CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Alex Jeremy Raichman
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 – accidental death; respite care; voluntary out of home care (VOOHC); unsafe environment in VOOHC; Civic Disability Services
File Number:	**2018 /12778**
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) Mr D Baran for the Raichman Family (i/b Ms B Purdon, Legal Aid NSW) Mr Elliott Rowe, O'Brien Criminal and Civil Solicitors, for Mr K Chapman Mr B Kelleher SC for Civic Disability Services (i/b Ms G Morris, Colin Biggers and Paisley) 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:	Pursuant to s 74, I make a non-publication order: i. over the names of any child or young person aside from the names of the young persons, the subject of these inquests, whose names may appear in the brief of

	evidence;
Findings	**Identity** The person who died was Alex Jeremy Raichman. **Date of death** He died on Sunday 22 April 2018. **Place of death** He died on train tracks near Oatley Railway Station, NSW. **Cause of death** Alex died from multiple injuries sustained by when he was struck by a train on 22 April 2018. **Manner of death** Alex's death occurred because he was able to abscond through an unlocked window and climb over an inadequate fence whilst he was in respite care being provided by Civic Disability Services ("Civic") at a respite home it operated, located at 46 Oatley Parade, Oatley. He was struck by a train around half an hour after running from the property.
Recommendations:	**To the Office of the Children's Guardian:** It is recommended that the Office of the Children's Guardian: a) Consider whether an amendment to the definition of "substitute residential care" (SRC) to capture entities providing respite care for more than one night in any 7-day period would be appropriate; b) Take steps to ensure that Civic does not provide SRC or "specialised substitute residential care" (SSRC) to persons under the age of 16 years. c) In circumstances where Civic seeks to be authorised for Statutory Out of Home Care as a designated agency,

	consider any findings of this inquest and any deficiencies in Civic's provision of past VOOHC when making that decision; and d) Provide to the appropriate Minister a copy of the findings of this Inquest.
	To Civic Disability Services It is recommended to Civic Disability Services: a) That it agrees to a restriction that it does not provide SRC or SSRC to children and young persons under the age of 16 years; b) Devise and roll out a training program for staff addressing the processes available for alerting all levels of management in Civic of risks within the Civic environment, including direct contact with the CEO.

Table of Contents

Introduction

1. This inquest concerns the death of Alex Jeremy Raichman, who was born on 12 March 2007.

2. Alex was 11 years of age at the time of his death. He was fun-loving and active. He enjoyed the outdoors, climbing and running. He had a wide range of passions and interests including swimming and water play, collecting rocks and chasing birds. He was described by his mother as affectionate with his immediate family. He enjoyed being with teenagers and adults who were animated and interactive.[1] He was greatly loved by his parents and brother and was a valued member of his school community.

3. Alex had been diagnosed with autism and global developmental delay when he was 20 months old. Alex did not develop speech and accordingly, the challenges involved in understanding the world and expressing himself led, at times, to extreme frustration and long meltdowns.[2] He also had severe sensory processing issues and was extremely sensitive to noise.

4. Alex was strong, fast and agile. He had very little understanding of environmental risk. His mother explained that if he saw something that fascinated him, he would block out the rest of the environment to pursue his interest. He would cross the road to chase a bird without a care for oncoming traffic and he could climb to great height or run at great speed into the distance.

5. It is very clear that Alex was greatly loved by his family. Over the years, they put in place careful systems to allow him to explore the world in safety. Given his strength and speed, great care needed to be taken to supervise him appropriately at all times.

6. Alex had every right to a long, meaningful and joyful life. His death is an enormous and completely preventable tragedy. His parents, supported by family and friends, attended this inquest to honour Alex and in a generous attempt to shine a light on the factors that contributed to his death. They wanted to make sure that no other family experiences what they have gone through. Their terrible heartbreak and searing pain were palpable in the court room. Their courage to attend in these circumstances is gratefully acknowledged.

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[1] Sharon Braverman's Public Submission to the disability Royal Commission, as attached to her final submissions to this inquest, attached to Court file.
[2] Sharon Braverman's Public Submission to the disability Royal Commission, as attached to her final submissions to this inquest, attached to Court file.

7. I record my utmost respect for Ms Sharon Braverman and Mr Dale Raichman. I acknowledge their profound sorrow and loss and send my sincere condolences to Alex's close and wider family.

The role of the coroner and the scope of the inquest

8. 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]

The evidence

9. The court took evidence over eight hearing days.[5] The court also received extensive documentary material in three initial volumes along with other exhibits. This material included witness statements This material included witness statements and procedural documents from Civic Disability Services (Civic), material from the Office of the Children's Guardian and an expert opinion.

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

11. A list of issues was prepared before the proceedings commenced. These guiding issues were:

- The manner of Alex's death, including the factors contributing to his death.
- Whether Civic failed to adequately assess the premises on which it provided Alex with respite care as being suitable for providing care to Alex.
- Whether Civic failed to address known hazards in the premises on which it provided Alex with respite care in a timely or appropriate manner.
- Whether Civic would have benefitted from more information concerning Alex during his respite stay.
- The role of the Department of Communities and Justice.

[3] Section 81 *Coroners Act 2009* (NSW).
[4] Section 82 *Coroners Act 2009* (NSW).
[5] This inquest was heard with the inquest into the death of Riley Shortland, a child who died in similar circumstances while on respite in out-of-home care and the death of Rachel Martin, a respite worker who was caring for Riley at the time of each of their deaths. The court sat for 8 days in total.

- The role of the OCG at the time and presently.
- Adequacy of supervision and behavioural support provided to Alex in the period prior to his death.
- Whether there should be a policy regarding certain information which must accompany all children on all respite care arrangements with respect to high needs children who receive short-term respite care.

Fact-finding and Agreed Facts Document

12. Prior to commencing the inquest, a summary of facts taken from the extensive available material 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 here.

13. 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 expert evidence in these reasons where appropriate, incorporating her words. The interested parties' written submissions in reply to those submissions have also been considered closely.

Brief Chronology

14. Alex Raichman was born on 12 March 2007. He was a twin sibling to Samuel and the child of Sharon Braverman and Dale Raichman. Alex had a known diagnosis of autism spectrum disorder, his condition was regarded as severe. He also lived with an intellectual disability and had been diagnosed with epilepsy. Alex lived with his family and attended the Warrah Special School at Dural.

15. During the school holidays in April 2018, Alex's family had the opportunity visit family in Melbourne. They planned to take Samuel, but it would have been impossible to take Alex. It is important to acknowledge the need for respite care for families such as Alex's. The importance of protecting and strengthening family relationships is crucial for long-term survival. There is a pressing need for carers to have short breaks to recharge their energy. Without appropriate respite, families become isolated, exhausted and unable to cope.

16. Ms Braverman proceeded to organise respite care for Alex, and she did this with a non-government organisation, Civic. Ms Braverman filled in the relevant form for

the period that the family intended to be away.[6] That respite was subsequently arranged to commence at 3pm, Thursday, 19 April 2018 and was due to conclude on Tuesday, 24 April 2018.

17. Alex had attended respite care with Civic on a number of occasions prior to 19 April 2018, initially at the Civic site known as Hinkler[7] and later, at the premises at Oatley. Hinkler had a secure perimeter fence that Alex could not climb over or abscond from.

18. The respite care occurred in the early period of the operation of the National Disability Insurance Scheme (NDIS). Alex had been approved to become an NDIS participant on 4 September 2017, when he was almost 10.5 years of age.[8] His first plan commenced on 23 November 2017, just five months prior to his death. His second plan commenced on 16 March 2018, just over one month prior to his death.

19. Going back to 1 December 2017, prior to Alex commencing any form of respite with Civic, Ms Braverman had completed the Civic 'Children Services Application Form' and 'Booking Form'. On that form, she wrote that Alex was a "*profound absconding risk. Has previously absconded, found on the bus, inside neighbours pool, can climb ANY fence, runs FAST".*[9] She could not have been clearer about the risks involved.

20. Ms Braverman and Ms Pauline Stanley, an NDIS funded support worker, attended to viewing the Oatley premises, which they understood was a venue where respite care would be conducted. On 13 February 2018, Ms Stanley informed Civic that in her view, the garden was a risk for Alex due to the low fence, and very close supervision of Alex would be necessary.[10]

21. On or about 23 February 2018, Ms Braverman inspected the property and informed Civic that Alex "*definitely might try*" to get out of the windows and informed Civic that locks would need to be placed on the windows.[11] Civic did not place locks on the windows or secure the windows in any form prior to 20 April 2018.

22. Alex attended the Oatley premises for respite on the following occasions prior to 19 April 2018:

    - 23 – 25 February 2018
    - 9 – 11 March 2018

[6] Although Alex was an NDIS client, the NDIA was not involved in the arrangement of this respite.
[7] 15 Hinkler Ave Caringbah NSW
[8] NDIA Submissions para 8 in reply 26 July 2022
[9] Exhibit 1 Brief of Evidence Vol 1: Tab 6 Statement of Sharon Braverman
[10] Exhibit 1 Brief of Evidence Vol 3: Tab 40 Annie Doyle Statement Annex. H
[11] Exhibit 1 Brief of Evidence Vol 1: Tab 6 Sharon Braverman statement

- 23 – 24 March 2018
- 6 – 8 April 2018[12]

23. Civic expressed concerns in relation to Alex's escalating behaviours when he first attended Oatley on 23 - 25 February 2018. These concerns were put down to the "*new environment and some new staff*".[13] During the visit that occurred on 23 - 24 March 2018, Civic requested permission to return Alex home early due to lack of staffing. Ms Braverman sent an email to Alexandra Vall Rojo, Civic Practice Leader, regarding the respite stay, including a complaint about insufficient supervision.[14]

24. On the night of 19 April 2018, Alex attempted to abscond through a window in the Oatley house. That night at 9.29pm,[15] Ms Vall Rojo contacted various persons within Civic by email requesting immediate work on the windows and expressing concern for Alex's safety.

