IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2008 0297

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: KRISINDA CARMEN SMART

Hearing Dates:	26, 27, 28, 29 and 30 November 2012 and 23 and 24 April 2013 (7 days)
Appearances:	Mr Ron Gipp, counsel on behalf of the Chief Commissioner of Police, instructed by the Victorian Government Solicitors' Office. Mr Nicholas Batten, counsel on behalf of Jason Jackson, instructed by the Victorian Aboriginal Legal Service. Ms Erin Gardner, counsel on behalf of the Department of Human Service (as it then was)[1]. Mr Ben Ihle, counsel for Mr Naisbitt, Constable Anderson and Senior Constable McPhee.
Counsel Assisting the Coroner	Ms Trish Riddell, counsel, instructed by Ms Jodie Burns, Senior Legal Counsel.
Findings of:	AUDREY JAMIESON, CORONER
Delivered On:	7 May 2015
Delivered At:	65 Kavanagh Street, Southbank 3006

[1] In 2008 it was known as the Department of Human Services. At the time of finalising the Finding the Department had changed its name to the Department of Health and Human Services.

I, AUDREY JAMIESON, Coroner having investigated the death of KRISINDA CARMEN SMART AND having held an inquest in relation to this death on 26, 27, 28, 29, 30 November 2012, 23 and 24 April 2013 at Melbourne

find that the identity of the deceased was KRISINDA CARMEN SMART

born on 29 July 1992

and the death occurred on, or about, 20 January 2008

at 24 Grey Street, St. Kilda 3182

from:

1 (a) TOXICITY TO HEROIN

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances:**

1. Krisinda Carmen Smart (Krisinda) died, aged 15, on or about, 20 January 2008 from toxicity to heroin in a rooming house in St Kilda. Russell Hall (Mr Hall) and his girlfriend Heidi O'Day (Ms O'Day) are the last known persons to have associated with her. At the time her death, Krisinda was a child in the care of the Department of Human Services (DHS), and subject to a Custody to Secretary Order, a condition of which was that she was not to attend the St Kilda area. She was also a resident of a care facility, in Marchant Avenue, Reservoir, managed by the DHS.

BACKGROUND CIRCUMSTANCES

2. Krisinda was born on 29 July 1992 in Tasmania to Cheryl-Anne Smart and Jason Jackson and was of Aboriginal descent. Her parents separated in approximately 1995 and between 2000 and 2005 Krisinda lived with her father in South Australia.
3. Krisinda's formative years were punctuated with neglect, sexual abuse, behavioural problems and a lack of adult supervision.

4. Krisinda was subject to multiple Child Protection notifications in South Australia relating to issues of behavioural problems and lack of supervision.[2]

5. On 25 December 2005 the DHS received a notification related to concerns that Krisinda had absconded from South Australia to Victoria after an altercation with her father. Krisinda was unable to be located for a period of 3 months and it was understood she was attempting to locate her mother.[3]

6. On 28 March 2006 the DHS issued a Protection Application in relation to Krisinda. Once located, Krisinda was placed in foster care before later being placed in various residential units.

7. In April 2006, the DHS placed Krisinda on the High Risk Adolescent Schedule.

8. On 20 June 2006, a Custody to Secretary Order was made by the Melbourne Children's Court, with the consent of her mother, for a period of 12 months[4]. Later in that month, on 26 June, her case management was contracted to the Salvation Army, Intensive Case Management Service (ICMS) which specialised in high risk youth and included a specialist drug and alcohol worker and a mental health clinician.

9. On 15 May 2007 Monica Tulloch, Child Protection Worker, Unit Manager of the High Risk Youth Unit, DHS was engaged to undertake the role of case planner for Krisinda.

10. In June 2007, Krisinda travelled to Tasmania to reconnect with her origins and it is reported that this was a positive experience for her. Upon her return, she was moved to the High Support Residential Unit at Marchant Avenue, Reservoir (the Unit).

11. By July 2007, Krisinda, at the age of 15, was regularly absconding, using illicit drugs including marijuana, heroin and methylamphetamines in addition to abusing prescription medication. She had also resorted to prostitution to support her habits. She was regularly in the company of older males, a regular visitor to Secure Welfare, had overdosed several times, including on her 15th birthday when she was revived by paramedics with Narcan.

12. In August 2007, after an interview with her father, Jason Jackson, where her early childhood was discussed, it was recommended within the DHS that a full review of her history be conducted.

13. By September 2007, her case management transferred from ICMS back to the DHS and a caseworker from Moreland Hall was introduced to the team of professionals working with her

[2] Statement of Monica Tulloch, Inquest Exhibit 19.
[3] Statement of Monica Tulloch, Inquest Exhibit 19.
[4] The Secretary to Custody to order was later extended continued at the time of her death.

and the Principal Child Protection Practitioner, was consulted to assist with Krisinda's complex needs.

14. Towards the end of 2007, the case plan was looking towards reuniting Krisinda with her father for a possible return to South Australia. To that end, a schedule of regular visits was mapped, Jason Jackson made several visits to Victoria and Krisinda was taken by the DHS staff to South Australia on several occasions, including Christmas 2007.

15. In her short life, Krisinda had 27 admissions to secure welfare for a total of 238 days and 47 warrants for safe custody.

JURISDICTION

16. At the time of Krisinda's death the *Coroners Act 1985* (Vic) applied. From 1 November 2009, the ***Coroners Act 2008*** **(the Act)** has applied to the finalisation of investigations into deaths that occurred prior to the commencement of the Act.[5]

PURPOSE OF A CORONIAL INVESTIGATION

17. The purpose of a coronial investigation is to independently investigate a reportable death[6] to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[7] The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances, but is confined to those circumstances sufficiently proximate and causally relevant to the death and not merely all circumstances which might form part of a narrative culminating in death.[8]

18. The broader purpose of coronial investigations is to contribute to the reduction of the number of preventable deaths through the investigation findings and the making of recommendations by coroners, generally referred to as the 'prevention' role.[9] Coroners are also empowered to report to

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[5] Coroners Act 2008, section 119 and Schedule 1. All references which follow are to the provisions of this Act, unless otherwise stipulated.

[6] The Act, like its predecessor the Coroners Act 1985, requires certain deaths to be reported to the Coroner for investigation. Apart from a jurisdictional nexus with the State of Victoria, the definition of a reportable death in section 4 includes deaths that appear "to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury" and "the death of a person who immediately before death was a person placed in custody or care".

[7] Section 67(1) of the Act.

[8] *Harmsworth v The State Coroner* [1989] VR 989; Clancy v West (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

[9] The "prevention" role is now explicitly articulated in the Preamble and purposes of the Act ?? as opposed to the Coroners Act 1985 where this role was generally accepted as "implicit".

the Attorney-General on a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[10] These are effectively the vehicles by which the prevention role may be advanced.[11]

19. It is not the Coroner's role to determine criminal or civil liability arising from the death under investigation. Nor is it the Coroner's role to determine disciplinary matters.

20. At the time of her death, Krisinda, was a person placed in "custody or care" as defined by section 3(a) of the Act because she was a child in the care of the DHS and subject to a Custody to the Secretary Order. Section 52(2) of the Act mandates that an inquest be held in these circumstances.

21. This finding draws on the totality of the material, the product of the coronial investigation of Krisinda's death. That is, the court records maintained during the coronial investigation, the inquest brief and evidence obtained at the inquest. In writing this finding, I do not purport to summarise all of the evidence, but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity.

INVESTIGATION

Identification of the deceased

22. Initially, there was some confusion over the correct spelling of Krisinda's name. This was clarified by Krisinda's father and her identity was not disputed and required no further investigation.[12]

23. I find that the deceased was Krisinda Carmen Smart, born 29 July 1992.

Medical investigation into the cause of death

24. On 24 January 2008, Dr Michael Burke, Senior Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an autopsy on Krisinda's body and determined that her medical cause of death was toxicity to heroin. The post-mortem examination showed no evidence of any

[10] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations respectively.

[11] See also sections 73(1) and 72{5) of the Act which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

[12] Transcript, p. 48-49.

injury that would have lead directly to her death, nor was there any evidence of any natural underlying disease process.

25. Toxicological analysis "showed the presence of 6-monoacetylmorphine within urine indicating use of heroin."[13]

26. I formally find that Krisinda's medical cause of death was toxicity to heroin.

Coronial Investigation

27. Detective Senior Constable (DSC) Dale Hallinan was the nominated coroner's investigator[14] and prepared and submitted the inquest brief.

Suppression Order

28. On 18 April 2011, I ordered, pursuant to section 73(2) of the Act, that the Report of the Child Safety Commissioner not be published, other than to be provided to the interested parties, as I considered doing so would be contrary to the public interest.

Directions hearings

29. Prior to the commencement of the inquest, seven Directions Hearings were held on 28 February 2011, 18 April 2011, 7 June 2011, 1 August 2011, 15 February 2012, 20 March 2012 and 11 May 2012.

30. I granted leave for the following interested parties to be represented at the inquest:

    a. Jason Jackson, Krisinda's father,
    b. the DHS;
    c. the Chief Commissioner of Police;
    d. Detective Acting Sergeant Naisbitt (Mr Naisbitt)[15];
    e. Constable Anderson;[16]
    f. Senior Constable McPhee.

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[13] See Toxicology Report

[14] A coroner's investigator is a member of the police force nominated by the Chief Commissioner of Police or any other person nominated by the Coroner to assist the Coroner with his/her investigation into a reportable death. The coroner's investigator takes instructions directly from a Coroner and carries out the role subject to the direction of a Coroner.

[15] Mr Naisbitt having left his employment with the Victoria Police will be referred to as Mr Naisbitt.

[16] Transcript, p. 105: as at 17 January 2008, Mark Anderson was a Constable in rank.

Issues investigated at Inquest

31. At the 11 May 2012 Directions Hearing, I set the scope of inquest to include:

    a. the actions of Mr Hall and Ms O'Day during the time of Krisinda's death;

    b. actions of police, namely officers Mr Naisbitt and Constable Anderson on Thursday 17 January 2008;

    c. interaction with the police and the DHS on Saturday 19 January 2008; and

    d. recent DHS Child Protection involvement and opportunities for improvement.

32. Whilst a large volume of material relating to the life of Krisinda formed part of the inquest brief, I directed that the inquest focus on the circumstances of Krisinda's life approximately one month prior to her death.

***Viva voce* evidence at inquest**

33. A seven day inquest was conducted between 26 - 30 November 2012, and 23 - 24 April 2013. Ms Trish Riddell, barrister, was counsel assisting me.

34. *Viva voce* evidence was obtained from the following witnesses at the inquest:

    a. Russell William Hall;

    b. Heidi Anne O'Day;

    c. Luke Geoffrey Marchant;

    d. Darren Scott Naisbitt, ex Victoria Police officer;

    e. Constable Mark Anderson, Victoria Police;

    f. Senior Constable Victoria Kathleen McPhee, Victoria Police;

    g. Paul Adam Vose, Streetworks Outreach Service, DHS;

    h. Fiona Rogers, Specialists Residential Care Worker, DHS;

    i. Monica Tulloch, Child Protection Worker and Unit Manager of the High Risk Youth Unit, DHS;

    j. Robert Ross, Senior Policy Advisor, Child Protection Policy and Practice, Children Youth and Families, DHS;

    k. Inspector Glenn Desmond Jackson, Victoria Police; and

    l. Detective Senior Constable Dale Hallinan, coroner's investigator.

35. At the conclusion of the evidence, I received written submissions from counsel on behalf of Jason Jackson, the DHS, the Chief Commissioner of Police, Mr Naisbitt, Constable Anderson and Senior Constable McPhee. The interested parties, through their respective legal representatives, also made oral submissions on 23 and 24 April 2013.

CIRCUMSTANCES SURROUNDING KRISINDA'S DEATH

11- 16 January 2008

36. Between 11 - 16 January 2008, Krisinda spent time in South Australia with her father and family for his birthday.

37. On 16 January 2008, Krisinda, having returned that day from South Australia, left the Unit almost immediately only to return later that evening substance affected.

17 January 2008

38. On the morning of 17 January 2008, Krisinda left the Unit, without permission. An after hours contact alert was placed on the DHS CASIS client file.

39. At approximately 1.00pm, Krisinda was spoken to, in the company of 28 year old Luke Marchant (Mr Marchant), in Footscray by police officers, Mr Naisbitt, a Detective Senior Sergeant (the senior officer) and Constable Anderson.[17]

40. Both Krisinda and Mr Marchant appeared heavily drug affected and admitted to the police officers they had used heroin approximately 15 minutes earlier.

41. The police officers separated Krisinda and Mr Marchant, Mr Naisbitt questioned Krisinda and Constable Anderson questioned Mr Marchant. Mr Naisbitt searched Krisinda and found her in possession of a wallet, that was not hers, to which she claimed to have found on the train (the Wallet). Mr Naisbitt, when questioning Krisinda states he did not recognise her young age and status as a child, despite the fact that she provided him with her correct date of birth. Mr Naisbitt openly conceded that he made a "*significant oversight*"[18] in not calculating Krisinda's age. He said, "*She did give me her date of birth but to be honest I did not even twig at her age. I've written her date of birth down but I did not twig it, the age she was at all. It was a mistake and oversight of mine at the time.*"[19] Mr Naisbitt proffered a number of reasons as to why taking her

[17] As at 17 January 2008, Mark Anderson held the rank of Constable. He is now a Sergeant.
[18] Transcript p. 108.
[19] Transcript, p. 90-91.

date of birth did not lead him to conduct the arithmetic and why, in the circumstances, he did not turn his mind specifically to Krisinda's age; including that she looked 18-20.[20] I do not accept Mr Naisbitt's evidence in this regard, that Krisinda appeared older than her 15 years. I prefer the evidence of Ms Tulloch and other DHS workers who knew Krisinda well as not being one to dress up and wear a lot of makeup or try to look older.[21]

42. Mr Naisbitt conceded that had he been cognisant of Krisinda's age and status as a DHS client, it would have rung alarm bells[22] and he would have "*done a lot more*"[23] such as making contact with the DHS in accordance with the Victoria Police Manual and taking their advice as to how he should proceed in the circumstances.

43. Constable Anderson's evidence was that he had previously encountered Krisinda, on the street "*maybe up to half a dozen*"[24] times, and on some of these occasions had formed the opinion she was affected by heroin.[25] His evidence was that he had not personally spoken to her, was unaware she was a child and believed her to be between 18 to 21 years old.[26] Despite this evidence, Constable Anderson stated that had he personally checked her, he would have identified that she was under age.[27]

44. Constable Anderson explained that whilst Mr Naisbitt mainly interacted with Krisinda and he spoke with Mr Marchant, had he known of Krisinda's age "*everything would be different*".[28] He "*most certainly would have*"[29] conducted a Law Enforcement Assistance Program (LEAP)[30] person check on her, enquired as to where she should be and whether her parents might be looking for her. Had parents not been contactable, he would have contacted the DHS.

45. Mr Naisbitt and Constable Anderson both conceded, with the benefit of hindsight, further enquiries should have been made, such as LEAP person checks (via radio) in relation to both Krisinda and Mr Marchant. Mr Naisbitt stated that he was surprised that LEAP person checks

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[20] Transcript p. 92.
[21] Transcript, p. 322.
[22] Transcript, p. 91.
[23] Transcript, p 92.
[24] Transcript, p. 156.
[25] Transcript, p. 177.
[26] Transcript p. 156.
[27] Transcript p. 156.
[28] Transcript, p. 170.
[29] Transcript, p. 161.
[30] On 1 March 1993, Victoria Police implemented the Law Enforcement Assistance Program (LEAP) state-wide. The LEAP database is relational and stores particulars of all crimes bought to the notice of police as well as family incidents and missing persons. The database is accessible by Police online and updated constantly, 24 hours a day (source: http://www.police.vic.gov.au/content.asp?Document_ID=781 accessed (insert date)).

were not conducted, especially given his usual practice was to do so. Mr Naisbitt opined that the absence to do so must have been due to some practical reason which he did not identify. Constable Anderson also could not recall the reason why person checks were not conducted, but stated that if a similar situation arose now, he would conduct such checks.[31]

46. It is extremely concerning that the police members seized the Wallet without any further checks, such as a simple routine LEAP check. The police members, faced with a young person who admitted to taking heroin, was drinking alcohol in the company of an older male, who on his own evidence was drug affected, and was in possession of someone else's wallet, did nothing.

47. Counsel on behalf Mr Naisbitt and Constable Anderson submitted "*Notwithstanding the fact that her death was preventable, care must be taken to avoid retrospective analysis of the individual decisions and actions of those she came into contact with in the days preceding her death, without properly acknowledging all the circumstances in which such contact was had. The preventability of her death does not mean that any particular person, by their act or omission, causally contributed to her death. Rather, her death was preventable in the sense that it was a foreseeable consequence of her drug-taking habits and her risk-taking behaviour.*"[32]

48. I agree with counsel that it is not appropriate, in this jurisdiction, to apportion blame, however, prevention is a very important coronial function and therefore it is important to analyse the actions of relevant persons involved in the immediate surrounding circumstances to determine whether there are matters relating to public health and safety and the administration of justice relevant to preventing similar deaths.

49. The police members' failure to conduct a LEAP check on 17 January 2008 was a lost opportunity of significant proportions. It was a lost opportunity to confirm Krisinda's age, her status as a DHS client; the existence of numerous warrants to secure her welfare; her history of self-harming; and her history of offending and illicit drug taking.

50. I do not accept the submission on behalf of Mr Naisbitt and Constable Anderson that their failure to identify that Krisinda was a child in the DHS' care did not deprive the DHS of realistic opportunities to have meaningfully intervened.

51. I accept that the DHS had identified Krisinda as a 'High Risk Youth'. They knew of her illicit drug taking, associating with older persons and high-risk behaviours. However, it is critical when

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[31] Transcript, p. 156-7.

[32] Submissions on behalf of Darren Naisbitt, Sgt Mark Anderson and S/C Victoria McPhee dated 5 April 2013.

managing children with such complex needs as Krisinda for the DHS, as the legal guardian, to be fully appraised of all relevant information (where possible), such as this incident, to enable informed risk assessments and implementation of appropriate control measures to ensure Krisinda's safety.

52. I agree with Fiona Rogers, DHS Specialist Residential Care Unit Manager of the Unit (Ms Rogers), whose evidence was that *"the more information you have the more power you have to make better decisions and better conversations."*[33]

53. Despite the concessions of Mr Naisbitt and Constable Anderson in relation to conducting more thorough checks of Krisinda on 17 January 2008, they rejected any suggestion that this situation warranted the exercise of their police protective intervener powers of apprehension.[34] Even allowing for the failure to recognising her age, they did not consider that the necessary pre conditions for the exercise of that power existed at the time.

54. I agree with the submissions of the Krisinda's father, Jason Jackson, that whilst Mr Naisbitt gave evidence that had he realised Krisinda's age, he would have done things differently, some answers given under cross-examination indicated that this would not have been the case. In particular, I was troubled with Mr Naisbitt's evidence that, whilst Krisinda appeared drug affected, she was not *"off her face"*;[35] she looked like *"every other punter in the street"*,[36] her conversation was street wise, particularly in relation to drugs;[37] she was co-operative with police;[38] she was happy with what she was doing and who she was with;[39] and in those circumstances, unless there was a safe custody warrant, there was no need for protective action on his part and he would have let her go even if he had realised her age.[40] Mr Naisbitt also gave evidence that had he realised her age, he would have had a good laugh with her about how street smart she was.[41] This evidence is difficult to reconcile with his evidence that while he was aware of the police role as protective interveners in relation to children, his dealings with Krisinda paid no heed to protective issues.

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[33] Transcript, p. 286.
[34] Transcript, p. 167-8.
[35] Transcript, p.102.
[36] Transcript, p.91.
[37] Transcript p. 92, 100.
[38] Transcript p. 100-1.
[39] Transcript, p. 93 and 100.
[40] Transcript p. 102-3, 112-3, 133-4.
[41] Transcript p. 134.

55. Mr Naisbitt initially stated in evidence that his understanding of his role as a protective intervener, by virtue of being a police officer, was limited to a child in *"extreme danger"*[42] to which he later modified to *"I meant harm – I didn't, yeah, I don't know why I used the word "extreme", I was thinking at the time about it - if there's any immediate harm, et cetera."*[43] Later in his evidence, Mr Naisbitt's was asked to explain his understanding of what circumstances his obligations, as a protective intervener in the capacity of a police officer, would be invoked and he responded *"Well, I suppose first and foremost that she didn't want to be there, that there was immediate concern for her welfare, like she'd been assaulted, abused, self-harm, anything that any normal girl or woman would not want to be - situation to be in unless it's by their own free will."*[44]

56. Alarmingly, in the absence of coercion or immediate physical threat, Mr Naisbitt regarded voluntary use of heroin by a child on the street as not raising protective concerns.[45]

57. Constable Anderson also did not regard drug taking as a protective concern under the *Children Youth and Families Act 2005*,[46] although he stated that he was now more aware of the issue as a protective concern under new Victoria Police Manual.[47]

18 January 2008

58. On Friday 18 January 2008, Krisinda was at the Unit, although she was believed to be substance affected.

19 January 2008 at the St Kilda Police Station

59. On Saturday 19 January 2008, Krisinda left the Unit early in the day. At 10.25am, she was arrested in St. Kilda on allegations of stealing a mobile phone from a car. Krisinda was interviewed at the St. Kilda Police Station in the presence of Ms Rogers, who acted as an independent third person.

60. After Krisinda was interviewed, she was released from police custody and left the police station with Ms Rogers. However, upon leaving the police station, Ms Rogers could not convince

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[42] Transcript p. 102.
[43] Transcript p. 104-5.
[44] Transcript p. 132-133.
[45] Transcript p. 143.
[46] Transcript p. 167.
[47] Transcript p. 170-1.

Krisinda to come back with her to the Unit. Krisinda left stating, *"she wanted to get some cigarettes, and needed to meet her friend."*[48]

61. While some of Ms Roger's evidence was to the effect that Krisinda was, at the time, *"in great spirits"* and "*in a good place*",[49] she assessed it unsafe and unsatisfactory for Krisinda to go off on her own. Ms Rogers was concerned that Krisinda was likely to engage in prostitution[50] and use the proceeds to obtain drugs.[51] So concerned was Ms Rogers for Krisinda to return to the Unit[52] that she:

    a. firmly directed Krisinda to return with her to the Unit;[53]
    b. asked a police officer *"Can't you do anything?"*[54] and
    c. sought direction from the DHS On-Call service to obtain the advice of a senior child protection worker.[55]

62. Ms Rogers believed, at that point, that the police had greater coercive powers over Krisinda than she did and looked to the police officer to stop Krisinda leaving. The police officer, and Ms Rogers, believed that in the absence of a safe custody warrant, there was little they could do to stop Krisinda leaving.[56] However, there is no evidence that Ms Rogers or any other DHS personnel conveyed to the police officers who dealt with Krisinda on this day that there were protective concerns for her, such that she required them to exercise their protective intervener powers. Therefore, I make no criticism of the police officers who dealt with Krisinda in relation to allegations of stealing a mobile phone for not taking her into safe custody without a warrant.

63. Submissions on behalf of Jason Jackson was that the DHS crisis management plan for Krisinda provided, under the heading *'if Krisinda absconds'*, that if she is un-contactable and her whereabouts were unknown, After Hours was to be contacted for a warrant.[57] However, this plan was silent as to how to exercise the powers under section 172(3) *Children, Youth and Families Act 2005*, that is, the power of the Secretary to the Department to detain Krisinda without warrant. In evidence, Ms Rogers stated that the word 'abscond' was inapt to describe Krisinda's departure

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[48] Inquest brief, p. 64.
[49] Transcript p. 303.
[50] Transcript p. 276.
[51] Transcript p. 278. Also see evidence of Tulloch at p. 418.
[52] Transcript p. 268-9.
[53] Transcript p. 280.
[54] Inquest brief 65C at [17].
[55] Transcript p. 270, Inquest brief p. 64.
[56] Transcript p. 270.
[57] Ex 22, p. 1071.

from the St Kilda police station[58] because she had not been released by police into her care, but had been interviewed by police and was free to go.[59] As Ms Rogers saw it, even directions from her to Krisinda to get in the car with her and return to the Unit did not alter Krisinda's freedom to leave as she chose. I agree with Jason Jackson's submissions that the DHS had legal custody of Krisinda and was entitled to detain her "*without warrant*" for her effective protection on the basis that the circumstances gave rise to a *"substantial and immediate risk of harm"*[60] and she could have been placed in secure welfare. It was Ms Rogers' evidence that she was hoping a return to placement warrant or a warrant to have her assessed for secure welfare would have been issued.[61] Similarly, Ms Tulloch acknowledged that even at this time on Saturday, 19 January 2008, there were grounds for an application for a warrant.[62]

64. The difficulty Ms Rogers faced on this day, like most DHS residential workers, was that she was not a Child Protection Worker and did have any protective intervener powers under the *Children, Youth and Families Act 2005.* It is clear from Ms Rogers' evidence that this was a frustration for her because she felt "*hamstrung*"[63] in terms of her ability to detain Krisinda despite her reasonable view she was at risk of harm. I note Ms Rogers' evidence that it is not the role of residential workers or Child Protection Workers to physically restrain a young person from leaving their residential unit.[64]

65. I do not criticise Ms Rogers for her actions on this day. She did all that she reasonably could in the circumstances. She consulted the On-call service after Krisinda's departure to obtain guidance on how to get her back to the Unit and more importantly requested guidance on obtaining a warrant.[65] On instructions from the On-call service, she drove around the streets looking for Krisinda with the view to persuading her to return to the Unit.[66]

66. Inexplicably, despite the inability of Ms Rogers to find Krisinda and her unrestricted presence in St Kilda (contrary to the terms of the Custody to the Secretary Order), no request was made by the Secretary to a Magistrate for a safe custody warrant.

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[58] Transcript p. 279.
[59] Transcript p. 279.
[60] Section 173(2)(b) *Children, Youth and Families Act 2005*
[61] Transcript p. 271.
[62] Transcript p. 397.
[63] Transcript p. 301.
[64] Transcript p. 457, 471-2, 480-1.
[65] Transcript p. 271, 276.
[66] Inquest brief p. 64.

19 January 2008 after the St Kilda Police Station

67. Evidence suggests that Krisinda was again in the company of Mr Marchant in St. Kilda that evening.

68. At 11.57 pm, the Unit staff made contact with Specialist Outreach Service (SOS) to alert them to the fact Krisinda had not returned. They were given a description of what she was last known to be wearing.

20 January 2008

69. At 12.15am on Sunday 20 January 2008, SOS workers Paul Vose and Kelly Rolfe believed they observed Krisinda in Greeves Street, St. Kilda near Vale Street, talking to a male in a white commodore (the Vehicle).

70. Before the SOS workers could reach Krisinda, the Vehicle left the area. Despite the SOS workers being unsure if Krisinda was in the Vehicle, they conscientiously conducted a search of the area, but failed to find her or the Vehicle.

71. Ms Rolfe recorded the Vehicle's registration and the Vehicle was later identified by police as a white commodore hire car, hired in the name of Russell Hall of 9/24 Little Grey Street, St. Kilda.

72. Appropriately, Mr Vose and Ms Rolfe made contact with the DHS, After Hours Child Protection Emergency Services (AHCPES). Despite their concerns that Krisinda was believed to be in a area well known for prostitution; believed to be talking to a male in a vehicle, likely got into the Vehicle and was likely to engage in illicit drug use, they were advised there was not enough information to seek a warrant. I agree with the submissions of Jason Jackson that this decision was demonstrably wrong and it is very difficult to understand how that conclusion could be reached.

73. At 12.50am, Mr Vose and Ms Rolfe appropriately attended St. Kilda police station, spoke to Senior Constable McPhee and provided her with the details of their sighting and the registration number of the Vehicle. They did not report Krisinda as a 'missing person' and no action was taken by police.

74. Whilst Senior Constable McPhee had no independent recollection of her involvement with Mr Vose and Ms Rolfe on this night, she accepted the events as described by them.[67] Senior Constable McPhee described the relationship between Streetworks staff and St Kilda police as

[67] Exhibit 12 (Statement of McPhee dated 7 March 2012).

"*excellent*"[68] and "*great*".[69] As at 20 January 2008, Senior Constable McPhee was aware of regular occurrences of Streetworks staff at the St Kilda Police Station,[70] and that standing orders existed for relaying specific information imparted by Streetworks staff.[71] Senior Constable McPhee was also aware of meetings between senior officers and Streetworks representatives.[72]

75. Mr Vose said that in giving the information to St Kilda police, he expected the information to be disseminated to other officers on shift.[73] His hope was that if police came across Krisinda, they would contact the After Hours service.[74] He also hoped that police might have information about the Vehicle owner.[75]

76. On this night it appears there was a misunderstanding in communications and what transpired was that Mr Vose *"[B]asically updated Constable McPhee..."*[76]. Mr Vose stated "*I suppose under those circumstances we just provide the general information that if police happen to come across Krisinda that we would ask them to contact after-hours child protection and then they can have a conversation about the best outcome for Krisinda at that time.*"[77]

77. Senior Constable McPhee, whilst having no memory or record of the attendance of Streetworks, believed she treated the information provided to her as part of informal intelligence gathering.[78] Such information was usually passed on to other police, but only in an ad hoc and informal way.[79] Senior Constable McPhee emphasized the importance of a warrant for a formal attempt to find a child to be made.[80] Had there been a warrant, Streetworks staff and their intelligence would have been referred to a Section Sergeant.[81] Such information was then likely to be passed on at 'read outs' to police beginning their shifts. It bears noting that Constable O'Connell, at 8.06am on 20 January 2008, checked the Vehicle, however, there was nothing to alert him to concerns raised by Mr Vose and Ms Rolfe.

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[68] Transcript p. 201.
[69] Transcript p. 206.
[70] Exhibit 12 (Statement of McPhee, dated 7 March 2012).
[71] Transcript at p. 201– 202; Exhibit 13 at [10] – [11].
[72] Transcript p. 201.
[73] Transcript p. 239.
[74] Transcript pp. 239-40.
[75] Transcript p. 248.
[76] Transcript p. 238.
[77] Transcript p. 240.
[78] Transcript p. 222.
[79] Transcript pp. 200-1.
[80] Transcript p. 210.
[81] Transcript pp. 199, 209-10.

78. Despite the miscommunication between Mr Vose, Ms Rolfe and Constable McPhee, I consider that a warrant under section 598 of the *Children, Youth and Families Act 2005* should have already been sought by the DHS long before Krisinda was sighted by the SOS workers in St Kilda. A warrant would, almost certainly, have been granted had the available information been put before a Magistrate. It is unacceptable to have a child on a protection order with a history of prostitution and illicit drug use moving freely in a known area of street prostitution at night and for the Secretary with knowledge of the facts to delay taking the only statutory action available for protection of the child.

79. Had earlier action been taken by the Secretary to obtain a warrant, it may have linked Krisinda to the vehicle seen by Constable O'Connell on Sunday 20 January 2008. It was, yet another opportunity, albeit remote, to interrupt the fatal course of events that ensued.

80. I am informed that since 19 January 2008, there have been increases in Streetworks resources, including staff, and the introduction of a formal process for communication between Streetworks and St Kilda police, which includes a dedicated Streetworks notebook. I consider these positive developments.

81. I make no criticism of Mr Vose or Ms Rolfe's actions on this night - they did the best they could with the resources they had to secure Krisinda's safety. Similarly, I make no criticism of Senior Constable McPhee for not escalating the matter based on the limited information she was provided.

82. However, the delay by the DHS in obtaining the warrant was unacceptable. There were enough 'red flags' for the DHS to make an application for the warrant after the SOS first made contact.

CIRCUMSTANCES WITHIN WHICH DEATH OCCURRED

83. In the meantime, Krisinda had entered the company of Mr Hall and his girlfriend Ms O'Day. Shortly after meeting, Mr Hall purchased heroin using money provided by Krisinda and they all returned to a rooming house at 24 Grey Street, St. Kilda.

84. Mr Hall and Ms O'Day both gave evidence at the inquest that they were with Krisinda in the early hours of 20 January 2008 until her death, during which time Mr Hall shared heroin with her.

85. Ms O'Day had a poor recollection of the details and Mr Hall's evidence in relation to his dealings with Krisinda was, for the most part, unreliable. Whilst Mr Hall was not an impressive witness, he did acknowledge his part in obtaining the heroin and providing it to Krisinda and that he assisted her to inject it at 1.30am on the morning of 20 January 2008. Some time later in the

morning, Mr Hall observed Krisinda sleeping on the bed with Ms O'Day. He then left the address and at 4.00pm that day was arrested trying to break into cars in the Coles supermarket car park in St. Kilda.

86. Given Mr Hall's unreliable evidence it is not possible to make findings on the precise circumstances in which Krisinda died, save that the place and cause of death are known.

87. At 6.35pm on 20 January 2008, AHCPES obtained a warrant for safe custody in relation to Krisinda.

88. At 6.49pm on the same day, SOS workers received a page notification alert from the Unit staff that a warrant was issued in relation to Krisinda.

21 January 2008

89. At 6.30am on the morning of Monday 21 January 2008, Mr Hall and Ms O'Day could not wake Krisinda in their room. They called 000 and at 7.10am an ambulance was dispatched, paramedics attended and confirmed Krisinda to be deceased. Tragically, the evidence of Mr Hall and Ms O'Day revealed that they were both with Krisinda for over a 24 hour period prior to calling the ambulance, and for a significant part of that time Krisinda was *"asleep"*[82] and most likely unconscious.

90. Mr Hall's actions of providing heroin to Krisinda and/or allowing her, as a child, to use it was not only illegal and irresponsible but contributed to her death. In relation to Krisinda's medical cause of the death of toxicity to heroin, Mr Hall and Ms O'Day's failure to call an ambulance earlier was a lost opportunity to assess her condition and obtain what could have been life saving treatment. Nevertheless, it is not possible to definitively find that calling an ambulance earlier would have altered the outcome. Mr Hall's and Ms O'Day's own use of illicit drugs in all probability affected their individual ability to make reasonable decisions.

91. Mr Hall was prosecuted for trafficking heroin and using heroin and on 5 July 2010 he was convicted and fined $800.00.[83] The person who supplied (sold) the heroin was also prosecuted at the Melbourne Magistrates' Court on a number of offences, including trafficking heroin and

[82] Transcript, pp.32-33.
[83] Transcript, p. 554.

possessing heroin and was sentenced on 24 March 2010 to an aggregate three month imprisonment to be served concurrently and wholly suspended for 18 months.[84]

FINDINGS and COMMENTS pursuant to section 67(1) and (3) of the ***Coroners Act 2008***

General Comments

92. