CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Riley Christopher Shortland
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 – respite care; Voluntary out of home care (VOOHC); Statutory out of home care (SOOHC); Special Care Placement; Behavioural Support Plan; supported out-of-home care; cl. 32 of the *Children and Young Persons (Care and Protection Regulation) 2012*; 'special care placement'; safety restraints; transport death
File Number:	2017/00335331
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 Riley Christopher Shortland. **Date of death** He died on 5 November 2017. **Place of death** He died at M1 Pacific Motorway near Cameron Park NSW. **Cause of death** Riley died from multiple injuries sustained when he was hit by a truck on the M1 Pacific Motorway. **Manner of death** On the day of Riley's death, he was being cared for under a respite arrangement supervised by SNAP Programs. That respite was arranged through the offices of the DCJ in circumstances where the Department held case management responsibility for Riley. Riley died while escaping from the care of Rachel Martin, the carer employed by SNAP Programs to care for him while in respite care. It is likely that Riley removed a car seat harness while the car was travelling on the motorway. Ms Martin stopped the vehicle. Riley exited the back seat of the vehicle from the driver's side and ran directly onto the motorway into the path of oncoming traffic.

Recommendations:	**To the Office of the Children's Guardian** It is recommended the Children's Guardian: 1. Require organisations providing what is now known as specialised substitute residential care (SSRC) and substitute residential care (SRC) to have a transport policy. It is recommended that the Children's Guardian consider such policies require an assessment of each client's transport needs and the requirement for the transportation of children and young people assessed as requiring 1:1 support or who have behaviours of concern during the transportation process to be with a driver plus a dedicated carer for the child. 2. Engage with the Department of Communities and Justice to devise an appropriate checks and balance assessment sheet for potential providers of special care pursuant to cl. 27 of the *Children and Young Persons (Care and Protection) Regulation 2022* (formerly cl. 32 of the Care Regulation). **To the Department of Communities and Justice** It is recommended that the Department: 1. Devise a checks and balance assessment sheet for potential providers of special care pursuant to cl. 27 of the *Children and Young Persons (Care and Protection) Regulation 2022* (formerly cl. 32 of the Care Regulation), to ensure that the individual needs of the recipient of the Special Care can be met by the persons providing the care. 2. Devise a policy or procedure setting out the minimum paperwork to travel with a child or young person the subject of a special care placement, noting that such providers are not designated agencies and do not have access to ChildStory. 3. Make enquiries with Mobility and Accessibility for Children in Australia Ltd. (MACA) for the purpose of, subject to funding limitations, exploring whether MACA can assist in the formulation of transport related policies and learnings (the "Safe Travels" learnings), particularly within the focus of safety harnesses for children and young people with Autism Spectrum Disorder.

4. Consider making available to organisations delivering SSRC or organisations and individuals supporting children and young persons with Autism, the 'Safe Travels' learnings, following a successful trial and roll out to DCJ staff and designated agencies.

To SNAP PROGRAMS

It is recommended to SNAP that SNAP:

1. Review and 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 (representing two 8 hour shifts, or in the alternative, a sleep over shift (where the sleep over 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 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 as to staffing challenges, with such process to be independent of executives and managers.
4. Ensure that training in the character of PART, or similar training, becomes 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 the safe driving, 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 / 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 to 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 Riley Shortland. Riley was only eight years of age at the time of his death. He lived with his mother during his early years, however she struggled to cope with his very significant needs and Riley eventually entered State care. He lived in a temporary placement before settling with Fiona Martin and her sons in Woy Woy, NSW.

2. Riley had a diagnosis of a moderate to severe Global Development Delay, Attention Deficit Hyperactivity Disorder and Autism Spectrum Disorder (assessed as level 3 Autism, known as ASD-3 on the Autism Spectrum Disorder Scale). His ASD diagnosis was confirmed on 22 May 2013.[1] Riley was predominantly non-verbal and functioned at the developmental level of an 18-24 month old. Riley required close supervision at all times.

3. Fiona Martin, Riley's foster mother attended each day of the inquest. She explained that having Riley come to live with her family had been an immensely positive experience, that had taught them not to "*stress the small stuff, not to judge too quickly and to be more appreciative of what we have and who true friends are*."[2] She described Riley as affectionate, creative and talented. He had a love of the outdoors, running, balls and water play. He loved celebrations of all kinds. Fiona Martin told the court that Riley developed a strong emotional bond with her children and celebrated many milestones with her family. I acknowledge Riley's death has had a significant traumatic impact on her family and I saw her great sorrow and pain.

4. I also acknowledge Riley's birth family and while they did not participate in the inquest, I send to that family, my sincere condolences.

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

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[1] Exhibit 1 Brief of Evidence ebrief Volume 1, p. 227.
[2] From Fiona Martin's family statement, attached to the Court file.
[3] Section 81 *Coroners Act 2009* (NSW).
[4] Section 82 *Coroners Act 2009* (NSW).

The evidence

6. The court took evidence over eight hearing days[5]. The court also received extensive documentary material tendered 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, extensive records concerning Riley's history and care arrangements and selected material from the SafeWork NSW prosecution proceedings against SNAP and the Department of Communities and Justice (DCJ).

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

8. A list of issues was prepared before the proceedings commenced. These issues guided the investigation. The issues were:

    1. The manner of Riley's death, including the factors contributing to his death.

    2. 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.

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

    4. Whether Rachel, his carer, was provided with sufficient information in respect of Riley to ensure both her safety and that of Riley.

9. As the inquest progressed, the real issues under investigation were somewhat narrowed both by the appropriate concessions and changes made by DCJ following their own internal investigation and by concessions made by SNAP in earlier proceedings.

[5] Three inquests were held together and some evidence was applicable to each inquest. In total the court sat for 8 days.

Fact finding

10. This inquest took place following proceedings in the District Court where many of the circumstances surrounding Riley'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.

11. Further information was received in oral evidence. Counsel Assisting also summarised much of that material in her comprehensive closing 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 closely.

Background

12. Riley Shortland (Riley) was born on 27 December 2008 to Amanda Taylor and Mark Shortland.

13. Riley was diagnosed with Autism Spectrum Disorder and global development delay in 2012. He had limited speech and communication skills.

14. On 1 July 2013, Amanda Taylor signed a temporary care arrangement with the Department. This arrangement was expressed to operate from 1 July to 1 October 2013 (subject to relevant intervening events).

15. On 4 July 2013, three days after the commencement of the temporary care arrangement, Riley commenced residing at a house operated by SNAP Programs (SNAP). The evidence of the founder of SNAP, Ms Karin Ford, is that Riley resided with her in her own residential home during this period,[7] and, pursuant to that arrangement, SNAP staff would attend her home to work with Riley 24 hours/day, 7 days a week.[8] That placement continued until 4 October 2014, a period of fifteen months. This early placement is relevant to SNAP's later confidence that despite not having received the appropriate documentation, it had an understanding of

[6] *SafeWork NSW v SNAP Programs Limited and State of NSW (Department of Communities and Justice)* [2021] NSWDC 259.
[7] 20.04.22 T114.25 – 27.
[8] 20.04.22 T115.3 – 5.

Riley's needs.

16. 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*') and an application was filed in the Children's Court in respect of Riley.

17. 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.

18. On 4 October 2014, Riley was placed with Fiona Martin[9], 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*. 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).

19. At the time of his death, Riley remained under the parental responsibility of the Minister for Communities and Justice. On the day of his death, Riley was being cared for under a respite arrangement supervised by SNAP. That respite was arranged through officers of the Department of Family and Community Service (now known as the Department of Communities and Justice (DCJ)) in circumstances where, at that time, DCJ held case management responsibility for Riley as a child in SOOHC.

20. Riley received funding for his disability care through the National Disability Insurance Scheme (NDIS). Riley's NDIS plan commenced on 22 March 2017.

Brief chronology

21. The events leading up to Riley's death are set out in the Agreed Facts[10]. In short Riley and his carer Rachel Martin were driving in a SNAP vehicle, a Toyota Tarago, along the M1 Motorway, for the purpose of Riley's return journey from respite care to his home with Fiona Martin. It appears likely that Riley somehow removed his restraint while the vehicle was moving. This would explain why Rachel Martin pulled the vehicle over into the breakdown lane. Once the car was stationary, Riley exited the vehicle and ran across the motorway followed closely by Rachel Martin. I am satisfied that she was trying to save his life. Both Riley and his carer were struck by a motor vehicle travelling south on the motorway.

[9] I note for completeness that Fiona Martin and Rachel Martin are not related.
[10] Appendix A to these findings.

Cause of Death

22. An external examination report was conducted by Dr Allan Cala on 8 November 2017. He concluded that the cause of death was 'multiple injuries'.[11] These injuries included a fracture of the base of the skull, fracture of the pelvis and severe chest trauma. Toxicological testing found prescription drugs at therapeutic levels as expected. I accept as accurate the forensic pathologist's recorded cause of death.

Riley as a child in Statutory Out-of-Home Care – the statutory framework

23. It is important to note at the outset that the relevant legislative regime in place at the time of Riley's death has since been altered. Changes have occurred since this inquest commenced and continued even after the filing of submissions. The process has greatly complicated consideration of recommendations proposed by counsel Assisting in this and the related inquests.

