IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 004808

REDACTED FINDING INTO DEATH WITH INQUEST

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

Deceased:	**JF**
Delivered on:	13 December 2016
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	31 August 2016
Findings of:	CORONER ROSEMARY CARLIN
Counsel assisting the Coroner:	Leading Senior Constable Joanne Allen from the Police Coronial Support Unit
Representation	Ms Teresa Porritt for Department of Health and Human Services

HER HONOUR:

Introduction

1. JF was 16 years old when she died on 23 October 2013 after an intentional prescription drug overdose.

2. JF, as she was known, was born on 5 June 1997 to TF and an unknown father. She was the seventh of TF's nine children. TF had mental health, drug and alcohol issues which meant she was unable to care for her children. As a result JF was in foster care from the age of two until her death.

3. In March 2009, JF started living with Mrs and Mr V and their three children[1] in Rye, Victoria. This was JF's fourteenth foster care placement. The Vs were very loving and supportive of JF. They told her that they were her permanent family and she would not be moving again.

4. Mrs V reported:

> *JF came to live with us when she was 12 years old. Right from the beginning she called us mum and dad, and we truly became her mum and dad, never her foster parents. She quickly became a loved member of our whole family.*

5. Five days prior to her death, JF was removed from the V's home due to behavioural issues and placed in a residential care facility in Hampton. Despite reassurances that it was a temporary measure JF was worried she would never be going home. The day before she died JF was very distressed by news that she had to remain in the facility for another four weeks.

6. JF's death affected a great number of people. Even though she could not see it, she was a much loved and valued person. Mrs V wrote:

> *I feel a deep ache in my heart. I miss JF every day. She was my dear friend, ally and my precious daughter.*

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[1] The Vs had two daughters and one other foster child, a son.

The coronial investigation

1. JF's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Further, as JF was in the care of the Department of Health and Human Services (**DHHS**) at the time of her death an inquest into her death was mandatory.

2. The role of a coroner is to independently investigate reportable deaths to find, if possible, identity, medical cause of death and with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. Coroners make findings on the balance of probabilities, not proof beyond reasonable doubt.[2]

3. The law is clear that coroners establish facts; they do not cast blame, or determine criminal or civil liability.

4. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

5. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation into JF's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses, and submitted a coronial brief of evidence. I obtained additional material including health and Medicare records and further statements and submissions from institutions and individuals involved in JF's care.

6. An inquest was held on 31 August 2016. DHHS appeared and was represented by Ms Porritt of counsel. A number of other interested persons were present including Mrs V, and individuals from DHHS and OzChild (the agency with immediate responsibility for JF's care). Evidence was given by Taanya Gounas, a child protection manager from DHHS who had reviewed the case and Christine Prendergast, the OzChild team leader in charge of JF.

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[2] In the coronial jurisdiction facts must be established on the balance of probabilities subject to the principles enunciated in *Briginshaw* v *Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

7. This finding is based on the totality of the material obtained during my coronial investigation, including the inquest. Whilst I have considered all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity.

Identity of the deceased

8. JF was formally visually identified by Mr V on 23 October 2013. Identity was not in issue and required no further investigation.

Background

Department of Human Services involvement

7. In early 1999 it was reported to Child Protection at DHHS that JF and her siblings had been exposed to family violence and lacked supervision. In April 1999, all of TF's children were taken out of her care following an incident of significant family violence.

8. On 7 December 2000 JF was placed on a Guardianship Order after TF relinquished care of all her children. JF was 3 years old. She remained on a Guardianship order until her death.[3]

9. Upon being taken into care JF was separated from her siblings who were either given permanent placements or placed with extended family. Tanya Bearup, Advanced Child Protection Practitioner at DHHS[4], reported that due to her many placement breakdowns and the separation from her siblings, JF '*experienced grief and loss issues and behavioural problems including outbursts of aggression, hyperactivity and withdrawing from others*'.

