FORM 37

Rule 60 (1)

REDACTED FINDING INTO DEATH WITH INQUEST

Section 67 of the ***Coroners Act 2008***

Court reference: 1430/08

In the Coroners Court of Victoria at Melbourne

I, JUDGE JENNIFER COATE, State Coroner

having investigated the death of:

Details of deceased:
Surname:
First name: AARON
Address:
AND having held an inquest in relation to this death on 9, 10 and 11 August, 2010
at 250 William Street, Melbourne
find that the identity of the deceased was AARON
and death occurred on 8th April, 2008

at 1 Surrey Road, South Yarra, Victoria 3141

from
1a. INJURIES SUSTAINED IN FALL FROM HEIGHT

in the following circumstances:

Introduction

1. Aaron was the eldest of the three children of his mother ML. Tragically, on 8 April, 2008, he took his life at the age of 14 years and 9 months old by jumping from an 11th floor balcony of a Ministry of Housing multi-storey complex at 1 Surrey Road in South Yarra. At the time of his death, he was living with his mother and two younger siblings in emergency housing premises in Albert Park.

2. At the time of his death, Aaron was enrolled as a student at Malvern Central School. According to the evidence of Ms Wendy John,[38] Assistant Principal, Aaron was an intelligent boy who was popular amongst other students and teachers although he was not the most diligent of students. Ms John painted a picture of a troubled boy who, although often at odds with the teachers, had a strong friendship network and found school to be a haven. Ms John described

[38] Exhibit 8 : Statement of Wendy John

Aaron as kind with younger students, a boy who loved animals and enjoyed spending time with his friends.

3. Aaron's father, JE, lived in Heidelberg. He does not appear to have had any contact with Aaron for about the last three years of Aaron's life. The reason for this is not clear. He has had no involvement with these proceedings and made no statement to police.

4. During Aaron's life he was the subject of 14 separate notifications to child protection ("DHS") over 12 years, being from the time he was 22 months old. At the time of Aaron's death, he was not on any formal child protection orders but DHS were still actively involved in his life.

5. The recurring nature of the child protection notifications was that Aaron had a lack of any or any appropriate adult supervision, was being exposed to many incidents of domestic violence, psychiatric illness, environmental neglect, exposure to substance abuse by his father, mother and mother's partner, lack of school attendance, homelessness of himself and his family and that his emotional and psychological wellbeing was either actually being harmed or at risk of being harmed by all of the above.

6. The material produced supports a finding that for a number of years of Aaron's life, his mother worked nights as an escort. The evidence is that this lifestyle often resulted in the children being left unattended overnight, or inappropriately placed and, as Aaron got older, reports that he was required to care for his younger siblings whilst his mother worked, began to emerge. ML's interaction and co-operation with DHS over the years was unpredictable and erratic. It was often characterised by short periods of responsiveness and engagement at the time of intervention, but these periods were not sustained as is apparent from the 12 year history.

7. On surveying Aaron's child protection history, it was not surprising that during the last few years of Aaron's troubled life, as he reached his adolescence, his behavior and attendance at school became problematic and concerning. He was suspended on a number of occasions for fighting and failing to respond to teachers' instructions. It is apparent that he was often not staying at home overnight, and not apparently eating or sleeping properly and consuming alcohol. In the last 12 months of his life he engaged in several apparently overt acts of self-harm until the final tragic act which took his life.

8. ML was approached to make a statement for the inquest but declined to do so. Thus, it was not possible to get her response to any of the material contained in the inquest brief. She attended at the first Directions Hearing for this inquest. She sought an adjournment to engage legal representation. This adjournment was granted. However, she did not attend for the adjourned Directions Hearing. She did not attend at the Inquest and thus her responses or views about the evidence or the circumstances surrounding Aaron's death could not be taken into account.

General comments as to the role of the coronial investigation

9. The fact finding role of the coronial investigation has often been stated as one focused on establishing the truth of what happened as best the evidence allows, to establish the circumstances surrounding the death. At times, in the course of investigating and establishing the circumstances surrounding the death, opportunities for improvement in systems of public health and safety which may contribute to a reduction in preventable deaths are identified. When this occurs, the Coroner has the power[39] to comment on any matter connected to the death including matters that relate to public health and safety and the administration of justice. The Coroner's investigation should not be seen as an exercise in apportioning blame against individuals or agencies, even though it is acknowledged that the process of the investigation and inquest may well be perceived by those individuals involved in the investigation as such an exercise. However, sometimes to achieve improvements to our systems of public health and public safety, it may be necessary to put under scrutiny the actions of individuals trained and working inside those systems to highlight the need for improvement.

10. Aaron's death was a reportable death pursuant to s.3 *Coroners Act 1985* (at the time at which it was reported) and s.4 Coroners Act 2008, the law applicable at the time at which it went to inquest.[40]

Circumstances of Aaron's last day alive

11. Aaron was still enrolled at Malvern Central School at the time of his death, although on the last day of Term 1 he had told his school friends Alina and Isabelle and the Assistant Principal Ms John that he did not intend to return to the school for Term 2. He had been enrolled at the school since February 2007.

12. In the wake of Aaron's death some of Aaron's school friends spoke with police. It is clear from their statements that they had spoken with Aaron previously about his thoughts of killing himself. When Aaron told Alina and Isabelle on the last day of Term 1 2008 that he would not return to school in Term 2, he would not tell the girls why that was so. However, Isabelle told police that on the last day of Term 1 Aaron "again mentioned that he was going to kill himself as he didn't want to be at home on the holidays and had nothing else to do."[41]

13. The girls told the police that one of them had removed a knife she found in Aaron's bag when they were together on that last day of Term 1 2008. According to Isabelle they spoke to Aaron at some stage on the last day of Term 1 about the knife they found in his bag. In the course of the

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39 See S.67(3) **Coroners Act 2008**

40 See Schedule 1 **Coroners Act 2008** for the transitional provisions. No issue was taken with the 2008 Act being the applicable Act for this inquest.

41 Statement of Isabelle P.35 Inquest Brief

discussion they stated they told Aaron he should not kill himself with the knife, implying that Aaron had previously spoken to them about taking his own life. The girls stated that in response to this, Aaron said that he would just jump off a building instead. Isabelle stated that he indicated towards the commission flats as he said this.[42]

14. Alina and Isabelle were with Aaron the day he died. They told the police they had previously been with Aaron in that same building in Surrey Road during the Term 1 school holidays. The building was being renovated and the upper floors were not intended for public access. They told the police that Aaron had gone to the 11th floor and had been walking around close to the opening. On that occasion they had managed to talk him into coming downstairs with them. Isabelle stated they told him how much they cared about him and how he had his whole life in front of him.