24. It is nevertheless necessary to set out some of the background.

25. Since 2013 Riley had been in SOOHC, as that phrase was defined in s. 135A of the *Care Ac*t.

26. "Out of Home Care", as defined by s. 135 of the *Care Act* (and as defined at the relevant times), means residential care and control of a child or young person that is provided:

    (a) by a person other than a parent of the child or young person, and

    (b) at a place other than the usual home of the child or young person,

    whether or not for fee, gain or reward.

27. At the relevant time, and as at the date of the Inquest, the *Care Act* provided for 3 types of out-of-home care for the purposes of the *Care Act*, namely, SOOHC, supported out-of-homecare and Voluntary Out of Home Care ('VOOHC') (VOOHC having the meaning afforded to it under the *Children's Guardian Act 2019*). VOOHC has since been removed as a type of "out of home care". Riley was in SOOHC from 5 August 2013.

28. At all relevant times, s. 135A of the *Care Act* defined SOOHC as out-of-home care that is provided in respect of a child or young person for a period of more than 14

[11] Exhibit 1 Brief of Evidence Volume1, Tab 4.

days—

(a) pursuant to a care order of the Children's Court, or

(b) by virtue of the child or young person being a protected person.

29. Section 136 of the *Care Act* has, at all relevant times, provided that SOOHC may be provided in respect of a child or young person only by an authorised carer and further, a person, other than an authorised carer, who provides SOOHC in respect of a child or young person is guilty of an offence.

30. Section 137 of the *Care Act* at all relevant times has defined "authorised carer" and has included within that definition, the principal officer of a designated agency and a person who, in accordance with the regulations, is authorised as an authorised carer by a designated agency. Fiona Martin was authorised by HWNS as an authorised carer.

31. Section 138 of the *Care Act*, provided that arrangements for the provision of SOOHC or supported out-of-home care may be made only by a designated agency, or the Children's Guardian.

32. At the relevant time, s. 139 provided that a "designated agency" meant, inter alia, an organisation (or branch or other part of an organisation) that arranged the provision of out-of-home care, if the Division or organisation (or branch or other part of the Division or organisation) was accredited for the time being in accordance with the regulations. That definition is now found in the *Children's Guardian Act 2019* at s.72. The HWNS was registered as a "designated agency" by the Office of the Children's Guardian (OCG).

33. SNAP has never been accredited by the OCG as a SOOHC provider and, as such, has never been a designated agency or been authorised to plan for the provision of SOOHC. SNAP itself is not an authorised carer. SNAP was, at all relevant times, registered with the OCG as a VOOHC provider. The placement of Riley with SNAP between 4 July 2013 and 4 October 2014 was not a placement falling under VOOHC but was pursuant to cl. 32 of the *Children and Young Persons (Care and Protection Regulation) 2012* ('*Care Regulation*')[12] (a 'special care placement'). That regulation was repealed and replaced on 26 August 2022 with a 2022 regulation of the same name. Clause 32 no longer exists in the form it did at the time of Riley's death and as it did at the time of the hearing of this inquest. Clause

[12] 19.04.22 T32.37 – T33.38.

27 in the 2022 Regulation embraces, albeit in amended terms, the concept of the cl. 32 special care placement.

34. In July 2017, HWNS informed DCJ 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.

35. Riley remained in full-time care with Fiona Martin. At the time of Riley's death, case management had not been transferred to Allambi Care, with the effect that DCJ held case management responsibility for Riley.

36. The transfer of case management from the HWNS to DCJ was an unusual occurrence and was pursuant to s. 141(1) of the *Care Act* which operated in the circumstances where a designated agency could no longer fulfil its responsibility of supervising the placement of a child or young persons under the parental responsibility of the Minister. Section 141(1) of the *Care Act* provided:

> *"(1) If a designated agency, other than the Department, is designated to supervise the placement of a child or young person in out-of-home care and that agency ceases to be able to fulfil its responsibilities in relation to the child or young person, the Department is to supervise the placement of the child or young person."*[13]

The transfer of Riley's case management to DCJ

37. On 31 July 2017, Kim Housden, HWNS Foster Care Service Manager, provided to Wendy Wilson, FACS Manager of Client Services, Riley's NDIS Plan.[14] That was provided to Allambi on 29 September 2017 by Kathleen Davis, Manager CaseWork, Central Coast Child and Family District Unit, DCJ.

38. The facts as found by the District Court in the SafeWork sentencing matter, for which agreed facts were filed,[15] included that on 29 September 2017, Ms Housden, met with Ms Wilson to complete a case management transfer for Riley. At this meeting, Ms Housden provided Ms Wilson in both paper form and on a USB, a copy of Riley's updated file, which included the 2016 Behaviour Support

[13] Section 141(1) *Children and Young Persons (Care and Protection) Act 1998*.
[14] Exhibit 1 Brief of Evidence Volume 1, Tab 22, p. 1.
[15] Exhibit 1 Brief of Evidence Volume 3, Tab 50, p. 9.

Plan (BSP) and a vehicle plan dated 28 June 2016. Ms Housden informed Kathleen Davis and Ann Cochrane, both DCJ employees, that HWNS always needed two carers to support Riley for respite and transport. Ms Wilson nominated Ms Cochrane to be the FACS contact person for Fiona Martin. DCJ conceded that the handover on 29 September 2017 was rushed[16].

39. Two further significant failings were that no DCJ staff member reviewed Riley's file post-handover and the then electronic case management system called "Key Information and Director System" (KIDS) in respect of Riley had not been updated with the most recent information that was contained in the HWNS file, including the 2016 BSP and vehicle plan. The SafeWork sentencing hearing found that KIDS only contained Riley's 2013 Client Information Form, the 2014 Child Assessment Tool and the 2014 BSP. The 2013/2014 documents did not have information in relation to Riley's current transportation needs and targeted behaviour of trying to remove his seatbelt when in a moving vehicle and trying to get out of a moving vehicle.[17]

Changes to s. 141 practices since Riley's death

40. Following Riley's death, the November 2017 Internal Child Death Review ('ICDR') recommended the development of policy and procedure to guide practice for when case management of children in out of home care returns to DCJ.[18] DCJ implemented a number of changes to the practices when a funded service provider (FSP) is unable to fulfil its obligations and case management of any child or young person within their case load is returned to DCJ pursuant to s. 141 of the *Care Act*. In response, DCJ consulted and drafted the "*Supervising placement when a service provider is no longer able to fulfil its duties"* policy. This policy was approved on 3 November 2020 and provides clear guidelines setting out what is required when DCJ becomes responsible for supervising a placement under s. 141. The policy applies, inter alia, when a designated agency ceases to operate or hold out of home care accreditation.[19] This policy requires a nominated unit to immediately commence supervision of the child's placement.[20]

41. During the inquest, Simone Walker, then Deputy Secretary, gave evidence that at the time of the transfer from HWNS to DCJ, the staff were far less clear on the role

[16] Exhibit 1 Brief of Evidence ebrief Volume2, Tab 26, pp. 3, 8.
[17] Ebrief V3: p. 849 Safework NSW v SNAP Programs Limited & State of New South Wales (Department of Communities and Justice) [2021] NSWDC 259 at [41].
[18] Exhibit 1 Brief of Evidence ebrief: Volume 2, Tab 26: p. 11.
[19] Exhibit 1 Brief of Evidence Volume 3, Tab 47 [105] – [108], Annexure N, p. 306 (ebrief: Volume 3: p. 472); Tab 47A p. 2 [8] – [9].
[20] Ibid at p. 318 (ebrief Volume 3: p. 484).

and responsibilities arising when s. 141 operated and DCJ's own understanding that it needed to take responsibility of case management very seriously was "*looser*".[21] Ms Walker agreed that a very significant change that has arisen as a consequence of Riley's death, is a much more rigorous understanding and greater clarity of DCJ's role where management is transferred back to it.[22] This is to be commended.

42. I find that the management of Riley during the period DCJ had case management was significantly below expected standards and was the result of confusion in relation to its role during the transfer period, as well as DCJ having limited experience to draw on in such circumstances. This resulted in a lack of focus on actual case management. It is pleasing that DCJ have acknowledged and attempted to remedy this situation.

Arranging Riley's SNAP Weekend Respite Placement

43. The NDIS Plan emailed to DCJ by HWNS on 31 July 2017 provided some important information, including the fact that Riley's current respite arrangements (expressed as 1 night a month on a weekend with grandparents in Campbelltown, and two 4-hour blocks on other weekends) did not meet his needs.[23]

44. The evidence suggests that the details around Riley's respite arrangements were already out of date by the time the NDIS Plan was provided to DCJ in July 2017. They were inconsistent with the respite details set out within the HWNS Child/Young Person Summary later provided in September 2017.[24]

45. The HWNS Child/Young Person Summary referred to Riley attending respite at Camp Breakaway and the fact that HWNS had not heard from Riley's maternal grandfather since May 2017. Therefore, respite with his grandfather had not been taking place as was suggested in the NDIS Plan.

46. As to other important information about respite needs, the HWNS Child/Young Person summary said:

> *"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*

[21] 19.04.22 T18.20 – 25; T18.45 – T19.5.
[22] 19.04.22 T19.34 – 37.
[23] Exhibit 1 Brief of Evidence Volume 1, Tab 22a, p. 3.
[24] Exhibit 1 Brief of Evidence Volume 2, Tab 35, p. 4.