10. Ms Bearup explained that DHHS '*usually enters into contracts with out of home care agencies to undertake day to day case management tasks*' for children residing in foster care or residential care units. From 2003 JF's ongoing case management was contracted to OzChild, a non-government organisation providing foster and other support services. JF's case manager at OzChild was Alisha Hunter, whose team leader/supervisor was Christine Pendergast (nee Cosimi).

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[3] Guardianship orders grant custody and guardianship to the Secretary of DHHS 'to the exclusion of all other persons' and may remain in force until the child turns 18 or marries.

[4] Ms Bearup became JF's allocated Child Protection Practitioner on 22 February 2013.

11. Ms Bearup's contact with Ms Hunter varied from a '*number of times per week to fortnightly according to what was happening for JF*'. She received updates about JF anywhere between a few times a week to monthly.

Involvement with mental health services

12. JF was diagnosed with depression at a young age. She was also diagnosed with borderline personality disorder[5] and reactive attachment disorder[6]. She had a history of self-harm and suicidal ideation. On occasions she threatened to end her life and left suicide notes. Throughout her life, a number of different service providers and clinicians were involved in her care.

13. JF's first documented contact with public mental health services was in 2004. Her next contact was in 2008. From early 2012 she was engaged with Monash Health Early Life Mental Health Service (**ELMHS**) and Peninsula Health. She was admitted as an inpatient to the Monash Health adolescent inpatient unit, Stepping Stones, for two weeks in February 2012. JF remained engaged with ELMHS until May 2013 when her case was closed because she was reluctant to engage in therapy.

14. In June 2013, JF began seeing private psychiatrist Dr Ian Haywood. She saw him regularly and he prescribed the anti-depressant, fluoxetine and anti-psychotic, quetiapine.

Circumstances leading to JF's death

15. Until 2013 JF had always lived in a home environment even during periods of respite. Due to her escalating behaviour and deteriorating mental health, during 2013 JF had periods in out of home care, either in a DHHS residential unit or a mental health facility. When this happened the Vs still visited JF and reinforced the temporary nature of the situation.

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5 The diagnosis of borderline personality disorder (BPD) is based on an assessment of symptoms over time and across a range of situations. People with BPD have a fragile sense of self and have trouble controlling their emotions, with periods of strong overwhelming feelings, including thoughts of suicide and self-harm, poor impulse control, and problems with sustaining meaningful relationships.

6 Reactive adjustment disorder includes a consistent pattern of inhibited, emotionally withdrawn behaviour toward adult caregivers, a persistent social and emotional disturbance, and the child has experienced a pattern of extremes of insufficient care (social neglect/deprivation, repeated changes in primary carer).

16. In July 2013, JF's close school friend committed suicide. According to Mrs V, JF was '*devastated*' but also angry that her friend was able to '*kill herself properly but she couldn't*'[7]. Then, two days after her friend's death, JF's boyfriend broke up with her. According to Mrs V '*this was pretty much the end of her mentally*'.

17. Around this time JF learned that her biological mother, who had nothing to do with JF, was having contact with her other children.

18. On the day of her friend's funeral, JF overdosed on fluoxetine and quetiapine. Dr Haywood organised for her to be admitted to Box Hill Hospital on 16 July 2013 for psychiatric care. She was admitted to Box Hill Hospital because Stepping Stones at Monash was full. She was discharged on 22 July 2013.

19. On 20 August 2013 JF presented to Frankston Hospital Emergency Department following another overdose. She was admitted to Stepping Stones and remained there until 26 August 2013.

20. On 28 August 2013 JF saw Dr Haywood for her regular appointment. She presented as drowsy and another overdose of quetiapine was suspected. Dr Haywood thought it would be counter-productive to admit her to an inpatient unit for the fourth time so he sent her home after organising blood tests. The results of the tests were normal.

21. After continued aggression at home JF was then placed in temporary accommodation in residential units. OzChild referred JF to the Peninsula Health Youth Mental Health Service for possible admission to the Youth Prevention and Recovery Centre (**YPARC**), a short stay therapeutic residential program.