15. Tuesday 8 April 2008 was the second day of Term 2. Aaron had not been at school on the first day of Term 2 which was Monday 7 April. On 8 April 2008 at the end of the school day Aaron spoke to Alina and Isabelle about not being at school the next day. Indeed Isabelle recalls that he had been telling them during the day that he was not going to be at school the next day but would not say why as you "try and get me out of it". Isabelle noted that he did not appear to be any different to normal other than "being happier and talking to us." She noted that he was giving out his money and yearly tram tickets which had seemed strange.

16. The girls described how the group left school together and traveled on the tram to the stop near Surrey Road where they got off. After they got off the tram, Aaron took off quickly towards the same building they had been in during the holidays. The group all pursued him believing that he was "doing the same thing as last time, trying to grab our attention".[43] Alina stated to police that when some of the group with Aaron followed him into the building and saw him trying to force the temporary door into the 11th floor, she said he was telling them to go away and that when asked why he needed to do this he stated "I just do". His friends made various endeavours to try and get him to come back down but he kept telling them to go away.

17. Alina and Isabelle returned downstairs believing at that stage that sooner or later he would get bored and come back down. They watched him for 20 to 30 minutes. They saw Aaron looking out from what appeared to them to be the 11th floor, sitting on the ledge, throwing various items over the edge.

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[42] Both Alina and Isabelle made statements to the police. Given their young ages and the trauma of their experience, they were not required to attend court to give evidence. The evidence attributed to them is derived from the statements they made to police and included in the inquest brief.

[43] Statement of Alina P.31 Inquest Brief

18. Alina and Isabelle then tried hiding from Aaron in the belief this may cause him to come down and look for them. After about 10 minutes of this strategy, both girls went back up to where Aaron was and saw him sitting on the window ledge of the 11th floor.

19. Again they asked Aaron why he was doing what he was doing and he replied that he had to do what he was doing. He momentarily got off the ledge, apparently looking around for something and telling the girls to go away. Aaron went back and looked out of the window and then said to the girls "The cops are downstairs". The girls hoped that he would follow them down, but as they went out past the temporary ply board door, Aaron locked it behind them so they could not regain entry.

20. They walked back down the 11 flights of stairs and by the time they got there, they could see that Aaron was on the ground.

21. Ms Amanda Wastell was working nearby that day. She stated that at about 5.10pm her attention was drawn to a man on the edge of a building with two girls "trying to talk him down". She went outside her building and saw him standing on a "tiny ledge" about 9 floors up the building. She saw no other person near him and could see him looking down. She dialled 000 and a few minutes later she met police who had arrived. They gathered proximate to the base of the building.

22. When the police arrived, they could not see Aaron. The police commenced to obtain details from Ms Wastell about what she had seen and where she had last seen Aaron and then asked her to wait where she was as they moved towards the building.

23. It was Ms Wastell's evidence that very shortly after the police moved off towards the building she saw Aaron come and go from view in an area where there was no glass in the window area of an upper storey apartment in the building. She stated that she then saw Aaron fly out of the window looking like he "was diving into an Olympic swimming pool" with his arms outstretched.[44] Ms Wastell screamed and looked away before Aaron hit the ground. She stated that the police returned to where she was standing a couple of minutes later.

24. Four police responded to the call from Police Communications to attend the Surrey Road flats where a male could be seen on the ledge of an open window near the top floor of the building. LSC Page stated that he attended with Constable Hammer within four minutes of getting the call. LSC Page stated that when he arrived LSC Berwick and Constable Konomas were already present.[45] LSC Page stated that about two minutes after arriving at the scene he saw a male come "flying out of an open window head first". He stated that it looked as if the male had taken

[44] Exhibit 1 Statement of Amanda Wastell
[45] Exhibit 2 Statement of LSC Page

a run before he jumped. The account of LSC Berwick is consistent with the other eye witness accounts of how Aaron jumped and landed.

25. LSC Page and LSC Berwick immediately went to where Aaron was lying, felt for a pulse, found none and assessed that he was deceased and called for an ambulance.

Issues raised in the course of the investigation

26. A Coroner investigating a death must find the identity of the deceased person, the cause of the person's death and the circumstances in which the death occurred.[46] In the course of this investigation and inquest, no issue was raised as to Aaron's identity or the cause of his death. There were issues raised about the circumstances in which his death occurred and it is this area that was the focus of this inquest.

27. The circumstances surrounding Aaron's death require attention to the role of the State in three separate categories; they are the police, the school and the Department of Human Services in its child protection role. There was also an issue raised on the material about the safety and security of the building the children were in.

Death in police presence

28. As described above, Aaron's death occurred in the presence of the police. In any case where this is so, given the role of the police in our state, it is necessary for a Coroner to address any issues about the actions or non-actions of the police in connection with the death.

29. In this case, the evidence is that Amanda Wastell called 000 after seeing Aaron in a perilous position on the outside ledge of the building. Ms Wastell's evidence was that the police then made contact with her on her mobile to get her exact location and then arrived "a few minutes" later.[47]

30. Ms Wastell stated that she was between 200 and 300 metres from the building when the police arrived, in a nearby car park.[48] She stated that the police spoke to her to confirm that she was the caller and then walked towards the building. Further, she stated that from the time the police arrived to the time Aaron jumped was shorter than five minutes but no more than that and maybe as brief as two minutes.[49]

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46 See Section 67(1) **Coroners Act 2008**
47 Statement of Amanda Wastell: p.2
48 Transcript p.8
49 Transcript p.7

31. Leading Senior Constable Kane Berwick stated that he had about a one minute conversation with Ms Wastell, to try and establish Aaron's location. He then spoke with his partner Constable Konomas and two other police members who had also arrived to develop a plan of action in response to the situation.

32. LSC Berwick stated that he then walked across the road to the footpath outside the estate fence. He looked up to where Ms Wastell had indicated Aaron was and at that time saw Aaron leap from the building. LSC Berwick described Aaron as having been "outstretched" like he had been running rather than just dropping from the ledge.

33. LSC Berwick stated that he ran to where Aaron had fallen and felt his neck for a pulse, but could not find one. He also noted that LSC Page had already called for an ambulance by the time he had felt for a pulse.

Conclusion as to police involvement

34. The evidence demonstrates that the police who attended this scene, led by LSC Berwick had arrived within several minutes of the call from Ms Wastell and acted quickly to attempt to execute a plan. Sensibly, they sought information about the situation they were responding to and then attempted to put a plan into action. I am satisfied that, in these circumstances, there was no action that the police should have or could have taken to prevent Aaron's death. He jumped before the police had any opportunity to make contact with him or attempt any form of interception.

Building

35. The investigation and brief raised some issues about the state of the building and whether or not young people should have been able to access the area where Aaron and the girls had entered.

