caused unsurvivable injuries. A post mortem examination conducted on 8 November 2017 by forensic pathologist, Dr Allan Cala, recorded the medical cause of her death as "multiple injuries". Rachel suffered extensive abrasions and lacerations. A post mortem CT scan identified extensive injuries to her head, chest, pelvis and limbs. She was 18 weeks pregnant.

Background

14. Rachel Martin was born on 14 December 1989. Rachel was a casual support worker under a contract of employment with SNAP Programs Limited (SNAP). Rachel was in the first trimester of a pregnancy. Rachel died on 5 November 2017 at age 28 years, 10 months.

[6] Safework NSW v SNAP Programs Limited and State of NSW (Department of Communities and Justice) [2021] NSWDC 259

15. Shortly prior to their deaths, both Rachel and the little boy she was supporting, Riley, were travelling in a SNAP vehicle, a Toyota Tarago, along the M1 Motorway. Rachel was taking Riley home after a weekend of respite care. It was during this journey that both Rachel and Riley died.

16. To understand what happened, some information about Riley and his background in care is necessary. Riley was an energetic child with high needs. He had a disrupted early life and while he was settling well with Fiona Martin and her family, he needed constant supervision and attention.

17. Riley was born on 27 December 2008 to Amanda Taylor and Mark Shortland. Riley was diagnosed with autism spectrum disorder and global development delay in 2012. He had limited speech and communication skills.

18. On 5 August 2013, Riley was assumed into the care responsibility of the Director General pursuant to s. 49 of the *Children and Young Persons (Care and Protection) Act 1998 ("Care Act").* On 24 April 2014, the Children's Court of NSW made final orders placing Riley under the parental responsibility of the Minister until he attained 18 years of age.

19. On 4 October 2014, Riley was placed with Fiona Martin, a carer authorised by the House with No Steps ("HWNS"), now known as Aruma, to provide Statutory Out of Home Care (SOOHC) under the *Care Act*. Fiona Martin is not related to Rachel Martin. From that time, Riley lived with Fiona Martin and her two biological sons, Hugh and Toby (aged 13 and 14 years at the time Riley died).

20. In July 2017, HWNS informed the Department of Communities and Justice (DCJ), as the government agency with oversight, that it was closing its foster care program. On 29 September 2017, Riley's care management reverted to DCJ with the aim that case management would soon be transferred to another non-government agency, Allambi Care. At the time of his death, this transfer had not taken place, and so Riley remained under the management of DCJ.

21. Fiona Martin, on the evidence before the court, took good care of Riley. The HWNS Child summary stated:

> *Riley is very well supported by his Carer and health professionals to meet his needs and support his development. Riley has a strong relationship with his carer Fiona. Fiona provides a consistent and structured environment that Riley responds really well to. He follows her instructions, engages in eye contact, and is affectionate towards Fiona. She understands Riley's body*

language, mannerisms and behaviour and responds effectively.[7]

22. However, Fiona was in need of regular respite to support and maintain the placement. She expressed her concerns to DCJ, who started the process of seeking respite programs for Riley.

23. In terms of Fiona's respite needs, the HWNS Child/Young Person summary noted:

> *Key issues of concern are Fiona's capacity to care for Riley given his high needs, the individual needs of her two sons who have mild autism, being a single carer and the impact these concerns has on her health and emotional wellbeing and the health and emotional wellbeing to her children. There has (sic) been instances of Fiona crying when respite for Riley [has] fallen through. She has been in tears on the phone and states regularly that she does not receive enough respite to support Riley.*[8]

24. These concerns and others were repeated by Fiona in various ways in various discussions with DCJ on 17 October 2017[9], via SMS the same day,[10] in discussions in the lead up to 23 October 2017,[11] on 27 October 2017,[12] and on 1 November 2017.[13]

25. Fiona was distressed when reporting that Riley was not attending his regular respite arrangements.[14] This dated back to her first discussion with DCJ on 13 October 2017. A file note from that conversation said, "*Fiona was concerned about respite and the fact that she has had none at all. Fiona said that she normally has monthly respite and is concern[ed] when her next respite is likely to be. Fiona got very teary as she stated she is tired*."[15]

26. Despite her requests, following the return of case management to DCJ, Riley and Fiona Martin were not provided with respite until 29 October 2017.

27. Respite was arranged with Camp Breakaway for the weekend of 29-31 October 2017. Ms Ann Cochrane, a Senior Aboriginal caseworker with DCJ who worked

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7 Exhibit 1 Brief of Evidence Volume 1, Tab 35

8 Exhibit 1 Brief of Evidence Volume 1, Tab 35

9 Exhibit 1 Brief of Evidence Volume 1, Tab 22e, p. 181

10 Exhibit 1 Brief of Evidence Volume 1, Tab 22f, p. 186

11 Exhibit 1 Brief of Evidence Volume 1, Tab 22c, p. 32

12 Exhibit 1 Brief of Evidence Volume 1, Tab 22e, p. 184 and Tab 22f, p. 188

13 Exhibit 1 Brief of Evidence Volume 1, Tab 23, p. 1; Tab 22c, p. 53

14 Exhibit 1 Brief of Evidence Vol 1, Tab 22a p. 3 - The NDIS Plan emailed to the Department on 31 July 2017 stated that Riley's respite was one night a month on weekend with grandparents and two four-hour blocks on other weekends. However that respite plan also inferred that HWNS had not heard from Riley's maternal grandfather since May 2017, with the effect that the respite was limited to the two four-hour blocks on other weekends.

15 Exhibit 1 Brief of Evidence Volume 1, Tab 22e, p. 181

with Funded Service Providers[16], relied on information provided by Fiona Martin to fill out Riley's application. In the submission to Camp Breakaway, Ms Cochrane noted that:

> *"Riley has attended Camp Breakaway previously. Riley requires two workers to work with [him] at all times around the clock due to his high needs."*[17]

28. On 24 October 2017, Amy Parker, a new FACS (DCJ) employee, was instructed by Ms Kathleen Davis, Manager, CaseWork, Central Coast Child and Family District Unit, to contact SNAP to ascertain whether they had any available weekend respite care placements for Riley going forward. Ms Parker had not placed a child in respite care placement before. She was not given any up-to-date information on Riley, and she could not find the paper copy of his file.

29. Ms Parker contacted SNAP requesting respite for Riley noting, "*He has been diagnosed with Autism and severe Global Development Delay and his behaviours reflect this. He attends the Aspect School Terrigal".*[18] No other information as to Riley's needs were provided. Riley was not attending school at Aspect Terrigal at that time and this information was out of date.

