STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Emily
Hearing dates:	5-9 November 2018, 19-20 November 2018
Date of findings:	26 February 2019
Place of findings:	NSW State Coroner's Court, Lidcombe
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	CORONIAL LAW – self-inflicted death, death of child in foster care
File numbers:	2014/263681
Representation:	Mr P Aitken, Counsel Assisting, instructed by Ms K Hainsworth, Crown Solicitor's Office
	Mr M Fordham SC instructed by Ms K Stewart, Norton Rose Fulbright, for Department of Family and Community Services
	Ms M Gerace, instructed by Ms M Baker, Department of Education
	Mr I Fraser, instructed by Ms J Kelly, the identified Out of Home Care Non-Government Organisation
	Mr S Beckett, instructed by Mr J Kamaras, Avant law Pty Ltd, for Dr Prabhuswamy
	Mr N Broadbent, instructed by Ms E O'Brien, Minter Ellison, for a private school
	Mr C McGorey, instructed by Ms R Dunlop for Foster Carers

Non-publication orders

I order that:

1. The unredacted full reasons for these findings and those parts of the findings relating to the means, mechanism, date and place of death are subject to a non-publication order made pursuant to section 75 of the *Coroners Act* 2009 (NSW), which order will continue to have effect after the making of these findings. These short-form summary of relevant reasons may only be published in an approved redacted form.

2. Pursuant to section 75(2)(b) of the *Coroners Act* 2009, a non-publication order is made with respect to the identity and any identifying information which could lead to the identity of Emily being disclosed, including the disclosure of the identity of any of the following :
   a) Emily's foster parents and foster sister;
   b) Emily's birth parents and siblings;
   c) Emily's schools attended during her life and the names of teachers from those schools who gave evidence in these proceedings;
   d) the Out of Home Care Non-Government Organisation with case management for Emily; and
   e) those whose names were mentioned in the evidence in these proceedings.

3. Pursuant to section 74 of the *Coroners Act* 2009 that there be no publication of any of the exhibits tendered as evidence in these coronial proceedings nor of any of the oral evidence taken in the inquest hearing or submissions or opening and closing addresses.

4. Pursuant to section 65 of the *Coroners Ac*t 2009 no access be given to the Coroner's court file in these proceedings without further order of the Court.

Findings

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

Identity

The person who died was Emily.

Date of death

Emily died in 2014.

Place of death

She died in NSW.

Cause of death

She died from [redacted]

Manner of death

Emily's death was intentionally self-inflicted.

I strongly urge that any published report of this death includes reference to suicide prevent and adolescent health contact points.

Short form summary of relevant reasons

- Reports to FACS indicated that there were significant welfare concerns in Emily's home life prior to Emily being taken into Out of Home Care.
- Emily was placed in short term foster care just before she turned one and in the care of her eventual long-term carers at the age of 15 months.
- In 2007 Emily commenced seeing a psychologist, her carers reported Emily having anxiety and panic attacks and exhibiting other concerning behaviours from about the age of five.
- The psychologist identified that Emily had very frequent contact with her birth parents in her early years in care.
- The psychologist concluded that Emily exhibited symptoms of anxiety related to attachment issues and underlying insecurities in relation to her sense of belonging. The psychologist also pointed to the sense of insecurity which might occur when other children on short-term placements were fostered in the home. The psychologist recommended that contact with both birth parents be reduced to four supervised visits per year to enable Emily to seek out a secure attachment base.
- In about 2007 the first case plan looking into adoption suitability was formulated. At about this time the psychologist was concerned that Emily appeared to have strong divided loyalties between her birth family and foster family.
- By 2009 the psychologist felt that Emily appeared more settled, but had concerns that Emily may experience the usual identity concerns that face many foster children in their adolescence.
- By 2012, in the psychologist's opinion, Emily wanted adoption to proceed. The psychologist was concerned about the recent short term placement of children in the placement and the subtle undermining this may have had to Emily's sense of security. She was of the view that Emily's seeming self-sufficiency could be deceiving.
- Evidence was received that a child with early childhood trauma and without a stable secure sense of belonging would be much more vulnerable to oppositional behaviours in adolescence.
- Emily's behaviour subsequently deteriorated at home and at school. Further clinical assistance was sought and provided. Unfortunately, those health professionals treating Emily in the last few years of her life were not given the benefit of complete background histories or reports from those previously treating Emily to assist in their assessment and treatment of her.
- In the same way, when Emily transferred schools, all information relevant to her ongoing welfare was not received by her new school.
- In 2013 the adoption process was put on hold for reasons that were explored in the inquest. Emily was informed of this decision by her caseworker. I am of the view that Emily would have benefited from skilled therapeutic input to understand the reasons for the decision and her response to it.
- In 2014, Emily took her own life.
- Expert appraisal was unable to conclude that any one factor was causative in Emily's death.
- Evidence was received at the inquest that FACS and the Out of Home Care (OOHC) Non-Government Organisation (NGO) responsible for management of Emily's OOHC placement failed to adequately recognise the series of serious cumulative risk factors Emily presented with in her last year of life. A more coordinated and urgent response was required.
- It was also recognised by the identified OOHC NGO at inquest that there was room for improving the training of foster carers for the transition of a child into adolescence (both as to what behavioural issues may emerge and the skills needed to deal with them).
- Other matters where room for improvement was explored and acknowledged are referred to in the recommendations.