36. Clearly, there were extensive renovations going on inside the building and in particular on the 11th floor which is where Aaron had entered. The windows had been removed and new ones had not yet been fitted. There were temporary barriers erected, intended to keep people out of the area. The evidence is that Aaron had forced the temporary door at the end of the stairwell to the 11th floor of the building. The group responsible for the safety and security of the building was Arrow International.

Conclusion as to building safety and security

37. The area was clearly "out of bounds". It was being patrolled by a security presence. Aaron put considerable effort into getting into the area where he wanted to be.

38. In the wake of Aaron's death, WorkSafe, Arrow International, DHS and Victoria Police met with the contractors performing the renovations on the building. New safety and security measures were put in place which included erecting mesh grills over the windows and replacing the plywood doors with more secure doors.[50] This action was both sensible and appropriate and requires no further investigation or comment.

School

39. As stated above, Aaron had enrolled at his current school in February 2007 and was still enrolled at the school at the time of his death. The circumstances surrounding his death raise issues as to whether or not there was anything the school generally could have or should have done to contribute to Aaron's safety and wellbeing and potentially prevent his death.

40. Ms John stated that Aaron was suspended numerous times for a range of incidents including physical fighting and lack of work and failure to comply with teacher's instructions.

41. Ms John said that the school started to become concerned about Aaron in Term 2 of 2007. She gave evidence about some particularly serious incidents of concern as well as a more general picture of observations and ongoing concerns about Aaron.

42. For example, she stated that on 17 August 2007, Aaron was observed in class to have slashed his diary with a blade and to have cuts on his knees and to have a blade in his mouth. This behaviour was the subject of a notification to DHS.[51]

43. In September 2007, Aaron was located in a classroom with a group of students. He had a can of deodorant and a lighter and was assessed by his school to be self-harming and acting destructively. Further, it was the school's assessment that Aaron had been cutting himself and leaving visible scars, although he denied this behaviour when confronted with it.[52]

42. This behaviour was also brought to the attention of DHS.[53]

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50 Exhibit 7: Statement of Costa Petropolous
51 This was the 14th notification to DHS about risk to Aaron's safety and well being.
52 Exhibit 8: Statement of Ms John, Assistant Principal
53 Exhibit 8: p.1

44 On 1 November 2007, according to Ms John, Aaron attended school in an apparently intoxicated state. It was not clear whether he was drunk or drug affected. He was observed in his classroom to lapse into apparent unconsciousness and an ambulance was called which conveyed him to the Royal Children's Hospital. The school was not made aware of what the cause of that collapse was or the outcome of any hospital assessment. DHS attended the hospital.

45. Ms John stated that throughout Aaron's problems at school his mother was difficult to contact and engage. She noted that it was also difficult to get Aaron to open up although she noted that Aaron had apparently been more open with a couple of his friends at school and in particular Alina and Isabelle. The girls would sometimes inform the teachers of Aaron's problems but Ms John stated that Aaron would deny anything was wrong when questioned.

46. She also stated that he would sometimes come to school out of uniform but in the same clothes for a few days in a row and she suspected he was not going home. She also stated that Aaron would regularly fall asleep at school. Ms John stated that she eventually found out that Aaron would sometimes stay out all night rather than go home. Ms John stated:

> *"When I asked about this, he stated he would ride the trains and trams until they stopped running and would then find a park to sleep in. From this and information received via other kids, that he was not happy at home and that there were issues which caused him to not want to be at home, I was unable to contact his mother to find out these issues. Aaron would always turn up to school though, yet sometimes without food or his uniform".*[54]

47. Carum another 13 year old junior school student also spoke with police. He described Aaron as "often hurting himself by cutting his wrists". He also stated that Aaron was always saying "bad things" about his mother and was often engaged in "attention seeking" behaviour.

48. These same sorts of sentiments were expressed by Alina and Isabelle to the police in the wake of Aaron's death. Isabelle stated that about a month before Aaron's death he had been talking about killing himself saying he had not been sleeping, was under a lot of pressure at home and that he had been drinking.

49. As to Aaron's state of mind, Ms John gave evidence that when she spoke to Aaron about his behaviour and how things were for him, he would close up. She recalled that once he said to her:

> *"What's the point . ..... nothings going to happen .... Nothing can make anything better and that's all."*[55]

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[54] Exhibit 8: p.2
[55] Transcript p.43

She stated that she asked some of his friends how he was going and if everything was all right and was told, "things aren't great at home, but he's handling it".[56]

50. In oral evidence Ms John painted a picture of doing the best she could to try and find out what was happening in Aaron's life to help support him better at school, but generally not making much headway with his mother or his friends or Aaron. The evidence is that, sadly in the wake of Aaron's death, Ms John learned considerably more about Aaron's life. She stated that it appeared that school was Aaron's "haven."

51. Ms John also gave evidence that she was "imploring" DHS to get involved. She stated that she felt she did not get a lot of "feedback" from DHS and felt it was somewhat frustrating as she wished to be in a relationship with DHS in which the school and DHS were working together for the benefit of Aaron.[57] Ms John felt that she lacked a lot of information about Aaron's situation and that more information may have assisted them to support him in a more successful way.[58] She also felt she would have benefitted from advice and guidance from DHS about how to deal with Aaron.

52. Ms John did state that Aaron had "seemed a lot happier" in 2008. She stated that he seemed enthusiastic to be at school and was being more productive. However, on the last day of Term 1, 28 March 2008 Aaron got into some trouble with a teacher and when spoken to by Ms John, he told her that he would not be back at the school after the school holidays.

53. As stated above, Aaron did not attend school on the first day of Term 2 (April 7, 2008) but Ms John saw him at his locker on the morning of April 8, although not in uniform. It would appear that he participated in school that day and his spirit and upbeat mood were apparently so notable that a couple of teachers who spoke with Ms John at lunch time on that day told her that Aaron told them he was "great" and he was noted to "be co-operative, participating and seemed happy". It was that evening that Ms John received a telephone call advising her of Aaron's death.

Conclusion as to school involvement in Aaron's life

54. Ms John's evidence paints a picture of a compassionate and engaged school community that tried to accommodate Aaron's behaviour and lifestyle and keep him engaged with and attending school, aware that his peer support was a great comfort to him. Ms John gave evidence that Aaron's friendship group was "the most important thing for him".[59]

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[56] Transcript p.38
[57] Transcript p.72
[58] Transcript p.74
[59] Transcript p.51

55. There is little evidence that DHS gave much in the way of tangible support, guidance and advice to the school in its efforts to keep Aaron engaged and attending. School was Aaron's haven and ongoing connection to community and peer support. Whilst he kept attending school, this gave DHS a real opportunity to work with him and the school, to support and protect and understand what life was like for him. Sadly, that opportunity was not capitalised upon.

DHS

Overview

56. As stated above, Aaron had been the subject of 14 notifications to DHS over a 12 year period beginning from when he was 22 months old.[60] Seven of the notifications were not proceeded with beyond the initial assessment stage. The other seven notifications resulted in investigations which were closed at the "intake" phase. The evidence from Lucas Ford, the last DHS worker allocated to Aaron for notification 14, is that once Aaron was provided with a youth worker, the plan was again to withdraw from Aaron's life.

57. The evidence is that only one report of the 14 notifications over 12 years resulted in DHS taking any court action. Even that one court application resulted in DHS withdrawing before any findings or final orders mandating child protection intervention were made to protect Aaron. Aaron and his brother were made the subject of one interim accommodation order into the care of their maternal grandmother.[61] At that time, ongoing concerns were identified based on ML's current and past suicide attempts and frequent mood changes. Following further assessment of ML's parenting capacity, the protection applications were withdrawn on August 29, 1996 on the basis that ML agreed to work with a range of services and her extended family would support her and her family.

58. There were 9 further notifications to child protection after this time.

59. In summary, as stated above the nature and range of the notifications related to Aaron's exposure to domestic violence, neglect, exposure to his mother and father's substance misuse and his mother's partners violence, poor school attendance and his mother's mental health functioning.[62] There were also issues of concern raised about the family's transience, Aaron's mother's avoidance of DHS and the children's lack of schooling. The last couple of notifications contained concerns that Aaron was expected to provide primary care for his younger siblings while his mother worked nights. There was also evidence that Aaron's relationship with his mother was often very strained, that he was sad and self-harming and staying out at nights to avoid being at home.

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60 Written submissions of DHS filed November 12, 2010
61 The DHS file was provided to the Coroner together a summary of DHS interventions.
62 Statement of John Daniliuc 20.7.2010

60. At the time of Aaron's death he was not the subject of any formal orders pursuant to the *Children Youth and Families Act 2005 (Vic)* but DHS still considered itself to be actively involved in "case managing" Aaron.

The last notification (Number 14)

61. The last formal notification to DHS for Aaron came to the Southern Metropolitan Region of DHS in August 2007. Concerns were raised about Aaron's behavioral and mental health issues including self-harming and aggressive behaviour, cutting himself, erratic school attendance, falling asleep in class, conflict at home between Aaron and his mother and her absence from home overnight.

62. I have had the benefit of reading the comprehensive and extensive summary of the history of DHS involvement in Aaron's life set out in the Child Death Inquiry report provided by DHS.[63] With the benefit of that knowledge, I shall turn only to the last notification for Aaron and the wake of that notification to examine the effectiveness or otherwise of the State's protection in this case.

63. Mr Lucas Ford, the team leader of the Adolescent Team responsible for the management of Aaron at the time of his death provided a statement to police for this investigation and gave evidence at the inquest. In his statement[64] he noted he was aware of the 13 notifications dating back to when Aaron was 22 months old. He then went on to describe the history of the most recent intervention from August 2007 as follows:

> *"While Child Protection was involved with the family, Aaron's mother fluctuated between seeking assistance from the Department and refusing to engage. On numerous occasions, ML was non-contactable or not willing to discuss the situation with protective workers. ML was always afraid her children would be removed from her care. During child protection involvement, the concerns in relation to Aaron appeared to subside. It is believed that this occurred as Aaron and his mother improved their relationship. Aaron was residing at home with his mother and attending school when he was not suspended. Moreover, he had not self-harmed since the beginning of the child protection involvement (August 2007). During involvement, child protection staff offered counselling/mental health support to Aaron but he did not wish to engage with such a service ....."*

64. This statement is to be contrasted with the material in the DHS file which appears to lead to conclusions to the contrary. On a number of grounds, the above conclusions of Lucas Ford do not appear to be sustained by the evidence.

63 See commentary in "Comments" section with respect to the production of this report.
64 Exhibit 9: Statement of Lucas Ford

65. For example, by mid October 2007, Aaron had not attended school for a month and had apparently been reported by his mother to police as a missing person. Aaron was subsequently located and had apparently been staying with his aunt. Early in December he was found sleeping at the Shrine of Remembrance and by mid December ML was indicating to DHS that Aaron could not live with her. During December 2007 and January 2008 he was staying at the houses of friends and relatives. This evidence does not support a conclusion that Aaron was residing at home and getting along with his mother. This information was either known by DHS at the time or should have been known by DHS.

66. During a meeting on 24 October, 2007, three months after the August notification, Aaron's mother presented to DHS as "chaotic and running on adrenaline". She stated she was not coping and that she and Aaron needed a break. She also stated she believed all of her children were suffering from depression. She would not let DHS representatives speak separately to Aaron. However, during her absence from the room, Aaron stated that he was "sick" of looking after his siblings and could not handle living with his mother. He stated he was happy living with his aunt and wanted that arrangement to continue. This evidence does not support a conclusion that Aaron was living at home and getting along with his mother.

67. On 1 November, 2007 DHS were made aware that Aaron had been found unconscious at school and taken to hospital. The DHS investigation revealed an array of serious concerns about Aaron's home life including his mother's apparent precarious mental health. DHS spoke to Aaron at his school on November 20, 2007 during which time Aaron told them he did not want to live at home with his mother as she did not love him, he did not have a positive role model in his life or an adult that he felt close enough to talk to about his problems; he was suffering from insomnia and waking up every two hours; he had not seen his mother happy in a long time and she neither smiled, nor talked to him any more and he had not had any contact with his father since the beginning of 2007. This evidence does not support a conclusion that Aaron had not self-harmed since August 2007. Nor does it support a conclusion that he was getting along with his mother and that his relationship with his mother had "improved". This information was recorded in DHS files as at November 2007.

68. On 30 November, 2007 a meeting was held with DHS and Aaron and his mother and it was decided that DHS would remain "voluntarily" involved on the basis that various supports would be engaged for the family and they would co-operate with them.

69. On 7 December, police contacted DHS in the early hours of the morning advising they had found Aaron at the Shrine of Remembrance and he was stating that he did not want to go home as he did not get along with his mother. The police arranged for him to stay with his aunt.

70. On 11 December, 2007 Aaron's school was again providing information to DHS that he was staying on the streets at night and attending school in a tired and disheveled state and appearing substance affected. Further, the school was reporting that it was unable to engage with either Aaron's mother or aunt. This evidence does not support a conclusion that Aaron was not engaging in self-harming behaviour and that he was getting along with his mother and living at home.