30. It appears that Ms Parker was not aware that there was a paper copy and USB file for Riley which contained updated information, including Riley's 2016 Behaviour Support Plan and other information which indicated that Riley required two carers and that his need was categorised as Level 3.[19]

31. The CEO of SNAP, William (Butch) Hays, replied on 25 October 2017 and confirmed that SNAP was able to provide respite care placement for Riley between 3-5 November 2017 at a cost of $2,995 plus GST. The fee would cover transport, activities, meals and support. I accept that Mr Hays was not informed that two workers would be needed for transport, or it would have been reflected in the cost estimate he gave. The quote was provided in the absence of knowing Riley's current needs including the level of support he required generally, and the specific support he required when being transported. Mr Hays made no such enquiries as to these matters before sending the quote and indicating positively that SNAP could accept the respite placement. Mr Hays sent Ms Parker a SNAP referral form

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[16] Exhibit 1 Brief of Evidence Volume 3, Tab 53

[17] Exhibit 1 Brief of Evidence Volume 1, Tab 24c, p 1

[18] Exhibit 1 Brief of Evidence Volume 1, p. 62

[19] See Safework NSW v SNAP Programs Limited and State of NSW (Department of Communities and Justice) [2021] NSWDC 259 [46]

and noted that the Department needed to complete that form.

32. It was clear that SNAP prided itself on being able to assist on short notice. In oral evidence, Mr Hays, the CEO of SNAP Programs, explained the rationale for his organisation was born out of frustration that other organisations could be too slow to respond when *"the Department or families were screaming out for help*."[20] The company was formed to provide a "*quick response".*

33. Wendy Wilson, Manager Client Services within DCJ in the Child and Family District Unit[21], was informed of SNAP's availability to take on the respite. Ms Wilson did not immediately accept that quote, seemingly on the basis that "*respite is a process for Special Care, so a form needs to go up to the ED for approval. A camp does not require this level of approval."* She enquired whether any camps were available through SNAP. There was nothing available at the time.[22]

34. By 1 November 2017, Ms Wilson directed Ms Parker to ask Allambi if they were available to provide respite for Riley and Fiona Martin noting "*SNAP is a special care provider and requires the special care request to be completed and signed by Dep Sec which can take time*".[23] No one from DCJ had returned a completed referral form to SNAP who were left unsure about whether the respite care would take place. Nevertheless, Mr Hays contacted Ms Parker by email regarding her completion of the referral form and enquiring where Riley would be collected from.

35. On 2 November 2017, DCJ approached Allambi to provide respite for Riley commencing Friday 3 November 2017. By email of the same date, Allambi refused the request for the provision of respite care, stating in effect that the arrangement was too rushed. [24]

36. On 3 November 2017, the day respite with SNAP commenced:

    a. Ms Parker emailed Ms Wilson saying "*Allambi have nothing this weekend but can look at future dates. Fiona is absolutely pulling her hair out and has been crying on the phone to Maria. Is there any possible way that we could get approval for SNAP this weekend? Or is there any one I can try that you think would have availabilities this weekend?",* to which Ms Wilson responded "*The only way we may get approval is to request urgent through*

[20] Transcript 20 April 2022 p. 147 L20
[21] Exhibit 1 Brief of Evidence Volume 3, Tab 52
22 Exhibit 1 Brief of Evidence Volume 1, Tab 22c: p. 55 - 56
[23] Exhibit 1 Brief of Evidence Volume 1, Tab 22c: p. 544
[24] Exhibit 1 Brief of Evidence Volume 1, Tab 22c: p. 46

Special Care with SNAP. I'll send you the form. It needs to clearly articulate that he has a disability that is permanent, resulting in reduced capacity [in] Confirm that the diagnosis [are] permanent or likely permanent and that these diagnosis/disabilities have resulted in significantly reduced capacity in which of the following areas: communication, learning, mobility, decision making and or self-care" (sic).[25]

b. At 2.21pm, it was noted internally within the Department, that no probity checks had been done on SNAP or Mr Hays.[26]

c. At 2.57pm, the relevant forms to allow a special care placement to take place were emailed from Ms Wilson to Ms Parker.[27] Mr Hays returned his Working With Children Check and Police Check at 3.07pm[28] and the signed Code of Conduct document at 3.31pm.[29]

d. The paperwork to permit the placement was sent to the Direction Operations Central Coast at 3.27pm.[30] The paperwork placed significant emphasis on SNAP and Mr Hays knowing "*Riley well*" and "*already knowing Riley's behaviours and needs"*.[31]

e. The document stated that the Department "*will provide SNAP with Riley's latest CIFS and CAT"* which entail his recent behaviours, needs and medication dosage.[32] This did not occur. Amy Parker, in an email following Riley's death stated "*when I spoke with Butch on that Friday, he said not to worry about sending the CIFS and CAT through as SNAP already had this information from Riley's placement with them as well as the times they did respite after Riley went into Fiona's care."*[33] I am satisfied that this was an error by Ms Parker and the information should have been provided regardless of the attitude of SNAP.

f. The Special Care form was signed by the then Deputy Secretary, Simone Walker, and the approval came through to Ms Wilson at 5.34pm.

g. Riley was collected from Fiona Martin's home by Karin Ford at 5.45pm. I

[25] Exhibit 1 Brief of Evidence Volume, Tab 22c, p. 53
[26] Exhibit 1 Brief of Evidence Volume, Tab 22d, p. 67
[27] Exhibit 1 Brief of Evidence Volume, Tab 22d, p. 8
[28] Ibid at p. 109
[29] Ibid at p. 99
[30] Ibid at p. 113
[31] Ibid at p. 115
[32] Ibid at p. 115
[33] Exhibit 1 Brief of Evidence Volume,Tab 41, p. 2

accept her evidence that Riley was pleased to see her.

37. Ms Ford relied upon the limited information SNAP had received. There was also a brief conversation between Ms Ford and Ms Fiona Martin about Riley's transportation needs at the time he was collected. Ms Fiona Martin explained that Riley could undo a normal seatbelt and that a clip, or what has been called a Houdini strap in these proceedings, was necessary. Ms Ford told the court that the situation "*didn't give me enough alarms to say this child needs two workers*."[34] She relied on her previous experience transporting Riley and the fact that she was aware that Ms Fiona Martin was a single woman who apparently transported Riley alone. She said there had been nothing in the original request to suggest two workers were necessary.