22. On 13 September 2013 an intake assessment with the YPARC and Youth Mental Health Team (**YMHT**) took place and JF was assessed as having a high risk of aggression/harm to others, high risk of suicidal behaviours and impulsivity. Later that day, after a family meeting, JF was transported by ambulance to Frankston Hospital Emergency Department (**ED**) because she was threatening violence and self harm. She was assessed for a sore left foot (apparently the result of her dropping television on it) and discharged back to the residential service.

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[7] Statement of Mrs V dated 12 March 2014, page 3.

23. On 14 September 2013 Peninsula Health Frankston Hospital made a referral to Latrobe Regional Hospital. On 16 September 2013 JF was assessed by Latrobe Regional Hospital Senior Child and Youth Mental Health Service (**CYMHS**) Clinician, Liz Harbridge, in the company of Mrs V. The assessment was comprehensive and identified that JF was keen to return to her foster family and high school. She did not want to continue her long term Australian Childhood Foundation (**ACF**) counselling, but did discuss other counselling options. Following the assessment, a Peninsula Health team review was held and staff raised concerns that JF was unsuitable for YPARC due to her history of poor engagement and recent behaviour.

24. On 17 September 2013 Dr Haywood told Ms Bearup that JF's risk to herself and others increased when she became '*elevated*' after any incident that served as a trigger.

25. On 18 September 2013 JF saw her general practitioner Dr Martin Coffey for a repeat contraception prescription. According to Dr Coffey, JF discussed her friend's suicide and said she was having trouble sleeping because of bad dreams.

26. On 23 September 2013 Peninsula Health YMHT informed DHHS, JF and Mrs V that she was not accepted at YPARC. JF was offered ongoing services by YMHT, but refused. It was therefore decided she would be referred back to current supports. JF returned home to the Vs on about 27 September 2013.

27. On 17 October 2013 JF and Mrs V had an argument during which JF '*grabbed a golf club and smashed up the kitchen*'. Later that day JF saw Dr Haywood in the company of Mrs V and Ms Prendergast and the incident was discussed. It was decided there was no option but to place JF in residential care for some time because of the risk of further aggression at home. JF was then taken to the MacKillop Family Services residential unit (**MacKillop**) in Hampton, Victoria.

28. On 22 October 2013 a 'Placement Disruption Meeting' was held in Dandenong between representatives of OzChild, Berry Street Intensive Case Management Service (**ICMS**), ACF and DHHS's Case Contracting Team and Adolescent Protective Team. The purpose of the meeting was to discuss JF's future case management and the ongoing viability of her placement with the Vs.

29. JF was aware that the meeting was scheduled for that day and was very worried about it. Her usual case manager Ms Hunter was on leave so JF telephoned Team Leader, Christine Prendergrast, prior to the meeting and told her she wanted to return to the Vs. Ms Prendergast promised to telephone JF after the meeting to inform her of the decision.

30. Mrs V likewise spoke to Ms Prendergast before the meeting and told her she wanted JF to return home as soon as possible.

31. Ms Prendergast advised the meeting of the wishes of JF and Mrs V. The meeting notes record: '*unlike previous residential admissions this time JF was adamant that she wanted to go home and was willing to apologise to carer*'.

32. The meeting decided that JF was to remain in residential care for 4-6 weeks until it was assessed as safe for her to return home. Return home remained the ultimate goal but only after significant therapeutic intervention. In the meantime JF was to have weekly overnight stays with the Vs, the first being on 24 October 2013. Further, JF's ongoing management within DHHS was to be transferred to the Adolescent Protective Team and the contracted agency was to be changed from OzChild to the more specialised Berry Street ICMS.

33. The meeting concluded at around 4.30 to 4.45pm. Immediately afterwards Ms Prendergrast telephoned Mrs V and advised her of the outcome. Knowing that JF was anxiously waiting, Ms Prendergast then telephoned MacKillop. Prior to speaking to JF, Ms Prendergast told a MacKillop staff member what was happening and ensured that the staff member stayed with JF during the telephone call.