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. Clearly, respite was necessary so that Riley could continue to be loved and cared for by his foster mum operating at her best (so far as circumstances allowed). The Department concedes Riley and Fiona's respite needs should have been anticipated and properly managed from the start."

47. Instead, respite arrangements were quickly made only in response to Fiona's distress when reporting Riley was not attending his regular respite. 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*."[25]

48. These concerns and others were repeated by Fiona in various ways in multiple discussions with DCJ on 17 October 2017[26], via SMS the same day,[27] in discussions in the lead up to 23 October 2017,[28] on 27 October 2017,[29] and on 1 November 2017.[30]

49. Fiona Martin expressed reservations about Riley attending respite with SNAP if it was to occur at the original place where Riley was placed with that agency (it was not).[31]

50. Following case management being returned to DCJ, Riley and Fiona Martin were not provided with respite until 29 October 2017, despite there being a clear and known need for respite to protect Riley's ongoing placement with Fiona Martin. The need for respite was clearly identified and was one of the issues that delayed Fiona Martin's assessment as an authorised carer for Allambi.[32]

51. Respite was arranged with Camp Breakaway for the weekend of 29-31 October 2017. Ms Cochrane relied on information provided by Fiona Martin to fill out Riley's

[25] Exhibit 1 Brief of Evidence Volume 1, Tab 22e, p. 181.
[26] Exhibit 1 Brief of Evidence Volume 1, Tab 22e, p. 181.
[27] Exhibit 1 Brief of Evidence Volume 1, Tab 22f, p. 186.
[28] Exhibit 1 Brief of Evidence Volume 1, Tab 22c, p. 32.
29 Exhibit 1 Brief of Evidence Volume 1, Tab 22e, p. 184 and Tab 22f, p. 188.
30 Exhibit 1 Brief of Evidence Volume 1, Tab 23, p. 1; Tab 22c, page 53.
31 Exhibit 1 Brief of Evidence Volume 3, Tab 47A, page 351.
[32] Exhibit 1 Brief of Evidence Volume 1 Tab 22c, p. 36-37.

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."*[33]

52. This was a respite placement which should have proceeded pursuant to cl. 32 of the *Care Regulation* but did not. This was probably because DCJ staff mistakenly identified it as a "holiday camp", which is specifically excluded from the definition of "out-of-home care" by virtue of cl. 28(1)(b) of the *Care Regulation*.

53. Riley's attendance at Camp Breakaway was not signed off under cl. 32 of the *Care Regulation*. The evidence of Craig Leyton[34] of DCJ was that he assumed that the Department staff were relying upon cl. 28(1) of the *Care Regulation* which expressly excludes from OOHC "*a holiday camp, outdoor recreation centre or similar facility where children and young people undertake or receive education, training or instruction in academic, religious, athletic or recreational pursuits, but does not include any such camp, centre or facility the primary purpose of which is to give respite to the carers of children and young people or to address the challenging behaviour of children and young people".* While it is apparent that the primary purpose of the camp was respite for Riley and Fiona Martin,[35] attendance at the Camp was not treated as such, thereby the cl. 32 special placement provisions were not invoked.

54. 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. It seems likely that HWNS had previously provided the BSP to Camp Breakaway, given they were the organisation who first arranged Riley's attendance there.

55. On 24 October 2017, Amy Parker, a new FACS employee, was instructed by Ms Davis to contact SNAP to ascertain whether they had any available weekend respite care placements for Riley. Ms Parker had not placed a child for 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.

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[33] Exhibit 1 Brief of Evidence Volume 1, Tab 24c, p. 1.
[34] 19.04.22 T70.50 – T71.3.
[35] 19.04.22 T29.15 – 35; T71.14-39. See also Exhibit 1 Brief of Evidence Volume 1, Tab 22c, page 34.

56. 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*".[36] No other information as to Riley's needs were provided. Riley was not attending school at Aspect Terrigal.

57. The CEO of SNAP, Mr William (Butch) Hays, replied on 25 October 2017 and confirmed that SNAP was able to provide a respite care placement for Riley between 3 to 5 November 2017 at a cost of $2,995 plus GST. The fee would cover transport, activities, meals and support. This quote was provided in the absence of knowing Riley's needs including the level of support he required generally, and the support 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 and noted that DCJ needed to complete that form.

58. It was clear that SNAP prided itself on being able to assist on short notice. In oral evidence the CEO of SNAP programs, Mr William Hays 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*."[37]The company was formed to provide a "*quick response*".

59. Ms Wendy Wilson 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*" and enquired as to whether any camps were available through SNAP. No camps were available at the time.[38]

60. 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*".[39] No one from DCJ had returned a completed referral form to SNAP who remained 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.

61. 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

[36] Exhibit 1 Brief of Evidence Volume 1, Tab 22d, p. 62.
[37] 20.04.22 T147.20 – 21.
[38] Exhibit 1 Brief of Evidence Volume 1, Tab 22c, pp. 55 – 56.
[39] Exhibit 1 Brief of Evidence Volume 1, Tab 22c, p. 54.

the request for respite provision, stating inter alia:

> "*Additionally, it would only be fair to both Riley and his carer Fiona to do this in a more planned way, so that at least some of the staff could possibly meet them prior to him coming in, learn more about his needs and for us to ensure we have the right staff working with him. I was informed today that Riley was very unsettled after returning from the last respite he had with Camp Breakaway, so if we are going to do this, we want to do it well."*[40]

62. The approach of Allambi was appropriately child focused and risk aware.

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

a. Ms Parker emailed Ms Wilson "*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 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).*[41]

b. At 2.21pm, it was noted internally within DCJ, that no probity checks had been done on SNAP or Mr Hays.[42]

c. At 2.57pm, the relevant forms to allow a special care placement to take place were emailed from Ms Wilson to Ms Parker.[43] Mr Hays returned his Working With Children Check and Police Check at 3.07pm,[44] and the signed Code of Conduct document at 3.31pm.[45]

d. The paperwork to permit the placement was sent to the Direction Operations Central Coast at 3.27pm.[46] The paperwork placed significant emphasis on

[40] Exhibit 1 Brief of Evidence Volume 1, Tab 22c, p. 46.
[41] Exhibit 1 Brief of Evidence Volume 1, Tab 22d, p. 53.
[42] Exhibit 1 Brief of Evidence Volume 1, Tab 22d, p. 67.
[43] Exhibit 1 Brief of Evidence Volume 1, Tab 22d, p. 8.
[44] Ibid at p. 109.
[45] Ibid at p. 99.
[46] Ibid at p. 113.

SNAP and Mr Hays knowing "*Riley well*" and "*already knowing Riley's behaviours and needs*".[47]

e. The document stated that DCJ "*will provide SNAP with Riley's latest CIFS and CAT"* which entail his recent behaviours, needs and medication dosage.[48] 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."*[49] It appears 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 accept her evidence that Riley was pleased to see her.

64. 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*."[50] 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.

65. The organisation of this period of respite was extremely rushed, and no proper assessment of Riley's needs was made in that process and consequently, it was not adequately child-focused. This is a clear failing and has been properly acknowledged by DCJ.

66. It is also clear that SNAP needed to have demanded further information before accepting Riley. I accept that SNAP was persuaded and comforted by their belief

[47] Ibid at p. 115.
[48] Ibid at p. 115.
[49] Exhibit 1 Brief of Evidence Volume 2, Tab 41, p. 2.
[50] 20.04.22 T116.1 – 37.

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.

Information from HWNS about Riley's particular needs around transport

67. On 23 June 2016, HWNS updated Riley's Behaviour Support Plan with the assistance from Riley's speech and occupational therapists. 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*". Another part of the plan said "*Riley'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 is travelling in a vehicle… to be used for ALL vehicle travel, regardless of the length of the trip*". A Houdini Stop is an aftermarket device designed to keep the shoulder straps of a child's restraint's inbuilt harness together to minimise the chance of these coming off the shoulder.[51]

68. HWNS purchased the E-Z On Vest for Riley in or about September 2016.

69. Riley received funding for his disability care through the NDIS. Riley's NDIS plan commenced on 22 March 2017.

70. Riley saw an Occupational Therapist (OT) fortnightly in clinic and at home and monthly at school. In May 2017, Riley's occupational therapist prepared an update report that stated, inter alia:

> "*Riley used an 'E-Z On Vest' for a short period, as a harness for the car; however, he was able to get out of it. This is the most supportive harness on the market, so we are currently working on a bespoke one, designed just for Riley with the company 'Paediatric Mobility Equipment', who are the main supplier in this field. An appointment has also been made with Aidacare to trial a suitable stroller/wheelchair and other harnesses on 5 June 2017."*

71. In the interim, HWNS continued to use the Houdini Stop and ensured that there was always a support worker seated next to Riley for transport at respite and out in the community while waiting for a new harness to be sourced.

72. Riley had used both the Houdini Stop strap (with his booster seat) and the E-Z On

[51] Exhibit 11 Statement of Helen Linder, MACA at p. 9

Vest with straps between the legs while travelling in a vehicle to limit his ability to get out of his car seat. The Houdini strap and booster seat were too small for Riley. The E-Z On Vest did not meet Australian standards but was used widely in Australia.

73. When case management was transferred from HWNS to DCJ on 30 September 2017, the E-Z On Vest was returned to the HWNS at their request. Fiona Martin was not provided with an alternative harness to the E-Z On Vest for Riley by DCJ who took over case management, and she continued to use the Houdini strap when travelling in a vehicle with Riley.

