STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of DT
Hearing dates:	14-17 August 2017
Date of findings:	13 October 2017
Place of findings:	NSW State Coroner's Court, Glebe
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	CORONIAL LAW – Educational neglect, self-inflicted death, multiple reports to FACS Helpline
File numbers:	2013/45699
Representation:	Dr P Dwyer, counsel assisting, instructed by Ms J Mooney, solicitor, Crown Solicitors Office. Ms Stevens of counsel, instructed by solicitors for the Department of Family and Community Services. Ms A Bonnor of counsel, instructed by Ms Baker for the NSW Department of Education. Ms Idowu, solicitor, Makinson d'Apice Lawyers for the Catholic Education Diocese of Wollongong. Mr B Haverfield instructed by Mr Deards, solicitor, Office of General Counsel for the NSW Commissioner of Police. Ms R Rodger of counsel, instructed by Mr Kamaras, solicitor, Avant for Dr Higginbotham.

Findings pursuant to section 81 *Coroners Act* 2009 (NSW)

Identity	The identity of the deceased was DT.
Date of death	DT died on 13 February 2013.
Place of death	[redacted].
Cause of death	[redacted].
Manner of death	DT's death was intentionally self-inflicted.

Recommendations pursuant to section 82 *Coroners Act* 2009 (NSW)

To the Minister of Family and Community Services

I recommend that,

The Department of Family and Community Services give urgent consideration to,

Amending existing policy/procedure so that where a mandatory report is made and screened out as non-ROSH, the mandatory reporter is advised of the outcome within 21 days.

Introducing and evaluating further training for Helpline and CSC staff in respect of "unconscious bias" when dealing with parents who have separated from the primary carer and are reporting concerns about their children.

Creating a referral service operating at the Helpline stage, so that where referrals are screened out as "non-ROSH", reporters are informed that the information will be kept on file as relevant history in the event of further calls and the referrer is given the contact details of other service providers that may be able to assist (e.g. Anglicare, CatholicCare, local adolescent medical health services, Brighter Futures)

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Introduction

1. DT died on 13 February 2013. [redacted] His family found him when he failed to come out for dinner that evening. While resuscitation was commenced, DT could not be saved. He was only 13 years of age.

2. DT was a talented cartoonist and artist. At the time of his death he had recently completed a letter that he hoped would help him obtain work or experience as a comic book illustrator.

3. DT's death continues to cause profound and ongoing grief to his family and community. The tragic circumstances surrounding DT's death call for close scrutiny of the care and support available to him at that time. Although greatly loved by his family, it appears that DT felt a growing despair that he could not communicate to others. There were health and educational professionals in his life, but it appeared that nobody was truly aware of the depth of his misery.

4. As a community, we were unable to keep DT safe. The purpose of an inquest in these tragic circumstances is not to apportion blame or criticize those involved in DT's care, but rather to see if it is possible to identify opportunities to reduce the kind of risks he faced. Almost everyone involved in this inquest has been committed to trying to understand how a boy with so much promise could fall through the cracks. His family has approached this inquest in the hope of preventing other families from suffering a similar tragedy in the future.

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 death. The coroner is also to address issues concerning the manner and cause of the person's death.[1] In addition, the coroner may make recommendations in relation to matters that have the capacity to improve public health and safety in the future.[2]

6. In this case there is no dispute in relation to the identity of DT, or to the date and place or medical cause of his death. For this reason the inquest focused on the manner and circumstances surrounding DT's death. In particular, the inquest examined the professional support DT had at the time of his death. Evidence was gathered in relation to his schooling, his medical treatment and advice and the role played by the Department of Family and Community Services (FACS) in his life.

7. A guiding list of identified issues was circulated prior to the inquest commencing. These issues included,

   - Did FACS respond in an adequate and timely manner to notifications about the risks to DT's health and well-being?

   - Did DT's general practitioner (Dr John Higginbotham) provide adequate care in relation to the physical and mental health issues reported by DT, including issues relating to the prescription of antidepressants, treatment of migraines and referral to specialist services.

[1] Section 81 *Coroners Act* 2009 (NSW)
[2] Section 82 *Coroners Act* 2009 (NSW)

- Did [redacted] provide appropriate treatment and support services for DT, and liaise appropriately with the Department of Education in relation to DT's welfare needs?

- Did [redacted] (Department of Education) provide appropriate treatment and support services for DT, and liaise with [redacted] in relation to DT's welfare needs?

- Are there any recommendations that are necessary or desirable that should be made in relation to any matter connected with DT's death?

The evidence

8. The court heard oral evidence over three days and received extensive documentary material, including witness statements, expert reports and photographs. At the close of evidence, detailed written submissions, touching on possible recommendations, were prepared by a number of parties.

Background

9. DT was one of three children born to M and F. The couple separated in 2011 and from that time DT lived with his mother and two sisters. The girls were aged 12 and 15 at the time of DT's death. For some of that time DT's older sister's 19 year old boyfriend, H was also living with the family. H was receiving a Centrelink payment to act as a carer for M, who reportedly suffered from a number of debilitating and painful conditions, including osteoarthritis, back problems and migraines. As a result of these conditions, M had serious mobility issues and had developed a significant reliance on a variety of pain medications.

10. The evidence revealed just how incapacitated M was during this period. DT's sister[3] noted that her mother was using OxyContin and sleeping pills. She would get really bad arthritis and migraines and had bad knees. She often complained about being in pain and was debilitated by her prescription medication. According to her daughter, M would fall asleep on the lounge and would stay in her pyjamas for days on end, unable to do anything much at all. From time-to-time when M was feeling extremely bad she would get the children to obtain medication for her. Although the children tried to clean the house, and do the shopping and cooking, life was difficult for them and the house was reported to have been dirty and disorganised. The children did not always eat proper meals. DT's sister noted that home was not a happy place and the siblings mostly did their own thing[4]. Although she loved her children, it is evident that M was unable to provide adequate care for DT at this time and was in desperate need of support herself.