25. At 8am on 20 April 2018, Alex was reported to have "*got out his bedroom window and jumped to the ground. He played outside for an hour"*.[16] It was recorded on the Staff Handover that Alex "*will try to get out and abscond when awake*".[17]

26. At 7.30am on 20 April 2018, the following morning, Alexandra Vall Rojo sent another email regarding the lack of locks and again expressed her concerns for Alex's safety.[18] At 2.30pm that day, Robert McKay, Civic handyman, attended the premises to make the windows safe.

27. Robert McKay placed screws in the bedroom window frames allowing the windows to be open to a maximum of 9 cm. He did not however secure the *en suite* window in Bedroom 2.

28. At 4pm on Sunday, 22 April 2018, Pratima Sodha, Civic Disability Support Worker, came onto shift. Alex was the only client in the house from 4.30pm. Bedroom 2, not being the bedroom occupied by Alex, had a table placed in front of the door to limit Alex's entry into that bedroom.[19]

29. At about 6.45pm that day, Alex entered Bedroom 2 and escaped through the unsecured *en suite* window. He immediately ran from the property. CCTV footage confirms that Alex ran to the nearby Oatley Railway Station. He entered the Station

[12] Statement of Sharon Braverman dated 17/5/18, [30], [37]; OCG response, Vol 1, Tab 2, 'Child Placement History' annexed to document commencing re email dated 23/4/18, 9:22 am
[13] Exhibit 1 Brief of Evidence Vol 3: Tab 40 Annie Doyle Statement Annex. MM
[14] Exhibit 1 Brief of Evidence Vol 1: Tab 7 p. 18
[15] Exhibit 1 Brief of Evidence Vol 1: Tab 10 p. 40
[16] Exhibit 1 Brief of Evidence Vol 3: Tab 40 Annie Doyle Statement Annex. ZZ
[17] Exhibit 1 Brief of Evidence Vol 3: Tab 40 Annie Doyle Statement Annex. ZZ
[18] Exhibit 1 Brief of Evidence Vol 1: Tab 10 p. 31
[19] Exhibit 1 Brief of Evidence Vol 1: Tab 4 [98]; Tab 11 [15]

and moved onto Platform 1. He passed the fence at the end of the platform and moved onto the railway tracks.

30. I am satisfied that the available evidence establishes that Alex died following being hit by a train at 7.24pm, less than 45 minutes after he left the Oatley property.

Discussion of Issues

Cause of Death

31. The medical cause of Alex's death was uncontroversial. He sustained immediate and unsurvivable injuries and his death would have been instant.

32. Forensic Pathologist Dr Liliana Schwartz undertook a post-mortem examination on 24 April 2018.[20] She recorded the direct cause of Alex's death as "multiple injuries" – these included decapitation of the top of the head; bruises, abrasions and lacerations to the face, trunk, arms and legs; fracturing of the skull and facial bones; avulsion of the brain tissue; and fracturing of long bones. A toxicology report showed therapeutic levels of aripiprazole and carbamazepine. I accept Dr Schwartz's conclusions.

Civic Disability Services Limited

33. The court investigated the manner and(?) circumstances of Alex's death. This required some focus on the actions and procedures of Civic, an organisation tasked to care for Alex at the relevant time.

34. The inquest heard oral evidence from Ms Annie Doyle, who was the CEO of Civic in 2018 and currently, and who also provided a detailed statement to the inquest, and from Mr Kulander Chapman, Mr Owen Talauta, Ms Alexandra Vall Rojo and Ms Pratima Sodha, who were or remain employees of Civic.

35. The background to the setting in which Alex and his family found themselves is set out in Ms Doyle's statement:[21]

> *"In 2016, the disability sector across Australia was preparing for the shift from state-based funding to NDIS funding. In NSW, this shift included the closure of many traditionally government operated services, such as centre-based respite. In NSW, the Department of Ageing, Disability and Home Care (ADHC) had been historically known for being a last resort provider of centre-based respite services for families. The phasing out of ADHC services was due to complete in June 2018, however, by the end of 2016,*

[20] Exhibit 1 Brief of Evidence Vol 1: Tab 3 Limited Autopsy Report, p.2
[21] Exhibit 1 Brief of Evidence Vol 3 :Tab 40 at p.1

the demand for non-government organisations, such as Civic, to fulfil this need in the community was already apparent.

Many families contacted Civic, asking about respite services, as they were desperate for support. The demand on NGOs to step into the shoes of ADHC at this time was further compounded by changes to the way in which centre-based respite services were being funded. Prior to the introduction of the NDIS, organisations like Civic received a predetermined fixed amount of funds to provide centre-based respite services. This gave us the ability to roster and ensure that staff could fill a shift regardless of whether a client accepted or cancelled a booking.

This changed under the NDIS because funding became tied to the client. If a client cancelled a booking, the organisation would not be paid to cover the staff rostered to complete the required shift(s). Respite services were therefore no longer viable for many organisations to operate, which meant that not-for-profit NGOs were pulling out of this type of service provision."

36. Civic had been providing services under a shared accommodation model as well as centre-based respite services to adults at 15 Hinkler Avenue, Caringbah.

37. Around this time, Civic took a strategic decision to grow its business and expand into children's services. Kulander Chapman, who had experience in that area, was engaged by Civic as Practice Manager to set up and deliver the new service. To meet the strategic plan, Civic was required to locate appropriate residences to house the children and young people.

38. Having reviewed all the evidence, it is clear that Civic was ill-prepared to move quickly into children's services. Too much reliance was placed on Mr Chapman and there was insufficient oversight from above. In oral evidence, Ms Doyle admitted as much and agreed that while she assumed she had appropriately delegated tasks, there were times when it would have been in her best interest "*to have asked the question*" and been more involved.[22]

39. Civic rented the Oatley premises through the private rental market in April 2017. Ms Doyle gave evidence that Civic had enormous trouble leasing a property and it took 62 applications before Civic was successful in obtaining a lease over Oatley.[23] After listening to Ms Doyle and Mr Chapman, it appeared that Civic was always aware that there were problems with the property, but it was the only residence that Civic could secure at the time. I was very troubled by Ms Doyle's evidence, particularly her acknowledgement that Civic always knew that Oatley

[22] Transcript 22 April 2022 p. 264 L30 onwards
[23] Transcript 22 April 2022 p. 317 L44

was a substandard property.[24]

40. At the time of securing Oatley, Civic did not use an external risk assessment group or company to conduct an assessment of Oatley. Ms Doyle confirmed that it is not Civic's practice to consult a third party to review properties.[25]

41. An assessment of Oatley was performed but it was not focused on the needs of the proposed clients. It was a general consideration of the physical environment of the property with a primary focus on whether it was structurally sound. The Civic Site – "Hazard & Risk Identification Assessment" form was used for this purpose.[26] That form has a limited capacity to assist in determining whether a property will meet the relevant physical and environmental needs of particular clients.

42. Nevertheless, Carrie Voysey, then General Manager, Service Improvement at Civic, who completed the form, recorded under "Other hazard", the side fence stating, "*the side fence is quite low and could pose as an easy access point for clients to jump over and wander away*".[27]

43. On 14 March 2017, Mr Chapman again identified the fence as a risk, expressly stating in an email to Annie Doyle that Civic would "*need to put an extension on one of the fences at a minimum*".[28] This issue was not addressed prior to Civic using the property for children's services or at any time it had a lease over the property. This failure has had devastating consequences.

44. Civic presented to the Department of Family and Community Services (as it was then known, now the Department of Communities and Justice) ("the Department")), a budget of $46,500 set up as costs for Oatley. $12,000 was allocated to "*rails and fence extensions*".[29] Mr Chapman in his evidence stated his "*vision would have been to raise the height of the side and front fence*".[30] Civic received from the Department funds in the amount of $33,500.[31] No work was ever carried out to the fence. $1,351 was apparently spent on a balustrade.[32] It is impossible for this court to know how the rest of the funds were actually acquitted.

45. Mr Owen Talauta, then Civic Facilities Manager (and now Civic Property and Facilities Manager), commenced at Civic following the Oatley lease being entered but prior to it being used for clients. Mr Talauta did not recall seeing the $46,500 budget and said he would not expect to see it.

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[24] Exhibit 1 Brief of Evidence Vol 3: Tab 40 Annie Doyle Statement Annex. L
[25] Transcript 22 April 2022 p. 317 L40 – p. 318 L4
[26] Exhibit 1 Brief of Evidence Vol 3: Tab 40 Annie Doyle Annie Doyle Statement Annex. L
[27] Exhibit 1 Brief of Evidence Vol 3: Tab 40 Annie Doyle Annie Doyle Statement Annex. L
[28] Exhibit 1 Brief of Evidence Vol 3: Tab 40 Annie Doyle Annie Doyle Statement Annex. H
[29] Exhibit 6 - 2 Emails dated 25/04/2022 plus Family & Community Services Ageing, Disability & Home Care Service Provider Proposal document.
[30] Transcript 26 April 2022 p. 369 L16
[31] Transcript 26 April 2022 p. 371 L50
[32] Statement of Kimberley Rathmanner dated 28 April 2022 attaching "CAPEX Spend" document

46. Mr Talauta's position was a new role and his "*core responsibility was to make sure that the property that was being leased was generally safe on a structural basis and then, on top of that, to be advised as to the risk to safety as to the potential cohort that was going to move in".* Mr Talauta clarified "*the initial general safety was to make sure the actual house was safe for any occupant, and then to apply the required disability modifications for the individual cohorts that were to occupy that house*".[33]

47. Mr Talauta recalled attending Oatley prior to it being set up and recalled the fence being raised as an absconding risk. His evidence was that the need for a new fence or a fence modification was not raised with him, and he made no approach to the landlord in respect of the fence.[34]

48. Mr Chapman in evidence explained his decision not to upgrade the fence on the basis that the first children to move in were "*not absconders*" as one "*had to use a wheelchair for mobility*" and the other client "*did as part of his profile have at risk of absconding, but … was only when he was in the community being escorted around, say parks and shopping centres. He was not at risk of leaving the property without staff supervision"*.[35] It was a short-sighted and superficial approach to risk management.