74. A handover meeting for Riley involving HWNS and DCJ took place at the Hunter Central Coast CFDU on 29 September 2017. Riley was not the only child discussed at the handover. The Manager of Client Services who attended the meeting said the meeting felt rushed.[52]

75. HWNS handed over their file for Riley. Information about Riley's particular needs could be obtained in various documents within the file. However, those documents were not necessarily consistent with one another, nor up to date. DCJ submitted that this is not unusual given that such files typically contain documents that reflect a child's changing needs and arrangements over time.

76. The inconsistency between documents within the file and the changing needs of children, points to the need for a careful handover (then and now) from a designated agency to DCJ with a focus upon selecting the most important and up to date information about the child's current arrangements and needs from amongst the totality of documents included within any file.

77. In Riley's case, the evidence suggests that prior to receiving the HWNS file, DCJ received a copy of Riley's NDIS plan. This was emailed to DCJ by HWNS on 31 July 2017.[53]

78. The NDIS plan provided information about matters such as Riley's active behaviour, tendency to run away, need for funding for school transport and capacity to damage the car he was riding in. The NDIS plan did not *specifically* set out the need for one-on-one support (independent of the driver) when travelling in the car.

[52] Exhibit 1 Brief of Evidence Volume 2, Tab 26, p. 53.
[53] Exhibit 1 Brief of Evidence Volume 1, Tab 22a, p. 1.

79. That specific information was, however, contained within the BSP of 28 June 2016,[54] included within the HWNS file, which was later provided to DCJ.

80. DCJ conceded that this file was not considered or reviewed upon receipt. Indeed, the caseworker who later completed documentation for Riley to attend respite with SNAP was unaware the file was even available. She instead searched the KIDS database to obtain details for Riley.[55]

81. The ICDR Report clearly found that *"[t]he documents provided by HWNS should have been looked at, considered and checked."*[56]

82. Had this occurred, the caseworker would have been able to access the most up-to-date BSP for Riley from 2016, rather than an outdated BSP from 2014 still available on the KIDS database. (The 2016 BSP was due for review in December 2016,[57] but that further review had not been completed by the time DCJ assumed supervisory responsibility in September 2017. The draft updated BSP was apparently still with Riley's psychologist for review in consultation with his occupational therapist).[58]

83. The 2016 BSP identified on the first page that "*Riley is unable to block out unimportant sensory information in his new environment and hence becomes overwhelmed when trying to complete challenging or new tasks choosing to 'flee' the situation on most occasions unless supported 1:1*." [59]

84. This was important information to help understand the way Riley was likely to respond when overwhelmed, including by things that might not overwhelm a neurotypical child of the same age.

85. The BSP on its first and third pages specifically referred to the use of the Houdini strap when Riley was travelling in a car. Further, attached to the BSP was a document titled, "*There are just a few things you should know about me*", which referred to specific matters relating to "*travelling in a car or van*", including "*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.*"[60]

86. The BSP did not specifically refer to Riley using an E-Z On Vest for car travel,

[54] Exhibit 1 Brief of Evidence Volume 1, Tab 37.
[55] Submissions for DCJ 29 July 2022 [38].
[56] Exhibit 1 Brief of Evidence Volume 2, Tab 26, p. 54.
[57] Exhibit 1 Brief of Evidence Volume 2, Tab 37, p. 14.
[58] Exhibit 1 Brief of Evidence Volume 2, Tab 35, page 5; Volume 2, Tab 40, pp. 32-3.
[59] Exhibit 1 Brief of Evidence Volume 2, Tab 37, p. 1.
[60] Exhibit 1 Brief of Evidence Volume 2, Tab 37, p. 17.

probably because HWNS purchased the vest sometime around September 2016, which was some months after the BSP was completed.

87. HWNS say the handover meeting with DCJ included a discussion about the need for two people to support Riley for respite and transport in the community.[61] DCJ did not provide an alternative harness to the E-Z On Vest when taking over supervisory care for Riley and was not aware of the existence of the E-Z On Vest.

88. However, DCJ did take steps to try and follow through with obtaining a harness for Riley to use after Fiona raised concerns. It is important to record the contents of correspondence from Sue Watson, Occupational Therapist, dated May 2017. Ms Watson says:

> *"EZ On vest was used for a short period as a harness for the car for Riley, however he was able to get out of it. This is the most supportive harness on the market so we are currently working on a bespoke one, designed just for Riley with the company "Paediatric Mobility Equipment" who are the main supplier in the field."*[62]

89. Further, the HWNS case manager told the ICDR team:

> *"The [E-Z-On Vest] travel harness is approved in America but not in Australia. When we realised this…Riley's school would no longer use it and Fiona had stopped using it because Riley had gotten out of it once. So we kept using the Houdini [chest clip] and we made sure there was always a support worker seated next to Riley for transport at respite and out in the community. We were waiting for NDIS to approve a new harness for Riley…one that was like a rock climbing harness…something he couldn't get out of. Six months later we were still waiting on NDIS."*[63]

90. If Riley's school would not use the E-Z-On Vest, if Fiona had stopped using it because Riley could get out of it, and if HWNS were awaiting NDIS funding to try a different type of harness, it would make sense that DCJ was not told about the E-Z-On Vest in September 2017, because it was no longer being used.

91. In any event, on 23 October 2017, a DCJ caseworker emailed the Manager of Client Services, Ms Wilson, noting "*Fiona said that Riley is too big for his car booster seat. She had organised for a special car body harness and the company couldn't*

[61] Exhibit 1 Brief of Evidence Volume 2, Tab 26, p. 53.
[62] Exhibit 1 Brief of Evidence Volume 2, Tab 40, p. 14.
[63] Exhibit 1 Brief of Evidence Volume 2, Tab 26, p. 50.

provide a carsticker. Fiona has found a company to get the body harness and sticker off and needs it urgently. Riley is getting bruises from his seat."[64]

92. This prompted the response from the Manager of Client Services, "*I also wondered if we could purchase the harness that is required. Did you locate the NDIA plan for Riley and is there money in this for respite or the harness*".[65]

93. An email the next day on 24 October 2017, from the Manager Casework (Kathleen Davis), noted

> *"…re NDIS Plan/Harness – I sent the NDIS plan to Tim [of Allambi Care] on 29/9/17…My reading of it is that there is $1000 for things such as slings. Can you ring the carer to get more details on what she wants and who we need to speak to at NDIS to make this happen. (If she has spent the allocated money on other things for Riley then ask her how much it is etc as we may be able to purchase this)."*[66]

94. There does not seem to have been any further follow up on this aspect. Attention instead focused upon arranging respite for the weekend of 29-31 October 2017 prior to the caseworker who was then liaising with Fiona going on leave on 27 October.

95. Nonetheless, it is important to fairly record that DCJ had *begun* steps to try to arrange a harness for Riley, even if nothing had come of it by the time of his death.

Special out-of-home care pursuant to clause 32

96. From a systemic DCJ perspective, Riley's out of home care arrangements across the weekend of 3-5 November 2017 were unusual for two distinct and unrelated reasons:

    1. First, he was within the small group of children in the Hunter Central Coast CFDU who had come into the supervisory care of DCJ pursuant to s. 141 of the *Care Act* upon HWNS closing their foster care service, prior to Riley's placement being transferred to a new designated agency. Most other children had been placed with new providers.

    2. Second, when DCJ needed to arrange respite for Riley and no accredited SOOHC organisation was able to provide it, DCJ had to fall back upon the

[64] Exhibit 1 Brief of Evidence Volume 1, Tab 22c, p. 32.
[65] Exhibit 1 Brief of Evidence Volume 3, Tab 47A, p. 384.
[66] Exhibit 1 Brief of Evidence Volume 3, Tab 47A, p. 383.

special out-of-home care provisions in cl. 32 of the *Care Regulation*.

97. As set out in the statement of Simone Walker,[67] special out-of-home care applies to a limited group of children or young people already in SOOHC, where one of DCJ's accredited districts is providing case management and where the child or young person is living with a disability or impairment of the type specified within cl. 32.

98. Special out-of-home care arrangements involve placing a child with a non-designated agency. They are therefore uncommon and require sign off from a DCJ Deputy Secretary.[68]

99. Ms Walker, as Deputy Secretary, Northern Cluster, DCJ, was familiar with the authorisation process from her involvement in other cases from across the state.

100. However, caseworkers based in DCJ District Offices may have been less familiar with the special out-of-home care procedures and were also sadly unfamiliar with Riley and his needs.