38. Ms Fiona Martin had every right to expect that Riley's transport needs had already been conveyed to SNAP through official channels.

39. The organisation of respite care was extremely rushed, and there was no proper assessment of Riley's needs. The process was not child focused. This is an obvious failing and has been properly acknowledged by DCJ.

40. It is also clear that SNAP needed to have demanded further information before agreeing to care for Riley. I accept that staff members at SNAP were persuaded and comforted by their belief that they knew Riley. However, their knowledge was not up to date. SNAP's philosophy of "*always being able to assist quickly*" led them into error on this occasion. It resulted in staff, such as Rachel, being ill-informed and unsupported in relation to the risks involved in transporting Riley.

41. On 24 October 2017, when the request for respite availability had been made by Amy Parker, Mr Hays was asked "*Let me know if there's anything else you need*". The only matter requested of DCJ was that it complete and return the SNAP referral form. While Mr Hays asked for that document on another occasion, he should have been more proactive in requiring it was returned to SNAP and should have informed DCJ that respite would not occur unless the document was completed.

42. Mr Hays should also have requested from Ms Parker copies of all documents relevant to Riley's needs. Relying on SNAP having worked with Riley when he was six years of age (some three years earlier) was a poor and unsafe decision,

[34] Transcript 20 April 2022 p. 116 L35

in light of the significant changes that may (and indeed had) occurred in the meantime.

43. On 3 November 2017 at 10.28am, Amy Parker expressly asked Mr Hays "*Do you still have a copy of Riley's BMP (behavioural management plan) by any chance*" to which Mr Hays did not reply.[35]

44. Mr Hays subsequently told NSW Police that he "*assumed that [SNAP] did have it"*[36]. However, Mr Hays did not look for that document and did not direct anyone to obtain that document.[37]

45. It appears that Mr Hays should have more actively sought out information relating to Riley so that staff working with him could have had a better understanding of Riley's needs, his previous behaviours and the risks involved in his care.

SNAP Programs

46. SNAP Programs Ltd was founded in 2012 by Karin Ford, Operations Manager, and William 'Butch' Hays, Chief Executive Officer, both of whom gave evidence before this Court.

47. SNAP describes itself on its website as '*assisting organisations and families, in supporting both, young people and people with a disability, through a variety of different programs'.* Ms Ford expanded on this in her evidence, saying "*we are an NDIS provider and we are also a voluntary out of home care provider and we're also - we have DCJ engage us as a special needs provider at different times and also an ACA placement provider*."[38]

48. Ms Ford and Mr Hays had diverse backgrounds. Ms Ford has a Certificate IV in Disability and was part way through a degree. She also has some thirty years of experience of working with children with disabilities. The court heard Mr Hays has a Bachelor of Arts in Sociology and Social Welfare from the University of California at Berkley, USA. He told the court that he had been a professional basketball player and had been involved in running basketball camps for disadvantaged young people prior to working in the disability sector.

49. I accept that both Ms Ford and Mr Hays were well acquainted with Riley and had strong memories of the earlier period when he was in their care. It was not an

[35] Exhibit 1 Brief of Evidence Volume 1, Tab 22c, p. 59
36 Exhibit 1 Brief of Evidence Volume 3, Tab 53A, p. 149 A48
[37] Transcript 20 April 2022 p. 152 L49
[38] Transcript 20 April 2022 p. 94 L45

unsubstantial period of time. From 2014, Riley had lived in Ms Ford's own house for 15 months[39] under the arrangements for care that were in place when SNAP commenced operations.

50. Rachel Martin was employed by SNAP Programs under a contract of employment as a Casual Support worker for twelve months commencing on 24 July 2017.[40] She had no prior experience of working with Riley.

51. I had the opportunity to closely observe both Mr Hays and Ms Ford during the coronial proceedings. Both expressed their great sorrow in relation to Rachel and Riley's deaths. I accept that they were genuinely affected by their involvement in these tragedies.

52. I also accept that the plea of guilty entered in the Safework proceedings demonstrates that their organisation has properly accepted responsibility for the shortcomings identified. It should be noted that Scotting DCJ was well satisfied that since the incident SNAP had taken significant steps to improve its safety systems. I accept this is the case.

The last twenty four hours before Rachel and Riley died.

53. According to Karin Ford's documented file note,[41] on the evening of Friday 3 November 2017:

> *"I arrived at the respite house [Singleton Avenue, Thornton] with Riley. Stacey McIvor was the worker on shift and was at the respite house. I spoke with her personally and relayed all the information I had been given from Fiona, together with some information I already knew about Riley. Stacey wrote this down for all workers to read when arriving at the house and before beginning their shift."*

54. According to Stacey McIvor's oral evidence[42] and the agreed facts, upon arrival at the respite home Karin Ford and Ms McIvor transferred Riley's car seat from Ms Ford's vehicle into the SNAP Toyota Tarago and checked that the child locks were activated.

55. Ms Ford continued:

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[39] Note 55 supra page 114
[40] Exhibit 1 Brief of Evidence Vol 2, Tab 42
[41] Exhibit 1 Brief of Evidence Vol 2, Tab 42
[42] Transcript 21 April 2022 p. 174 lL7

I rang Brooke Houlison the same night and spoke to her about Riley and his support needs. I ensured she was aware that Riley liked to run away from his worker and thought this to be a fun game. I repeated Fiona's words, "even when Riley looks like he is doing the right thing, don't trust him".

On Saturday morning, around 9 am, I rang and spoke with Rachel Martin. Rachel had said she was going to attend another young female clients' birthday party today and was that okay? Rachel said she wanted to help get the party ready and didn't want to get paid or anything. I told Rachel I was happy for her to do that however she needed to put that on her time sheet and she would be paid.

She agreed. I then offered to replace her shift with Riley, but she said was fine to do the shift. I then spoke with her about Riley, giving her the same information as I gave Brooke. I again repeated Fiona's words, "even when Riley looks like he is doing the right thing, don't trust him".

Saturday afternoon, I rang Brooke to see how she was going with Riley. She said everything was fine. She told me, Riley had stripped off his clothes at one point and refused to put them on again. Brooke said it took her a few minutes to work out that Riley wanted a bath and that's why he had taken his clothes off. I asked Brooke to pass on all the information we had on Riley to Alex Dongo at changeover, as I would scattering my sister's ashes at this time and won't have had a chance to speak to him. Brooke assured me she would do this.