71. When Aaron returned to school in February 2008, the school set a range of conditions which were made clear to DHS. During February 2008, Aaron was suspended twice and the school advised DHS that Aaron may be better off at another school that had a higher staff student ratio.

72. Leaving to one side the accuracy of the statement of Lucas Ford in light of these facts, notwithstanding all of the above, DHS appear to have placed weight on a meeting Lucas Ford had with Aaron on 14 March, 2008 in which Aaron stated that he would try and stay out of trouble and that the situation at home was "going well". Mr Ford became the allocated DHS worker for Aaron and met him for the first time on March 14 2008.

73. The evidence of his friends from school was that this was the period in which Aaron was talking to them about ending his life.

74. In the meeting of 14 March, Mr Ford noted that Aaron was initially shy but then engaged well.[65] Mr Ford went on to note that during this meeting Aaron stated to him that he did not want a mental health worker but that he would engage with a youth worker. Mr Ford stated that Aaron was not presenting as suicidal as he was talking about future goals and aspirations and appeared very interested in engaging with a youth worker. Mr Ford's case note for 14 March, 2008 indicates that he advised Aaron that he would organise a youth worker with a view to ceasing DHS involvement. He went on to say that Aaron seemed very excited by the idea of having a youth worker and very excited about the prospect of playing grid iron. When asked about the follow up from this meeting, Mr Ford stated that he found a grid iron team and then wrote a letter to Aaron and his mother and told them he had found a team in Nunawading.[66]

75. On the issue of DHS continuing to place weight on ML's representations that she would co-operate with DHS and engage with support services when her history spoke loudly to the contrary, Mr Ford stated that (DHS) were used to parents being upset and aggressive with the DHS involvement and basically DHS should just keep trying to engage and "stick with it".[67]

76. Mr Ford sought to clarify why he stated that Aaron was not displaying any significant "risk taking behaviours" as at 14 March, 2008. He stated in evidence that he meant Aaron wasn't

65 Statement of Lucas Ford: p.4
66 Transcript p.127 (See comments section (2))
67 Transcript p.137 (See comments section (3))

engaging in *"chronic absconding... he wasn't using substances all the time... He wasn't substance affected all the time ..... he wasn't self-harming all the time ..... compared to other young people in the adolescent program his issues were not that visible.*[68]

77. Mr Ford gave evidence that he was an experienced youth worker who had been trained to look for concerns about suicidality in youth. Mr Ford was asked by me as to what he made of the information that Aaron had been found at school, a few months earlier, to have been drinking "White Out", cutting himself, creating fireballs with aerosol cans and a cigarette lighter and assessed by the Assistant Principal to have been engaging in self-harming behaviour? He answered:

> *"I guess it made me think something - there is something that is bothering him, something that is on his mind."*[69]

78. Mr John Daniliuc, a very experienced and senior child protection practitioner currently employed in DHS as assistant manager at the Southern Metropolitan Region Child Protection program gave oral evidence in this Inquest. He did not have any involvement with the management of Aaron but had reviewed the DHS file and prepared a statement for the inquest brief. He impressed as a thoughtful and measured witness. When asked about the quality of the assessment of Aaron's state of mind in the months before his death, he stated with considerable candour that he did not consider that DHS had had a lot of direct contact with Aaron and were not in a position to really know who he was. In this context he stated:

> *"Can I just say Your Honour, that over the whole life of this case we didn't know Aaron and I think that's one of the saddest things. We've been involved with him since he was 22 months old and we had no idea what this boy was about."*[70]

79. Mr Daniliuc was of the view that Aaron had social skills and could have engaged well with a skilled worker. He agreed that, given Aaron was voicing intentions to kill himself to his friends, that information may have been made available to somebody who actually had made a connection to Aaron. Mr Daniliuc also agreed that as at October 2007 when Aaron was saying he couldn't handle living with his mother and he wanted to live with his aunt, that DHS could have responded in a more timely way and been an advocate and a support for him.

80. Mr Daniliuc agreed that DHS could have given more assistance to support the school and thereby assist Aaron to stay engaged: He stated: "I*n my experience schools are incredibly committed to their students".* He gave evidence about the new protocol introduced in May 2010 as between DHS and the Department of Education and Early Childhood Development to assist in

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[68] Transcript p.149 (See comments section (4))
[69] Transcript p.152
[70] Transcript pp.182-206

the development of more collaborative practices regarding the safety and wellbeing of young people including information sharing.[71]

Conclusions re DHS involvement

No Assessment of Aaron

81. In the 12 years of engagement with Aaron there was no proper in depth assessment of Aaron's mental and emotional health made by DHS. This is difficult to explain in the context of the information DHS had from Aaron's school about his behaviour, his history of self-harming and what DHS knew of Aaron's history accumulated in 12 years of notifications of protective concerns from infancy to adolescence. To fail to make the connection between Aaron's documented history with DHS, and the most recent descriptions of his range of behaviours including expressing concerns that he does not wish to live at home, that his mother does not love him, that he has been staying out on the streets, engaging in behaviour described by his school as self-harming does no credit to the Victorian child protection system. To fail to try and assess what Aaron was actually experiencing was to fail him.

Lack of Action to Assist Aaron

82. Given there was no proper in depth assessment of Aaron's state of mind, thus, it was not possible to say what Aaron's state of mind was and what was distressing him. Mr Daniliuc agreed that whilst the file revealed various actions and activities on the part of DHS staff, after 8 months of DHS involvement (from August 2007 to April 2008) nothing concrete eventuated for Aaron, through his eyes, in terms of even a supportive adult to whom he could connect. The allocated DHS worker appears to have changed at least three times throughout these 8 months as his case moved through DHS processes. Whilst the material reveals that a number of ideas and proposals were discussed with Aaron, such as joining sporting groups and getting a mentor, none of it had happened for him at the time of his death.

Episodic Responses/Lacking Analysis

83. The DHS material reveals years of serious reports of child protection concerns for Aaron. The DHS interventions are characterised, at best, by a few months of involvement, some apparent level of "settling" of the issues and then a withdrawal with no apparent ongoing monitoring of Aaron's safety or well being. The "episodic" nature of DHS intervention into and withdrawal from Aaron's life over the years without a more strategic and planned involvement

[71] Transcript pp.191-200 (See comments section (5))

was not desirable and failed to take into account the need to look at Aaron's history and assess his behaviour and risks to his emotional and psychological safety in the context of his own history, rather than against some bench mark of "high risk adolescents" generally.

Lack of Evidence of Comprehension of Cumulative Harm

84. Whilst it is not difficult to understand how and why this may happen a few times, by the time DHS are receiving notification 6, 7, 8, 9 and beyond, it is simply unacceptable that, with all of the expertise available to a child protection authority, it does not, at the very least comprehend the likely risk of cumulative harm for Aaron from years of exposure to the disruptions and issues detailed above.