34. Ms Prendergast told JF that she would be remaining at MacKillop for approximately four weeks. She explained that she would continue to see Dr Haywood, her ACF worker and go to her school, Rosebud Secondary College. She would also go home in two days' time. Even though she reassured JF that her placement with the Vs was not ending, Ms Prendergast described JF as '*very distressed*' by the news.

35. According to residential staff, JF was heard crying on the night of 22 October 2013, but the next morning (23 October 2013) she appeared fine and was looking forward to school. Shane Wallace, a staff member from Welfare Personnel (an agency that provides transportation and other services to DHHS clients), took JF to an early appointment with Dr Haywood. She told Dr Haywood she was upset that she had to stay at the residential unit and was looking forward

to returning home. She also said she wanted to go back to the Vs after school that day, but agreed to return to MacKillop. Dr Haywood described her as tearful and upset but not having any psychotic features.

36. At approximately 10.15 a.m. Mr Wallace drove JF to Rosebud Secondary College. She told him she did not want '*to go*' and reportedly also sent a friend a text message saying she was not going to school. However, according to Mr Wallace, he watched her walk into her class.

37. At approximately 3.15 p.m., Mr Wallace returned to JF's school to collect her, but she was not present. At that stage her teachers advised him that she had not attended classes that day. Relevant agencies were immediately informed of JF's disappearance. The Vs were also informed and police were contacted.

38. Searches were conducted around the V's house including JF's room and the local area. Around 10.30 p.m. the Vs found her lying under her bed, deceased. She had left a suicide note apologising for '*everything*' and thanking the Vs for '*being there*' for her. She also said '*I can't stand the thought of living without you*'. The note was signed *JV*, rather than *JF*, presumably to further signify her love and gratitude to the Vs.

39. Police found a number of packets of prescription medication in the house. Some were empty and some had tablets remaining. Discarded medication packaging was later found in a rubbish bin in JF's wardrobe. Medication was found in the bathroom and in a safe in Mrs V's room.

Cause of Death

40. Dr Sarah Parsons, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed an autopsy on JF's body. Toxicological analysis of post mortem blood samples revealed multiple substances in JF's system including oxycodone (0.4mg/L), citalopram (0.2mg/L), fluoxetine (0.1mg/L) and quetiapine (0.7mg/L). Dr Parsons recorded the medical cause of death as 1(a) mixed drug toxicity (oxycodone, citalopram, fluoxetine and quetiapine).

DHHS management of JF's final removal from home

41. I reviewed the circumstances of JF's death with the assistance of the Coroners Prevention Unit (CPU)[8]. My focus was on the events after 17 October 2013, particularly the Placement Disruption Meeting and its aftermath.

Removal of JF from the V residence

42. JF had resided with the Vs since 2009. She considered them to be her family and was extremely worried about losing that bond. DHHS and OzChild were acutely aware of JF's attachment to the Vs. According to Ms Hunter, '*getting moved again was [JF's] biggest fear*'[9]. However, JF's recent behaviour necessitated consideration by DHHS and OzChild of the safety implications for the Vs if she were to return home immediately, or at all. So, whilst JF's fragile mental state meant that any possible disruption to her living arrangement required delicate handling, I am satisfied it was reasonable to place JF in residential care, at least in the short term.

43. I am also satisfied that it was reasonable to transfer JF's ongoing case management to Berry Street ICMS as it was likely she would benefit from the more inclusive and participatory model of service provided by adolescent services at Berry Street.

Suitability of MacKillop

44. When JF was placed in MacKillop it was an unfamiliar environment with unfamiliar people. Further, it was located in Hampton some distance away from the Vs and JF's support network on the Peninsula. DHHS and OzChild tried to maintain continuity in JF's life by ensuring she saw her psychiatrist and went to her usual school.