On Sunday afternoon I spoke to Rachel and she told me how cute Riley had been with dipping his fingers in the peanut butter when she was spreading his toast, and then licking it off while smiling. Rachel said she had had no issues and had a lovely time with Riley.

I texted Rachel at 4pm just to ensure she had the details for the drop off. Rachel text me back letting me know they may be a while, as Riley didn't want to put his seat belt on.

Butch and I were together at a noisy venue. I checked my phone and saw there was a missed call from Rachel a moments ago. The after hours phone rang and Butch moved to a quiet place to take the call. I assumed it was Rachel calling. When Butch returned a few minutes later I asked if that was Rachel and he said no. I then went outside to call Rachel. The phone said

the person was on another call. I tried a few times over the next 15 minutes. Rachel answered the call. I asked "everything okay?" Rachel said, "all good, I have got this". I could hear she was driving. I said okay and hung up.

I later found out that Rachel had called a work colleague, Michael Daddo at the time I was trying to call her. Rachel knew that Michael had previously worked with Riley. Michael told me that Riley was refusing to put on his seat belt. He said he spoke to her and suggested something that she could try and this worked. Michael said Rachel had put Riley's seat belt on and she had just driven off when he said goodbye to her.

56. Stacey McIvor was the first SNAP employee to work with Riley on the Friday evening. She told the court in evidence that she was rostered to work with Riley in advance of the Friday. While she could not recall whether it was the week or a couple of days before, she gave evidence that she was notified of the shift beforehand and "*it definitely wasn't the day*".[43] The only information that Ms McIvor was given was Riley's name and "*maybe he was non-verbal*". She was informed by Ms Ford prior to the placement that Riley had autism and needed to use sign language.[44]

57. The court also heard from Brooke Whitely (formerly Houlison), who was the second SNAP employee to work with Riley, and whose evidence was of considerable assistance. Ms Whitely commenced her shift on the Saturday morning. It was her first respite shift with SNAP.[45] Ms Whitely recalled that she was rostered to work with Riley in advance of the Saturday, either the Thursday or Friday morning.[46] The only information that Ms Whitely was given was it "*was an eight year old non-verbal autistic boy*".[47] Ms Whitely gave evidence that on reflection, based upon her own experience of initial information received for clients at SNAP, she should have asked for more information.[48] In terms of handover, Ms McIvor went through the hand written notes with Ms Whitely and gave some additional information about Riley based on her experience of the shift.

58. Tigere (Alex) Dongo, who was also rostered to work with Riley, gave evidence that he also had never done a respite shift and had never worked at the house where respite was being offered. There was no induction into that house but he received

[43] Transcript Day 21 April 2022 p. 162 L3 - 8
[44] Transcript 21 April 2022 p. 172 L47
[45] Transcript 21 April 2022 p. 212 39 - 45
[46] Transcript 21 April 2022 p. 213 L13
[47] Transcript 21 April 2022 p. 213 L21
[48] Transcript 21 April 2022 p. 214 L31-32

a handover from the outgoing worker.[49] He was offered the shift the day it took place and it was close to the time the shift was due to take place, noting the shift for Mr Dongo was for two hours and was a late cover as Rachel Martin was delayed in attending the shift.[50]

59. In terms of handover, Mr Dongo went through the handwritten notes with Brooke Whitely. When Rachel came on shift, Mr Dongo passed that document to Rachel and referred Rachel to management if she had to transport Riley. Mr Dongo was given no additional information to provide to Rachel about Riley's transport needs.[51]

60. The lack of information gathering meant that SNAP failed to understand Riley's current behaviours and support needs. It is not suggested that the care given to Riley by individual workers was sub-standard. The evidence of Ms Whitely in particular indicates that she provided a high standard of child-focused care that reflected Riley's capacity. However, SNAP as an organisation failed to provide sufficient information to allow appropriate assessments to be done and accordingly, failed to safeguard the safety of Rachel and her colleagues. SNAP workers were not adequately briefed on the risks involved with caring for Riley, particularly the risks involved in driving with him.

61. In my view, that responsibility lies with both DCJ and with SNAP. DCJ ought to have provided the information it held about Riley's support needs, behaviours and medical needs to SNAP in advance of the respite being arranged and certainly before its commencement. DCJ's failure to pass on information it knew, including the same information it had provided to Camp Breakaway two weeks earlier, was a most significant error and one that could have protected Rachel Martin had it been provided.

62. Mr Hays ought to have required much more detailed information from the time DCJ first made contact seeking respite care and he should have insisted the Referral Form was provided in advance of accepting the contract. Mr Hays also ought to have actively sought out information held by SNAP, particularly where he failed to follow up information from DCJ on the basis that it was information already held by SNAP.

63. SNAP also failed to provide Rachel Martin and other staff with sufficient

[49] Transcript 21 April 2022 p. 194 L25 - 45
[50] Transcript 21 April 2022 p. 195 L30 -- 40
[51] Transcript 21 April 2022 p. 196 L48; p.197 L8

information about Riley's needs and behaviours. The only current information received to support Riley and to inform staff of matters relevant to their own safety was the one-page handwritten document prepared by Ms Ford with Stacey McIvor when they arrived at the SNAP house on the first night of respite[52]

Were SNAP staff adequately trained to provide care for Riley?

64. Evidence was before the Court that Rachel Martin had completed 'Work Health and Safety training' in 2013[53], First Aid Training in 2014 and a Certificate IV in Community Service (Youth) also in 2014.[54]

65. The court heard evidence that SNAP delivered its own training to its employees and also engaged third party providers to deliver training. The training was at times specific to a client's needs and at other times general skills relevant to working with children with disabilities.

66. Rachel had completed an induction program for SNAP on 26 January 2015[55] (during an earlier contract of employment) and 'Responding Professionally to Challenging Behaviour' on 11-12 March 2015.

67. The court heard that on 16 May 2017, Kathleen Power, a third-party provider, delivered training on Autism Spectrum Disorder to SNAP workers providing care to another child at a cost of $550.

68. Rachel Martin attended that training although no other person caring for Riley on the weekend of his death, attended that training.[56] The engagement of individualised training to meet the needs of a specific client is appropriate.

69. The Inquest heard about 'PART' training. The records of SNAP disclose that Rachel received PART training on 11-12 March 2015.[57] Ms Whitely identified it as 'Predict Assess Response Training', which aims to impart skills for "*how to predict, and how to respond and how to act if a client's having a meltdown, or whether they're having a physical outburst"*. Ms Whitely had used PART outside of SNAP, and considered it to be very useful training although she had not been asked to attend any refresher training on PART with SNAP.