101. DCJ acknowledges that it "*should have allocated his case to a worker who could know him, plan for him and keep his needs at the centre of all decisions. Riley also required a support plan that recognised his needs as a child in out of home care, who had complex disabilities, and specific support needs*."[69]

The provision of information to SNAP – the Behavioural Support Plan

102. The DCJ caseworker who completed the submission for funding when Riley attended Camp Breakaway noted in that submission, "*Riley has attended Camp Breakaway previously. Riley requires two workers to work with him at all times around theclock due to his high needs*."[70]

103. As noted above, there is no evidence to suggest Camp Breakaway obtained a copy of Riley's BSP from DCJ.

104. The DCJ caseworker who arranged the Camp Breakaway respite in October 2017 said during her interview with SafeWork that in making those arrangements, she relied upon information from Fiona and Camp Breakaway's previous involvement. She specifically said, "*I didn't have the file or USB of Riley. It wasn't till after that*

[67] Exhibit 1 Brief of Evidence Volume 3, Tab 47A, p. 8 [26].
[68] Exhibit 1 Brief of Evidence Volume 1, Tab 22d, p. 114; Volume 3, Tab 47A, p. 15 [58(g)].
[69] Exhibit 1 Brief of Evidence Volume 2, Tab 26, p. 6.
[70] Exhibit 1 Brief of Evidence Volume 2, Tab 26, p. 57.

that I got that." [71]

105. Nonetheless, at the very least, such information as was provided to Camp Breakaway should also have been provided to SNAP when organising respite for the following weekend. This included the vital information that "*Riley requires two workers to work with him at all times".*

106. DCJ concedes that Riley's file from HWNS should have been reviewed,[72] which would have alerted caseworkers to the existence of the 2016 BSP, which should have then been provided to SNAP.

107. The court heard from Michelle Dodd,[73] who provided evidence as an independent expert with an extensive background in disability services, on the purpose of BSPs. Ms Dodd's evidence was that a BSP outlines critical information about a person's needs but are only put in place when a person has what are often referred to as 'challenging behaviours'. Such behaviours include the child or young person placing themselves or others at risk, be that of harm or damage to property, or damage to self. Ms Dodd called the BSP "*a critical document if it exists because if - you're responsible for providing support to that person, you need to understand what their behaviours are and how - and the best way to manage those*."[74]

108. The evidence suggests that this document would operate to ensure the safety of the child or young person, the staff members working with the children, and the wider community who may encounter the young person's behaviour in the public domain.

109. There is no reason why such a child under the parental responsibility of the Minister, accessing SSRC or cl. 32 special care, in an organised and planned manner, should not have available to the care provider a current BSP prior to the commencement of such respite.

110. It is recognised that DCJ is at times required to find urgent accommodation for children and young people with '*challenging behaviours'*. The circumstances leading to this situation can result in children not having an existing BSP or DCJ not being able to gain access to such documents within the available timeframe. It is accepted that in these non-planned respite placements that a BSP may not

[71] Exhibit 1 Brief of Evidence Volume 3, Tab 53, p. 18.
[72] Submissions for DJC 29 July 2022 [83].
[73] Exhibit 1 Brief of Evidence Volume 3, Tab 48.
[74] 28.04.22 T581.16 – 28.

be available to be provided, however this was not the situation in Riley's case.

Adequacy of support for Fiona Martin and Riley

111. A further issue concerned the question of the adequacy of the support provided to Riley and Fiona Martin.

112. During the period that DCJ held case management of Riley in Fiona Martin's care, the evidence suggests that limited support was provided to Riley and Fiona.

113. The court heard that Ms Cochrane, the nominated contact person for Fiona Martin during the period had not read Riley's file and, on her evidence in the sentencing proceedings, was unaware of the existence of the file.

114. Ms Cochrane contacted Fiona Martin by telephone on 13 October 2017,[75] 17 October 2017, and 23 October 2017. Respite was discussed on all three occasions and Fiona Martin expressed concern about respite and the fact that she had none for some time. Ms Martin also raised concerns about Riley's booster seat being too small and giving him bruises.[76] A further opportunity to discuss Ms Martin's concerns about transporting Riley in the car was lost on 27 October 2017 during a discussion about Camp Breakaway. There were several text messages about the Camp on 17, 20 and 23 October before Ms Cochrane proceeded on six weeks leave.

115. On 1 November 2017, Maria Hanks of DCJ took a call from Fiona Martin who said asked for urgent repair for a broken window. Ms Martin told Ms Hanks that Riley was "*very strong and difficult to control'* and had pushed her to the ground causing injury. Ms Hanks recorded that "*throughout the conversation she sounded distraught and clearly needed support for her care for Riley*." [77]

116. This information does not seem to have been passed onto any relevant DCJ staff. The response was insufficient. No real supports were provided. Reactive and rushed steps were taken to provide respite care rather than wholistic case management of Riley's placement.

117. The reactive and hasty process whereby respite was arranged resulted in important information not being clearly recorded or shared internally by DCJ or with external service providers such as SNAP. The information Ms Cochrane

[75] Exhibit 1 Brief of Evidence Volume 1, Tab 22e, pp. 181 – 184.
[76] Exhibit 1 Brief of Evidence Volume 1, Tab 22e, p. 32.
[77] Exhibit 1 Brief of Evidence Volume 1, Tab 22d, p. 178.

provided to Camp Breakaway for a 2 person-staffing level requirement was not documented elsewhere in the case management by DCJ and was information that DCJ staff ought to have had available to them at the outset of arranging respite. The information as to Riley's physicality was not documented appropriately by Ms Hanks.

118. It is highly concerning that not one worker read Riley's file. The failure to access the file resulted in a significant lost opportunity in understanding Riley and Fiona Martin's needs.

119. Ms Simone Walker gave written and oral evidence in these proceedings. Ms Walker recognised that DCJ staff were "*task focused on making sure that Riley's case management was picked up by the next provider, and with the tasks at hand, rather than really knowing and understanding what Riley's needs were at the time".*[78] I accept her analysis of this issue.

120. I am satisfied that the changes the court has heard about which have already been made by DCJ should mitigate against these circumstances arising in the future and that any further occurrence of DCJ assuming case management pursuant to s. 141 of the *Care Act* should now result in proper case management of the child / young person and carer and not simply proceed as supervision of the transfer to the next agency.

The Safework Prosecution of DCJ

121. DCJ and SNAP Programs were prosecuted by SafeWork NSW. Both SNAP and DCJ pleaded guilty to offences pursuant to s. 32 of the *Work Health and Safety Act 2011* ('*WHS Act*') for breach of the relevant health and safety duties owed by each to each of Riley and his carer Rachel Martin as well as two other employees of SNAP.

122. His Honour Judge Scotting handed his sentence down in the District Court of NSW on 18 June 2021.[79] 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.

123. His Honour provides a useful summary of some of the changes made by DCJ after Riley's death. He notes that the internal investigation made five recommendations

[78] 19.04.22 T19.8 – 13. 0
[79] Note 4 supra.

which DCJ have implemented. Further, DCJ:

a. undertook a further review into the use of temporary care agreements and cl. 32 of the *Care Regulation*;

b. implemented a range of policies following the incident to ensure that workers and children are not placed at risk of harm in the transportation of children including implementing a new specific policy relating to the transportation of children;

c. conducted an audit of BSP's for children and young people in out-of-home care and updated the training given to its case workers on BSPs;

d. entered into consultation with Transport for NSW relating to the transport of young people with disabilities; and

e. migrated to a new frontline information management tool system known as ChildStory; and

f. established a protocol for liaising with the NDIS through a dedicated team.

124. As I have stated DCJ's willingness to implement change in a timely manner has greatly reduced the scope this inquest and is to be commended. I note that DCJ has demonstrated its ongoing commitment to learning from these tragic deaths. Their attitude to recommendations suggested by Counsel Assisting at the conclusion of these proceedings demonstrates their genuine commitment to improvements.

SNAP Programs

125. SNAP Programs was founded in 2012 by Karin Ford, Operations Manager, and William 'Butch' Hays, Chief Executive Officer, both of whom gave evidence before this court. Ms Ford provided an additional statement in addition to the interviews they both gave for the proceedings commenced by SafeWork NSW, which were also before this court.

126. 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."[80]

127. Ms Ford and Mr Hays had diverse backgrounds. Ms Ford held a Certificate IV in Disability and was part way through a degree. She also had some thirty years experience with children with disabilities. The court heard that Mr Hays has a Bachelor of Arts in Sociology and Social Welfare from the University of California at Berkeley, 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.

128. 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 unsubstantial period of time. From 2014, Riley had lived in Ms Ford's own house for 15 months under the arrangements for care then in place when SNAP commenced operations.[81]

129. On 24 October 2017, when the request for respite availability was made by DCJ's Amy Parker,[82] 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 to be returned to SNAP and should have informed DCJ that respite would not occur unless the document was completed.

130. 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 6 years of age (some three years earlier) was a poor and unsafe decision.

131. On 3 November 2017 at 10.28am, Mr Hays was expressly asked by Amy Parker "*Do you still have a copy of Riley's BSP by any chance*" to which Mr Hays did not reply.[83]

132. Mr Hays subsequently told NSW Police that he "*assumed that [SNAP] did have it*".[84] However, Mr Hays did not look for that document and did not direct anyone to obtain that document.[85] Mr Hays should actively have sought out information

[80] 20.04.22 T94.41 – 45.
[81] Note 55 supra p. 114.
[82] Amy Parker was a DCJ Caseworker Placements CFDU. Her responsibilities included finding placement for children coming into the care of FACS with Funded Service Providers.
[83] Exhibit 1 Brief of Evidence Volume 1, Tab 22c, p. 59.
[84] Exhibit 1 Brief of Evidence Volume 3, Tab 53A, p. 149.
[85] 20.04.22 T152.49 – T154.43.

relating to Riley so that staff working with him could have had some understanding as to Riley's needs and his previous behaviours, and be provided with tools for caring for Riley.