45. In a submission received on 29 August 2016 Mrs V stated:

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[8] The role of the CPU is to assist coroners investigating deaths, particularly deaths that occur in a healthcare setting. The CPU is staffed by healthcare professionals, including practising physicians and nurses. Importantly, these healthcare professionals are independent of the health professionals and institutions under consideration. They draw on their medical, nursing and research experience to evaluate the clinical management and care provided in particular cases by reviewing the medical records, the medical examiner's report and any particular concerns which have been raised.

[9] Statement of Alisha Hunter dated 31 March 2014 page 1.

I would like to see more safe places for teens like JF so that they could be closely monitored and be kept safe. A place where families can be closely involved and return to home being the ultimate goal. There was no such place available for JF.

46. In a statement dated 29 August 2016, Taanya Gounas, Child Protection Manager at DHHS indicated that during a review of JF's death DHHS identified that a therapeutic respite placement (with specially trained therapeutic foster carers) would have better served JF's needs.[10] However, Ms Gounas explained that at the time no such facility was available and MacKillop (which was not a therapeutic facility) was the only facility that could accommodate JF.[11]

47. Clearly JF's placement in MacKillop was not ideal, however I am satisfied that at the time there was no alternative.

Engagement with JF during the process of determining her living arrangements

44. Mrs V reported that JF asked her if she could attend the Placement Disruption Meeting and she told her to ask her worker.[12] It is not clear if JF did ask to attend, however in her statement Ms Gounas explained that Placement Disruption Meetings are called when an issue is identified with a child's placement and it would not be in the best interest of the child to be present as detailed discussions about the child occur.

45. OzChild confirmed '*[c]urrent practice is that carers and young people do not attend*' Placement Disruption Meetings, however OzChild ensures their opinions are conveyed and considered, as happened here.[13] OzChild explained that there were other case planning meetings to which JF was invited, indeed encouraged, but she declined.

46. The advantages of enabling youth to engage in decision making and to feel a part of their life plan have been well documented,[14] and DHHS promotes a family sensitive and youth inclusive approach.[15]

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[10] See paragraph [20] of statement.

[11] Transcript at T14.29-15.2.

[12] Mrs V's submission.

[13] Statement of Niall McCaul on behalf of OzChild dated 22 August 2016 p 3.

[14] Australian Research Alliance for Children & Youth, 2008. Preventing Youth Disengagement and Promoting Engagement:page<http://www.aracy.org.au/publications-

47. Ms Pendergast gave evidence that the afternoon of 17 October 2013 was spent talking to JF about the options for her future residence. Ms Pendergast explained to JF that she was likely to be at MacKillop for some time before returning home. Other than being asked her wishes, it is not clear that JF participated in the decision making process in a meaningful way.[16]

Input of mental health services

48. Dr Haywood saw JF regularly in the lead up to her death and yet it appears he had no input into the Placement Disruption Meeting. Nor was he consulted for advice as to how best to convey the important decisions made at the meeting. Through the statement of Ms Gounas, DHHS conceded, and I agree, that further efforts should have been made to engage Dr Haywood in the decision as to JF's accommodation.[17]

Communication regarding outcome of Placement Disruption Meeting

49. It was predictable that JF would react badly to the news that she would not be returning to the Vs. Ms Prendergast was aware of this but had promised JF she would call her at the end of the meeting. The late hour meant she was unable to travel to Hampton to tell JF in person straight away.[18] She therefore made sure someone was with JF when she spoke to her on the telephone.[19] Ms Prendergast also mitigated the news by only saying that JF would need to stay at MacKillop for '*approximately four weeks*' (rather than the possible six weeks) and she did not mention that JF's case management would be transferred to Berry Street.[20]

50. Ms Prendergast was clearly trying to do the right thing by JF and I make no criticism of her. Further, everyone at the meeting knew that she was going to call JF afterwards and no-one raised any concerns. That said, JF was emotionally fragile and in an unfamiliar environment

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resources/command/download_file/id/120/filename/Preventing_Youth_Disengagement_and_Promoting_Engagement.pdf>

[15] Child Protection and Integrated Family Services State-Wide Agreement (Shell Agreement) 2010: <http://www.dhs.vic.gov.au/__data/assets/word_doc/0009/742383/Child-Protection-Integrated-Family-Service-Statewide-Agreement-Shell-Agreement-2010-12.doc>

[16] Transcript at T23.25-26.31.