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[52] Exhibit 1 Brief of Evidence Volume 3, Tab 53A p. 24; Transcript 21 April 2022 p. 174 L30
[53] Exhibit 1 Brief of Evidence Volume 2, Tab 42
[54] Note 47 ibid
[55] Exhibit 1 Brief of Evidence Volume 2, Tab 44
[56] Exhibit 1 Brief of Evidence Volume 3, Tab 42, p. 18-19
[57] Exhibit 1 Brief of Evidence Volume 3, Tab 42

70. The other staff attending to Riley that weekend had not all received PART training. Ms McIvor did the training but could not recall what PART was.[58] Mr Dongo did this training in 2018 after Riley's death. He recalled it was delivered in person by a third party over a couple of hours and was training for "*how to deal with clients with autism",* "*how to handle certain situations*" and managing escalated behaviours.

71. It is appreciated that organisations like SNAP have limited means to fund staff training, however, both general training and training specific to the needs of the client is essential. The training identified as PART, came across in evidence as a valuable tool for those working with children at SNAP.

72. Training of this nature ought to be provided to SNAP employees as a part of a cyclic refresher training program particularly given the nature of respite care may mean individualised training is not always available. This places a greater emphasis on workers having solid core skills.

73. There is no minimum level of training required for persons wishing to be employed with children and young people with disabilities who receive respite from organisations such as SNAP. People can work as a disability support worker without formal qualifications.[59] The NDIS Code of Conduct and associated guidelines mandate providers ensure workers have the necessary training, competence and qualifications for the services delivered. Mandating a minimum level of training for the disability care industry is not generally supported at this time. It is considered that such a requirement could adversely impact the recruitment of disability support workers and subsequently the provision of services to the persons in need of the support. Michelle Dodd, an expert who assisted the court, gave evidence that there is already an undersupply of disability support workers which would be further impacted if such a change were made.[60]

74. As mentioned earlier, SNAP and DCJ were prosecuted by SafeWork NSW. Both SNAP and DCJ pleaded guilty to offences pursuant to s. 32 *Work Health and Safety Act 2011* for breach of the relevant health and safety duties owed by each to Riley and his carer Rachel as well as two other employees of SNAP.

75. His Honour Judge Scotting of the District Court of NSW handed his sentence down

[58] Transcript 21 April 2022 p. 165 L29

[59] Exhibit 1 Brief of Evidence Volume 3, Tab 28, p. 6

60 Exhibit 1 Brief of Evidence Volume 3, Tab 28, p. 6

on 18 June 2021[61]. Both SNAP and DCJ were convicted. A fine was imposed on SNAP in the amount of $75,000 and a fine imposed on DCJ in the amount of $150,000.

76. Relevantly, that decision sets out the improvements to systems of work following the deaths of Riley and Rachel. The improvements made by SNAP are set out at paragraphs 84 – 91 of the judgment and include:

    a. An internal review was conducted by SNAP's directors. SNAP reviewed various documents and information, and its induction, training and intake processes to amend and improve its safety systems: [84]

    b. In February 2018, SNAP reviewed its control measures regarding operation transportation of clients in motor vehicles and developed and introduced a comprehensive Transport Policy: [85].

    c. In March 2018, SNAP conducted training on its updated Transport Policy, duty of care, workers obligations and SNAP's Code of Conduct. All staff employed at the time attended the training, and it is now part of SNAP's induction so that every new staff member undergoes the training on commencement of employment [86]

    d. SNAP updated its Client Intake Referral and Application Form which includes a "Medical and Support Needs Information" section that asks detailed questions about the specific support needed for each client. This includes whether the client has behavioural difficulties, any safety risks and any special requirements regarding transportation: [87]; and

    e. SNAP developed and implemented a pro-forma risk assessment document that must be completed for children and young people who are transported by SNAP titled "Transportation of People We Support (PWS) Risk Assessment": [89]

77. Most significantly, and consistent with the evidence before this inquest, Scotting DCJ accepted that after Rachel and Riley's death, SNAP has refused referral placements when a risk assessment indicates safety risks, or when a second carer is necessary but not provided for in relevant funding ([91](a)). SNAP now conducts risk assessments for respite placements and considers transportation as a possible risk. SNAP uses its "Transportation of People We Support (PWS) Risk

[61] Note 4 supra

Assessment" form for this purpose ([91](2)).

78. While recognising the training already provided by SNAP, at the conclusion of proceedings counsel assisting suggested consideration of a recommendation for further training as well as the development of stronger Transport policy. I note that aside from a minor amendment SNAP supported the proposed recommendations. It appeared clear that some staff who gave evidence were unfamiliar with the SNAP's Transport policy. It was also evident that ongoing refresher training was called for and I intend to make recommendations in that regard.

79. Fiona's family were rightly concerned that the process of obtaining an appropriate harness for Riley should not have been so difficult. It is an issue I deal with more fully in the *Findings in relation to the Inquest into the death of Riley Shortland.*

Was the ratio of carers at SNAP for Riley adequate?

80. Riley was the only child at the respite placement with SNAP during the period 3-5 November 2017. Riley was provided with 1:1 care at all times. However, DCJ assessed Riley as always requiring two people for the purpose of respite at Camp Breakaway. It is unclear why that assessment was not maintained for SNAP's respite placement. If the DCJ accepted that Riley required two people at all times outside his usual home environment for the purpose of attending Camp Breakaway, then the 1:1 assessment with SNAP was demonstrably insufficient. Riley was not provided with an appropriate ratio of carers.

81. Riley, at the very least, should have been provided with an additional carer at all times when he was travelling in a vehicle during the period of respite care. Rachel was not provided with this additional support nor was Brooke Whitely or Karin Ford, each of whom also transported Riley.

82. The hours the SNAP staff worked that weekend were a focus during the Inquest. During the evening of 4 November 2017, Rachel had the following SMS communication with Stacey McIvor[62]:

> Rachel: Nearly 50 hours in 3 days. No sleep for me tonight either
>
> Stacey: … Ohh geez I'm on a triple 😢 don't u go to sleep on ur shifts

[62] Transcript 21 April 2022 p. 180 L18-2

Rachel: I am on respite, some I do and some you just can't 😭

83. The evidence establishes that Rachel did a four hour shift with SNAP (unrelated to Riley's respite) immediately prior to commencing her shift with Riley at 6pm. Rachel's shift continued up to and including her transporting Riley from the respite property at Thornton to his home with Fiona Martin in the late afternoon of 5 November 2017.