133. SNAP also failed to provide Rachel Martin and other staff with sufficient information as to 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.[86]

134. 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*".[87] 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.[88]

135. 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.[89] Ms Whitely recalled that she was rostered to work with Riley in advance of the Saturday, either the Thursday or Friday morning.[90] The only information that Ms Whitely was given was it "*was an eight year old non-verbal autistic boy*".[91] Ms Whitely gave evidence that on reflection, based upon her own experience and initial experience of information received for clients at SNAP, she should have asked for more information.[92] 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.

136. 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

[86] Exhibit 1 Brief of Evidence Volume 3, Tab 53A, p. 24; 21.04.22 T174.30 – 33.
[87] 21.04.22 T162.1 – 8.
[88] 21.04.22 T172.42 – T173.1.
[89] 21.04.22 T212.35 – 44.
[90] 21.04.22 T213.12 – 14.
[91] 21.04.22 T213.19 – 22.
[92] 21.04.22 T214.26-29.

a handover from the outgoing worker.[93] 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 2 hours and was a late cover as Rachel Martin was delayed in attending the shift.[94]

137. 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.[95]

138. 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 was sub-standard, and the evidence of Ms Whitely in particular supports that she provided a high standard of child-focused care that reflected Riley's capacity. However, the lack of information gathering meant that SNAP failed to provide sufficient information to allow appropriate assessments to be done and accordingly, failed to safeguard Rachel and her colleagues.

139. 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 both Riley and Rachel Martin had it been provided.

140. Mr Hays ought to have required much more detailed information from the time DCJ first made contact seeking out availability for respite and have required the Referral Form to be provided in advance of accepting the respite. Mr Hays also ought to have actively sought out information held by SNAP, particularly when he failed to follow up information from DCJ on the basis that it was information held by SNAP.

Were SNAP staff adequately trained to provide care for Riley?

141. The court heard evidence that SNAP delivered its own training to its employees,

[93] 21.04.22 T194.24-44.
[94] 21.04.22 T195.27 — 40.
[95] 21.04.22 T196.48 L48 – T197.8.

and also engaged third party providers to deliver training. The training was at times specific to a client's needs and other times general skills relevant to working with children with disabilities.

142. 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.

143. Rachel Martin attended that training although no other person caring for Riley on the weekend of his death, attended that training.[96] The engagement of individualised training to meet the needs of a specific client is appropriate.

144. The inquest heard about 'PART' training. The records of SNAP evidence that Rachel received PART training on 11-12 March 2015.[97] 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 with SNAP on PART.

145. The other staff attending Riley that weekend had not all received PART training. Ms McIvor did the training but could not recall what PART was.[98] 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. Mr Dongo recalled it was training for "how to deal with clients with autism", "how to handle certain situations" and managing escalated behaviours.

146. It is appreciated that organisations like SNAP have limited means to fund staff training but 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 children generally engaging in respite care at SNAP. Training of that nature ought to be provided to SNAP employees as a part of a cyclic refresher training program particularly given respite care may result in individualised training not being available, thereby placing a greater emphasis on solid core skill learnings.

147. 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

[96] Exhibit 1 Brief of Evidence Volume 3, Tab 42, pp. 18 – 19.
[97] Exhibit 1 Brief of Evidence Volume 3, Tab 42.
[98] 21.04.22 T165.29 – 31.

organisations such as SNAP. People can work as a disability support worker without formal qualifications.[99] The NDIS Code of Conduct and associated guidelines mandate providers ensure workers have the necessary "training, competence and qualifications for the supported and services delivered". Mandating a minimum level of training for that industry is not generally supported at this time. It is considered that such an outcome would adversely impact on 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.[100]

The Safework Prosecution of SNAP

148. As stated earlier, SNAP also pleaded guilty to offences pursuant to s. 32 *WHS Act* for breach of the relevant health and safety duties owed by each to each of Riley and his carer Rachel as well as two other employees of SNAP.

149. His Honour Judge Scotting sets out the improvements to systems of work following the deaths of Riley and Rachel. The improvements made by SNAP are set out at para [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

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

includes whether the client has behavioural difficulties, any safety risks and any special requirements regarding transportation: [87].

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].

150. Most significantly, and consistent with the evidence before this inquest, Scotting DCJ accepted that after Rachel and Riley's deaths, 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 Assessment" form for this purpose ([91](2)).

151. While recognising the training already provided by SNAP, at the conclusion of proceedings Counsel Assisting recommended 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.

Was the ratio of carers at SNAP for Riley adequate?

152. 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. 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.

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

154. The hours the SNAP staff worked that weekend were also a focus during the

Inquest. During the evening of 4 November 2017, Rachel had the following SMS communication with Stacey McIvor:[101]

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

155. The evidence supports that Rachel did a 4-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 on the late afternoon of 5 November 2017.

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

157. The evidence is that Rachel and Riley were struck by the vehicle at approximately 5.30pm. The effect of this is that Rachel was on shift with SNAP for 27.5 hours at the time of her death. This staffing arrangement was unacceptable. It does not appear to have been industry standard and Ms Dodd, the expert engaged in these proceedings, did not consider it to be standard.[102] To the extent it is known to occur, Ms Dodd gave evidence that it is usually where the employee works for multiple organisations.[103] This was not the case for Rachel. The 27.5 hours was work was solely with SNAP.

158. 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.

159. 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

[101] 21.04.22 T180.39 – T181.25.
[102] 28.04.22 T589.39 – 47.
[103] 28.04.22 T590.4 – 11.

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"*.[104]

160. 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.

161. 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.[105]

162. Ms Ford in her evidence on the long periods of respite shifts stated in her evidence "*Sometimes with respites that type of thing is it happens, it happens quite a lot*."[106]

163. 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 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 risk of harm.

164. 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"."*

165. Several matters fall from this evidence.

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[104] 20.04.22 T132.26 – 35.
[105] 21.04.22 T180.33 – 34.
[106] 20.04.22 T133.28 – 43.

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 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, who as evidenced by the witnesses in this Inquest, are often young adults who have not had the benefit of years of experience caring for that specific 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.

166. 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.

167. Counsel Assisting suggested that SNAP review its staffing policies to address some of these concerns. This was not resisted by SNAP.

Riley's transport needs

168. Prior to Riley's case management being transferred from HWNS to DCJ, Riley's needs were being addressed by a number of specialist organisations including Coastwide Therapy Services. Workers from HWNS appeared to play a role in the case management of these services. There is nothing to suggest that matters were being overlooked by reason of various agencies being involved. Transportation and harness issues had certainly been identified well before DCJ commenced case management.

169. The evidence suggests that all persons in Riley's life struggled to locate a suitable travel harness for Riley that compliant with Australian standards. Since Riley's death, DCJ has entered into consultation with Transport for NSW in relation to issues involving the transport of young people with disabilities.

170. Following Riley and Rachel's deaths, the Department has developed in conjunction with Transport for NSW, an e -learning program called 'Safe Travels'. The program will deliver '*key information on road safety while transporting children and young people including those with disabilities … using correct vehicle restraints*'.

171. The evidence before me was that the Safe Travels content has been developed and the program is in the finalisation phase with testing intended to be conducted in mid-2022. The Program will be delivered to DCJ staff initially. If the initial roll out is successful, it is then intended to deliver the program to agencies who have the case management of children who are in statutory out of home care.[107] Such agencies are accredited by the Office of the Children's Guardian to provide such care and are accordingly, a limited number of agencies. There was no firm plan to make the content available more broadly. It appears such a program is likely to be valuable to others, including in organisations delivering what was formerly known as VOOHC and for others having the care of children and young people with transport needs.

172. During the course of the hearing, Helen Lindner, Chief Executive of Mobility and Accessibility for Children and Adults Inc (MACA), provided a report to the court dated 9 October 2019, originally prepared as part of the SafeWork investigation and which became Exhibit 11 to these proceedings. Ms Lindner stated that a child with autism requires special consideration for safe travel in a motor vehicle and referred to, a 2019 literature review, which considered the evidence on the transportation of children with disabilities in motor vehicles. It highlighted that "*these children require special consideration during transportation, and standard child safety restraints and regulations do not always meet their needs. Moreover, it can pose a threat to the safety of others traveling in the vehicle or on the road".*[108]

173. Ms Lindner also stated, based on her research into this area that "*Children with behavioural disorders such as autism present challenges in keeping restraint fastened and maintaining the safety of all passengers".* Ms Lindner cited research from 2013 that for children with autism spectrum disorder, 74% escape their child

[107] Exhibit 1 Brief of Evidence Tab 47A at [43]; 20.04.22 T86.40 – 46.
[108] Report p. 8, citing Angela Downie, Angela Chamberlain, Rebecca Kuzminski, Sharmila Vaz, Belinda Cuomo & Torbjörn Falkmer (2019): Road vehicle transportation of children with physical and behavioural disabilities: A literature review, Scandinavian Journal of Occupational Therapy, DOI:10.1080/11038128.2019.1578408.

restraint, and more than 20% of parents report their child demonstrates aggressive or self-injurious behaviour during travel, affecting their safety and others[109]. These opinions are consistent with the lived experience of Riley's carers and Riley.

174. Ms Lindner offered the opinion that, based upon photographs provided to her, Riley's booster seat was not being used in accordance with the manufacturer's instructions[110] and did not appear to be tethered to a child restraint anchorage but likely to a luggage anchorage point[111]. This may highlight the need for further education, such as the e-learning that will be rolled out by DCJ, albeit to a limited audience.