49. The fact that one child was a known absconder ought to have raised a red flag as to the appropriateness of Oatley for that child. The fact that the child was not known to have actually absconded previously from a residential property did not absolve Civic of properly considering the potential risk.

50. Within six months of operating at Oatley, Civic deemed Oatley to be unsuitable for the initial clients allocated to Oatley and a new property in Sylvania was located. The original Oatley residents were relocated, leaving Oatley vacant. In December 2017, it was decided that Oatley would be used for a period of six months for children's overnight respite services, but that the lease would not be renewed.

51. On 12 March 2018, six weeks prior to Alex's death, Alexandra Vall Rojo commenced with Civic in the role of Practice Leader. On 20 March 2018, she sent an email to Mr Chapman and Mr Talauta completing a Maintenance Request Advice, requesting that locks be put on the windows and key locks on bedroom and bathroom doors. Ms Vall Rojo gave evidence that she followed up this request with Mr Talauta, and in relation to the windows, she was informed that it was being "*followed up"* which she understood to mean being followed up with the landlord.[36]

[33] Transcript 26 April 2022 p. 422 L29; Transcript 27 April 2022 p. 434 L1
[34] Transcript 27 April 2022 p. 432 L50; p. 433 L35
[35] Transcript 26 April 2022 p. 373 L20
[36] Transcript 27 April 2022 p. 496 L34 - 48

52. As to the fence, Ms Vall Rojo gave evidence that she spoke separately to Kulander Chapman and was told words to the effect "*we have to work on a budget*" and further that Civic was "*moving sites*".[37] Ms Vall Rojo's evidence was that she understood the fence was not to be modified due to budgeting issues. I will return to the way budget issues may have impacted Civic's response shortly.

53. As set out above, Civic had been fully informed of the risks inherent in housing a child such as Alex in a property with a low fence and unsecured windows. Ms Braverman, prior to Alex being accepted for Civic respite care, provided clear information as to Alex's absconding risk, his capacity to both climb and run fast, and specifically as to Oatley, the risk that was posed by the low fence and the lack of locks on the windows.

54. Mr Chapman gave evidence that he was aware of Alex's absconding risk and of the deficiencies in the Oatley property as they applied to Alex and further, gave evidence that he was the person who approved the placement.[38] In evidence, Mr Chapman stated that he relied upon Alex's mother and his support worker, Pauline Stanley, to assist with the risk assessment as to the suitability of the premises.[39] Mr Chapman noted that a proposal was made that would involve Civic providing one-to-one care when Alex was in the backyard.[40] Alex's funding proposal with Civic was for one-to-one care for a 24-hour period.

55. I have carefully reviewed the evidence and find:

    a. Civic did not undertake a formal risk assessment of Oatley that considered the needs of the clients against the physical environment of the property;

    b. Civic was aware at all times of the risks Oatley presented to clients who presented with absconding behaviours;

    c. Civic was specifically aware that the physical environment was not suitable for Alex given his known absconding behaviours and the low fence.; and

    d. Civic accepted Alex as a respite client at Oatley notwithstanding that it was aware the property was not suitable or safe for Alex given his absconding behaviours and his ability to climb and run fast.

56. Civic failed to provide a safe environment for vulnerable residents such as Alex. In doing so, it also failed in its duties and responsibilities as a registered VOOHC provider.

[37] Transcript 27 April 2022 p. 498 L4-21
[38] Transcript 26 April 2022 p. 390 L11 - 16
[39] Transcript 26 April 2022 p.391 L25 - 31
[40] Transcript 26 April 2022 p. 391 L30 - 35

57. Mr Chapman suggested that some reliance was placed on the fact that Ms Braverman and Ms Stanley accepted the placement, having visited the premises. I do not accept that any of the blame can be shifted onto Ms Braverman or Ms Stanley in this way. It is entirely inappropriate to suggest that full responsibility lies anywhere but with Civic, an organisation that was registered by the OCG. Civic had a responsibility to determine whether it could deliver a safe service to a vulnerable person.

58. Further, I do not accept the solution proffered by Mr Chapman, that one-on-one supervision *in lieu* was an appropriate risk prevention strategy. The physical environment of the house placed Alex and his care workers at a significant risk of harm which could not be adequately mitigated by one-on-one supervision.

59. I note the following factors in relation to the suggestion that a decision regarding one-on-one supervision was appropriate risk mitigation:

    a. Mr Chapman made the decision in the absence of any discussion about how to manage absconding risks;[41]

    b. One-on-one supervision was insufficient to address known inherent risks in the environment, being the low fence, windows that did not lock and an external sliding door that did not lock and was being secured by a plank of wood;

    c. The decision did not address the capacity of Alex to climb and run fast and relied upon the worker being at least as physically agile as Alex and to be able to cut off multiple points of escape; and

    d. The physical capabilities of the workers were not assessed to determine whether they were appropriate to care for Alex.

60. The court heard evidence that at the time this tragedy occurred, Mr Chapman felt overwhelmed.[42] Mr Chapman was managing numerous sites, with over 100 children attending Civic's services. During April 2018, it also appears that Mr Chapman's attention was particularly focused on two other children living at a Caringbah flat who were apparently causing a significant amount of property damage.[43] I have no doubt that these distracting and worrying matters impacted on Mr Chapman's ability to fulfil his duties at that time. I accept that he remains deeply affected by the tragedy that ensued. Nevertheless, in failing to properly assess whether the service it was offering provided a safe respite care environment for Alex, Civic clearly failed in its duty to Alex and his family and all

[41] Transcript 26 April 2022 p. 387 L39 - 43
[42] Transcript 26 April 2022 p. 403 L10 -37
43 Transcript 26 April 2022 p. 403 L14-27

staff working with Alex.

Whether Civic failed to address known hazards in a timely or appropriate manner.

61. As detailed above, Civic was on notice from the time it entered into the Oatley lease, that the perimeter fence height presented an obvious hazard to any client with absconding behaviours. There were numerous missed opportunities to rectify this hazard.

62. When the clear risk was identified by Carrie Voysey in the Site Hazard and Risk Identification Assessment on 22 March 2017, it ought to have been rectified prior to clients moving into the site. One of the other clients who was intended to be a resident of Oatley, had a known risk of absconding in the community. To justify the lack of rectification by relying on a report that the risk had only, to date, presented in the community, did not adequately address the hazard and was an insufficient risk response. It demonstrates a superficial and inadequate understanding of risk.

63. The next missed opportunity was at the time the property was being transitioned to respite care. Mr Chapman ought to have prioritised the setup costs from the Department for Oatley to make the fence safe but failed to do so and could offer no reason in evidence why priority was not given to that matter.[44]

64. The next missed opportunity was when Alexandra Vall Rojo had conversations with Mr Chapman and Mr Talauta about the need for a new fence or a short-term solution to make the fence higher.

65. The final missed opportunity was at the time that the fence was expressly identified as a risk to Alex by his mother and Ms Stanley.

66. It appears that by the time the property was to be used for respite care, it was obvious to all that it was a short-term proposition. I accept Mr Chapman's initial evidence, in his written statement, that the cost involved in raising the height of the fence was a factor relevant to his decision not to upgrade the fence, even though he did not maintain that evidence at hearing. I have taken into account the following factors:

    a. That was Mr Chapman's evidence in a police statement prepared approximately 2 months after Alex's death[45];

    b. As at February 2018, Civic intended to cease operations from Oatley in the near future;

[44] Transcript 26 April 2022 p. 372 L34-42
[45] Exhibit 1 Brief of Evidence Vol 1: Tab 13

c. Ms Vall Rojo gave clear evidence that she was informed that the works she sought could not be done due to budget issues and further that Oatley was a temporary site. I found Ms Vall Rojo a truthful witness. Her evidence was compelling and I accept her evidence on this issue;

d. In evidence, Mr Chapman accepted that the budget matters he had to operate within meant it was more than likely that he did inform Ms Vall Rojo that budget implications were a factor as to whether work could be carried out on Oatley;[46] and

e. While I note that Mr Chapman gave evidence that there was no general policy directing against spending money on Oatley,[47] he clearly felt a need to control his budget. Mr Chapman appeared to be under great pressure given the very rapid expansion of Civic's services into children services. Mr Chapman spoke of the "*undercurrent of financial pressure*" within Civic and felt that he might lose his job if the children's services operation was not financially viable.[48]

67. The decision not to rectify the fence is inexcusable. It is particularly outrageous that saving a small amount of money factored into the decision. I note that an extremely cost effective solution to the fence issue had been raised by Jeanne Jacobs by email dated 22 November 2017. She suggested bamboo fencing at a cost of approximately $15 for 3m. In evidence, Mr Chapman agreed that Civic "*should have done something like that*" but could offer no explanation for not doing so.[49]

68. Ms Doyle gave evidence that she had never denied funding a safety issue.[50] I accept that may well be true but the weight of the evidence establishes that the culture of the organisation she led required staff to limit spending. This was particularly relevant when the property was leased and it had been decided that it would only be used on a short-term basis.

69. Civic accepts that it is unable to give an adequate or appropriate explanation as to why it did not attend to minimising the known risks of absconding via the low fence at the Oatley property at any time prior to Alex's death.[51]

70. As to the locks on the windows, Civic were aware of this issue from at least 20 March 2018,[52] being the date that Ms Vall Rojo emailed Mr Chapman requesting

[46] Transcript 26 April 2022 p. 402 L12 - 30
[47] Transcript 26 April 2022 p. 387 L48
[48] Transcript 26 April 2022 p. 402 L34 - 50
[49] Transcript 26 April 2022 p. 375 L29 - 37
[50] Transcript 22 April 2022 p. 274 L45
[51] Undated written reply to Counsel Assisting's Submissions
[52] Exhibit 1 Brief of Evidence Vol 1: Tab 10 p. 20

locks for the Oatley windows. There is no explanation as to why this was not responded to prior to 20 April 2018. The request was only attended to after Alex had already climbed out of the window during his respite stay. This was a near miss that should have triggered an immediate response. Shockingly, even then the work that took place was incomplete and inadequate. A lack of attention to detail by staff involved left a window unlocked.

71. It is unfortunate that Ms Vall Rojo did not follow up on her request for new locks between making the request and the weekend commencing 19 April 2018. However I accept her evidence that as a new Civic employee she felt under immense pressure by reason of her reliance upon Civic for her visa sponsorship. I accept that she felt her that employment could be terminated if she continued voicing her concerns about the service being offered at Oatley. I also accept that the response Ms Vall Rojo's got from Mr Chapman and Mr Talauta was discouraging.

72. While Mr Chapman seemed to suggest that the inadequacies in the physical environment could be mitigated to some degree by a sound staffing policy, there were clear breaches in this area too. The court heard that Civic failed to comply with its own policies on staffing levels and failed to comply with the service agreement it had entered into with Ms Braverman in respect of the care of Alex. Exhibit 10, a document prepared by Counsel Assisting in consultation with Counsel for Civic, demonstrates the following staffing levels the weekend of 19 – 22 April 2018:

    a. Thursday, 19 April 2018

        i. 3.30pm – midnight: two staff for three children (Alex, and two others)

    b. Friday, 20 April 2018

        i. Midnight – 6am: one staff for three children (not Alex)

        ii. 6am – 7am: two staff for three children (not Alex)

        iii. 7am – 8am: one staff for three children (not Alex)

        iv. 8am – 11am: two staff for 1 child (Alex)

        v. 11am – 2pm: one staff for 1 child (Alex)

        vi. 2pm – 3pm: two staff for 1 child (Alex)

        vii. 3pm - 4pm: two staff for 1 child (Alex)

        viii. 4pm – 8pm: three staff for 3 children (Alex, and two others)

        ix. 8pm – midnight: one staff for 3 children (Alex, and two others)

c. Saturday, 21 April 2018

i. Midnight – 6am: one staff for three children (Alex, and two others)

ii. 6.30am – 4pm: three staff for three children (Alex, and two others)

iii. 4pm – 8pm: two staff for 3 children (Alex, and two others)

iv. 8pm – midnight: one staff for 3 children (Alex, and two others)

d. Sunday, 22 April 2018

i. Midnight – 6am: one staff for three children (Alex, and two others)

ii. 6.30am – 8am: two staff for three children (Alex, and two others)

iii. 8am – 3pm: two staff for three children (Alex, and two others)

iv. 3pm – 4pm: two staff for two children (Alex, and one other)

v. 4pm – 4.30pm: one staff for two children (Alex, and one other)

vi. 4.30pm – midnight: one staff for 1 child (Alex)

73. The failure of Civic to provide Alex with one-on-one care at all times is significant. Civic failed to provide the service it had specifically contracted with Ms Braverman and for which it was being paid. It also failed to comply with its own policies.

74. These failings impacted on the safety of each client and also placed staff at risk. Ms Pratima Sodha, who was on shift at Oatley, was under particular pressure and it appears, inadvertently telephoned Alex's mother on Saturday 21 April 2018 stating "*we have three children…and it's impossible to handle all three of them*".[53] Ms Sodha was on shift on Saturday from 4.30pm to midnight and on Sunday from 4pm to midnight, being the shift on which Alex died.

75. The Civic document "Child and Young Person's safety policy", at page 10, under the heading "Staff ratios and supervision", for VOOHC centre-based respite, requires the staff ratios to be two staff members at all times".[54] Oatley was a VOOHC centre-based respite premise. The evidence of Mr Chapman was that despite this policy Civic applied "*an industry standard at that point in time… a minimum of two staff on duty from 6am through to either 8pm or 10pm"* although if the child *"had exceptional needs and required it"* Civic *"would have put two staff on overnight".* However, the staff roster for the weekend commencing 19 April 2018 clearly discloses a failure to comply with its own policies and this reference to "industry standards", given that there were three children to one worker on Friday and Saturday nights and at times, three children to one worker before

[53] Exhibit 1 Brief of Evidence Vol 1: Tab 6: [51]
[54] Exhibit 1 Brief of Evidence Vol 2: Tab 24 p. 10 (of policy)

10pm.

76. Mr Chapman gave evidence that Civic would roster an additional person only where the child or young person was known to present with "*significant assaultive behaviours*"[55] or where three children were sleeping over and one child presented with "*assaultive behaviours*".[56] Alex was known to have "*assaultive behaviours*"[57] but no additional staff were rostered, notwithstanding that three clients were present for the Friday and Saturday night shifts.

77. On 21 April 2018, Pratima Sodha was the sole worker with three children from 8pm until midnight. When questioned about this, Mr Chapman gave evidence that he believed two of those children were probably about seven or eight years old, and it was anticipated that they would be asleep by 8pm and if there were issues, Ms Sodha could have contacted on-call support.[58] I do not accept this explanation or excuse. It does not take into account how quickly things could change and operates on an unsafe presumption that Civic had the capacity to rectify staffing shortages without notice, which was not consistent with the evidence before me.

78. It is of significance that Civic did not appear to have, as at April 2018, sufficient staff as well as sufficient *experienced* staff to meet the delivery of their children's services at Oatley. Ms Vall Rojo gave evidence that:

    a. the roster manager knew that Oatley did not have enough staff members and there was difficulty in fillings shifts and that rostering issues were across all sites;[59]

    b. Oatley did not have enough experienced staff members and new staff members did not have the opportunity to do buddy shifts;[60]

    c. Staff were being requested to do overtime shifts creating unsafe work practices;[61] and

    d. Staff did not feel safe working at Oatley without additional training[62].

79. Mr Chapman gave evidence that not only was he aware that Oatley had trouble attracting staff but that the whole organisation had a staffing issue at that point, such that Mr Chapman, in a discussion with the CEO and the General Manager on 29 March 2018, requested a review of opening one new group home every month because Civic did not have enough staff to backfill the vacancies.

[55] Transcript 26 April 2022 p. 394 L50
[56] Transcript 26 April 2022 p. 395 L 5
[57] Transcript 26 April 2022 p. 396 L1 – 3
[58] Transcript 26 April 2022 p. 398 L2 – 4
[59] Transcript 27 April 2022 p. 498 L45 – T49 L9
[60] Transcript 27 April 2022 p. 499 L12 – 15
[61] Transcript 27 April 2022 p. 499 L15 – 20
[62] Transcript 27 April 2022 p. 500 L5 – 20

80. I find that there were inappropriate staffing levels at Oatley on the weekend of 19 – 22 April 2022. The reason for this is multi-faceted, including:

    a. a failure by Civic to apply its own policies;

    b. poor assessment of client needs; and

    c. a lack of sufficient staffing pool.

81. Each of the above reasons is unacceptable and no satisfactory explanation was provided by Civic for the staffing deficiencies that weekend. Had a full complement of staff been present, the capacity for staff to engage with Alex one-to-one to limit or reduce his heightened behaviours would have been available. As it was, save for the period between 4.30pm and 6.45pm on 22 April 2019, Alex did not have one-to-one supervision.

82. I accept that Mr Chapman was under significant pressure. Mr Chapman conceded to being overwhelmed at that time.[63] It Is apparent that his attention was spread too thinly and that created danger for the vulnerable people in Civic's care.

83. Civic accepts that Mr Chapman and Ms Vall Rojo did not feel supported to raise legitimate concerns about issues of safety. Civic further accepts that this state of affairs grew from a poor understanding of risk fundamentals in the organisation and a lack of clear messaging to staff from management that safety of clients and staff is paramount.[64]

84. These deficiencies in Alex's care cannot be said to have been caused by the failings of a single person. Whilst it is clear that Mr Chapman played a role in the failings in Alex's care given the decisions for which he personally took ownership, the organisation as a whole, led by the CEO Annie Doyle, must take responsibility. Ms Doyle gave evidence before me and I had the opportunity to observe her closely. It was clear to me that she had a limited understanding of what was required of her when moving into the provision of children's services.