84. For the entirety of that shift, Rachel worked alone as a 1:1 support for Riley.

85. Rachel and Riley were struck by the vehicle at approximately 5.30pm. The effect of this evidence is that Rachel was on shift with SNAP for 27.5 hours at the time of her death. This staffing arrangement was in my view unacceptable. Ms Dodd, the expert engaged in these proceedings, did not consider it in line with industry standards.[63] To the extent that extended work hours are known to occur, Ms Dodd gave evidence that it is usually where the employee works for multiple organisations.[64] This was not the case for Rachel. The 27.5 hours was work solely with SNAP.

86. It is noted that eight hours of that shift was designated as a '*sleep* over' shift where the assumption is that the worker will receive a full 8 hours of '*uninterrupted sleep'.* However, on this occasion, Ms Ford directed that each worker was to sleep in the same room as Riley for safety reasons. Riley's past sleep behaviours as known to SNAP from his previous placement with the organisation, were such that it was considered necessary that a worker be in the same room as Riley so the worker would be aware of Riley's movements during the night.

87. Such an arrangement had the effect that SNAP ought to have assumed the shift was not a '*sleep over'* shift and that the worker was unlikely to have an 8-hour uninterrupted sleep during the shift. Ms Ford disagreed on the basis of information she received from Fiona Martin "*about [Riley] sleeping"* and the fact that "*while he was at respite, he got given some medication to help him sleep"*[65]

88. The fact that the worker was required to stay in the room with Riley, to effectively monitor him, is almost certainly incompatible with the worker being able to receive an uninterrupted 8 hour period of sleep.

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[63] Transcript 28 April 2022 p. 589 L45 – 50
[64] Transcript 28 April 2022 p. 590 L10
[65] Transcript 20 April 2022 p. 132 L33-34

89. As to Ms McIvor, the evidence was that Ms McIvor was asked to retain her usual shifts and do the additional sleep over shift with Riley which commenced at 4pm. Ms McIvor finished her shift with Riley at 8am (16 hours later), and then immediately went to another shift which she assumed in evidence was with her usual client.[66]

90. Ms Ford commented on the long work hours described. She stated in her evidence "*Sometimes with respites that type of thing is - it happens, it happens quite a lot*."[67]

91. It is of concern that both Ms McIvor and Rachel were working with a child with significant needs in those circumstances. It is of concern that it happens "*quite a lot*". Rachel's text messages indicate that she worked nearly 50 hours in three days. It is safe to assume from her messages that she was suffering fatigue. Long working hours may have contributed to both Riley and Rachel being at greater risk of harm.

92. Ms Ford stated in her evidence (in respect of the length of Rachel's shift that weekend with Riley):

> "*I suppose like you look at foster care there's somebody there doing it day in and day out and they never get a break, but the workers can sort of yeah it does happen. We try not to do it too often and obviously the higher needs person. It's also shifts that was put out because remember this didn't come to my original roster, and we were looking for workers to fill it in now and that, you know, it was going ahead on Friday and I rung, and you know, a number of works to say that I, a number of workers that I knew would be able to have the experience and the skills to be able to manage someone like Riley, so those people I contacted and asked them, you know, are they able to do a shift, and you know, spoke to Rachel and she said, "Yes".*

93. Several matters fall from this evidence.

    a. If SNAP could not have staffed the respite with sufficiently skilled workers in a safe manner, it ought not to have accepted the respite placement.

    b. I reject the notion that because parental carers maintain children for long periods without a break it was acceptable for staff to do it. A child in respite is out of their usual environment and away from their usual supports and

66 Transcript 21 April 2022 p. 181 L34, p. 182 L7 - 13
67 Transcript 20 April 2022 p. 133 L29

from the people they usually rely upon. Their behaviour by reason of those differences may be impacted.

c. It was the role of SNAP to protect its staff and to ensure the delivery of a safe service. It is not good enough to assert, a parent or carer can do it, so can the staff. Many working in the disability care environment are young adults who have not had the benefit of years of experience caring for, or having an ongoing relationship with, the child.

d. An employer should not simply rely on a staff member agreeing to a shift without assessing whether it is appropriate for that staff member to take on that shift. SNAP should not be rostering staff onto shifts that go for the period that both Rachel and Ms McIvor's lasted, or back-to-back shifts that result in that period.

94. Ms Ford further stated in her evidence that she spoke with Rachel on the Sunday morning and Rachel "*certainly wasn't indicating to me that she was very, very tired or had any issues there either*." Such a response fails to recognise the responsibility for the safety and wellbeing of staff lies primarily with the employer. As recognised by Ms Dodd in her evidence, there are risks to the safety of the employee and the child with an arrangement where the employee is working alone with a child with high needs for hours at a time

95. Counsel assisting recommended consideration of a review of SNAP's staffing policy to address some of these concerns. This was not resisted by SNAP.

The need for recommendations

96. Section 82 of the *Coroners Act 2009* 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.

97. As discussed, counsel assisting put forward a number of proposed recommendations to SNAP arising out of the evidence for the court's consideration. It is pleasing that aside from some small modifications, SNAP accepts them as appropriate matters to be considered. Further recommendations to other agencies arising out of this tragedy are dealt with in the associated proceedings of the Inquest into the death of Riley Shortland.

Findings

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

Identity

The person who died was Rachel Anne Martin.

Date of death

Rachel died on 5 November 2017.

Place of death

She died at M1 Pacific Motorway near Cameron Park NSW

Cause of death

She died from multiple injuries sustained when she was hit by a truck on the M1 Pacific Motorway.

Manner of death

Rachel's death occurred while attempting to prevent harm to Riley Shortland. At the time of her death Rachel was an employee of SNAP, an organisation which was providing Riley with respite care. Rachel ran onto the motorway in an attempt to catch Riley who had exited their vehicle.

Recommendations pursuant to section 82 *Coroners Act 2009*

99. For the reasons stated above, I recommend:

To SNAP Programs Ltd

100. It is recommended to SNAP that SNAP:

1. Review, amend, or draft a staffing policy addressing hours an employee may work. It is recommended that the policy prevent any employee being rostered on for a period in excess of a double shift. A double shift represents two 8 hour shifts or in the alternative, a sleep over shift (where the sleep hour shift is not more than 4hrs + 8hrs sleep + 4hrs) plus a further 8 hour shift, without a 10 hour break between the double shift and the next

shift, or as recommended by an expert in the area. It is understood that such a review would take into account the particular circumstances of staffing levels at camps and allow for exceptional circumstances.