11. DT had little contact with his father in the period before his death. The separation of DT's parents had been particularly acrimonious. While F remained concerned for the welfare of his son, the breakdown in family relationships meant that he was hampered in his attempts to help[5]. While F may not have known exactly how serious the situation had become, it is clear that he tried a number of avenues to get help for DT, including through contacting the NSW Police, and DT's

[3] Statement of S, Exhibit 1, Vol 1,Tab 17
[4] Statement of S, Exhibit 1, Tab 17 [8]
[5] Statement of F, Exhibit 1, Tab 18A

school. He tried unsuccessfully to remain in telephone contact with his children. When all else failed he contacted the Department of Family and Community Services (FACS) and reported his own children on a number of occasions. Unfortunately nobody from that authority ever visited the house.

12. During this difficult period, the family had contact with a number of individuals and organisations that should have been able to provide them some care and family support. Part of the work of this inquest has been to review what DT needed and what help he was offered in the lead up to his death.

The lead up to DT's death

13. M reported that in the period between 4 February and 13 February 2013, DT only went to school a couple of times as he was suffering from migraines. She stated that DT "saw the doctor and was told to take Panadol and get some rest to help with his migraines".[6] When she went to wake him and his younger sister to get ready for school on the day he died, DT told her that he felt sick and still had a headache. Aside from visiting the bathroom, he remained in bed all that day.

14. Around 5pm on 13 February 2013, M checked on DT and he was still in his room. She also felt unwell and returned to the lounge to lie down herself. Around 5.45pm M asked her younger daughter to check what DT wanted for dinner. N reported that DT was drawing. N later reported that she remembered DT's face "looked a bit funny".[7] Shortly afterwards, H entered the room and found DT [redacted].[8] H knew immediately that something was seriously wrong. He called M [redacted] and tried to commence CPR. Emergency Services were called, and ambulance officers and police quickly arrived at the house. Unfortunately, DT could not be revived.

15. Police described the family, especially M as very distressed. The house was extremely untidy. There was rubbish, dirty clothes and food scraps on the floor. The house had an odour of decay and there was evidence of rodents. Some of the beds had no mattresses and the linen was dirty.[9] There was clear evidence of a household that was not coping.

DT's death

16. A limited autopsy was conducted at the Department of Forensic Medicine on 14 February 2013. [redacted] There were no suspicious marks on his body or any sign of struggle noted.

17. Toxicological analysis detected small amounts of Chlorpheniramine, Codeine, Doxylamine and Paracetamol.

Was DT's death intentionally self-inflicted?

18. A finding that a death is self-inflicted must not be made lightly. The evidence should be extremely clear and cogent in relation to intention. In my view the weight of authority suggests that the proper

[6] Statement of M, Exhibit 1, Tab 15 [7]
[7] Statement of N, Exhibit 1, Tab16 [4]
[8] Statement of H, Exhibit 1, Tab18 [9]
[9] See statement of Constable Natalie Picker, Exhibit 1, Tab 11, [15] onwards

evidentiary standard to be applied to a coronial finding of intentional taking of one's own life is the *Bringinshaw* standard.[10]

19. It is especially important to consider this issue carefully when the deceased is as young as DT. One must be satisfied to the requisite legal standard that he clearly understood what he was doing and the effect that it would have.

20. No suicide note or communication was ever found. There is no evidence that he had ever expressed an explicit intention to commit suicide to any known person. However, for a boy of 13, DT already had a significant history of depression, for which he had been medicated. He had been isolating himself from family and friends. He had refused to attend school. He appeared to be in pain. The action that he took on 13 February 2013 involved deliberate conduct and there is nothing to suggest that he would not have understood its consequence. There is no evidence that he was intoxicated or affected by drugs such that he could have failed to understand the likely result of his actions. I am of the view that DT intended to die and that his death is properly recorded as intentionally self-inflicted.

Was DT's death foreseeable?

21. It would have been clear to anyone who entered the [redacted] home that the family were in serious trouble. The physical state of the premises reflected M's inability to cope. DT was not going to school, he was withdrawn from his siblings and father. DT also showed a number of worrying physical symptoms. He was losing weight and reported experiencing terrible migraines. Nevertheless, it appears that nobody realised just how serious the situation had become. It is necessary to carefully examine the contact DT had with the professionals involved in his life to ascertain what additional help he could have been offered.

The care provided by Dr Higginbotham

Summary of patient contact

22. One important point of contact with the outside world was the family's medical practitioner. DT had been seeing a general practitioner named Dr Higginbotham since 2006. Dr Higginbotham also treated DT's mother and sisters. The medical records disclose that the doctor initially saw DT in relation to a number of common medical problems such as asthma, an eye infection, eczema and respiratory infections.[11] In 2006 he referred DT to a specialist paediatrician, Dr Freelander in relation to migraines. No physical issues were identified and DT was asked by Dr Freelander to keep a diary of his headaches and attend in six weeks for further review. This does not appear to have occurred.[12]

23. The first recorded entry in Dr Higginbotham's clinical notes reporting "stress" occurred on 17 September 2012. Dr Higginbotham's notes do not reveal what was discussed or if any treatment was suggested at that point.
24. DT next presented on 10 October 2012. At that time DT stated that he had been "worried all the time for the last 3 weeks". He complained of headaches, insomnia and nausea. Anorexia is noted. Dr Higginbotham records that he prescribed an antidepressant fluoxetine (Lovan), at a dose of 20 mg per day. Dr Higginbotham's records do not indicate that he gave DT or his mother any

[10] *Briginshaw* v *Briginshaw* 60 CLR 336
[11] See statement of Dr Higginbotham, Exhibit 1, Tab19
[12] Correspondence from Dr Freelander, Exhibit 1, Tab 21

information about the possible side effects of the medication. It is not clear who was present at the consultation.