85. Under her watch, the organisation took a strategic decision to move into children's services, an area not previously within the experience of Civic. Ms Doyle had limited knowledge about that industry, and as stated in her evidence she, "*took it upon [her]self to understand this part of the sector by hiring appropriate staff… to understand exactly what was involved in offering children services and the accreditation process that was required, the training that was required, and the type of staff that were required*".[65] While Ms Doyle gave evidence that she was satisfied that the senior leadership team could sufficiently provide her with

[63] Transcript 26 April 2022 p. 403: L10 – 35
[64] Civic Disability Services submissions in reply to those of Counsel Assisting
[65] Transcript 22 April 2022 p. 240 L19 – 23

information about the service, the evidence was that the organisation operated within information silos and that information was not shared.[66] The policies relevant to the delivery of children's services sat on a shelf and were not incorporated into practice.[67] This lack of communication, coupled with Ms Doyle's limited exposure to and knowledge of the children's services industry, placed Civic in a vulnerable position when it came to providing a safe, child-focused service.

86. The evidence in relation to Civic procuring the Oatley house spoke of desperation to obtain a site so that operations could commence. The Corporate Governance and Risk Committee was not involved at any level[68] and identified problems were not escalated to the Board. Sadly, this desperation led to Civic neglecting its child-focused service.

87. Ms Doyle was unaware of how staffing was being managed at Oatley and specifically unaware that staffing was a 1:3 staff to client ratio during the night. Ms Doyle said this was not in accordance with Civic policy. This, however, appears in clear contrast to the practice at Civic at that time.

88. Ms Doyle did not have an adequate understanding of the operational dynamics at Civic during 2017 and 2018. Mr Chapman was feeling overwhelmed by his responsibilities. Ms Vall Rojo was feeling unheard and quite unable to escalate legitimate concerns.[69] Budgeting issues were driving decisions relevant to safety and risk mitigation at Oatley and risk fundamentals were not understood throughout the organisation.[70] As Ms Doyle said in her evidence, she "*did not have enough oversight of this area to make critical decisions that could've assisted*".[71]

89. While it is accepted that a CEO cannot know about every practical or operational, Ms Doyle needed to have a closer eye on the development of this new service within Civic. I note that:

    a. Ms Doyle failed to attend Oatley at any time over the 13 months to Alex's death,[72] notwithstanding the fact that within six months of operating Oatley, it was determined by Civic to be inappropriate for the use for which it was acquired;

    b. Ms Doyle agreed in evidence that Civic always knew it was a substandard property;[73] and

    c. Problems with the landlord were reported that limited improvements to the

[66] Transcript 22 April 2022 p. 272 L10; p. 290 L48 – p. 291 L6
[67] Transcript 22 April 2022 p. 273: L21 – 23
[68] Transcript 22 April 2022 p, 291 L31 – 34
[69] Transcript 22 April 2022 p. 273 L29 - 34
[70] Transcript 22 April 2022 p. 294 L7
[71] Transcript 22 April 2022 p. 309 L24
[72] Transcript 22 April 2022 p. 264 L15 - 27
[73] Transcript 22 April 2022 p. 318 L13 - 20

property were permitted to make it suitable to the needs of its incoming client base, including making use of a grant from Coca-Cola at the property.

90. Other aspects of Ms Doyle's evidence reflect that she was not sufficiently engaged with the children's services business in circumstances where it was a new area of business for Civic, and the changes in the industry generally due to the devolution of services from the Department to NDIS individual funding model presented a dynamic and evolving environment.

91. Ms Doyle, in her evidence, betrayed a lack of ownership of the children's services arm of Civic and she sought to remove herself from this aspect of the business.[74] Ms Doyle was adamant in her evidence that Civic had not developed a strategic plan to move into Statutory Out of Home Care and it was, at most, a thought of Kulander Chapman not shared with her or by her.[75] When the evidence did not support this position, this was blamed on memory failure by reason of the passage of time.[76] This evidence reflected a lack of ownership of the children's services arm of Civic and an attempt to shift responsibility.

92. Following Alex's death, in 2018, Civic retained the Beltin Group report known as the *Civic Disability Services Compliance Gap Analysis Report 2018*. That report sets out not only the prior failures of Civic regarding staff and clients but ongoing and continued failures including almost 300 red alerts that occurred after the death of Alex. As noted by Counsel for the Raichman family in submissions, those failures are not limited to minors.[77] At paragraph 4.4.6 (page 11) the authors of the report record:

> *"There are 841 incidents reported on I.ON.MY for the period March to November 2018. Figure 1 shows there are 201 OPEN incident reports in the system. CDS (Civic) has instigated action plan to address the open events, furthermore, reporting is being developed to track and monitor closure timeframes."*

Civic's response to Alex's death

93. Since Alex's death, Civic reported that it has made the following important improvements:[78]

    a. Ms Doyle referred to a new "onboarding process" for clients that engages clinical experts relevant to each client and they adopt a "Go, No Go" approach to onboarding a client and no client is accepted until the relevant

[74] Transcript 22 April 2022 p. 244 L23 - 31
[75] Transcript 22 April 2022 p. 243 L34 – 38
[76] Transcript 22 April 2022 p. 254 L30 – 33
[77] Submissions of David Baran for the Raichman Family at [24]
[78] Civic's Submissions in Reply to those of Counsel Assisting

clinicians in that process agree that the property matches the needs of the client.[79] That change is mapped out in Civic Client Intake Guide dated 27 November 2020. Such a change appears positive and appropriate.

b. The hierarchical person based system of complaint / risk alerts, that could prevent a matter being escalated by an individual, has been replaced with an electronic red flag system that automatically triggers an email to the CEO for each single red alert and each single category one emergency in a hazard;[80]

c. Since Alex's death, Civic has also moved from a manual-based information system to an online one (on the Microsoft 365 platform). All staff have access to this system through their Civic staff account. There have been four significant systems improvements that Civic has implemented to breakdown information silos:

   (a) HIVE (an incident and hazard reporting and management system);

   (b) My Property Info (MPI, a property repairs, maintenance reporting and management system);

   (c) Learn@Civic (a training and learning management system); and

   (d) the Client Document Centre (our client information management system).

94. The electronic system known as MPI divides work requests into four levels of urgency – level one for emergencies to level 4 non-urgent work. The urgent category has timeframes across it with service level agreements to ensure the timeframes are met. Where an emergency is imputed into the system, then a category one invokes emails to the property team, the operations team, senior management of Civic and the CEO. The email is apparently recurring until it is actioned and closed.[81]

95. HIVE is an incident and hazard management report which allows a Support Worker to enter an incident into their phone. That report goes to the practice leader, the practice manager, the operations manager, the on-call manager, and, in the case of a red alert, the senior leadership team and the CEO. There are timeframes around responding to those incidents. Those reports are analysed and placed within a dashboard form and provided to the Board.

96. Civic submitted that the rolling out of these systems to replace the paper-based and siloed reporting structure in place at the time of Alex's death has provided

[79] Transcript 22 April 2022 p. 279 L15
[80] Transcript 22 April 2022 p. 320 L27 – 29
[81] Transcript 26 April 2022 p. 354 L30 – 40

clear improvement in the safety of Civic's clients and the proper recognition of their needs.

97. These four systems are said to allow and require staff to not only understand the needs of clients and plan for them but to report problems in a structured manner. These systems ensure, by reason of the inbuilt alerts and notifications systems, that there is appropriate notification to reporting managers, senior management and the CEO of issues regarding client needs and safety.

98. Pratima Sodha gave evidence as a support worker that, since Alex's death, Civic has provided training about what to do if there is an issue concerning the safety of staff or clients. However, her evidence suggests that Civic's present reporting process is to discuss the issue with the team leaders or with the Human Resources team. Ms Sodha did not consider that she could take a complaint directly to the CEO.[82] This is inconsistent with Ms Doyle's evidence that staff can directly contact her with risk issues.[83] To the extent that this action is available , the message has apparently not been adequately communicated to staff.

99. At the end of Ms Doyle's evidence, I remained somewhat unsure about her ability to really drive meaningful change the organisation after Alex's death.

100. It is also of note that the ultimate outcome for Civic was to essentially step away from the provision of VOOHC for children and young people. As a consequence, the changes outlined have not been tested in the environment of respite for children and young people. Despite stepping away from that area, the court heard that Civic retain their registration as a VOOHC provider and could potentially resume operations at any time. I will return to that issue shortly

The need for recommendations

101. Section 82 of the *Coroners Act 2009* confers on a coroner the power to make recommendations that may be considered 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.

102. Counsel Assisting put forward a number of recommendations arising out of the evidence for the court's consideration. Comments on the proposed recommendations were received in submissions from interested parties and have been carefully considered.

[82] Transcript 27 April 2022 p.488 L5
[83] Transcript 22 April 2022 p. 319 L35

103. It was unfortunate that the inquest occurred so long after Alex's death. There were various reasons for the delay including the effects on court listings during the COVID-19 pandemic. The result is that the care environment in place at the time of his death is greatly changed. Civic no longer offer commensurate services for children and more recently there has been and continues to be substantial legislative reform overhauling the operation of the existing VOOHC scheme. While a number of the recommendations proposed are no longer appropriate, the court nevertheless attempted to grapple with some of the systemic issues raised by the evidence.

The role of the Department of Communities and Justice (DCJ) at the time and presently

104. At the time of Alex's death, there was a shift to NDIS individual funding by reason of the introduction of the NDIS. This shift resulted in the closure of respite centres which had been block funded by the Department and the emergence of private NGO-based respite services. The NGO services relied upon their own resources (fiscal, policy and physical resources) to provide respite and largely relied upon securing recipients of NDIS support packages to fund the respite service.

