IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 1457/2009

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of: CODY JACKSON

Delivered On:	12 April 2013
Delivered At:	Level 11, 222 Exhibition Street Melbourne 3000
Hearing Dates:	4, 5 and 6 March 2013
Findings of:	JUDGE IAN L GRAY, STATE CORONER
Representation:	Ms E Gardner for Department of Human Services,
Police Coronial Support Unit	Leading Senior Constable Amanda Maybury
Family	Mrs Budziarski (Mother of Cody Jackson)

I, JUDGE IAN L GRAY, State Coroner having investigated the death of
CODY JACKSON
AND having held an inquest in relation to this death on 4, 5 and 6 March 2013
at MELBOURNE
find that the identity of the deceased was CODY JACKSON
born on 6 November 1993
and the death occurred 9 March 2009
at 28 Dorchester Crescent, Carrum Downs, Victoria 3201
from:

1 (a) ASPHYXIA BY HANGING

in the following circumstances:

Summary

1. At about 4.45am on 9 March 2009 Cody Jackson[1] was found hanging from a swing set frame in the rear year of his home at 28 Dorchester Crescent, Carrum Downs.

2. He had gone to a party in Carrum Downs on the night of 8 March 2009, consumed some alcohol, been picked up by a friend, Elizabeth Garnett, and taken home at about 2.40am.

3. Sometime later he wrote a suicide note which he left on the kitchen table. He also left a suicide message as a draft on his mobile phone.

4. Senior Constable Iles of Frankston Criminal Investigation Unit attended at the address in Carrum Downs and noted that Cody had made a noose out of insulated steel tow cable, lashed it to the frame and tied his right arm to his right thigh. Police were satisfied there were no suspicious circumstances surrounding Cody's death and Detective Senior Constable Iles made the following observations:-

    - The backyard was totally enclosed and there was no sign of forced entry
    - There were signs that Cody had been practising how to tie nooses in the garage
    - There was no sign of a struggle in the backyard

[1] Referred to as Cody throughout this finding

- There was no sign of any other force or assault to Jackson
- There was a note left by Cody indicating he intended to take his own life.

5. I find that there were no suspicious circumstances.

Mandatory Findings

6. Section 67(1) of the *Coroners Act 2008 (Vic)* provides that a coroner investigating a death must find if possible:-

   a) the identity of the deceased;
   b) the cause of death; and
   c) the circumstances in which the death occurred.

Identity – s.67(1)(a)

7. The identity of the deceased was Cody Jackson born 6 November 1993

Cause of death –s.67(1)(b)

8. The cause of death is generally accepted as meaning the medical cause of death.

9. Forensic pathologist Dr Matthew Lynch inspected the body of Cody at 11.00am on 10 March 2009. On Cody's neck he found a ligature mark around the neck seen as a furrow in the skin about 1 centimetre in width. He inspected a length of "octopus type strap" and a length of black cable which had been delivered with his body to the mortuary. In his report he stated that the dimensions of the cable corresponded to the dimensions of the ligature mark.

10. He examined the body externally and reviewed a post-mortem CT scan. There was no evidence of any other injury. He expressed the cause of death as "hanging".

Circumstances in which the death occurred – s.67(1)(c)

11. Under this heading it is necessary to set out some background. The main focus of this inquest was on the actions of the various agencies assisting Cody.

12. Cody was born on 6 November 1993. He was the third child of Debbie Budziarski. He had one full sibling, two half siblings, two step siblings. He had a twin who died as an infant. He lived at home with his mother and his step-father Henry and four of his five siblings. He had a troubled family history including family violence, substance abuse and criminal behaviour. Cody's mother, Debbie Budziarski, did her best to address Cody's needs but found this challenging. Cody's behaviour became extremely difficult and combined with Debbie's parental responsibilities for her other children it proved to be too much at times.

13. Due to his family history, and ultimately his involvement in criminal offending, Cody was linked into a number of services including the Department of Human Services (DHS), Child Protection, Anglicare, Peninsula Youth and Family Services, Youth Substance Abuse Service, Carrum Downs Secondary College, Parkville Youth Justice Centre, Youth Justice, Adolescent Forensic Health Service and Frankston Police.

14. Although Cody was assessed as having multiple issues which needed to be addressed he was never assessed as being at risk of self-harm or suicide.

15. Despite his mother's best efforts and the involvement of a number of agencies, Cody at 15 chose to take his own life. There is always a question in such cases whether the tragic loss of a young life was foreseeable and/or preventable. Cody left a note before he died and it suggests that he could see no future for himself. His mother on the other hand thought her son had a lot to live for and at the end of the inquest spoke of his life, his hopes and his aspirations in a loving and moving statement. Mrs Budziarski was an impressive and a balanced witness.

<u>Cody's background and his involvement with agencies supporting him.</u>

16. There was a substantial amount of evidence given and tendered at the inquest about Cody's involvement with the DHS and other agencies. All relevant departmental files were made available.

17. One of the issues considered in this inquest was the adequacy or otherwise of the support provided to Cody (and his mother), and whether his tragic death was preventable or foreseeable. This involved a consideration of evidence about psychological and psychiatric diagnoses and interventions.

18. I heard detailed oral evidence from Mrs Budziarski, Robert Costante, a team leader with Child Protection DHS, Nicole Dowse, Youth Justice case manager (DHS) and Graham Cochrane, Psychologist Community Condition for the Southern Metro area DHS at the time. I also heard evidence from Leading Senior Constable Huxtable, who prepared the inquest brief.

Child Protection

19. One issue covered in the evidence related to the coordination of the agencies and personnel, working on Cody's case, particularly the staff of Child Protection and Youth Justice. Cody's case was clearly difficult and demanding. His family history, his needs and his involvement in criminal offending meant that multiple issues needed addressing. Good case coordination and collaboration was therefore important.

20. I accept the evidence of Mr Costante, Ms Dowse and Mr Cochrane and I believe they discharged their obligations towards Cody conscientiously. In my opinion, in reviewing the whole picture, they achieved a sufficient degree of cooperation and collaboration on the ground in dealing with a difficult case.

21. Ms Gardner, Counsel for DHS, summarised the DHS involvement in Cody's life as follows:-

> "In relation to Child Protection's involvement with Cody, from July 2000 to March 2009 the Department of Human Services Child Protection Division received eight reports pertaining to him. In summary, those concerns related to Cody's older half-sibling, and Cody's aggressive behaviour towards each other, their siblings and their mother. Violence between the parents and the father and the children. Mrs Budziarski's inability to cope with the children in the context of her ill health, her husband's ill health and the youngest child's elemental delays.

The last three reports to Child Protection pertained to Cody alone. His behaviour was challenging. He engaged in physical abuse of family members, property damage, absconding and criminal activity, including activity that put him at risk of physical harm, such as vehicle theft and unlicensed driving.

The final report to the DHS Child Protection concerning Cody was the eighth report. It related to concerns about his involvement in criminal activity and conflict with his parents in the family home. He'd been arrested by police for shoplifting and he was on bail for like offences. He was considered inappropriate for bail and his mother was unable to manage him."

22. Mr Costante's evidence detailed the involvement of Child Protection. It covered the history of court proceedings after Cody was remanded at the Melbourne Youth Justice Centre overnight on 15 September 2008, appearing before the criminal division of the Children's Court on 16 September 2008. He was again remanded at the Youth Justice Centre until 22 September 2008. On 22 September 2008 he was released and returned to his mother's care. However further offending was alleged, his mother informed Child Protection, and in late September 2008 a safe custody warrant was sought for him under the *Children Youth and Family's Act 2005*. The warrant was executed on 28 September 2008 when he was located at home. On 29 September 2008 he was the subject of an Interim Accommodation Order and placed in secure welfare for two weeks due to concerns relating in part to his mental health at the time. The order of Magistrate Power made on 29 September 2008 required DHS to arrange for a forensic psychiatric assessment. On 12 January 2009 his case returned to the Children's Court. A further Interim Accommodation Order was made. The case was back in court on 12 February 2009 and on that occasion Cody was placed on a Supervision Order for six months, with guardianship of Cody to his mother. I accept Mr Costante's detailed evidence covering these matters.

23. Mrs Budziarski was critical of the time it took for Cody's case to be allocated to appropriate workers. On the evidence, the relevant notification was received on 15 September 2008 and the case transferred to the case manager Mr Costante, on 23 September 2008. That meant an eight day timeframe to allocate the case to a worker which was not unreasonable in all the circumstances.

Youth Justice

24. Ms Gardner summarised Cody's involvement with Youth Justice as follows:-

"Cody first came to the attention of Youth Justice in May of 2008 when he was placed on a deferral sentence due to committing assault, intentionally and recklessly

causing serious injury, and theft, burglary and unlicensed driving. Ultimately he received a six month probation order for that offending, and in September of 2008 he was remanded to MJJC on charges of handling and receiving stolen goods, possessing ecstasy and theft from a motor vehicle.

In October of 2008 he received a further probation order in relation to that conduct.

Ms Dowse commenced as his case worker on 31 December 2008, and she remained involved with him until his death. At the time of his death he was due to appear in court on 12 March 2009 to respond to the outstanding criminal matters.

"The key efforts of interventions by Child Protection in the latter part of Cody's life included home visits by Mr Costante to the family home, telephone contact by Mr Costante, both to Cody and his mum. Mr Costante's efforts to interest Cody in employments, namely apprenticeships. The liaison between Mr Costante and Youth Justice. Liaison between Mr Costante and Mr Cochrane. Preparation of court reports by Mr Costante. And his attendance at court, the Family Division of the Children's Court in relation to Cody's dispositions. And I would also note Mr Costante's efforts, albeit unsuccessful, to seek to maintain a psychiatric assessment for Cody pursuant to Magistrate Power's order in September 2008."

"In relation to Youth Justice key interventions in the latter part of Cody's life included the face to face to face contact and supervision of Cody in relation to the probation orders he was on. A flexible approach to the supervision so as to enable Cody to maintain employment. By way of example, arrangements were made for him to be met outside normal business hours and sometimes it was agreed that he could contact by telephone rather than attend face to face."

"Arrangements were made for Cody to enrol in, and be interviewed in relation to the vocational educational program known as Hand Brake Turn, which Your Honour heard some evidence about. And I would note in relation to that matter, that was not simply a matter of making the referral, but there were practical steps made. For example, Ms Dowse didn't simply make the referral and say "go to the appointment", she said "would you like me to telephone you with a reminder?" There was an offer of transport should he not be able to get there himself. It was not simply going through the motions, there was a degree of thoughtfulness and care in the way the services were attempted to be delivered to him. She also had discussions with Cody, Ms Dowse did, about his upcoming court hearings, and from time to time there was assistance with getting any necessary court adjournments and facilitation that was required."

This is a fair summary of the evidence, and I accept Ms Gardner's submissions on the work of Mr Costante, Ms Dowse and Mr Cochrane.

Mental Health Issues

25. Although Cody was assessed as needing assistance and support in respect to a range of issues in his life, he was never assessed as being as risk of self harm or suicide. There was

a question however whether indicators of depression meant that he should have been provided with some psychiatric treatment or psychological support.

26. Both Dr Carla Lechner and Dr Lester Walton expressed opinions about Cody's mental health in reports written in April and June 2008 for Children's Court proceedings. Dr Walton (at page 7 in his report written) stated:-

> "While it is correct to state that Cody also has his own individual psychiatric difficulties, they seem to be of a relatively lesser nature and I suspect that in terms of the overall family dynamics, he has become the identified deviant, attracting attention to himself to divert from the life-threatening and other issues which afflict the family. However, this extended role has taken its toll upon Cody. He does not now present as mentally ill as such but he is psychologically underdeveloped and immature, with an increasingly low tolerance of frustration, rage reactions being in a recurring phenomenon, and there is also significant anxiety and depression, which he does not easily acknowledge."

27. Dr Walton went on to recommend that Cody be admitted to an acute psychiatric in-patient unit or in to protective custody.

28. Dr Carla Lechner expressed her opinion in strong terms.

> "Cody Jackson, a youth of 14 years and six months, is before the Court facing a number of theft, criminal damage, deal with proceeds of crime and assault matters, offences that occurred between June and November last year. The facts of this case are known to the Court. The writer notes that this is Cody's first Court appearance. He presents as a very troubled young person, with a dysfunctional background that has undermined his social, emotional, behavioural and educational development. His current angry, acting-out and self-destructive behaviour, is likely to be an expression of both intense rage and feelings of inadequacy and depression. He has previously been trialled on a number of medications, with limited benefit. It is strongly recommended that Cody undergo a psychiatric assessment at the court Clinic.
>
> At interview Cody presents as cognitively and emotionally immature, with a limited ability to reflect on the impact that his behaviour has on both himself and others. He is emotionally disconnected with a stated position that he cares for nothing. Cody is impulsive in nature and has a low tolerance for frustration. He finds it hard to both identify triggers to his negative feelings and to express them appropriately, tending to channel all internal distress through anger. Although he describes himself as "bored" rather than depressed, Cody presents as extremely low in mood with flattened effect. Psychometric testing was inconclusive, but tends to suggest that Cody is experiencing a high level of anxiety and that he feels unable to control his impulses, that he is lacking in self-confidence and may have drug/alcohol issues.
>
> The writer has immense concerns for Cody's mental health. His depression and rage seem to be intimately connected with his behavioural problems. He is not currently engaged in any educational program, although the Handbrake Turn course was

discussed with both him and his mother as a possible alternative course. In the absence of being occupied, Cody is at even greater risk of associating with negative peers who provide him with some form of acceptance and approval."

Mrs Budziarski told Dr Lechner that she believed Cody was a "very troubled and confused boy with mental health issues".

29. Although it is true that both Dr Lechner and Dr Walton only had a limited opportunity to observe Cody, I accept that he was clearly angry, disturbed and probably depressed. This is the consistent theme of the evidence although I note that, by contrast, his close friend Elizabeth Garnett described him as "a happy and generous kid", and "nothing seemed to really bother him".

30. On 29 September 2008, an order of the Family Division of the Children's Court dealt with a protection application relating to Cody. The Court ordered him to reside in secure welfare for three weeks because of concerns expressed about his mental state. At that point Child Protection was ordered to complete assessments of his psychological and emotional functioning and his drug and alcohol use.

31. Several attempts were made to arrange appointments with psychiatrists but none were available early enough. Ultimately Child Protection arranged for a psychologist to see Cody regularly and develop a treatment plan. That psychologist was Mr Cochrane.

32. Both Mr Cochrane and Ms Dowse of Youth Justice were seeing Cody at this time. Cody participated in the "Changing Habits and Reaching Targets" program (chart) under Ms Dowse's supervision. She attempted to get him in to the Handbrake Turn course that he was very keen to do and he was scheduled for an interview for that on 11 March 2009.

33. In his evidence Mr Cochrane expressed the opinion that Dr Walton's recommendations were "practically impossible" to implement. He said

> "Dr Walton's recommendation was not able to be implemented for several reasons. First, AFHS, Youth Justice and DHS Child Protective Services were unaware of any statutory authority under which Cody could be admitted to an Adolescent Psychiatric Unit Involuntarily. Cody did not present at any time during his AFHS involvement with acute psychiatric symptoms. Second, Cody's presentation made it clear that he would not consent to such an admission, and ethical considerations made it inappropriate to attempt to enforce a "voluntary" admission against Cody's wishes, especially without Statutory mandate. Third, public demand for admissions to Adolescent Psychiatric Units is chronically high, and AFHS, Youth Justice, and DHS Child Protective Services did not have privileged access to those facilities. Fourth, although clinicians working in the adult correctional system often have access to

Adult Inpatient Psychiatric Facilities through agencies such as Forensicare, no such equivalent facilities exist in the Youth Justice or DHS Child Protective Services systems."

34. Ms Gardner's submission on this point was:

> "As explained by Mr Cochrane, Dr Walton's recommendations were practically impossible to implement, however, it's contended that the ongoing involvement of the Adolescent Forensic Health Service in seeking to assist Cody and then provide secondary consult by counselling via Mrs Budziarski demonstrated a creative approach to seeking to properly identify any psychiatric illness Cody might be experiencing.
>
> The fact that Cody did not engage sufficiently to permit that to occur should not be viewed as a failure on the part of Adolescent Forensic Health Service, Child Protection or Youth Justice. It's a difficult reality associated with these hard to help young people.
>
> The situation was complicated by the fact that Cody was so guarded. Furthermore, he was too young to be definitively diagnosed with certain disorders because his brain and personality were still forming, according to the evidence of Mr Cochrane.
>
> The efforts made in relation to addressing his mental health issues, if any, were sensitive, sustained and directed. It's important to weigh into the mix Mr Cochrane's real concerns that more damage could be done to Cody if the issue of counselling or other mental health interventions were pressed. He gave evidence that there was no cessation of work regarding Cody, but that a different tack was tried so as to not perpetuate Cody's opposition to counselling. He described his work as a comprehensive psychological assessment in the community."

35. I accept Mr Cochrane's evidence. He was a thoughtful and fair witness and he made a constructive contribution to this inquest. I broadly agree with Ms Gardner's submission with the efforts made to address the mental health issues, although I have some reservations about accepting Ms Gardner's proposition that the efforts were "adequate in all the circumstances", noting that in his evidence Mr Cochrane very candidly made the point that his report originally contained an additional sentence to the effect that, with the benefit of hindsight, he felt that he should have referred Cody back to Dr Walton.

36. However given the evidence about Cody's reluctance to engage, and his tendency to be very guarded, I could not find that such a referral would have been likely to have changed things significantly. Apart from Cody's note, it is not possible to reach positive conclusions about what drove him to end his own life. I accept his mother's evidence that he may well have been afraid and insecure about the potential of others to harm him and his family. I note her evidence about threats made when certain people visited the home. Despite the history of troubles affecting the family and some of Cody's own actions within the family, he was clearly sensitive about their welfare, his mother's in particular. I accept

his mother's evidence completely about him being an "emotional boy". He does appear to have feared what others might do to his family and to have felt a degree of responsibility for creating a risk to them. I note also his mother stated that in early 2009 his moods changed and he became more withdrawn, nervous and anxious.

37. It is true that there is not always a clear connection between mental health and suicide and even though Mrs Budziarski was obviously concerned about her son's health and welfare she did not contemplate that he might take his own life.

38. Other people involved in Cody's life were of the same view. Mr Costante, Mr Cochrane and Ms Dowse all expressed shock and surprise that Cody took the drastic step of ending his own life. None of them identified anything close to the time of his death that suggested that he was at heightened risk of suicide. Ms Dowse gave evidence that she has specialist training concerning identification of suicide risk and was the last professional person to see him. She saw him on 6 March 2009 for Youth Justice supervision. They discussed Cody starting the Hand Brake Turn program. He was apparently positive about the program and was to attend an interview relevant to that on 11 March 2009. They also discussed his impending court case about criminal charges scheduled for 12 March 2009.

39. I agree with Ms Gardner that it is "impossible…to discern the extent to which his possible incarceration was playing on his mind, or any number of background features in his life concerning involvement with other people surrounding criminal activity, his peers, or those matters." I agree also that it was noteworthy that he commented to his close friend Elizabeth Garnett on the night of 8 March 2009, "well, I only have few days left in society so I might as well make the most of it."

40. Mr Cochrane said that he detected no indications of suicidal ideation, no self harming and no psychotic behaviour. His opinion was that there were no indications that Cody was contemplating taking his own life. On all of the evidence I conclude that Cody's suicide was not reasonably foreseeable to anybody working professionally with him.

Office of the Child Safety Commissioner Report

41. Cody's death was the subject of a report and findings by the Office of the Child Safety Commissioner ("CDI Report"). Recommendations were made by the Victorian Child Death Review committee ("VCDRC") based on the CDI Report.

42. The CDI Report and the VCDRC report are exhibited to the statement of Mary McKinnon which was tendered.[2] The purpose of the report (at paragraph 6) was to "provide information about development in Child Protection and youth justice policy and practice that had occurred since Cody's death". It describes in detail the developments and application of "the best interests case practice model" within the DHS since 2008. These are clearly positive developments in departmental policy and practice.

43. It summarises the position as follows:-

> "The publication of the specialist practice resources *Cumulative harm and Child development and trauma*, and the child protection operating model reforms are relevant to, and address, the first finding in the CDI Report that a trauma informed approach to working with Cody would have been beneficial. These practice improvements also address finding number three, that child protection did not assess that more proactive outreach contact with Cody was required, finding number four, that more assertive early intervention would have been of assistance in Cody's case, and finding number five, that significant indicators of risk were not considered which may have had a serious impact on Cody and others in this home."

44. Ms Gardner made the point that these reports:-

> "are compiled based on best practice in the area of child Protection and with a view to systemic improvement in the future. Workers can engage in best practice or sometimes not fulfil their obligations to the extent that we might hope, it doesn't always have tragic consequences. Equally, just because a young person has died in tragic circumstances doesn't necessarily mean there is a nexus between some deficiency in the conduct and that young person's death."

45. I accept that submission.

46. Mr Cochrane was asked to comment on each of the CDI Report findings and I will deal with his evidence on the matter briefly.

Finding 1

That Cody experienced multiple traumas and adverse events from birth, and that this occurred in the context of a family situation that was characterised by significant, long term complex and compounding "complicating factors." Despite efforts from different services over time, the effects of this cumulative trauma remained, placing Cody at risk of significant harm. A trauma informed case work perspective would have been beneficial.

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[2] Exhibit 14 – Folder including statement of Mary McKinnon

47. Mr Cochrane's evidence on the point was:-

> "the circumstances that were presented to me in reports from Children's Court Clinic, discussions with Youth Justice and my own experience working with Cody is probably consistent with that. It was evident that this – what was happening there was systemic in nature in terms of the whole family system and his peer groups and his social systems and it was also evident that there had been multiply traumas over extended periods of time, so I think that this is probably a very accurate finding."

48. Mr Cochrane is understandably in agreement that in cases such as Cody's a "trauma informed perspective" would be appropriate. He conceded that earlier engagement with Cody, when he was younger, may have been beneficial. Mr Cochrane's approach was intended to be therapeutic over time and he intended to work with Cody and the family for a longer period. However, his involvement with the case was brief and the fact is that the involvement of Mr Costante, Ms Dowse and Mr Cochrane, was all focused and on the last part of Cody's life. Doubtless, in cases such as Cody's, it makes sense that a "trauma informed perspective" is likely to be beneficial, although it does not follow that the workers in Cody's case were unaware of or insensitive to the trauma in his background

Finding 2

That despite Child Protection having the lead case management responsibility for Cody, there was little evidence of Child Protection collaborating with Youth Justice through formal planning and information exchange, and clarification of key roles and responsibilities

49. Mr Cochrane's evidence was:-

> "It's the inclusion of the word "formal" there that I would probably have to agree with but I did see a lot of collaboration between Youth Justice and child protective services, and as I say there was a lot of discussion, a lot of emails back and forth probably on a more informal basis, and I struggle with that term even. There was a lot of communication that went on between Youth Justice and child protective services and it didn't necessarily come under the heading of a care team or a case management team, but there was a lot of communication that went on at the time."

50. I accept that on the whole of the evidence there was in fact adequate collaboration between Youth Justice and Child Protection in handling Cody's case although some of it was obviously informal in nature (not necessarily part of a structured program of meetings). On this point Mr Cochrane also made the following comment in relation to part of the evidence contained in the statement by Mary McKinnon:-

> "Paragraph 26, so just over the other page, refers – Mary McKinnon comments, "Since Cody's death the department has undertaken a review of the protocol to remove obstacles to collaboration between Child Protection and Youth Justice:. Now

I realise that you were working closely with Youth Justice and I'm not sure exactly what obstacles Ms McKinnon's referring to but would you say that there were obstacles? --- I wasn't aware of any. I saw a good collegiate relationship and a sharing of information so I felt that the relationships between them were quite solid and very professional."

51. The evidence does not support a conclusion that a lack of cooperation or consultation caused or contributed to any deficiency in the quality of the support being provided to Cody.

Finding 3

That given Child Protection's statutory responsibilities to supervise Cody on an Interim Protection Order, Interim Accommodation Order and then a Supervision Order, it is of significant concern that the Adolescent Protective Team workers did not assess that more proactive outreach contact with Cody was required.

52. In respect of this finding Mr Cochrane said "I was aware that Rob did have contact with the family and that he had actually intervened in the family setting on occasions where there had been incidents, and I knew that he had contact ongoing with Mrs Budziarski, so I can't comment beyond that. I wasn't very aware of the full extent of this involvement with them and child protective services' involvement with the family and Cody."

53. I accept Mr Cochrane on this point and note that it is consistent with the evidence given by Mr Costante who proactively sought to assist both Cody in the short timeframe of his responsibility for the case.

Finding 4

That this case would have benefited from more assertive earlier intervention, when it had been clearly demonstrated over time that Cody's significant emotional and behavioural concerns had not been addressed by previous intervention attempts.

54. Mr Cochrane's response was "It's very clear that what was going on for Cody was long term and it extended over his lifetime, so earlier intervention or perhaps more vigorous early intervention would certainly have been helpful."

55. It was reasonable of Mr Cochrane to accept this finding and given the complexity of Cody's background and issues and the pressures on his family, especially his mother, it is probably correct that the earlier supportive interventions came the better. Mr Cochrane's evidence covered the involvement of DHS with Cody and his family. There were eight reports from July 2000 onwards. In his statement he says

"All reports received, prior to the most recent involvement, were either closed in the intake phase of Child Protection involvement, with referrals made to community services, or proceeded to initial investigation prior to closure."

56. The involvement of DHS with the family intensified in 2008 with Mr Costante's direct involvement between September 2008 and February 2009. This CDI Report finding would likely apply to any similarly complex case. The importance of the early intervention lesson appears to be recognised in the DHS adoption of improved practices (best practices) as set out in the McKinnon statement.

Finding 5

That this case highlighted an inadequate focus on Cody's siblings, and a lack of comprehensive assessment in significant placement decisions involving additional children. As a consequence, significant risk factors were not considered which may have impacted seriously upon Cody and all the other people living in the family home.

57. This recommendation goes outside the scope of this inquest

Finding 6

That this was a complex case with many "complicating factors" that would have proven to be difficult for the most experienced workers. However, earlier case conferencing and clear planning with all key workers would have possibly helped to clarify the most effective strategies for engaging Cody, and also assisted to share the responsibility of working with such a "hard to help" young person.

58. Mr Cochrane's most relevant evidence on the point was:-

"It was a complex case and a more systemic structured approach would probably have clarified issues earlier on and defined roles more efficiently. Whether that contributed to Cody's death, I can't comment but it certainly would have made the process more coordinated if that had been in place earlier."

This evidence must be placed in the context of Mr Cochrane's evidence, referred to earlier about the professional relationship and the effective, although often informal, communication between Youth Justice and Child Protection.

59. Mrs Budziarski was critical, understandably from her point of view, of the fact that the interventions described by the witnesses only took effect when Cody was fourteen. As Mr Cochrane's evidence on the point was:-

"....and I think the complexity of the situation plus the fact that a number of us, Youth Justice and myself for example were brought in at the age of 14 for Cody, instead of much, much earlier in the process was problematic, so some early intervention would certainly have been very helpful for this young man and his family but other than that I can't think of any systemic problems that would have contributed to the outcome."

60. His answer to my question about whether more could have been done or should have been done, or the case handled differently, he said:

> "It is a broad question. Systemic flaws, probably not. With any of the young clients that we work with in the Youth Justice, Child Protection context, there was a limitation of the number of workers and the hours available to work with them and the resources available, and it's I think sometimes very easy to talk about best practice, but it can be very, very difficult to implement that on limited resources. So the resourcing was limited and that meant that instead of being - for me, for example, being able to contact Cody or his family two, three times a week, I had much less opportunity than that and I'm aware that the case loads were very high for all the professionals involved with Cody. So other than the resourcing and simply the sheer time and resources available to provide service to Cody and his family, I'm not aware of systemic problems. My sense was that Youth Justice and child protective services did collaborate and coordinate on this fairly well and that their conduct was very professional, and I think the complexity of the situation plus the fact that a number of us, Youth Justice and myself for example were brought in at the age of 14 for Cody, instead of much, much earlier in the process was problematic, so some early intervention would certainly have been very helpful for this young man and his family but other than that I can't think of any systemic problems that would have contributed to the outcome.

COMMENTS

Pursuant to section 67(3) of the *Coroners Act 2008*, I make the following comment(s) connected with the death:

1. I accept that earlier intervention in Cody's life, and possibility that of his family, by one or other of the agencies ultimately assisting him, may have made a difference. However the evidence does not allow me to conclude that it necessarily would have done so. There were many factors at play in a complex case. It is not possible to conclusively state that any particular additional, or earlier, intervention would necessarily have made a difference to the tragic outcome. However it is clearly highly desirable, in providing proper protection for young people at risk, that well considered interventions take place as soon as possible after problems are identified. I commend the DHS development of the Best Practice Procedures which are annexed to the statement of Ms McKinnon.[3]

[3] Exhibit 14 – Folder including statement from Mary McKinnon

2. Deaths such as Cody's must be learnt from, and that any such death, as Ms Gardner accepted, gives the community, and in this case in particular the DHS, pause for thought. I agree with her comment that: "As a community it's difficult to accept that even with professional intervention and assistance it's not always possible to keep vulnerable young people from harming themselves." However I accept her ultimate submission that in this case no issue has been identified which would justify a conclusion that a particular act, omission or combination of acts or omissions on the part of Child Protection or Youth Justice caused or contributed to Cody's death.

3. Cody's death was a tragic waste of a young life. Cody was a young man with potential despite the complex challenges that confronted him and his family and despite his difficult history.

4. I express again my condolences to Cody's family and to his friends.

I direct that a copy of this finding be provided to the following:

Mrs Debbie Budziarski

The Department of Human Services

Signature:

JUDGE IAN L GRAY
STATE CORONER
Date: 12 April 2013