25. On 17 November 2012, DT presented again with "continuing migraine". Dr Higginbotham states that a "school change was planned for 19/11/12 and he was to see a "school counsellor". Dr Higginbotham wrote a retrospective medical certificate for DT's absence from school for the two month period from 18 September 2012 to 16 November 2012, noting that DT was suffering from a "medical condition".

26. On 4 December 2012, DT visited Dr Higginbotham once again. Dr Higginbotham recorded that DT was "much happier" at school and that he had been there for one week. However, DT had taken that day and the day before off "due to a migraine". DT apparently informed Dr Higginbotham that he now had alternative transport available so that he was not completely reliant on M.

27. On 14 December 2012, Dr Higginbotham saw DT again. DT complained of having headaches for the last five days. Dr Higginbotham's records suggest that he spoke to DT about more consistent use of Lovan. DT was referred to Dr Freelander. The letter reads "DT with increased headache and visual symptoms, objects in room moving, vomiting last 2 days? Management".[13] There is no mention of stress or the prescription of an antidepressant.

28. Dr Higginbotham's records indicate that DT was issued with a new prescription for Lovan on 18 December 2012. There is no indication of whether DT actually saw the doctor on that day.

29. On 1 February 2013, DT presented with nausea. He was again issued a medical certificate.

30. On 6 February 2013, DT presented at Dr Higginbotham's surgery. He complained of having been in bed with a migraine for a number of days. A medical certificate for three days was issued.

31. On 8 February 2013, DT visited Dr Higginbotham. A diagnosis of a probable viral infection was made. This was the last time Dr Higginbotham saw DT. H took DT to the last two appointments, he recalled that DT had been told to "take Panadol and have a rest".[14]

Quality of care received

32. Dr Higginbotham's care and treatment of DT was reviewed by an independent expert, Dr James Jeong. Dr Jeong gave impressive and thoughtful evidence. He was highly critical of Dr Higginbotham's note taking and clinical records. He found the notes "minimalistic" and "well below the standard expected of an ordinary skilled general practitioner".[15] Based on what was included in the records he found Dr Higginbotham's treatment of DT as "simplistic, superficial and incomprehensive".[16] There is always the possibility that inadequate notes can fail to properly record a fulsome and appropriate consultation. However, after listening to Dr Higginbotham give oral evidence, I came to the view that the notes accurately reflected the quality of the care he gave. Dr Higginbotham was an extremely unimpressive witness who showed a serious and ongoing lack of insight into his many inadequacies.

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[13] Unsigned referral note from Dr Higginbotham, Exhibit 1, Volume 2, Tab 26, page 255
[14] Statement of H, Exhibit 1, Tab 18 [6]
[15] Report of Dr James Jeong, Exhibit 1, Tab 25, page 2
[16] Report of Dr James Jeong, Exhibit 1, Tab 25, page 3

33. Dr Jeong assisted the court in identifying a number of specific significant concerns relating to the care offered to DT. These issues included,

- Dr Higginbotham's clinical notes were completely inadequate. A point conceded by Dr Higginbotham in oral evidence.[17]

- Dr Higginbotham's decision to provide DT with a medical certificate for a two month period, without further investigation was clearly inappropriate in all the circumstances.[18]

- Dr Higginbotham's assessment of DT's mental state was wholly inadequate. Given DT's presentation he should have been referred to a psychiatrist or other mental health professional and the doctor should have prepared a comprehensive mental health plan. No appropriate mental health screening, which could have potentially identified a risk of suicide, took place. This failing was also conceded by Dr Higginbotham, to some degree.[19]

- Dr Higginbotham showed a troubling lack of knowledge in relation to local services, mental health assessment tools, information about the drugs he was prescribing, awareness of addiction and other issues.

- Dr Higginbotham made no attempt to follow up any school counsellor who may have been involved. In evidence, Dr Higginbotham appeared to suggest that DT's involvement with a school counsellor gave him some comfort. However, his notes do not record the existence of a counsellor until 17 November 2012, a month after DT's anti-depressant medication had been commenced.

- Dr Higginbotham's referral to Dr Freelander was wholly inadequate. There was no mention of the ongoing "stress", and no mention of the recent prescription of anti-depressant medication. I do not accept Dr Higginbotham's evidence that he thought it was Dr Freelander's role to deal with the mental health issue, given that Dr Freelander was not a psychiatric specialist or indeed informed of the issue. On the other hand, if Dr Higginbotham thought the cause of migraine was organic, it is hard to understand why no scans or blood tests were ever obtained.[20]

- Dr Higginbotham's prescribing of Lovan was extremely troubling. He appeared to have little understanding of the potential side effects. He stated that he was not aware of the potential risk of suicide or self-harm. There is no record that he explained the effects to DT or to his family. There is no record to suggest that he tried to engage DT's family in relation to better compliance with this medication. Despite the doctor's oral evidence that he "would have asked him to come back in two weeks"[21] after the initial prescription, there is no record of that occurring or of any attempt to follow it up. Essentially a 13 year old boy was prescribed an anti-depressant medication, which can in some patients increase the chance of suicide, with no follow up or proper advice. It is clear that the drug was commenced without adequate mental health screening or the development of a positive therapeutic relationship between doctor and patient.