105. At the time of Alex's death, this respite environment was emerging and its governance was in its infancy. Following Alex's death, there has been significant change in the governance of NDIS approved providers providing services to NDIS recipients. In July 2018, the NDIS Quality and Safeguarding Framework was put in place by the National Disability Insurance Agency (NDIA) to protect the safety of NDIS participants and to ensure the quality of the services participants receive under the scheme. Practice Standards and a Code of Conduct were introduced, which applies to all NDIA registered providers, of which Civic is one.

106. Further, the NDIA requires proposed providers to pass a Third Party Verification (TPV) process to qualify for NDIA registration. TPV is an essential part of the Quality Framework Reporting that ensures providers meet quality safeguards.

107. Given the ongoing Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, and the developments post Alex's death, the role of the NDIA and NDIS, and matters such as funding adequacy under the NDIS, were not matters touched on by this inquest.

108. Within this environment, by the time of Alex's death, DCJ had no role in respite involving VOOHC providers. Alex lived with his mother, father and brother. He was a child not under the parental responsibility of the Minister and was not being case

managed by DCJ. His placement in respite care was not subject to any oversight by DCJ. Further, despite Alex's known disabilities, as a child not in the care of the Minister, Alex's respite care was not subject to the special care provider provisions under the Regulations to the *Children and Young Persons (Care and Protection) Act 1998* ("the Care Act"). Respite care attended by Alex fell under VOOHC, the governance of which was overseen by the OCG.

109. By reason of the role of the Children's Guardian and the role of the NDIA, there is no independent role for the DCJ in VOOHC. The addition of another level of oversight would not appear to present any benefit to the industry.

The role of the Office of the Children's Guardian (OCG) at the time and presently

110. The Children's Guardian is a statutory officer presently constituted under the *Children's Guardian Act 2019*. At the time of Alex's death, the Children's Guardian was constituted under the Care Act.

111. The role of the Children's Guardian, as it applied to providers of respite care for children from 2015 until its repeal in 2019, was set out at s. 181 of the Care Act and included at subs. (f) "*to register organisations that provide or arrange voluntary out-of-home care and to monitor the carrying out of their responsibilities under this Act and the regulations".*

112. The VOOHC legislative framework was introduced in 2011. The Children's Guardian describes it as being "*purposefully light touch to minimise government intervention in these arrangements made by parents. A light touch regulatory approach was adopted as the former Department of Family and Community Services (FACS, currently Department of Communities and Justice) had direct oversight of these arrangements through its case management and clinical services and contractual control*".[84]

113. By the time that Alex and his family commenced accessing Civic's services, the regulatory approach described by the Children's Guardian was in a state of flux and the industry was transitioning to NDIS. As described by Annie Doyle in her statement:

> *In 2016, the disability sector across Australia was preparing for the shift from state-base funding to NDIS funding. In NSW, this shift included the closure of many vital traditionally government operated services, such as centre-based respite. In NSW ADHC had been historically known for being a last*

[84] Exhibit 1 Brief of Evidence Vol 3: Tab 38 p. 3

resort provider of centre-base respite services for families."[85]

114. Notwithstanding this shift, the "light touch" described by the Children's Guardian remained.

115. Since the conclusion of the hearing of evidence in this inquest, there has been further significant legislative amendment relevant to the role of the Children's Guardian in this space. This is addressed more fully below. The changes include the removal of the category of VOOHC provider and the introduction of a new SSRC class of provider.

116. The OCG discloses in its submission that a temporary self-certification process was introduced to fast track new providers as VOOHC providers before the new SSRC regime commences. The continued use of self-assessment in favour of third party assessment under the new scheme is unfortunate, noting the deficiencies in that system and the benefits that were more recently observed by a move from self-assessments to verification and in person attendances upon agencies wishing to provide VOOHC.

117. The new tool under development appears to be a self-assessment tool, applicable to SSRC providers only. The tool appears under development but relies upon the organisation itself providing information in response to requests made. It appears that the present process will not maintain the system that was developed in 2017 where policies would be submitted and *assessed* against the statutory procedures.[86]

118. In my view, self-certification disclosed difficulties in the past and any move back to that kind of system is likely to be undesirable.

Civic's registration as VOOHC provider

119. Civic was first registered with the Children's Guardian to provide VOOHC on 25 October 2016. At that time, Civic (consistent with all agencies wishing to be registered) was required to contact the OCG to discuss its intention to seek registration and submit a registration form and a self-certification checklist. The self-certification checklist was a record of the organisation confirming that its processes and practices complied with the Statutory Procedures: VOOHC in NSW (Statutory Procedures). An organisation was also required to self-identify areas where it may need to make changes in order to comply with the requirements, by way of developing an action plan. Registration was then granted to an organisation following the receipt of the registration form and self-certification checklist.[87] An

[85] Exhibit 1 Brief of Evidence Vol 3: Tab 40 p. 1
[86] Evidence of Candy Leung: Transcript 28 April 2022 p. 558 L39
[87] Exhibit 1 Brief of Evidence Vol 3: Tab 38 p. 3

obvious flaw in this process was that there was no external monitoring or verification of whether the policies were in fact being complied with or if the organisation was operating consistently with the expectations of the Children's Guardian.

120. Once an organisation attained registration as a VOOHC provider, that registration did not lapse unless cancelled by the Children's Guardian. The effect of this is that a provider may cease providing VOOHC for significant periods of time and then step back from the provision of such services. It appears that a system of lifetime registration for VOOHC providers (or its equivalent) is not in the best interests of children and young people and such a position should be reconsidered.

121. In 2017, the self-certification was replaced with, inter alia, the submission of an applicant's actual policies to the Children's Guardian for assessment. Agencies providing VOOHC at this time continued to be registered with the Children's Guardian retrospectively assessing their policies.

122. By email dated 18 January 2017, Civic were requested to submit their relevant policy statement to the OCG for review.[88]

123. Following Alex's death, an onsite visit on 29 – 31 July 2019 by the Children's Guardian took place at a Civic property (not Oatley). The Children's Guardian determined that Civic partially understood its obligation as a registered agency and was assessed as compliant in care environment, case planning and supervision of a child or young person in VOOHC. Through this visit, Civic was assessed as not compliant in Intake and Assessment, Behaviour Support Practices, VOOHC Register and Reportable Conduct.

124. The Children's Guardian documents show that Civic had failed to achieve compliance in its VOOHC policies as at 21 October 2019 and was required to submit its revised policies by 15 November 2019. Civic was required to complete an Action Plan addressing the non-compliant areas and provide the plan to the VOOHC Monitoring Team for review and feedback by 8 November 2019.[89]

125. This non-compliance with policy speaks of the then flaw in the Children's Guardian process of self-certification. These assessments suggest that for more than 18 months following Alex's death, Civic were still deficient in aspects of VOOHC relevant to Alex's death, namely, its Intake and Assessment processes and its Behaviour Support Practices.

[88] Exhibit 1 Brief of Evidence Vol 2: Tab 32 p. 1
[89] Exhibit 1 Brief of Evidence Vol 3: Tab 2 V33 p. 134

Current VOOHC registration and removal of the VOOHC registration process

126. Since Alex's death, but unrelated to his death, the OCG conducted a review in 2018 which aimed to define the impact of the NDIS roll out, the commencement of the NDIS Commission, the step down of disability services and changes in the funding model from the Department's funding model on the VOOHC program, identify the associated risks, and make recommendations for the regulatory framework in the full scheme environment. The review involved consultation with key policy stakeholders, a range of VOOHC agencies, and a parent of a child who had accessed VOOHC arrangements.[90]

127. Towards the end of 2018, the Children's Guardian required all agencies registered to provide VOOHC to engage with the application process and to submit copies of their actual policies and procedures for assessment by the Children's Guardian. Failure to do so resulted in the Children's Guardian cautioning the organisation to cease providing VOOHC, and engage with the application process, if they wished to continue.[91]

Amendment of the Children's Guardian Act 2019

128. The hearing of this inquest took place between 19 and 29 April 2022. On 18 May 2022, the *Children's Guardian Amendment Bill 2022* was introduced to the Legislative Council. It was later passed without amendment and sent to the Legislative Assembly on 9 June 2022where that House passed the Bill on 22 June 2022.

129. Schedule 1[12] and [14], to the extent that it inserted proposed s. 85(1C), [15], [16], [18]-[20], [38], [39] and [46], commenced on 18 July 2022. The residue of the Act commenced on 1 September 2022. Further, the *Children's Guardian (Amendment) Regulation (No 2) 2022* commenced on 1 September 2022.

130. It is unfortunate that this changing environment was not known during the inquest. It is difficult to understand that it was not under contemplation when Ms Leung gave detailed positive evidence about the benefits of moving away from self-accreditation and the benefits of the OCG's more recent practice involving an increased number of "*onsite monitoring visits*".

131. While the whole of the Amending Act has not commenced, it is noted that the provisions pertaining to VOOHC have been omitted and provisions commenced that introduce the two new concepts of SRC and SSRC. These new concepts were not and could not have been considered in these proceedings. Nevertheless,

[90] Exhibit 1 Brief of Evidence Vol 3: Tab 38 p. 14
[91] Transcript 28 April 2022 p. 558 L45 - p. 559 L1

there are aspects of the new regime which are directly relevant to evidence arising from this inquest.

132. The OCG in its reply submissions dated 13 September 2019, acknowledged that the effect of the Amending Act is to abolish the registration process which has to date applied for the regulation of VOOHC providers in NSW. However, the OCG submits that it does not consider such a step to be a retrograde one, nor a watering down of the OCG's regulatory function. Rather, it submits that the Child Safe Scheme is intended to overcome the shortcomings of the former registration system by increasing the OCG's ongoing monitoring and review of agencies' practices and procedures. It suggests that there will now be review of the actual implementation of those policies and procedures on the ground, rather than assessing agencies on an exclusively paper-based approach at a single point of time, being at the time of registration.