[17] See paragraph [12] of statement.

[18] Ibid T29.26-30.4.

[19] Ibid T26.10-26.11.

[20] Ibid T26.15-21.

with unfamiliar people. A face to face meeting was clearly preferable. Ms Prendergast acknowledged this in hindsight.[21]

51. In her review of the case, Ms Gounas also conceded that the decision that JF would stay in residential care ought to have been discussed with her in person. She stated that a communication plan should have been developed at the Placement Disruption Meeting.

Rosebud Secondary College

52. At the conclusion of the inquest an issue arose as to the knowledge and response of Rosebud Secondary College to JF's absence on 23 October 2013. As the school did not appear at the inquest I requested that it file a statement and any submissions subsequently.

53. In a letter dated 18 October 2016 the Assistant Principal, Geoff Seletto, detailed the school's involvement with JF. He stated that JF was absent from school between 5 September to 7 October 2013 due to mental health reasons, and the school was aware that she was living in a residential care arrangement. She returned to school on 7 October 2013 pursuant to an already established management plan which set out the school's expectations of JF and outlined strategies to assist her cope. Her attendance during that term was irregular and she was marked present only five times in the fortnight leading up to 23 October 2013.

54. Mr Seletto explained that 23 October 2013 was the Year 12 final '*muck up*' day at the school causing considerable distraction to the staff. That fact and JF's recent absences meant her absence on 23 October '*did not trigger an immediate response on the day*'.

55. At the time of JF's death, the school had a general policy of following up student absences with telephone calls to parents or carers the next day, and repeat absences were followed up with meetings and referrals to the wellbeing team. In JF's case, on occasions the school had called the Vs or Ms Hunter immediately upon noticing that JF was absent.

56. Following JF's death, the school implemented a number of changes in its management of student attendance, including:

[21] Ibid T28.10-28.11.

- the use of student management software that permits parents and carers to view attendance '*live*' by logging in to check their child's file;

- having Year Level Co-ordinators monitor attendance and follow up absences by way of telephone calls, parent or carer meetings, and attendance monitoring cards;

- creating a list of students that require close monitoring and designating a staff member to telephone parents and carers of those children;

- identifying students who require sensitive follow-up (such as students with a history of self-harm), and ensuring parents and carers are telephoned immediately an absence is noted; and

- notifying parents and carers of repeated absences.

57. It is unfortunate that a combination of circumstances meant that JF's absence on 23 October 2013 did not elicit an immediate response from the school, however to the school's credit, it immediately implemented changes to the way it deals with student absences and I am satisfied those changes are responsive and appropriate.

JF's access to medications

59. JF overdosed on a combination of prescription medication including oxycodone (0.4mg/L), citalopram (0.2mg/L), fluoxetine (0.1mg/L) and quetiapine (0.7mg/L).

60. Quetiapine, citalopram and fluoxetine had all been prescribed to JF prior to her death in compliance with clinical guidelines. Oxycodone was not prescribed to JF, but was prescribed to another member of the V household.

61. Following JF's overdose in July 2013, the Vs bought a lockable safe which they placed in their wardrobe and used to store the family medication. The safe had a code pad however Mrs V preferred to use a key for access. When police inspected the house on the night of JF's death they found the key inserted in the lock and medications and empty packaging within.

62. The Vs did their utmost to protect JF, including purchasing a safe to store drugs. Although it appears the safe was not secured on the day that JF died, the Vs could not have predicted that

she would return home from Hampton and access the safe and the medication stored within. I am satisfied they are not responsible for her death in any way.

FINDING

Pursuant to Section 67(1) of the *Coroners Act 2008* I make the following findings:

63. JF born on 5 June 1997 died on 23 October 2013 from mixed drug toxicity, including oxycodone, citalopram, fluoxetine and quetiapine.