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[17] Evidence of Dr Higginbotham 14/8/17, page 51 lines 14 onwards
[18] For discussion of this issue see Dr Jeong's oral evidence, 15/8/17, Page 15 onwards
[19] Evidence of Dr Higginbotham 14/8/17, pages 42-48
[20] For discussion of this issue see Dr Jeong's oral evidence, 15/8/17, Page 11, line 35 onwards
[21] Evidence of Dr Higginbotham 14/8/17, page 41, line 40 onwards

- Dr Higginbotham must have been aware that the [redacted] family was under considerable stress. He had been treating M for a number of years and was prescribing her Oxycodone, OxyContin, Fentanyl, Temazapam and Pethidine. Dr Higginbotham stated that he had no concerns about her possible "over use" of pain medication[22], despite having received a discharge summary which noted that she demonstrated "drug seeking behaviour". It is likely, from the records before the court, that some of M's prescriptions were collected without consultation. All the other contemporaneous evidence suggests that M was often incapacitated by pain and that the effects of her medication were very obvious. In the circumstances, it appears impossible that Dr Higginbotham could not have identified a potential problem of addiction. When faced with a record of the drugs he had apparently prescribed he stated "I just can't imagine myself doing any such thing. In other words that doesn't look like I've prescribed them". He went on to suggest that his script pad may have been stolen and his signature forged.[23] I was completely unimpressed by his evidence and find it impossible to rely on.

34. It is acknowledged that the area where DT was living had scarce resources in relation to adolescent mental health. For this reason DT's contact with his general practitioner became even more crucial for his survival. However, in my view Dr Jeong accurately identified that the real problem with Dr Higginbotham's approach was not that he lacked information about the existence of any particular mental health service, but quite simply that he lacked sufficient empathy and care.[24] Certainly, Dr Higginbotham lacked specific knowledge about services, but as Dr Jeong stated he also failed to understand "that a 13 year old boy was crying out for help".[25] Had he taken the time with DT to work through some of the issues the boy faced, he may have begun to understand the danger DT was in. I accept Dr Jeong's view that the interaction between DT and his doctor reflected "a lack of care" by the general practitioner.

35. It is clear that Dr Higginbotham failed to develop any rapport with a 13 year old boy who was in dire need of counselling and support. Dr Higginbotham was aware of the family breakdown and of the medical difficulties, including depression suffered by other children in the family. He shut his eyes to the clear warning signs that this was a family in great danger.

36. Dr Higginbotham has since retired. Had he not provided a statutory declaration[26] indicating that he will never reapply for medical registration I would have had no hesitation in referring him to the Health Care Complaints Commission (HCCC).[27] While I do not intend to refer a formal complaint, a copy of these findings will be sent to the HCCC for abundant caution, to be held on file, in case the doctor should ever change his mind.

37. I have carefully considered whether any recommendations should flow from the care provided by Dr Higginbotham, but on reflection I am of the view that his failings were personal rather than systemic. Dr Jeong convinced me that there are resources available for doctors who have a will to find them.

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[22] Evidence of Dr Higginbotham 14/8/17, page 29, line 47
[23] Evidence of Dr Higginbotham 14/8/17,page 33
[24] Evidence of Dr Jeong 15/8/17, page 15, line 45 onwards
[25] Evidence of Dr Jeong 15/8/17, page 16, line 1
[26] Exhibit 2
[27] It is worth noting as a matter of public record that Dr Higginbotham has been criticised in relation to his prescribing practises previously. See *Inquest into the Death of Christine Drinnan*, 23 October 2015

The support provided by [redacted]

38. In primary school DT had attended [redacted]. Records indicate that he had multiple periods of absenteeism and often arrived late or left early[28]. Reasons provided for DT's absences included M's poor health, DT's own health and medical appointments for other family members. As a result of his absenteeism, [redacted] made a referral for DT to participate in the CatholicCare "School, Student and Family program". DT later attended 5 sessions with this CatholicCare program.

39. In 2012, DT commenced high school at [redacted]. The court received detailed evidence about the pastoral care and student welfare programs at [redacted].[29] It is clear that as DT had come from a "feeder school", [redacted] was immediately aware that it was important to monitor DT's attendance. His pastoral care teacher, [redacted] checked on him regularly and would have had the chance to speak with him at least three times a week.

40. The school became aware of financial difficulties which were apparently being experienced by M in February 2012. While DT missed a few days in February, it was not until [redacted] spoke with F in March 2012 that the school understood that instability at home may be affecting DT's attendance at school. There was further absenteeism and the school learnt that the split between M and F had been particularly acrimonious.

41. The court received evidence that the pastoral care team continued to watch the situation closely and offered DT further opportunities for counselling, which were refused.[30] The school continued to monitor DT's attendance, but was unable to establish meaningful engagement with M in relation to the problem. According to Mr John Lo Cascio, the Head of School Improvement Services, Secondary Schools for Catholic Education, Diocese of Wollongong, it appeared to staff that when he was at school DT seemed relatively happy. He had friends and appeared to enjoy being there.

42. During October 2012 the school contacted DT's parents at least six times in relation to the attendance issue. This culminated in a call with M on 22 October 2012 where M advised that DT was "still unwell" and had been prescribed "anti-anxiety" medication. She was urged to attend a meeting, together with DT and the pastoral care team, on 24 October 2012. This meeting was later cancelled by M.

43. By 23 October 2012, DT had been absent from school for almost 30 consecutive school days. The school was concerned about the risk of significant harm arising from educational neglect. It had been unable to engage DT's mother in a meaningful way. Pursuant to its relevant policy, "Supporting the regular attendance of children at school", the school made a "Risk of Significant Harm (ROSH) report" to the FACS. On 26 October 2012 the principal also wrote to M in an attempt to meet with her to discuss DT's attendance and to provide her with further support if necessary.

44. On 7 November 2012, M informed the school that DT had enrolled at [redacted] subsequently informed the Department of Education that DT was no longer enrolled at the school.

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[28] Statement of John Lo Cascio, Exhibit 1, Volume 4,Tab 30 [15]
[29] Statement of John Lo Cascio, Exhibit 1, Volume 4,Tab 30 [24] onwards
[30] Statement of John Lo Cascio, Exhibit 1, Volume 4,Tab 30 [36] onwards

45. I am satisfied that the pastoral care team at [redacted] acted appropriately in the care they offered to DT and his family. It is unfortunate that the ROSH report they made to FACS was screened out and no action taken by the Department. DT's lack of attendance and his mother's attitude towards it clearly indicated a need for further investigation into what was occurring at home.