133. The OCG further submits that the requirement that all SSRC providers complete the self-assessment tool, brings the agencies to the attention of the OCG as agencies within the OCG's regulatory purview (in a similar way to registration). The OCG submits that the Court should not be alarmed by the abolition of the registration system when it has been replaced by an improved regulatory approach, and one which derives empirical support from the evidence and findings of the Royal Commission into Institutional Responses to Child Sexual Abuse, "Final Report, Volume 6, Making Institutions Child Safe" at Chapter 4.5.

134. It is impossible to properly assess whether the new measures will be successful. Only time will tell whether the new regime provides greater safety. Given it appears to encompass an approach quite at odds with the evidence provided by Candy Leung of the OCG about the positive impact of closer oversight, I retain some doubts.

135. I note for the record that but for the change to the legislation, I had envisaged making a recommendation asking OCG to review the concept of lifetime registration for VOOHC providers.

136. Given VOOHC no longer exists and the registration of VOOHC (now SSRC) is no longer a requirement, the recommendation is redundant and cannot be progressed. However, it is relevant to raise the issue noting the significant concerns I hold in relation to lifetime registration of organisations providing care to vulnerable children and young people.

137. I also note that the OCG submissions appear to accept that the definition of SSRC and SRC captures an entity providing care for more than 2 nights in any period of 7 days to a single child. The definition, by reference to subs. (c) of the Definition

which ends "*other than the child's parents or relatives*" may not include an entity that provides care akin to SRC that is not more than 2 nights care in any period of 7 days, even where it is provided to multiple children.

138. If this construction is correct, the effect is that an entity can provide respite care, similar to what was being provided to Alex Raichman, limited to two nights a week and not come under the oversight of the OCG, even where that arrangement takes place on a regular basis, such as fortnightly or monthly. If this is the effect of the legislation, it is unsatisfactory. The OCG indicate in its further reply submissions that as part of the OCG's consideration of issues relating to the reportable conduct regime and the scope of the entities included in Schedule 1 more broadly, the OCG will consider whether an amendment to the definition of "substitute residential care" to capture entities providing respite care for more than one night in any 7-day period would be appropriate.

Principal Officer of SSRC

139. The definition of "Principal officer" at s. 8ZC is defined to mean: "the principal officer of an entity providing specialised substitute residential care means the person who has the overall supervision of the entity's arrangements for providing specialised substitute residential care".

140. This definition may not clearly identify a single person and may cause confusion. For example, in the related inquests into the death of Riley Shortland[92] and the death of Rachel Martin[93], the identity of the person with overall supervision of the Special Needs Accommodation Programs (SNAP)'s arrangements for providing VOOHC was unclear and the responsibility appeared to be shared between the CEO, William Hays and Karin Ford. Not requiring an organisation to clearly identify the Principal Officer may create difficulties in the future where multiple persons consider that they hold that role, and may impact on whether the action is deemed authorised by the entity if approved by a person not in fact found to be the Principal Officer.

OCG and child-safe premises

141. The Children's Guardian, as at 2016, 2017 and 2018, did not require providers of VOOHC to specify when VOOHC services were being delivered from new premises. The evidence was that the Children's Guardian was not aware that Civic

[92] 2017/00335331
[93] 2017/00336274

was providing VOOHC from Oatley and Civic was not required to undertake and or submit to the Children's Guardian an assessment of the property's suitability for its purpose. This gap in the registration process has since been addressed, with the Children's Guardian having introduced a requirement for all agencies to notify the OCG in writing of the address of any location in which the agency provides VOOHC within 5 working days of commencing to provide VOOHC at that location. The court heard that this requirement is progressively being formally added to agencies' conditions of registration.[94] It is unclear to me how that will now operate given that providers of SRC and SSRC are not required to be registered with the OCG.

142. While it was open to representatives of the Children's Guardian to attend upon an agency delivering VOOHC and conduct an onsite assessment, including to request an agency to complete an environmental assessment of any identified location from which it intends to provide VOOHC, the Children's Guardian does not inspect each property from which it is proposed VOOHC is to be delivered. It remains the Children Guardian's position that it is not its role to assess and / or ascertain the suitability of premises for the delivery of VOOHC. The onsite assessments that are conducted are not concerned with certifying the physical safety of the premises, but rather are focussed upon the registered agencies' compliance with the statutory procedures.

143. However, the court was informed that in 2018 – 2020, the OCG was provided with supplementary funding that permitted onsite monitoring. This process brought into focus for the Children's Guardian, matters relevant to the physical environment of VOOHC. The evidence was that agencies registrations were cancelled following onsite monitoring visits.[95]

144. In 2018, the Children's Guardian introduced an "Environmental Checklist" following an onsite monitoring assessment at a (non-Civic) VOOHC registered agency in which the environment was found to be cluttered and hazardous. The OCG recognised at the time that there was no requirement in the Statutory Procedures in relation to the care environment. The OCG therefore developed the Environmental Checklist to address this gap. The Environmental Checklist was based upon the OCG's own policy decision to consider the care environment. It is not a legislated requirement or process.[96] The identification of this deficit and the introduction of the tool speaks of the benefit of in person attendances at VOOHC provider sites and also the deficit in not including as a positive obligation or

[94] Exhibit 1 Brief of Evidence Vol 3: Tab 38 p. 6
[95] Transcript 28 April 2022 p. 555 L15 – 45
[96] Exhibit 1 Brief of Evidence Vol 3: Tab 38 p. 11

requirement to assess the physical environment for the purpose of delivering VOOHC.

145. The evidence suggests that that there are gaps in the Environmental Checklist.[97] However, it is accepted that the individuality of a client's needs is unlikely to be able to be addressed in a pro-forma checklist and the intake and assessment policies of the organisation, if operating properly, should be identifying where the physical environment of the proposed respite premises does not meet the specific child's needs. However, there are some matters that should be a matter of course for all providers of VOOHC, such as secure perimeter fences and gates and locks on windows and exit / entry doors that limit the risk of absconding but permit emergency exits. It appears that the Environmental Checklist ought to include such matters.

146. The evidence suggests that important relationships were forged during on-site visits that have since resulted in agencies seeking the support of the Children's Guardian at relevant times.[98] That funding has ceased and operations of the Children's Guardian have had to move to remote monitoring. Ms Leung agreed in her evidence that remote monitoring will not be as effective as an in-person site visit and will "*have some disadvantage because we will be relying on the agency's self-reporting, and also provision of photographic evidence*":[99]

Adequacy of supervision and behavioural support provided to Alex in the period prior to his death

147. Alex did not have a Behavioural Support Plan ("BSP") at the time of his engagement with Civic's VOOHC service. It appears that this is likely attributed to the increased pressure on the VOOHC industry at that moment in time due to the shift to NDIS funded individualised care. It would have been beneficial for Civic to have a current BSP for Alex prior to the respite commencing with Civic.

148. Michelle Dodd, who provided evidence as an independent expert in the provision of disability services, described the BSP as "*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*."[100] While Civic may have benefitted by having access to an up-to-date BSP for Alex, it is clear the organisation already had sufficient information available to it to have kept him safe.

[97] Transcript 28 April 2022 p. 566
[98] Transcript 28 April 2022 p. 571 L19 – 28
[99] Transcript 28 April 2022 p. 557 L2
[100] Transcript 28 April 2022 p.581 L25 – 28

149. It was clearly understood that Alex could and would open and close windows, he presented as an absconding risk, he could climb and he could run fast. Without doubt, Alex required one-to-one supervision at all times. Alex was entrusted to Civic by his family on the basis he was to be provided one-to-one care based upon his needs.[101] This care was not provided.

150. The evidence establishes that there was inadequate supervision of Alex during respite commencing 19 April 2018 and inadequate understanding of his behavioural needs and how to manage them by the Civic support workers.

151. The court considered whether it would be appropriate to recommend that any child or young person accessing VOOHC with challenging behaviours, ought to have available to the agency providing VOOHC, a current BSP. However, as previously stated the recent legislative change prevents me from properly considering how this consideration could fit into the new regime or indeed who could monitor such a requirement.

Safework's capacity to investigate organisations such Civic

152. The Raichman family asked the court to consider a recommendation to the relevant minister to extend Safework NSW's powers of investigation over premises conducting out of home care. The request was grounded in understandable dissatisfaction with Civic's internal investigation and a lack of confidence in the OCG's capacity to monitor the VOOHC environment.

153. The court received information, in a short submission from Safework NSW that Safework NSW already has the power to undertake the kind of investigation envisaged by the Raichman family. I accept that Safework NSW has the relevant powers of inspection and enforcement referred to in the Family's submission.

154. I note that the issue was raised in submissions after evidence had closed. I note that there was no evidence before me to indicate whether or not Safework NSW had considered inspection or prosecution after Alex's death. I note that in two inquests which were heard at the same time as these proceedings Safework prosecuted the agency involved.

Findings

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

[101] Exhibit 1 Brief of Evidence Vol 1: Tab 6: p. 31, 32; Vol 3: Annie Doyle Statement Annex. KK

Identity

The person who died was Alex Jeremy Raichman.

Date of death

He died on Sunday 22 April 2018.

Place of death

He died on the train tracks near Oatley Railway Station, NSW.

Cause of death

Alex died from multiple injuries sustained when he was struck by a train on 22 April 2018.