Failed to Seek Statutory Intervention

85. When Aaron was 5 to 6 years old he was the subject of his 7th child protection notification. This notification was not from a concerned member of the public, this notification came from the Family Court of Australia pursuant to its statutory powers. The end result of that report was that the concerns were "not substantiated". Aaron acquired 7 more notifications after this. One cannot help but wonder at what point a reasonable child protection worker, looking at Aaron's history might have considered that, given the extraordinary number of notifications about this boy's risk of harm inside his family and the increasingly concerning nature of those reports as he reaches adolescence, that the patterns inside his family were not amenable to on-going voluntary involvement?

No Skilled Worker Linked to Aaron

86. Understandably, Aaron's death came as a shock to his mother and to the school and to DHS and to his friends. He had not spoken of taking his own life to an adult. However, there is no evidence that Aaron had developed a relationship with a skilled adult who could assist him to reveal his feelings. There is no evidence that Aaron had had any mental health assessment at all, despite some very overt self-harming behaviour in the last few months of 2007 and a troubling set of circumstances at home.

87. It is not possible now to conclude what was in Aaron's mind that caused him to feel like there was "no point" as he told Ms John on more than one occasion. But it might have been possible had more successful work been done on making a link between Aaron and a skilled youth worker or mental health worker who had maintained a skilled and stable presence in his life. This may have enabled a rapport and trust to be built with Aaron to assist in engaging him with the supports he needed. The tragedy is we will not know how successful this might have been.

CONCLUSION:

88. I find that Aaron, intentionally propelled himself from the outer ledge of the 11th floor of 1 Surrey Road South Yarra, dying instantly from his injuries when he hit the ground below. I further find that Aaron did this with the intention of taking his own life.

89. There appears to be little controversy on the evidence of the experts that making an accurate assessment as to the risk of suicide to a person is a very difficult task. This task of assessing risk is especially difficult in circumstances where that person is a 14 year old boy. Further, it is also a difficult task for a Coroner to conclude whether, on the balance of probabilities, there is evidence sufficient to find that a 14 year old boy has sufficiently understood the ramifications of his actions such that one can find he has intentionally taken his own life.

90. Sadly, in Aaron's case, as stated above I have come to that conclusion. This is based on the following evidence:

(a) At the end of Term 1 Aaron was disengaging with his school community by announcing he did not intend to return in Term 2

(b) Over the Term 1 holidays he was "rehearsing" his plan by visiting the building and even the location inside the building

(c) In the month before his death, he was talking to his friends about killing himself

(d) On the day he died he was giving away his money and his tram tickets

(e) On the day he died he appeared happier than normal and more engaged and talkative (a common retrospective finding in the immediate hours before suicide)

(f) When asked by his friends to come down and stop his behaviour he told them to go away and explained to his friends that he "needed" to do what he was doing

(g) The eye witness accounts of the circumstances of his "jump" leave no equivocation about the intentional nature of it rather than an accidental slip or fall

91. For the reasons set out above, I find that Aaron was showing strong signs of a significant level of disturbance by August 2007. His conduct in the months after this was responded to appropriately by his school by endeavouring to obtain assistance for Aaron from his home, his school and DHS as the child protection agency.

92. Whilst various referrals for assistance for Aaron were made in the last few months of his life, there is no evidence formal counselling or supports were put in place for Aaron. No mental health assessment was made of Aaron to make a professional assessment of his state of mind. No co-ordinated effort was launched by DHS to engage with Aaron's school to endeavour to keep him supported and connected to the one place where Aaron appeared to have a sense of belonging and comfort. From August 2007 to March 2008 there were at least three different workers allocated for Aaron as his case was moved through the DHS case management structure. This resulted in no continuity for Aaron, no capacity to build rapport and trust with him and no apparent understanding of the impact of this upon Aaron.

93. In its final written submissions, DHS submitted that the Court should find that its actions were appropriate having regard to the information available to it at the time of Aaron's death.[72] DHS added that, in any event, it would be speculative to draw conclusions about what the catalyst was for Aaron's final actions when he jumped from the building.

94. I accept that, on the evidence it is not possible to make a causal link between Aaron's suicide and the shortcomings of DHS as set out above. However, it is possible and appropriate to conclude that had a more timely and substantive and engaged response been made to Aaron's situation as at August 2007, it would at least have increased his chances of surviving the tragic state of mind which caused him to take his life on April 8, 2008.

COMMENTS:
Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death (including any notification to the Director of Public Prosecutions under Section 69(2) of that Act):

For Alina and Isabelle

1. Not surprisingly, Alina and Isabelle were shocked and deeply distressed and traumatised by Aaron's death. They were both 13 years old at the time. The evidence is that they were a great support and comfort to Aaron and he deeply valued their friendship. Whilst the girls may reflect many times throughout their lives on whether there was anything they could have or should have done differently, they must accept they were just barely into their teenage years and not equipped to handle the complexities of such a situation.

72 DHS final written submissions: p.7

The school

2. The perseverance of Ms John and the staff at Malvern Central should be noted for their efforts on behalf of Aaron. Ms John consistently reported her concerns to DHS and endeavoured to get assistance for Aaron.

Form of supports offered by DHS

No Mental Health Professional

3. (a) The evidence is that DHS did not engage the services of a mental health professional to make a proper risk assessment of Aaron and that it did not appear to be identified as necessary by DHS. It is not suggested that this is always an easy task, but given the evidence of Aaron's willingness to engage with a youth worker, it should not have been a difficult task for a skilled professional to have Aaron engage with an appropriately trained adolescent mental health worker.

No apparent understanding of reality of Aaron's capacity or his mother's capacity to support him

(b) At Aaron's last engagement he had with DHS, he was promised assistance to engage in a grid iron club. He was noted to be very excited about this prospect. What he experienced at most, in the wake of this promise was a letter telling him and his mother of the existence of a club in Nunawading. Bearing in mind Aaron was a 14 year old school boy, with no independent means, living in Albert Park with a mother who had a poor history of following through for Aaron, this appears to be a very poor piece of practice. It would seem almost cruel to excite a young person in Aaron's circumstances into believing assistance is going to be given to him to join a sporting club, to find that the assistance he gets is a letter telling him where the club is located. It does not pass the commonsense test and was likely to leave Aaron with the feeling that the intervention of DHS in his life was likely to achieve little.