46. Mr Lo Cascio gave evidence at the inquest. [redacted] I was impressed with the care that he showed and with his willingness to learn from the tragedy. It is clear that although the school was concerned about DT's non-attendance, it did not consider him to be at risk of suicide at that time. I accept that, while ultimately unsuccessful, the school tried to develop a helpful pastoral care relationship with DT. They offered him counselling, which he did not take up. The school also attempted to engage with M, without success. They reported DT's non-attendance to FACS by way of a ROSH report. When he did not return to the school they cancelled his enrolment and again notified FACS and the Department of Education. I offer no criticism of their conduct. I note that Mr Lo Cascio agreed that in the future, on reflection, he would encourage staff to take even more responsibility to make contact with the public system when a child left a Catholic school in circumstances such as this.

The support provided by [redacted]

47. DT enrolled at [redacted] on 26 November 2012. School records show that he attended on 27 November 2012, the majority of each day on 5 and 6 December 2012 and on 31 January 2013. The school year ended on 19 December 2012 and recommenced on 31 January 2013. His enrolment was somewhat unusual as most students would finish a school year at their old school and commence afresh the following year at the new school.

48. It may be inferred that [redacted] was aware that DT was likely to need extra support with his attendance. Enrolment documents note school attendance and anxiety as issues. The principal [redacted] spoke with M and slightly later the relieving principal [redacted] met with F. At some point it appears that [redacted] telephoned [redacted] for further background. However, there is no evidence to suggest that anyone at [redacted] understood the true extent of DT's struggles. I note that [redacted] recorded a learning support referral in December 2012 and on the first day of school DT was accompanied to class by a deputy principal to ease his introduction.

49. I accept that the staff at [redacted] had little further opportunity to engage with DT before his tragic death. I am not critical of the care they provided.

The involvement of the Department of Family and Community Services

What did FACS know at the time and what support and intervention took place?

50. The Department of Family and Community Services received a number of reports to the Helpline regarding the children of the [redacted] family between 2007 and 2012, with the majority occurring from late 2011.

51. In the last 12 months of DT's life, DT and his siblings were the subject of a significant number of reports to Family and Community Services. These reports raised a variety of concerns including educational neglect, M's mental health and addiction to prescription medication, the impact of M's mental health and depression on the children, the family's isolation from external supports, the role played by the children in relation to the care of their mother, DT's acting out behaviour including

violence towards his siblings and mother, inappropriate sexual experience in relation to DT's older sister and ongoing financial stress.

52. These reports were made by both mandatory reporters (including a report about educational neglect made on 23 October 2012 by [redacted]) and by non-mandatory reporters. While legislation normally protects people who wish to make anonymous reports, F indicated to the court that he made a number of these reports, himself.

53. From 2011, FACS was on notice that there were very significant school absences for DT and at least one other sibling. For example, on 23 September 2011 a mandatory reporter informed FACS that DT's younger sibling had 30 absences in a 100 day period and had missed 70 days of school in 2011 and that DT had missed 50 days in 2011. The family situation, including M's illness, was explained and it was specifically stated that "nothing would change unless supports were put in place".[31] At this time DT was 12 years of age and his sisters were 13 and 10. While the Helpline determined that the report met the threshold for "risk of significant harm", it was never allocated to a caseworker due to "competing priorities" in the area at the time.[32] Neither could the case be referred to the Brighter Futures program because of the age of the children. The case was then closed.

54. On 20 March 2012, a child protection report was made to the Helpline regarding DT and his two siblings. There were similar concerns expressed but this time none of the children were attending school, M could not be contacted and DT had said that "she could not get out of bed". M's issues with pain medication were noted. The Helpline determined that the report did not meet the threshold of "risk of significant harm", so the report was screened out at the Helpline stage and was not allocated to a Community Service Centre (CSC) for further assessment.

55. On 28 of April 2012, the same person who made the report called again to make a child protection report in relation to DT and his two sisters. This included that the children were not attending school and that M had mental health issues and was isolating herself and the children. The caller advised FACS that F was not able to have contact with his children and that court mediation was not proceeding. That same day the Helpline determined that this did not meet the threshold of "risk of significant harm" so the report was screened out at the Helpline stage and not allocated to a CSC for further assessment. No inquiries were ever made with the school.

56. On 25 June, and again on 27 June 2012, another report was made relating to similar issues concerning the emotional state of the children, their lack of school attendance and the declining health of M. In both instances the Helpline determined that this did not meet the threshold of "risk of significant harm" so the report was screened out at the Helpline stage and not allocated to a CSC for further assessment.

57. On 17 September 2012, a child protection report was made by the same person who had made the last four reports. The report expressed concerns about all the children and stated that M had chronic pain, was addicted to pain medication and spent most of the time bedridden. There was information that DT was physically violent to his siblings and mother and that M did not take her children to their counselling appointments. The reporter raised concerns that DT's sister may be in

[31] See Statement of Claire Donnellan Exhibit 1, Volume 3, Tab 29 [67]
[32] See Statement of Claire Donnellan Exhibit 1, Volume 3, Tab 29 for a summary of this material

a sexual relationship. The report was screened out at the Helpline stage and not allocated to a CSC for further assessment or action.[33]

58. It is now clear that these were just some of the attempts made by F to get help for his children.[34]

59. On 23 October 2012, another child protection report was made to the Helpline, this time by a mandatory reporter. It included that DT had missed approximately seven weeks of term three. M had not returned numerous messages left for her and had not initiated contact with the school about DT's extended absence. On 31 October 2012, the Helpline determined that this did not meet the threshold of "risk of significant harm" because there was insufficient information to screen the report as "Neglect-educational neglect". The Helpline noted that the school officials were yet to "sufficiently follow-up on the issue of attendance". As a result the report was screened out at the Helpline stage and not allocated to a CSC further assessment. During the inquest, Ms Donnellan, currently the Executive Director, Statewide Services at the Department of Family and Community Services, conceded in her evidence that this report met the criteria for "risk of significant harm" and should have been referred to a CSC.[35]

60. On 31 October 2012, DT's school made a further mandatory report in relation to educational neglect. There was no evidence on file that the school was ever informed that no action would be taken.