Recommendations pursuant to section 82 Coroners Act 2009

For reasons stated elsewhere (and which are subject to a non-publication order), I make the following recommendations:

I recommend to the Group Executive Manager, of the identified OOH NGO that consideration be given to:

Engagement of external clinicians

1. Taking steps to reintroduce the use of a written form to be used when children in the care of the identified OOHC NGO foster carer are seen by an external clinician. Such a form could be revised (from the form currently in exhibit 8), to include:
    a. Details of the role of the identified OOHC NGO in relation to the child, including authorising the provision of information by the clinician to the identified OOHC NGO.
    b. Information regarding relevant past treatments and clinicians.
    c. Provision for the external clinician to provide information regarding the clinician's diagnoses and recommendations.

2. Reviewing relevant policies with a view to provision being made for:
    a. Written reports to be obtained from external clinicians in relation to significant attendances relating to future management of foster children.
    b. Proactive sharing of relevant previous reports of other clinicians with external clinicians.
    c. External clinicians being invited to participate (either in person by or by way of written report) in multidisciplinary case conferences.

Communication with schools

3. Reviewing relevant policies with a view to provision being made for:
    a. A requirement that information be provided in writing to schools regarding significant past and emerging issues that affect the safety, welfare or well-being of a child in the care of the identified OOHC NGO foster carer (both at enrolment and on an ongoing basis). That information should include the name and contact details of mental health practitioners that have been engaged with the child where considered appropriate.
    b. Where a child in the care of the identified OOHC NGO foster carer is to transfer schools, information in writing should be requested from the school from which the child is exiting as to any significant past and emerging issues that affect the safety, welfare or well-being of the child.
    c. School representatives being invited to participate (either in person by or way of written report) in multidisciplinary case conferences.

Education of foster carers

4. Taking steps to develop a training package for foster carers specific to the transition to adolescence.

5. Developing and providing a training regime and schedule that prepares foster carers for various milestones in advance (such as commencement of school, transition to high school, adolescence, and leaving care), shortly before those milestones are reached.

Communications of significant decisions to children in OOHC

6. Developing policies relating to significant decisions regarding a child in the care of the identified OOHC NGO foster carer (such as changes to case plan goal and decisions relating to respite care) with a view to:
    a. Providing guidance on the steps to be taken to communicate significant decisions to the children.
    b. Ensuring Case Managers are equipped to effectively explain such decisions.
    c. Clinical support being available and considered in such cases.

Communication issues

7. Updating the identified OOHC NGO's "Parents information book'" to include:
    a. Guidance on appropriate communication to support the child's sense of belonging.
    b. Specific issues regarding communication via social media.

8. Taking steps to develop social media fact sheets for foster parents and children in foster care.

I recommend to the Minister, Department of Family and Community Services:

9. Consideration be given to whether:
    a. the currently available carer training used/recommended by FACS includes training directed at:
        i. anticipating possible limit testing and oppositional behaviour in the adolescent child in Out of Home Care;
        ii. understanding why such behaviours may be exhibited (i.e. 'acting out' in response to underlying trauma and attachment issues);
        iii. providing strategies for responding to and dealing with such behaviours, including seeking clinical support; and
    b. if the training in all or any of i), ii) and iii) above is not currently available, whether such training ought to be developed.

10. That the above recommendations, 1 to 8, directed to an identified OOHC NGO are circulated to all NGOs that provide OOHC in NSW, with a request that the NGOs review their policies and procedures to identify if there are any gaps which require remedying. [In making this recommendation, it is noted that this may complement a planned consultation by FACS with NGOs in 2019 to identify if there are any gaps in health and education pathways for children in OOHC].

Magistrate Harriet Grahame
Deputy State Coroner
26 February 2019
NSW State Coroner's Court, Lidcombe