2. To support a comprehensive understanding of any relevant regulations and the above developed staff rostering policy, it is recommended SNAP seek the support of an independent third-party advisor to:
   a) Deliver a session to the senior executive to understand broader risk implications in relation to staffing levels and related policies, legislative and regulatory requirements;
   b) Assess the appropriateness of the policy drafted in response to recommendation (1); and
   c) Deliver a workshop to staff and management to understand the risks around the associated policies and the failure to adhere to them.

3. Develop a policy to address a process for staff to elevate concerns regarding staffing challenges, with such process to be independent of executives and managers;

4. Ensure that training in the character of PART, or similar training, become a part of a cyclic refresher training program delivered by SNAP to staff and to new employees as soon as practicable after completing their probation period.

5. Update its transport policy to include the following:
   a) The transport driver should be provided with the details of an available contact person (hereafter referred to as ‘support person’) who can attend on the vehicle during that period of transport;
   b) Save for emergencies, a driver transporting a child or young person alone should not exit the vehicle whilst on a motorway, highway, or major public transport corridor. Where there is a need to pull over, such as where a child or young person is presenting a risk to safe driving or is a risk to other persons in the vehicle or themselves, emergency services or a support person should be contacted to assist in the safe access of the child or young person;
   c) Save for emergencies, whilst on a motorway, highway, or major public transport corridor, a driver transporting a child or young person alone should not open the vehicle’s door to access the child or young person.

Where there is a need to pull over and obtain access to the child in the vehicle, such as where a child or young person is presenting a risk to safe driving or is a risk to other persons in the vehicle or themselves, emergency services or a support person should be contacted to assist in providing safe access the child or young person.

d) Where there is a need to pull over and obtain access to the child in the vehicle, such as where a child or young person is presenting a risk to the safe driving, or a risk to other persons in the vehicle or themselves, emergency services or a support person should be contacted to assist in providing safe access the child or young person.

Conclusion

101. Many people have been devastated by Rachel's untimely death. She was in the prime of her life with so much to live for. Her death was preventable. She should not have been transporting Riley alone and her courageous attempt to prevent him from harm had tragic consequences. While nothing can bring her back, I hope Rachel's family take some small comfort from the changes Rachel's employer has already made to prevent further incidents of this kind.

102. I offer my sincere thanks to counsel assisting Gillian Mahony and her instructing solicitor Janet de Castro Lopo for their hard work and enormous commitment in the conduct of this inquest.

103. Finally, once again I offer my sincere condolences to Rachel's family, including her fiancé, and her mother. I offer particular thanks to Rachel's sister Amanda Martin and her husband Dean Olsen, who were in attendance during this inquest and made very valuable contributions to it. It is clear that Rachel will always be remembered and her memory cherished by those who loved her.

104. I close this inquest.

Harriet Grahame

Magistrate Harriet Grahame
Deputy State Coroner, NSW State Coroner's Court, Lidcombe
21 October 2022

Appendix A

AGREED FACTS

COURT DETAILS	
Court	CORONER'S COURT OF NEW SOUTH WALES
Registry	Lidcombe
Case number	**Rachel Martin (2017/00336274)**

TITLE OF PROCEEDINGS

Inquest into the death of Rachel MARTIN

AGREED STATEMENT OF FACTS

A. Rachel Martin

16. On 14 December 1989, Rachel Martin was born.

17. On 2 February 2015, Rachel commenced employment with SNAP in a casual capacity as a Casual Support Worker.

18. Rachel held a driver's license class of Provisional – P2, also known as a green P plate.

19. Rachel died on 5 November 2017 whilst in the course of her duties with SNAP. Rachel was in her second trimester of a pregnancy. Rachel was 27 years of age.

B. Immediate circumstances of the fatalities and cause of death

20. The fatal incident occurred at around 5.35 pm on Sunday, 5 November 2017 on

the M1 Motorway at Cameron Park.

21. At the time of the incident, Rachel was driving Riley Shortland home to his foster mother, Fiona Martin, who resided in Woy Woy on the NSW Central Coast. Riley had spent a weekend of respite care supervised by special care provider SNAP at a home in Thornton NSW, which had commenced on Friday, 3 November 2017. Aside from Rachel and Riley, there was no other person present in the vehicle, which was a white Tarago.

22. At the commencement of the journey, Riley was placed in his booster seat with the Houdini Strap, and was positioned behind the driver's seat, in the back row of the vehicle (with middle row of seats in between).

23. For a reason that is not known, the vehicle Rachel was driving and in which Riley was a passenger, stopped in the break down lane of the M1. Riley alighted from the vehicle and ran across the motorway, closely followed by Rachel. Both were struck by a southbound Isuzu flatbed 4.5 tonne truck.

24. Rachel and Riley each died at the scene from multiple, non-survivable injuries consistent with being struck by a vehicle.

25. Rachel's toxicological analysis was negative for drugs and alcohol.

26. Riley's toxicological analysis detected amphetamine, risperidone and citalopram at non-toxic levels, consistent with treatment in childhood for ADHD and related conditions.

27. The driver of the vehicle which struck Rachel and Riley also returned a negative result for alcohol and drugs. No charges were laid against the driver by police.

28. The notes of the Police Officer in Charge record that at the scene the Houdini Strap was unclipped on one of the arm straps and the main arm straps from the booster seat were also unclipped from the central buckle, in the Tarago which Riley and Rachel had been travelling in.

[1] External Examination Report for the Coroner (Tabs 4, 13)

29. Both Riley's foster mother and Rachel's mother requested an inquest be held.

C. Special Needs Accommodation Program (SNAP)

30. SNAP was the employer of Rachel.

31. Rachel commenced employment with SNAP in February 2015 as a casual Disability Support Worker.

32. At the time of Riley's death SNAP was registered by the Office of the Children's Guardian, as a voluntary out-of-home care (VOOHC) provider in NSW. SNAP was not accredited by the Office of the Children's Guardian as a designated agency. SNAP was providing respite care as a special care provider to Riley at the time of his death, with such care having been organised by DCJ.

33. On 29 November 2013, DCJ and SNAP entered into a Non Placement Support Services (NPSS) Standing Offer Agreement effective from 21 December 2013. The non-placement support services that SNAP agreed to provide to children and young people on a fee-for-service basis, including respite care (cl. 1.3(h)).