61. On 6 November 2012, a further report was made by F. It included information that DT had not been going to school since 1 September 2012. DT had to get M out of bed in the morning. That a truancy liaison officer had been to the house, but the children were still not attending school. DT was acting out with violence against his siblings and M. The children were socially isolated, DT had lost weight and missed school because of "kidney stones" but that his doctor thought it was caused by "stress". On the date of the call the Helpline assessed that this report did meet the threshold of "risk of significant harm" for educational neglect and the report was transferred to the Campbelltown CSC for further assessment within 10 days. However, the report was never allocated to a caseworker at Campbelltown CSC. On 7 November 2012 Campbelltown CSC determined that the report should be closed for "current competing priorities", meaning, in effect, that there was nobody available to follow it up.

62. At the date of DT's death, despite these numerous reports there had been no face-to-face contact with the [redacted] family. A face-to-face visit is only conducted in the event that a report is screened in, not closed due to "competing priorities", transferred to a CSC and assessed as necessary by a caseworker. FACS also had no communication with Dr Higginbotham, nor was there any follow-up with DT's school.

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[33] It was somewhat beyond the scope of this inquest but it appeared troubling that Ms Donnellan did not appear to immediately recognise that a 15 year old cannot legally consent to sex. (Transcript 15/8/17, page 55, line 6) The Court was certainly at a loss to understand how this report did not reach the threshold of ROSH for this reason alone. It was also Ms Donnellan's initial evidence that the allegation was not serious enough for a referral to JIRT.(see discussion of this point at Transcript 15/8/17, page 72, line 1 onwards) Given the child may have been 14, not 15,as was put to Ms Donnellan, the matter is even more disturbing. Considering the overall circumstances of what was happening at the house, it was a significant issue and appropriate that counsel for FACS made the a concession the following day, that the matter should have been screened ROSH because of risk of sexual harm. (Transcript 16/8/17, page 1)

[34] Evidence of Clare Donnellan, 15/8/17, page 51, line 10

[35] Evidence of Clare Donnellan, 15/8/17, page 63, line 5 onwards

63. It is understandable that F, who tried to interest the Department in the fate of his children, felt angry and let down. As well as contacting FACS, he contacted the local police, who he also asked to check on the family. There was evidence before me that police attended the home[36]. The police are not the appropriate responders to a family with such complex needs and I am not critical of the action they took in the circumstances.

What improvements or changes have FACS made since 2013?

64. The court was assisted by a comprehensive statement[37] and oral evidence from Ms Donnellan, who at the time of DT's death the person responsible for the oversight and operational management of the Department across South Western Sydney.

65. Ms Donnellan gave evidence about a number of changes that have been made since DT's death. Perhaps most relevantly there has been a change in the definition of "educational neglect" in the Structured Decision Making tool (SDM) which is used by Helpline staff to assess reports made[38]. It was Ms Donnellan's view that the expanded definition now used would likely have meant that reports made in relation to the [redacted] children would have met the ROSH threshold. That is a positive change, although of course it would not have guaranteed action if there were significant competing priorities.

66. Ms Donnellan also told the Court that since 2013 the Department had undertaken training on the issue of educational neglect, including joint practice research initiatives, a partnership with the Department of Education and NSW Police, and the "Schoolz In" project in NSW.[39] It is clear that poor school attendance or school refusal can be an extremely important indicator of family crisis in child protection work and it needs to be recognised early by workers in the field. The [redacted] children had a long history of very poor school attendance. This fact alone should have triggered further investigation.

67. Ms Donnellan also outlined other improvements in training for Helpline workers and improvements to the tool they use in triaging calls. She reported that there has also been further training for case workers on parental substance abuse and more recently neglect.[40] All of which is to be commended.

68. Ms Donnellan also informed the court about the realignment and restructure of South West Sydney District FACS, which she said had produced great results. There had been a recognition that more needed to be done in relation to non-ROSH reports and the establishment MIRS[41] had helped to improve the better integration of government and non-government services.

69. The court accepts that there have been improvements in response rates since the time of DT's death. Nevertheless a number of specific concerns remain. Quite apart from the concern the court had about the Department's inability to deal with reports that had actually been identified as ROSH, the court also had grave concerns about a number of reports to the Helpline which were screened

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[36] See oral evidence of Leading Senior Constable Renai Williams, 14/8/17, page 12 onwards and the evidence of Senior Constable Geoffrey Marsden, 14/8/17, page 20 onwards
[37] Statement of Clare Donnellan, Exhibit 1, Vol 3, Tab 29
[38] The detail of this change is set out in her statement in Exhibit 1, Vol 3, Tab 29, [109]
[39] See submission from the FACS and also the oral evidence of Clare Donnellan, 15/8/17, page 50 at [23] onwards
[40] See Statement of Claire Donnellan Exhibit 1, Volume 3, Tab 29 [112] onwards
[41] For information about this issue see Statement of Clare Donnellan, Exhibit 1, Vol 3, Tab 29 [126] and also in her oral evidence at Transcript 15/8/17, page 81, line[1] onwards

out, but which should have received further action. One suggestion considered after reviewing the FACS file was the possibility that Helpline staff may have failed to take the report seriously enough because it was made by a non-custodial parent involved in family law proceedings. The possibility of unconscious bias in these circumstances was raised. In response, Ms Donnellan provided the court with a supplementary statement[42] which outlined the nature of training already provided by FACS to its caseworkers. This included general training about the existence of "unconscious bias".