175. Counsel Assisting recommended that the court consider recommending further collaboration between MACA and DCJ in the formulation of policy and training in this regard. I note that DCJ did not oppose that course.

176. I hope that the work done by MACA will provide a level of expertise in assisting DCJ in its transportation work for children with whom they have contact and that there may be a beneficial knock-on effect to the broader community.

The nature of any oversight by DCJ over "special care providers"

177. SNAP, for the purposes of the respite commencing 3 November 2017, was providing special care pursuant to cl. 32 of the *Care Regulation*. When SNAP originally cared for Riley in 2014, it was also pursuant to this provision.

178. It is noted that Candy Leung of OCG, who gave evidence at the hearing, understood that Riley's placement was under cl. 33.[112] It is clear that at all times, the respite provided by SNAP fell within cl. 32 of the *Care Regulation*, and that Ms Leung operated under a misapprehension in this respect. It is not suggested that this misapprehension played any role at the time of Rachel and Riley's deaths.

179. Riley's placement with SNAP was authorised by the Department under cl. 32 of the *Care Regulation*. Subclause 32 provided:

> (1) In this clause—
>
> **special care prov**ider means an organisation that the Department has determined is suitable to provide special out-of-home care for children or

[109] Exhibit 11, p.10
[110] Exhibit 11, p.18
[111] Exhibit 11,p.19
[112] 28.04.22 T562.11 – 21.

young persons.

special out-of-home care for a child or young person means out-of-home care provided for a child or young person who has an intellectual, psychiatric, sensory, physical or similar impairment (or a combination of such impairments) that—

(a) is permanent or is likely to be permanent, and

(b) results in a significantly reduced capacity in one or more major life activities, such as communication, learning, mobility, decision-making or self-care.

(2) The Department, in its capacity as a designated agency, may authorise a natural person as an authorised carer who can provide special out-of-home care if the person is—

(a) an employee of a special care provider whose duties include providing, or supervising the provision of, care to children or young persons, or

(b) a contractor, being a natural person engaged by a special care provider (other than an employee of the special care provider) under a contract to provide services that include providing, or supervising the provision of, care to children or young persons, or

(c) an employee of a contractor whose duties as an employee include providing care to children or young persons.

(3) The Department must not authorise a person under subclause (2) unless the relevant special care provider has—

(a) informed the Department that the special care provider is satisfied that the person has complied with the requirements of the *Child Protection (Working with Children) Act 2012* for the child-related work as an authorised carer, and

(b) done anything else it is required to do under that Act in relation to the authorisation, whether before or after the commencement of this clause.

(4) The Department must not place a child or young person in the out-of-home care of a person authorised under subclause (2) unless the Department

has—

(a) determined that the child or young person has special needs for out-of-home care that can be best met by such a placement, and

(b) consulted the Children's Guardian about the placement.

180. While this provision no longer exists, cl. 27 of the 2022 Care Regulation, which came into force following the hearing of the Inquest, appears to contain provisions substantially similar to cl. 32 of the *Care Regulation*.

181. It appears that DCJ did not comply with its obligations under the *Care Regulation* in that it did not, prior to Riley's placement with SNAP, consult the Children's Guardian about the placement as it was required to do by reason of cl. 32(4)(b). The evidence established that the requirements of cl. 32 were otherwise met by DCJ in respect of that placement.

182. The failure to consult with the Children's Guardian was not a one-off failing but a reflection of the process that was in play at the time. The written statement of Simone Walker provides, at that time, a reporting protocol existed between the OCG and DCJ, for which DCJ provided quarterly reports to the OCG in relation to children placed with SOOHC providers.[113] In my view this process did not comply with the Regulatory requirements of "consulting" with the OCG prior to a placement taking place.

183. Simone Walker gave evidence that that process changed following 5 November 2017 and DCJ now formally consults with the OCG prior to placing a child with a special care provider.[114] The changes made by DCJ in consultation with the Children's Guardian are appropriate and were required given the obligations imposed by the *Care Regulation*.

184. The regulations are designed to provide a level of protection to some of the most vulnerable people in society. However, the requirement is so minimal it is likely to be of limited utility.

185. In the case of SNAP, the nominated supervisor of the organisation needed only have a Working with Children Check, a National Criminal History search, and a department check (presently through ChildStory). This is a superficial check that looks to whether there is any obvious prohibition or factor that counts against the

[113] Exhibit 1 Brief of Evidence Volume 3, Tab 47, p. 10 [36].
[114] Exhibit 1 Brief of Evidence Volume 3, Tab 47, p. 15 [60].

person being alone with a child or prohibits them from working with children. Given the character of SNAP (and all agencies operating in disability respite), the minimal requirements add little comfort that the provider is actually suitable for the person for whom the care is sought. The requirements do not require the people working with the vulnerable child or young person to have any minimum level of skill, training or experience relevant to the needs of the child. The current checks and balances do not look to the capacity of the organisation to meet the actual care needs of the child or young person.

186. The regulatory framework did not require the organisation or individual to be registered as a VOOHC provider or have any currency in providing such care. It does not require the organisation or individual to be registered as a provider through the NDIA. The effect is that an organisation (or individual), can provide cl. 32 special care with little real oversight.[115]

187. By way of example, in the related inquest into the death of Alex Raichman, the evidence was that Civic Disability Services (Civic) also provided cl. 32 care, including after Alex's death. As DCJ had no oversight of Civic as a VOOHC provider, it may not be aware of incidences relevant to the decision in approving the organisation as a special care provider. Further, while Civic no longer operates respite for children or young people, it could still be called upon by DCJ to provide cl. 32 care. A factor that DCJ looks for – namely 'Is the agency registered to provide VOOHC?', offers no comfort, given the fact that an organisation may have maintained its registration but not engaged in the service of respite for children and young people. While there was the potential for information sharing of relevant matters, such as the death of a child in VOOHC, which may be relevant to determining the appropriateness of a special care placement, this relied on informal reporting services and such information may not come to light immediately.[116]

188. Further, the evidence was that there is no requirement for the Children's Guardian to be informed of a death in VOOHC, although a requirement does exist where there is a death of a child in SOOHC. The absence of such a reporting requirement means that the Children's Guardian may miss an opportunity to identify a red flag in the delivery of services by a provider and take appropriate steps to mitigate risk. It also has a second effect that the Children's Guardian may not possess relevant information for the purpose of a cl. 32 consultation process for a special care

[115] 28.04.22 T568.46 – 50.
[116] 28.04.22 T550.33 – T552.3.

placement. If the death of a child in VOOHC was due to a systemic issue, such as poor intake procedures, such information would be essential to permit the Children's Guardian to fulfil its remit of consulting with DCJ prior to any cl. 32 placement. This is particularly so given DCJ has no oversight in any manner or form of VOOHC providers.

189. Noting the breadth of children that may fall within cl. 32, it is accepted that the development of an appropriate check and balance checklist suitable to address the large range of needs that may present itself may be a difficult exercise. Nevertheless the current checks and balances are not sufficient to address the needs of the cohort captured by cl. 32 of the *Care Regulation*.

The role of the Office of the Children's Guardian

190. The role of the Children's Guardian in respect of Riley's placement with SNAP was limited to the fact that it should have been consulted prior to Riley's respite placement in accordance with cl. 32 of the *Care Regulation*. Notwithstanding the fact that that SNAP was registered with the OCG to provide VOOHC, such registration was not an essential factor for the organisation being approved as a special care provider. Nevertheless, the court heard extensive evidence from Ms Candy Leung, who at the time of giving her initial statement was principal Project Officer of VOOHC at the Office of the Children's Guardian. The court accepted that strengthening systems in the VOOHC arena was a relevant factor for consideration, given the cross-over in organisations providing children's care. The court was also keen to understand the supervisory role played by OCG in the sector.

191. Among other things, Ms Leung outlined the process of self accreditation for organisations delivering VOOHC from 2011 and the changes which had taken place in the regulatory environment since then. She told the court in 2017, "…*the Office of the Children's guardian requested registered agencies to provide evidence of their policies and procedures."*[117] I understood her to suggest this greater level of oversight to have been a positive development. She also gave evidence about the fact that more recently the OCG had received additional funding which allowed for more "*onsite monitoring visits*" than had previously occurred. Again, I understood and accepted that this development was thought to be a positive development and one likely to reduce risk.

[117] 28/4/22 T559.23 – 28.

192. On the basis of her evidence and other material before the court, Counsel Assisting proposed detailed recommendations directed to the OCG for the court to consider. These recommendations were directed to issues such as requiring VOOHC providers to have transport and staffing policies, requesting OCG engage with DCJ in relation to a checks and balance sheet for potential providers of special care and requesting OCG to make representations to the relevant Minister in relation to mandating the report of certain deaths to the OCG in a timely manner.

193. It is important to note that since those recommendations were proposed there has been and continues to be substantial legislative reform in the area of child and disability care, including an overhauling of the VOOHC regime. It is not appropriate for me to address those issues in any detail given the timing of the changes and the fact that I did not hear evidence about the operation of the new scheme. Nevertheless, I record my surprise and concern that the new legislation abolishes the registration process previously regulating VOOHC providers in NSW.

194. In submissions, the OGC submitted that this step, the abolishing of the registration process previously regulating VOOHC providers, was not "*a retrograde step, nor should it be regarded as a watering down of the OCG regulatory function"*. Counsel for the OGC suggested the court "*should not be alarmed by the development*." Only time will tell if the new regime provides greater safety. Given it appears to encompass an approach quite at odds with the evidence provided by Ms Leung about the positive impact of closer oversight I retain doubts.

195. However, I note that insofar as the transport policy recommendation is concerned, the OCG supports the principle of the proposed recommendation and I intend to make it, knowing that it should now properly be directed to organisations now offering "specialised substitute residential care (SSRC).

196. Similarly, the OCG appear to support in principle the recommendation encouraging close engagement with DCJ to devise an appropriate checks and balance assessment sheet for special care providers pursuant to the *Care Regulation.* I intend to make a recommendation in that regard.

197. I note that legislative change appears to make the recommendation about death notification unnecessary.

The need for recommendations

198. 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.

199. For reasons stated above, I make the recommendations set out below.

Findings

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

Identity

The person who died was Riley Christopher Shortland.

Date of death

He died on 5 November 2017.

Place of death

He died at M1 Pacific Motorway near Cameron Park NSW.

Cause of death

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

Manner of death

On the day of Riley's death, he was being cared for under a respite arrangement supervised by SNAP Programs. That respite was arranged through the offices of the DCJ in circumstances where the Department held case management responsibility for Riley.

Riley died while escaping from the care of Rachel Martin, the carer employed by SNAP Programs to care for him while in respite care. It is likely that Riley removed a car seat harness while the car was travelling on the motorway. Ms Martin stopped the vehicle. Riley exited the back seat of the vehicle from the driver's side and ran directly onto the motorway into the path of oncoming traffic.

Recommendations pursuant to section 82 *Coroners Act 2009*

201. For the reasons stated above, I make the following recommendations:

To the Office of the Children's Guardian

202. It is recommended that the Children's Guardian:

1. Require organisations providing what is now known as specialised substitute residential care and substitute residential care to have a transport policy. It is recommended that the Children's Guardian consider such policies require an assessment of each client's transport needs and the requirement for the transportation of children and young people assessed as requiring 1:1 support or who have behaviours of concern during the transportation process to be with a driver plus a dedicated carer for the child.

2. Engage with the Department of Communities and Justice to devise an appropriate checks and balance assessment sheet for potential providers of special care pursuant to cl.32 of the *Care Regulation* (or its current equivalent)

To the Department of Communities and Justice

203. It is recommended that DCJ:

1. Devise a checks and balance assessment sheet for potential providers of special care pursuant to cl. 27 of the *Children and Young Persons (Care and Protection) Regulation 2022* (formerly cl. 32 of the Care Regulation), to ensure that the individual needs of the recipient of the special care can be met by the persons providing the care.

2. Devise a policy or procedure setting out the minimum paperwork to travel with a child or young person the subject of a special care placement, noting that such providers are not designated agencies and do not have access to ChildStory.

3. Make enquiries with Mobility and Accessibility for Children in Australia Ltd. (MACA) for the purpose of, subject to funding limitations, exploring whether MACA can assist in the formulation of transport related policies and learnings (the "Safe Travels" learnings), particularly within the focus of safety harnesses for children and young people with Autism Spectrum Disorder.

4. Consider making available to organisations delivering SSRC or organisations and individuals supporting children and young persons with Autism, the 'Safe Travels' learnings, following a successful trial and roll out of the learning to DCJ staff and designated agencies

To SNAP Programs

204. It is recommended to SNAP that SNAP:

1. Review and 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 (representing two 8 hour shifts, or in the alternative, a sleep over shift (where the sleep over 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 as to staffing challenges, with such process to be independent of executives and managers.

4. Ensure that training in the character of PART, or similar training, becomes 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 the safe driving, 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 / 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 to 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

205. Riley's death was a preventable tragedy. It has affected many who loved and cared for him.

206. 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 preparation of this matter.

207. Finally, once again I offer my sincere condolences to Fiona Martin, Riley's foster mother, her sons Hugh and Toby and daughter Paige, Ms Amanda Taylor, Riley's birth mother, and all of Riley's close and extended family.

208. I close this inquest.

Magistrate Harriet Grahame

Deputy State Coroner, NSW State Coroner's Court, Lidcombe

21 October 2022

Appendix A – Agreed Statement of Facts

AGREED FACTS

COURT DETAILS	
Court	CORONER'S COURT OF NEW SOUTH WALES
Registry	Lidcombe
Case number	**Riley Shortland (2017/00335331)**

TITLE OF PROCEEDINGS

Inquest into the death of Riley SHORTLAND

AGREED STATEMENT OF FACTS

A. Riley Christopher Shortland

1. On 27 December 2008, Riley Christopher Shortland ("Riley") was born to Ms Amanda Taylor ('Ms Taylor') and Mr Mark Shortland.

2. Riley had a diagnosis of Global Development Delay, Attention Deficit Hyperactivity Disorder and Autism Spectrum Disorder (assessed as level 3 Autism, known as ASD-3 on the Autism Spectrum Disorder Scale). His ASD diagnosis was originally made in 2012.

3. Riley was predominantly non-verbal and functioned at the developmental level of an 18 month old. Riley required close supervision at all times.

4. On 1 July 2013, Ms Taylor signed a temporary care arrangement with the Department of Family and Community Services ('FACS'), now known as the Department of Communities and Justice ('DCJ'). This arrangement was expressed to operate from 1 July to 1 October 2013 (subject to relevant intervening events).

5. On 8 August 2013, DCJ filed an application to initiate care proceedings in respect of Riley at Bidura Children's Court.

6. Riley was the subject of a final care order under the *Children and Young Persons (Care and Protection) Act 1998* ("the *Care Act*"), made by the Children's Court of NSW on 24 April 2014 placing him in the care of the Minister until he attained 18 years of age.

7. On 4 October 2014, Riley was placed in the care of a person authorised as an out of home carer by House With No Steps ('HWNS') for the purposes of the *Care Act*, namely Fiona Martin. From that time, Riley lived with Fiona Martin and her two biological sons (aged 13 and 14 years at the time Riley died). Fiona's biological sons also each have a diagnosis of ASD (mild on the spectrum).

8. On 23 June 2016, HWNS updated Riley's Behaviour Support Plan with the assistance from Riley's speech and occupational therapists. 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". Another part of the plan said "Riley'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 is travelling in a vehicle… to be used for ALL vehicle travel, regardless of the length of the trip".

9. Riley received funding for his disability care through the National Disability Insurance Scheme ('NDIS'). Riley's NDIS plan commenced on 22 March 2017.

10. In May 2017, Riley's occupational therapist prepared an updated report. The report said "Riley used an 'E-Z On Vest' for a short period, as a harness for the car; however he was able to get out of it. This is the most supportive harness on the market so we are currently working on a bespoke one, designed just for Riley with the company 'Paediatric Mobility Equipment', who are the main supplier in this field. An appointment has also been made with Aidacare to trial a suitable stroller/wheelchair and other harnesses on 5 June 2017." In the interim, HWNS continued to use the Houdini Stop, a type of seat belt clip, and ensured that there was always a support worker seated next to Riley for transport at respite and out in the community while waiting for a new harness to be sourced.

11. Riley's saw an Occupational Therapist ('OT') fortnightly in clinic and at home

and monthly at school. Riley had used both the “Houdini” strap (with his booster seat) and the “E-Z On Vest” with straps between the legs while travelling in a vehicle to limit his ability to get out of his car seat. The Occupational Therapist noted however that Riley was able to get out of both harnesses. A bespoke harness for Riley was being designed at the time of his death.

12. The Houdini strap and booster seat were too small for Riley.

13. The E-Z On Vest did not meet Australian standards but was used widely in Australia.

14. The House With No Steps (‘HWNS’), the service funded provider that case managed Riley from 19 December 2014 to 29 September 2017, purchased the E-Z On Vest for Riley in or about September 2016. When case management was transferred from HWNS to DCJ, the E-Z On Vest was returned to the HWNS at their request. Fiona Martin was not provided with an alternative harness to the E-Z On Vest for Riley and continued to use the Houdini strap when travelling in a vehicle with Riley. A bespoke harness was being sourced for Riley at that time.

15. Riley died on 5 November 2017 whilst in respite care supervised by an employee of special care provider, Special Needs Accommodation Placement Program (“SNAP”). Riley was 8 years and 11 months of age.

B. Immediate circumstances of the fatalities and cause of death

16. The fatal incident occurred at around 5.35 pm on Sunday, 5 November 2017 on the M1 Motorway at Cameron Park.

17. At the time of the incident, Rachel [Martin, the SNAP employee] was driving Riley 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.

18. 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).

19. 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.

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

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

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

23. 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.

24. 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)

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

C. Special Needs Accommodation Program (SNAP)

26. SNAP was the employer of Rachel Martin.

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

28. 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.

29. 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

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

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

32. 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.

33. 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.

34. 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.

35. 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.

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

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

38. 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.

39. 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.

40. 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.

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

42. 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.

43. 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

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

45. 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.

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

47. 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".

48. 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."*

49. 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.”

50. 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.

51. 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.

52. 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.

53. 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.

54. 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.

55. 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 workers at respite due to his behaviours.

56. 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).

57. 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.