D. Matters concerning Riley's placement and respite post July 2017

34. Riley's mother entered into a temporary care agreement with DCJ on 1 July 2013.

35. On 4 July 2013, at the conclusion of the temporary care agreement, Riley commenced residing with SNAP an emergency crisis placement.

36. On 5 August 2013, Riley was assumed into the care responsibility of the Director-General pursuant to s. 49 *Care Act* and pending the commencement of Children's Court proceedings. He and remained in the placement residing with SNAP.

37. Children's Court proceedings commenced in August 2013 and interim orders placed Riley in the parental responsibility of the Minister. He was cared for by

SNAP for 15 months until his placement with Fiona Martin commenced on 4 October 2014. During that period, case management of Riley rested with DCJ.

38. Final orders were made in the Children's Court in April 2014 allocating parental responsibility for Riley to the Minister until he attained 18 years of age.

39. On 19 December 2014, following Riley's placement with Fiona Martin, who was approved as authorised carer with HWNS, Riley's case management transferred to HWNS.

40. While Riley was case managed by HWNS he generally received respite care one weekend per month and four hours respite twice per month.

41. HWNS continued in that role until they ceased providing foster care services on 30 September 2017.

42. On 29 September 2017, Riley's care management reverted to DCJ with the aim that case management would be transferred to another non-government agency, Allambi Care. At the time of Riley's death, case management was in the process of being transferred to Allambi Care, however had not occurred, with the effect that DCJ held case management responsibility for Riley at the time of his death.

43. Following case management being returned to DCJ, Riley attended a weekend respite at Camp Breakaway on 29 October – 31 October 2017. A behaviour support plan was provided to Camp Breakaway for the purpose of Riley's stay. The behaviour support plan noted targeted behaviours and included proposed restrictive practices which could be used to support Riley during the camp. A letter from Dr Damon Shorter, consultant paediatrician, setting out Riley's diagnosis and medication dosages was also emailed to Camp Breakaway.

44. Aside from the one weekend at Camp Breakaway on 29 October – 31 October 2017 and the weekend respite provided by SNAP on 3- 5 November 2017, Riley and Fiona Martin had not received any other respite arrangements since case management was transferred back to DCJ on 29 September 2017.

45. SNAP had previously cared for Riley between 4 July 2013 and his placement with Fiona Martin on 4 October 2014.

46. On all shifts over the weekend from 3 to 5 November 2017 at the SNAP house, Riley was cared for by a support worker with a ratio of 1:1, meaning that one staff member was rostered to care for Riley at a time. Riley was the only client at the respite house that weekend.

47. Rachel commenced her shift with Riley on Saturday, 4 April 2017 at 6pm, taking over from Alex Dongo. She remained working with Riley up until her death at approximately 5.35pm on 5 November 2017. This was the first time Rachel had cared for Riley. No other person was on shift with Rachel throughout that period. Support workers had access to on call and after hours support if they experienced any problems.

E. Known Risk Profile for Riley

48. On 29 April 2014, a caseworker prepared a Child Assessment Tool report (CAT).

49. In another document, located behind the CAT indicated that a carer recommended that a minimum of two carers are required in order to provide Riley 24/7 care. It is not clear whether that document forms part of the CAT.

50. On 9 December 2015, a Risk Profile was created for Riley by HWNS. Traffic, roads and travelling in vehicle were identified as extreme risks.

51. On 23 March 2017, HWNS created a submission for Restricted Practice Authorisation (NSW) on the basis that Riley had "issues in relation to his personal safety and that of others and safe car travelling".

52. On 23 June 2016, HWNS updated Riley's Coastwide Therapy prepared a Behaviour Support Plan with the assistance from of Riley's Shortland speech and occupational therapists from Coastwide Therapy. HWNS staff noted in the Behaviour Support Plan, that Riley had a targeted behaviour of "getting out of his car seat whilst travelling in the vehicle" and that:

> *"Riley Shortland's developmental delay means he does not understand social/societal/safety rules. This is clear when he attempts to get out of his car seat and/or a moving vehicle… Houdini stop strap to be used at all times when Riley Shortland is travelling in a vehicle…to be used for all vehicle travel, regardless of the length of the trip."*

53. There was a further document titled “There are just a few things you should know about me” attached to Riley’s Behaviour Support Plan. The document contained the following recommendations for Riley Shortland when travelling in a car or van and stated:

> “Please be sure to follow the instructions for securing me into my car seat.
>
> - I always have a carer seated next to me when I travel as they are lonely and need me to entertain them during the journey.
>
> - If I manage to escape you will need to be in a safe location before attempting to strap me back into my car seat.”

54. The Behaviour Support Plan made a further recommendations in respect to Riley travelling in a car or van that he be placed behind the passenger seat due to kicking the back of the front seat with his legs.

55. In September 2016, Kim Donohoe, psychologist of Peninsula Clinical Forensic Psychology, prepared a report noting that Riley’s behaviours of concern included Riley removing himself from car restraints.

56. Around March 2017, Coastwide Therapy Services provided an Occupational Therapy Report in respect of Riley in support of his NDIS application which in part stated that Riley, when in a car fights his way out of the seat belt and attacks other passengers who are close enough for him to reach. This occurred where ever he was seated in the car and his behaviour included kicking Fiona Martin when she was driving.

57. On 1 August 2017, the Benevolent Society prepared a “My Support Plan” for Riley as part of his NDIS plan. Absconding and removing his seat belt were each identified as behaviours of concern.

58. On 7 August 2017, Sue Watson of Coastwide Therapy Services prepared a report for NDIS seeking, inter alia, a Crelling harness for the car noting that Riley was able to get out of the car seat harness.

59. On 5 September 2017, a report was prepared addressing Fiona Martin's needs to maintain Riley's placement in her home. That report recognised that Riley required two worker at response due to his behaviours.

60. On 30 October 2017, Dr Shorter provided a report to Dr Dewey of Umina Family Practice regarding Riley's diagnosis and medications. Dr Shorter observed "ongoing chronic difficult behaviours" and considered Riley "requires substantial support". That report was provided to Camp Breakaway by DCJ (being the letter referred to at [43] above).

61. At the time of his death, Allambi Care were in the process of assessing their ability to support Riley's placement needs and were also undertaking a carer assessment, which had involved multiple interviews with Fiona Martin in September and October 2017. As Riley's care had not transitioned at the time of his death, DCJ retained case management and responsibility for his care.