70. While Ms Donnellan appeared to concede that at least two reports concerning the [redacted] children may have been incorrectly screened out, she retained enormous confidence in the accuracy of the Structured Decision Making tool (SDM). The court did not share this confidence.

71. Following her oral evidence, the court received a supplementary statement from Trevor Bale, who is currently the Director of the FACS Helpline. He provided further information about the SDM tool used by FACS Helpline staff. It is a product licenced from the National Council on Crime and Delinquency's Children's Research Centre (CRC) in Wisconsin, USA.[43] That company has developed the tool and continues to monitor its effectiveness.

72. According to Mr Bale, the review conducted by CRC in 2015 found that of the randomly selected reports, 99% were correctly screened. It is clearly beyond the scope of this inquest to assess the legitimacy of the review conducted, however an independent review might be useful. If at least two of the reports made in relation to the [redacted] family were subsequently deemed incorrectly assessed, it is surprising that the company reported such a high level of accuracy.

73. Another issue identified as potentially concerning was the lack of feedback given to reporters. It makes sense that if a report has been screened out, that the reporter is contacted so that they are fully aware that if their concerns remain, they may need to try again or contact some other authority. Mr Bale gave evidence that FACS is implementing a new client information system, ChildStory, which will be operational by the end of 2017.[44] This system will allow mandatory reporters to register themselves for ChildStory and obtain real time feedback regarding a report they have made. This will mean that a registered mandatory reporter will know whether their report met the ROSH threshold, whether it has been transferred to a CSC or Joint Investigation Response Team, whether it has been allocated for a face-to-face assessment or whether it has been closed due to competing priorities. Mandatory reporters will be encouraged to register but if they don't, they will continue to receive feedback at both Helpline and CSC stage by email or letter. The Court accepts that the development of ChildStory appears to be a step forward.

A system in continuing crisis

74. Notwithstanding the changes already made, once again this court was faced with digesting the shocking statistics of an under-resourced Department. Ms Donnellan told the court that FACS gets around 300 000 reports a year and about half of them are screened out as "non-ROSH" at the Helpline stage.[45] Of the remaining reports, only a proportion would ever see any action.

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[42] Supplementary statement of Clare Donnellan, dated 7 September 2017, attached to court file.
[43] Statement of Trevor Bale, dated 6 September 2017, [7], attached to the court file
[44] Statement of Trevor Bale, dated 6 September 2017, [24], attached to the court file
[45] Evidence of Clare Donnellan, 15/8/17, page 29, line 10 onwards

75. Ms Donnellan told the court that at the time of DT's death, the South Western Sydney District FACS office was only able to respond to one in five ROSH reports.[46] It is worth pausing to reflect on the shocking reality of that situation. It is clear that a report must disclose a very serious situation to even get classified as reaching the ROSH threshold. That four out of five cases meeting this level, by the Department's own criteria, were left without face-to-face contact is both astounding and deeply distressing.

76. Ms Donnellan told the Court that across the state, FACS was now able to respond to about 30% of all ROSH matters. She outlined a number of changes she had been responsible for making that had improved the response rate and she should be commended for that work. I have no doubt the Department is staffed with many employees who work very conscientiously to improve the current response rate. Nevertheless, there was an acceptance of the situation expressed in her evidence, which cannot be tolerated. The unacceptable nature of the situation was put squarely to Ms Donnellan, as a senior representative of the Department in the following question from counsel assisting,

> "..it's just not acceptable for a child in an affluent country like Australia to not get the assistance that they needed after being determined to be at "risk of significant harm" like DT was in November 2012, is it?"

Ms Donnellan's answer was,

> "As tragic as it is, we can only do what we can do with ... the resources we have and we will often allocate resources for follow-up work and face-to-face assessments to...younger children and babies because they're obviously more vulnerable, and so it is...a sad state of affairs that we can't get to everything that we need to get to."[47]

77. It is more than a "sad state of affairs", it is an ongoing crisis. Time after time, this court grapples with the results of an under-resourced Department of Family and Community Services. Once again I find myself urging both the Premier and the Minister to review the facts of a coronial case and to reconsider current resource levels.

The need for recommendations

Medical treatment

78. The tragedy of DT's death calls for sincere consideration of whether there are further systemic improvements that can be made to reduce the chance of another child falling through the cracks.

79. As I have stated, in my view Dr Higginbotham's failings are personal, rather than systemic. While I accept that the provision of mental health services for young people in South Western Sydney is woefully inadequate[48] , I do not identify this as the prime problem with DT's medical care. The lack of care shown by Dr Higginbotham in this case makes me reluctant to believe that he would have used the appropriate services even if they had existed. He was clearly incapable of accessing useful material on the internet and did not even undertake the obvious step of trying to find a

[46] Evidence of Clare Donnellan, 15/8/17, page 30, line 1 onwards
[47] For this exchange see the evidence of Clare Donnellan, 15/8/17, page 64, line 10 onwards
[48] See discussion of this issue by Clare Donnellan, 15/8/17, page 83, line 24 onwards

mental health provider who could offer him advice. I propose to make no recommendations in relation to DT's medical care.

Catholic Education Office

80. When reviewing the evidence of Mr Lo Cascio, he appeared to have the view that the Catholic system was somehow hampered in relation to the kind of enforcement that could be undertaken by Home School Liaison Officers within the state system.

81. Following the oral evidence, the Court received further detailed information from the Department of Education about how the government system responds to significant attendance issues, including information about the Home School Liaison Officer (HSLO) program.[49] Ms Bale's evidence tracks the steps which are to be followed before a referral to the HSLO program and to even stronger enforcement measures that are available. It is clear that these systems were not tested in the government sector in relation to DT, who died in week three, of term one, in 2013, before a clear pattern had sufficiently developed.