Manner of death

Alex's death occurred because he was able to abscond through an unlocked window and climb over an inadequate fence whilst he was in respite care being provided by Civic at a respite home it operated, located at 46 Oatley Parade, Oatley. He was struck by a train around half an hour after running from the property.

Recommendations pursuant to section 82 *Coroners Act 2009*

156. For the reasons stated above, I recommend:

To the Office of the Children's Guardian

It is recommended that the Office of the Children's Guardian:

a) Consider whether an amendment to the definition of "substitute residential care" (SRC) to capture entities providing respite care for more than one night in any 7-day period would be appropriate.

b) Take steps to ensure that Civic does not provide SRC or SSRC to persons under the age of 16 years.

c) In circumstances where Civic seeks to be authorised for Statutory Out of Home Care as a designated agency, consider any findings of this inquest and any deficiencies in Civic's provision of past VOOHC when making that decision;

d) Provide to the appropriate Minister a copy of the findings of this inquest.

To Civic Disability Services

It is recommended to Civic Disability Services:

a) that it agrees to a restriction that it does not provide SRC or SSRC to children and young persons under the age of 16 years.

b) devise and roll out a training program for staff addressing the processes available for alerting all levels of management in Civic of risks within the Civic environment, including direct contact with the CEO.

Conclusion

157. The court recognises the profound loss suffered by Alex's family. The trust they placed in Civic to care for their precious child was betrayed. His death was entirely preventable if adequate safety measures had been in place. Alex's family will never stop grieving and I acknowledge their ongoing pain.

158. 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.

159. I close this inquest.

Harriet Grahame

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	2018/127718

TITLE OF PROCEEDINGS

Inquest into the death of Alex RAICHMAN

AGREED STATEMENT OF FACTS

A. Alex Jeremy Raichman & known risk profile

1. On 12 March 2007, Alex Jeremy Raichman ('Alex') was born.

2. Alex had a diagnosis of severe intellectual disability, epilepsy and autism spectrum disorder.

3. Alex was non-verbal and required assistance when dressing, washing and eating although he was toilet trained.

4. Alex lived with his birth parents, Sharon Braverman and Dale Raichman and his fraternal twin brother, Samuel, who also had a previous diagnosis of borderline developmental delay, although this was milder than Alex's.

5. According to Dr Jessica Roediger, General Paediatrician who was treating Alex at the time of his death, Alex was a constant danger to himself and required constant supervision, noting he had high needs in relation to his care.

6. Alex attended Warrah Special School in Dural and travelled to school with the Department of Education assisted transport, with his own driver and attendant, both of whom were with Alex to and from school, door to door.

7. In a letter dated 20 November 2017, the school principal stated that the school held concerns about keeping Alex safe, his biting of other children and his absconding tendencies.

8. Until Alex died, he had a carer who assisted with up to 50 hours per week at home, who was employed by Zestcare through Centrelink as an 'Educarer'. This was NDIS funded home support.

9. In early 2018, Alex was admitted to St George Public Hospital after suffering a grand mal epileptic seizure. He stayed in hospital for six nights.

10. Alex received funding for his disability care through the National Disability Insurance Scheme ('NDIS'). Alex's first NDIS plan was approved on 23 November 2017. In a plan request review form completed by Alex's NDIS Independent Support Coordinator, Future Insight, Pauline Stanley and submitted by Alex's mother, Ms Braverman on 12 February 2018, additional funds were requested due to Alex's complex behaviours. Increased funds were allocated for assessment and reports to gather evidence of Alex's behaviour in the second NDIS plan that issued on 16 March 2018.

11. The February 2018 NDIS plan request review form stated that Alex required 1:1 care, and a referral for a Behaviour Intervention and Assessment Plan ('BIAP') was made, however one had not been completed at the time of his death.

12. At the time of his death, Alex was being treated by paediatrician Dr Jessica Roediger and psychiatrist Dr Lisa Myers, and his prescribed medications included Abilify, Catapres, Seroquel and Tegretol. His medication regime was due to be reviewed on 4 July 2018.

13. In 2016, Alex had climbed over a fence at his house and boarded a bus alone, and in his underwear. He was missing for one hour. Following this incident, the family were home bound for several months, with restrictions on unlocking doors. This information was not known to Civic Disability Services ('Civic').

14. Alex had previous interactions with other respite and care services, including Sunnyfield, which are purpose-built homes for children and adults with disabilities. He attended respite at Sunnyfield approximately five times a year for a weekend at a time.

15. When Sunnyfield discontinued their care for children with disabilities, Alex commenced attending day respite at Civic in August 2017, and then increased to overnight stays at the Oatley Parade premise commencing on 23 February 2018.

B. Civic Disability Services – (Civic)

16. On 13 October 2016, the CEO of Civic Disability Services Ltd ('Civic'), Annie Doyle signed a Voluntary out-of-home care ('VOOHC)' Registration and self- certification form, seeking to provide VOOHC to children and young people aged between 6 and 17 years. On 14 October 2016, this form was provided to the Office of the Children's Guardian ("the OCG") to allow for the registration of Civic as a VOOHC provider.

17. On 25 October 2016, the OCG confirmed Civic's registration as a VOOHC provider. The OCG provided Civic its Notice of Conditions of Registration as a VOOHC provider.

18. In January 2017, Civic commenced a trial of Vacation Care for children with disabilities at 88 Venetia Street, Sylvania during the summer holidays. Vacation Care was not a funded program, it was funded by Civic.

19. Civic was already operating an adult-based overnight respite service at a premise at 15 Hinkler Avenue, Caringbah ('Caringbah premise') and planned to use this premise one week every month for children's respite.

20. Civic rented a new premises at 46 Oatley Parade, Oatley ('Oatley premise') in April 2017. Civic leased the Oatley premises initially for a specific cohort of children for VOOHC. The Police Officer-in-Charge described the premises as an "older style 3 - 4 bedroom red brick single level house." It had a large backyard that was fenced on all sides, with the northern side fence being low lying. The rear of the property backed onto another residential property which backed onto a rail corridor.

21. In December 2017, it was determined by Civic staff that the Oatley premises would be used for a period of six months for children's overnight respite services.

22. During Alex's stay at the Oatley premises in April 2018, there were periods in which 1:1 care was not provided, and further, 1:1 care was not provided during the wake over shifts from midnight to 6am.

23. On 6 January 2018, Civic's maintenance department and Luke Muttdon, Practice Leader for Oatley, were informed by email of a request to install window locks on all the bedroom windows at Oatley. On 28 March 2018, Alexandra Vall (PL) / Kulander Chapman (PM) completed a Civic Maintenance Request – Form requesting "*locks put on the windows (as a deterrent for absconders*. Locks were not placed on the windows in accordance with these requests prior to 19 April 2018.

24. At 7.30am on 20 April 2018, Owen Talauta from Civic, received an email from Alexandra Vall Rojo, stating “Oatley 46 windows not locking. Immediate concerns for client’s safety’” and further that the (unnamed) client was a “huge absconding threat”.

25. At approximately 1:00 pm on 20 April 2018, a Civic maintenance officer secured windows in the bedrooms, office and kitchen of the Oatley premise. The bedroom en suite window was not secured.

26. On 22 April 2018, at about 7.00pm, Alex went to a bedroom in the Oatley premises where he was staying. He climbed out of the en suite window and absconded from the property.

C. Civic’s knowledge of Alex’s risk profile

27. Alex was assessed as requiring 1:1 care, meaning a ratio of one staff member to one child at all times.

28. Civic held the following documents outlining Alex’s behaviours:

29. Civic My Safety Plan, completed 31 July 2017, which notes Alex had risks in relation to traffic awareness and safety on roadways

30. Risk Profile, completed 14 February 2018

31. Vacation Care application/ booking form, completed 1 December 2017. Of note is the following: ‘Profound absconding risk. Has previously absconded, found on a bus, inside neighbour’s pool, can climb ANY fence, runs FAST.’

32. Civic Community Services Assessment, completed 7 February 2017

33. Civic Support Profile, unknown date of completion

D. Immediate circumstances of the fatality and cause of death

34. Alex was booked in to stay at the Civic Oatley premise from 3pm, Thursday 19 April until Tuesday, 24 April 2018. This booking was during school holidays.

35. mother and brother left Sydney on the afternoon of 19 April 2018 to fly to Melbourne to visit relatives, and were to return on Tuesday, 24 April 2018. Alex’s father joined them in Melbourne on 20 April 2018.

36. On Sunday, 22 April 2018 around 7pm, Alex escaped the Oatley premise through an open and unsecured en suite window, and jumped the property's low-lying fence, before running away from the property.

37. Alex's support worker saw Alex on the other side of the window, motioned and said to him that they were coming outside to get him. In the time before they could get outside of the property, Alex was across the road.

38. By the time the support worker reached the outside area at the front of the premises, Alex had run across the road to a park and was continuing to run. The support worker followed on foot and called emergency services at 7.13pm, and then hailed a passing police car. The support worker and police continued to look for Alex around the suburb.

39. At 9.30pm, Alex was formally found deceased on railway tracks at Oatley Railway Station. The Police Officer in Charge is of the view that Alex died at approximately 7.24pm after being struck by the 615M train as it approached the station, as Alex is last captured on CCTV footage on platform 1 at 7.23pm.

40. Alex died at the scene from multiple injuries, consistent with being struck by a train.

41. Alex's toxicology report indicated therapeutic levels of aripiprazole and carbamazepine, consistent with treatment for Autism and related conditions.

42. Alex died on 22 April 2018 whilst in respite care supervised by Civic, a non- government agency. He was 11 years of age.

43. Alex's mother requested an inquest be held.