64. JF deliberately consumed these prescription medications with the intention of ending her life.

65. Foster parents Mrs and Mr V provided a loving and nurturing environment for JF.

66. Similarly the individuals involved in JF's care from DHHS, OzChild and other services were dedicated and committed to JF's welfare.

67. The decision to remove JF from the Vs on 17 October 2013 was appropriate, as was the decision to place her in MacKillop given the absence of any other suitable facility.

68. The decisions that JF was to remain at MacKillop for some time and her care transferred to Berry Street ICMS were reasonable, however it would have been preferable for Dr Haywood to have been consulted and for JF to have been told in person.

69. Ideally JF's school should have noticed her absence in the morning and communicated that immediately to DHHS. A combination of factors meant that this did not happen. The school has now changed its procedures to ensure that student attendances can be monitored by parents or carers.

70. Mrs V described JF as intent on killing herself. The extent of her determination is evidenced by the fact she hid under her bed in the Vs's home so that initial searches could not find her. It is not clear that JF's death was preventable.

COMMENTS

Pursuant to Section 67(3) of the *Coroners Act 2008* I make the following comments connected with the death:

1. In April 2016 the Victorian Government published a document '*Roadmap for Reform: strong families, safe children*' in response to the Royal Commission into Family Violence and observations of the Victorian Auditor General and the Commissioner for Children and Young People. In that document the Government announced a significant funding boost for children and families' services and in particular the foster care and residential care services. $35.9 million was promised over the next two years to transform the current model of residential care to a clinical treatment model. It is to be hoped the changes announced will go some way towards helping children like JF in the future.

2. Placement Disruption Meetings are clearly significant events as they concern the future accommodation of vulnerable children. In this case it appears that JF's sense of urgency about her situation may have infected the adults involved in her care leading to less than ideal preparation for the Meeting. There needs to be a well-planned structure around such meetings including obtaining professional input from mental health professionals, detailed discussion with the child and foster carer and consideration of the best method of communicating the results to the child.

3. Ms Gounas conducted a review of this case on behalf of DHHS. The purpose of the review was to report to the Secretary of the Department, so that the Minister could be briefed by the Secretary.[22] However the review did not involve OzChild, nor were the results of the review conveyed to OzChild, who were unaware of Ms Gounas's opinions that more effort was required to involve Dr Haywood in the decision as to JF's future accommodation and that JF should have been spoken to in person, until they received her statement prior to the Inquest.

4. Internal reviews by agencies involved in a person's death are an important part of the process for improving systems. Individual and institutional professional reflection is to be encouraged. DHHS conducted such a review but it is not clear to me how it intended to utilise the results of the review to improve its (or its agencies') processes, especially since the results

[22] Transcript at T13.12-14.10; 16.26-18.23.

were not communicated to a significant party (the relevant agency). In that regard Ms Gounas suggested that DHHS relied on the fact that a more detailed review is undertaken by the Commission for Children and Young People (**CCYP**). However, she acknowledged that the CCYP review process only resulted in limited information being provided to interested parties.[23]

RECOMMENDATIONS

Pursuant to Section 72(2) of the *Coroners Act 2008* I make the following recommendation:

1. In the event of the death of a child under its care the Department of Health and Human Services consider including any agency contracted to care for that child in its internal review process and distribution of its report to that agency.

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

Mr and Mrs V, foster carers of deceased
The Office of The Hon Jenny Mikakos MLC, Minister for Families & Children and Minister for Youth Affairs
Ms Kirsty McIntyre, General Counsel and Chief Legal Officer, DHHS
Ms Sharon McRae, OzChild
Ms Erica Capuzza, Legal Division, Department of Education and Training
Ms Liana Buchanan, Principal Commissioner for Children and Young People
Senior Constable Joel Cowton, Coroner's Investigator, Victoria Police

Signature:

ROSEMARY CARLIN
CORONER
Date: 13 December 2016

[23] Ibid T17.7-18.23.