82. However, many of the steps actually taken by [redacted] the previous year mirror what would be considered best practice in the state school system. A specific staff member had "pastoral care responsibility" and counselling support was offered, absences were tracked, contact was made with both parents, staff tried to arrange meetings with M, and eventually a report was made to FACS.

83. Consideration was given to whether the Catholic system was hampered in any way in dealing with the attendance issue it faced. Having reviewed the information now available I am of the view that while it would be open to the Catholic education sector to develop its own internal HSLO system, if indeed it identifies a gap in the service it currently provides, the Catholic education sector already has access to the same enforcement procedures as the state system, should it require them.

84. Part 5 of *the Education Act* contains powers in relation to enrolment that can be exercised in addressing the attendance of children at both government and non-government schools. While a non-government school would use a different pathway to a government school to engage the Department's functions under part 5 of the *Education Act*, I accept that the enforcement options ultimately available to both government and non-government sectors were in fact identical at the time of DT's death.

85. I have carefully considered the need for formal recommendations[50] in relation to these issues. While it appears that there was some confusion demonstrated by Catholic Education, Diocese of Wollongong in relation to the enforcement procedures that operated at the time of DT's death, I am of the view that following the submissions made by the Department of Education in this inquest that issue has been cleared up. There is no evidence before me to suggest that there is a wider confusion within the Catholic system. In any event, given Mr Lo Cascio's willingness to learn from the circumstance of DT's death, I am confident that he will share this information with the wider Catholic school community.

86. Given the Department of Education's stated willingness to liaise with other sectors to strengthen systems supporting information exchange between the various educational sectors I see no need

[49] See statement of Robyn Bale dated 8 September 2017, attached to the Court file
[50] The draft recommendations which were circulated to the parties are attached to the court file

for a formal recommendation. However, I urge Ms Bale, currently the Executive Director of Learning and Wellbeing at the Department of Education to consider ways of facilitating greater information exchange and training between the sectors on dealing with difficult attendance issues.

Department of Family and Community Services

87. Four draft recommendations arising out of the evidence were circulated at the conclusion of proceedings suggesting possible improvements to the FACS systems which were in place at the time of DT's death[51]. Detailed submissions were received from the Department, arguing against the need for some of the draft recommendations, given the changes and improvements that have already been made since the time of DT's death.

Advice to mandatory reporters when a report is screened out

88. I accept that ChildStory, when it is fully introduced, may, if it has a significant take-up rate, largely remove the need for a mandated response time. However, it is an opt-in system that requires a reporter to log in to the ChildStory computer system. It remains, in my view, crucial that mandatory reporters are given accurate and timely information, as a matter of course, about the result of their reports. This allows a mandatory reporter to re-report if necessary or to make appropriate decisions about following up other action. Notwithstanding the Department's planned implementation of ChildStory, I intend to make a recommendation in this regard.

Specific training in relation to the issue of unconscious bias in relation to reports from separated parents

89. F made a number of reports which, although on the face of it appeared serious, did not make it past the Helpline stage. In reviewing the material it appears a real possibility that the reports were viewed in the context of 'family court matters' and as a result were not given the attention they warranted. While I accept that the Department conducts training in respect of unconscious bias in general terms, I consider the specific issue identified in this inquest is one which should be considered for future training. Notwithstanding the training already offered by the Department, I intend to make a recommendation in this regard.

Provision of information to reporters where a report does not meet the ROSH threshold.

90. F made a number of reports to FACS seeking support and assistance. None of his efforts resulted in action. He was never given any information about what else he could try or where else he could turn. It is apparent that he needed further assistance and referral, at the very least. He did not know what else to do.
91. FACS has stated it is supportive of the draft recommendation in principle, but it is a proposal which would require a significant allocation of resources. I intend to make a recommendation for the Minister's urgent consideration of this issue.

Conclusion

92. DT's death is a terrible tragedy. It was unforseen by those closest to him. His mother and siblings were in many respects also struggling to survive. His general practitioner offered no material assistance.

[51] The draft recommendations which were circulated to the parties are attached to the court file

93. F's attempts to make contact with DT were unsuccessful. When all else failed, he turned to the Department of Family and Community Services for assistance, taking the significant step of reporting his own children. This was a step DT's school had already made. The pressure on the Department of Family and Community Services meant that the family never received a face-to-face visit, despite numerous calls, until after DT's death. The court accepts that there are no simple solutions to the problems faced by DT and his family, nevertheless several opportunities for positive change have been identified. I trust the Department of Family and Community Services will give them full consideration.

Findings pursuant to section 81 *Coroners Act* 2009 (NSW)

The findings I make under section 81(1) of the Act are:

Identity
The person who died was DT

Date of death
DT died on 13 February 2013

Place of death
[redacted]

Cause of death
[redacted]

Manner of death
DT's death was intentionally self-inflicted

Recommendations pursuant to section 82 *Coroners Act* 2009 (NSW)

To the Minister of Family and Community Services,
I recommend that,

The Department of Family and Community Services give urgent consideration to,

Amending existing policy/procedure so that where a mandatory report is made and screened out as non-ROSH, the mandatory reporter is advised of the outcome within 21 days.

Introducing and evaluating further training for Helpline and CSC staff in respect of "unconscious bias" when dealing with parents who have separated from the primary carer and are reporting concerns about their children.

Creating a referral service operating at the hotline stage, so that where referrals are screened out as "non-ROSH", reporters are informed that the information will be kept on file as relevant history in the event of further calls and the referrer is given the contact details of other service providers that may be able to assist (e.g. Anglicare, CatholicCare, local adolescent medical health services, Brighter Futures)

Finally I offer my sincere condolences to M and F and their respective families. I thank them for their brave participation in this inquest.

I strongly urge that any published report of DT's death includes reference to suicide prevention and adolescent health contact points.

I close this inquest.

Magistrate Harriet Grahame
Deputy State Coroner.
13 October 2017
NSW State Coroner's Court, Glebe