Assessing the ability and likelihood of a parent to act protectively

4. This comment comes in the context of Mr Ford's evidence that he was well used to parents being upset and aggressive in the face of DHS involvement in the family's life and that basically it was required to just persevere and work through this. Whilst this sounds like a laudable sentiment from a child protection authority, is it an appropriate one after 14 notifications in the life of a child over 12 years of the child's life? That is, a reasonable professional making constant assessments of the capacity of a parent to sustain the necessary changes to maintain minimum standards for a child in his care, has to ensure that the "perseverance" is not futile. There simply must come a point where the decision has to be made to increase the capacity to obtain on-going

mandated compliance with child protection by using the *Children Youth and Families Act* to support the State's intervention for the benefit and proper protection of the child (see comment 7 below).

Assessment of Aaron based on behaviour of high risk" adolescent generally

5. This comment flows from the evidence of Mr Ford about how he assessed whether or not Aaron was a "high risk" adolescent. The assessment appeared to be based around where Aaron fitted on the **scale** of high risk adolescence, rather than an assessment of his state and his needs. The danger of "bench marking" Aaron's behaviour against the worst end of the disturbed adolescent spectrum is to risk not "seeing" or knowing Aaron. The system should be one which makes a thorough assessment of the young person and their life and circumstances before deciding what "stream" they should be placed in. If this does not happen, there are multiple risks. One is that the "skew" of the system is to wait until the young person's behaviour deteriorates into significant chronic dysfunction before he warrants significant intervention and, sadly, the intervention is less likely to be positive. Another risk is that the young person who is not "acting out" in a dramatic way will be more likely to be overlooked by the system. DHS through Mr Daniliuc advised that since Aaron's death the system has put considerably more emphasis on developing an understanding inside DHS on the significance of multiple reports to child protection and that child protection workers are trained to actively understand and consider the possibility of cumulative harm rather than looking only at the report to hand.[73] This is a good development and DHS are to be commended for it. Seen in this context, however, it must always be based on a thorough assessment of the child or young person who is the subject of the notification.

Information sharing between DHS and Department of Education

6. This issue was raised in the evidence of Ms John who was firm in her view about what would have assisted her in trying to cope with keeping Aaron at school and engaged with his school community. She was disappointed in what she perceived as a lack of support and guidance and collaboration including information sharing from DHS. Mr Daniliuc for DHS gave evidence about a new published protocol between DHS and the Department of Education addressed at improvements in this area. This is a good initiative and the parties involved are to be commended for this achievement.

Schools should be seen by the child protection system as crucial 'allies' for obvious reasons. Schools are full of trained and committed teachers who spend more time with the children and young people in those schools than any child protection worker or any other professional could achieve short of in-patient or residential care. School staff observe the students in social and

[73] Transcript p.201

academic settings. Schools also regularly interact with families. The insights, observations and advice from school staff available to child protection workers for the benefit a child is invaluable for this reason alone. The capacity to monitor, assist and support a child or young person who maintains a connection to school cannot be understated. Quite simply schools are an invaluable resource for the ongoing protection of children in this state. To maximise the benefit to a child who is being managed, assisted or cared for by DHS, DHS should ensure that it provides support, guidance, information and advice to the school of a young person to maximize the chances of that young person staying connected to school.

Value of formal application/mandated intervention

7. Our State has a regime in place to provide for the intervention of the state into the life of a child if the State, through its child protection authority, forms the belief on reasonable grounds that a child is at risk of a range of possible harms inside his or her family. The Department of Human Services (DHS) is the body which has the responsibility for the operation of the child protection regime in Victoria. DHS is given a range of powers and responsibilities housed in the *Children Youth and Families Act 2005 (Vic)* to carry out its child protection functions. Included in that range of powers is the capacity to bring a "protection application" before the Children's Court of Victoria to use the authority of the State to support and protect a child at risk of harm inside his or her family. Such form of State intervention into the family is considered to be a last resort to protect a child, but sadly necessary in circumstances such as where repeated attempts to work voluntarily with a family to ensure the safety of a child have clearly not been or are unlikely to be successful based on the history to date.

8. After the close of evidence and submissions and with the assistance of the Coroners Prevention unit, I have been provided with further information from the Department of Human Services advising that it is currently reviewing the content of the training material relating to adolescent mental health with the assistance of Dr Neil Coventry. I commend this initiative. I have also been advised that the Department of Human Services has recently developed a specialist practice resource titled "Adolescents and their Families" published by the Department of Human Services in collaboration with the Australian Institute of Family Studies. I commend this initiative. I am also advised that work is progressing between Children, Youth and Families Division of the Department of Human Services and the Mental Health, Drugs and Regions Division of the Department of Health regarding the priority access of child protection clients to Child and Adolescent Mental Health Services. I also commend this initiative.

Production and distribution of the Child Death Inquiry Report

9. (a) The *Child Well Being and Safety Act 2005* requires the Child Safety Commissioner to conduct an enquiry and prepare a report to the Minister in relation to a child who has died whilst

a client of child protection. The report prepared is known as a Child Death Inquiry Report ("CDI report").

(b) A very comprehensive Child Death Inquiry (CDI) report was provided to the court by DHS at the commencement of the Inquest. The issue of its production to the court and its distribution or publication was the subject of some controversy in these proceedings. Indeed, the production of the Child Death Inquiry reports to Coroners generally has been the subject of some tension and controversy. For this reason, I thought it worthy of some comment in this case.

(c) In this case, both DHS and the Child Safety Commissioner resisted the court's request to produce the CDI report to the Coroner. Through Ms Gardner of Counsel representing both, the concerns of both of her clients were that, in essence, persons who willingly participate in their inquiry will cease to do so if it is understood that this information will be provided to the Coroner. This lack of willingness will be a detriment to the stated aim of the Child Death Inquiry which is to promote continuous improvement in policies and practices in child protection.

(d) When a child dies whilst a client of DHS, a Coroner is required to investigate to establish, amongst other things, the circumstances surrounding the death. If appropriate, a Coroner may use the investigation into the circumstances surrounding the death to make comments or recommendations addressed to public health and safety issues, in particular, for the purpose of contributing to the reduction in preventable death. The *Coroners Act* also makes clear that Coroners in the conduct of their investigations should liaise with other investigative authorities to avoid unnecessary duplication of inquiries and investigations and to expedite the investigation.[74] Ms Gardner submitted that it is necessary to give meaning to the word "unnecessary" in this context. That is, that given the two different purposes of DHS and the Coroner, the duplication might be illusory. That is, DHS are engaged in a much broader exercise than the Coroner and thus it is not a duplication for each to conduct their own separate enquiry at public expense. That submission is accurate as far as it goes in that DHS may be engaged in a much wider enquiry than the Coroner, but there will be a considerable overlap.

The question of how the public interest is best served in this context is a balancing exercise. On the one hand, the public interest seems well served by the Coroner having the report. The public interest is also served in having DHS respond as quickly and fully as possible to a fatality to ensure the on-going protection of children is as thorough and as immediate as possible and to address any identified public health or safety issues in a more timely way than a coronial investigation can achieve.

The Coroner provided with the internal report or review can be greatly assisted in the conduct of his or her investigation and can provide a more timely completion to his or her own

[74] See section 7 **Coroners Act 2008**

investigations and reduce the amount of public time and money used to re-investigate issues or have to compel witnesses into court to be cross examined. On the other hand, DHS submit that the public interest is best served by the provision of frank and open disclosures which are protected.

(e) Ms Gardner also submitted that the report contains the opinion of the chosen CDI investigator and writer and thus does not alleviate the Coroner of his or her functions to investigate "independently". It is accepted that the opinion of the writer or the findings of the writer of the CDI report do not bind a Coroner. Clearly, DHS select extremely senior and competent persons experienced in child protection matters to prepare and provide those reports, thus, their opinions are very helpful.

(f) In directing the production of the report, I was confident that the contents of the report were likely to address an extensive range of systemic issues in this case in considerable detail and thus reduce the need to pursue these issues in the coronial enquiry. That is, the production of the CDI report was likely to mean that not only would I not have to spend days reading 12 years of DHS files, but I would not require the attendance of numbers of workers and other witnesses as it was likely they had all been interviewed in depth during the Child Death Inquiry and a summary of what had happened would be contained in the report. This will not always alleviate the need for the calling of witnesses, but it often will.

(g) Ms Gardner accepted that s.40 of the *Child Well-Being and Safety Act 2005* **does not protect** or **prohibit** the report from production to the Coroner. There is then the issue of its distribution and publication that requires consideration.

(h) There is a distinction between the **production** of the report to the Coroner and the **publication** of the report, both to the interested parties and to others beyond the interested parties. In making decisions for any dissemination or publication, Coroners are always mindful of balancing the public interest being served by the frank and open disclosures encouraged by the promise of confidentiality and/or anonymity and the public interest in not prolonging an investigation and getting the best information available to the Coroner's investigation.

In this case, there were no other interested parties. No other person or party was seeking a copy of the report. In balancing the tensions, I was satisfied it was appropriate to require the production of the report to the Coroner to meet community expectations that the Coroner would be satisfied that a thorough investigation had been completed and appropriate recommendations made, and then assess whether or not any publication limited or otherwise was necessary. As a general observation, it would seem to be in very rare and exceptional circumstances that even limited publication of a Child Death Inquiry report would be warranted. Whilst interested

parties may need to be provided with some information from the report, consistent with the rules of natural justice, appropriate constraints on its further use or dissemination can be made.

(i) Ms Gardner for DHS sought to rely on *D v National Society for the Prevention of Cruelty to Children* [1978] 171 as authority for the proposition that the greater public interest to be served in a case such as this is absolute confidentiality of the Child Death Inquiry report. However, in my view that is not the effect of this decision. The decision relates to a consideration of whether or not a protected notifier who makes a disclosure of suspected child abuse should be protected from disclosure in a civil suit arising out of that notification. In short compass, these circumstances are completely distinguishable. The request for the production of the report to the Coroner investigating the same death, does not breach the prohibition on identifying notifier details. DHS usually provides its file to the Coroner and keeps the notifier details in a separate sealed clearly marked envelope. In my view, this is sound practice. It would be perfectly proper to produce a Child Death Inquiry report to the Coroner in the same way. Further, notifier details should be protected during or in the wake of a coronial enquiry unless the interests of justice demand otherwise.

(j) In my view, the public interest is best served by ensuring that the Coroner gets as much frank information as possible from the agency under scrutiny, be it Victoria Police, a government department such as DHS or a major public hospital. I accept that there is a real risk that reviews which obtain the frank co-operation of agencies and individuals involved in the death may be compromised if routinely made public in the course of a coronial enquiry.

(k) I consider the production of the Child Death Inquiry report to be a very valuable aid to my investigation and consistent with requirements of s.7 of the **Coroners Act 2008.** However, I am also satisfied that it is in the public interest to protect the contents of the report from general dissemination or publication. In this way, I am satisfied this strikes the correct balance between protecting the public interest in ensuring that candid reviews, performed by highly qualified senior people for public agencies whose actions are under scrutiny by the Coroner are provided to the Coroner whilst protecting the identities of those who have given information to assist in the continuous improvement of our public systems and to help identify any systemic concerns in a timely way.

Based on the reasoning set out above, I am satisfied that it is contrary to the public interest to make public the Child Death Inquiry report produced in this case and have already made an order suppressing its contents.

RECOMMENDATIONS:

Pursuant to section 72(2) of the **Coroners Act 2008**, having made the above findings of fact and conclusions, together with the above comments, I make the following recommendation:

To enhance the opportunities to identify early intervention for children at risk of harm, I recommend:

1. That the Department of Human Services give serious consideration to imposing a mandatory practice standard for Victoria that requires a unit manager or above to review the proposed DHS response to any child protection notification once that child's history accumulates three notifications, but has not resulted in a response beyond voluntary intervention. If a response beyond voluntary intervention is not deemed appropriate the unit manager (CPW5) should record an explicit rationale for this decision on the file.

To develop and maintain skills in identifying adolescent mental health risks and issues, I recommend:

2. That the Department of Human Services child protection practitioners (CPW 2/3), team leaders (CPW4), and unit managers (CPW 5) working primarily with adolescents, undertake mandatory training at commencement and then every two years thereafter to develop and maintain staff skills in identifying and addressing adolescent mental health issues.

To enhance knowledge and understanding of appropriate use of services for assessment and support of adolescents I recommend:

3. That the Department of Human Services develop clear and detailed guidelines outlining when child protection practitioners should make a referral to a specialist mental health professional or service to ensure timely mental health advice and treatment is received when necessary. These guidelines should be incorporated into all the current practice advice within the Child Protection Practice Manual relating to adolescence and mental health issues

Signature:

Judge Jennifer Coate
State Coroner
Dated: 16 May 2011

I **direct** that this Finding be distributed to the following for their action:
Secretary, Department of Human Services

I also **direct** that this Finding be distributed to the following for their information:
The Hon. Attorney-General
The Hon. Minister for Health
The Hon. Minister for Education
Ms Wendy John, Assistant Principal, Malvern Central School
S/C Antolini: Coroner's Assistant
LSC Berwick: Investigating Member
ESD, Victoria Police
Ms ML
Parents of Isabelle and Alina
The Hon. Philip Cummins, Chair Protecting Victoria's Vulnerable Children Inquiry
Mr John Daniliuc, Department of Human Services
Robyn Miller, Principal Practitioner, Department of Human Services
Mr Bernie Geary OAM, Office of Child Safety Commissioner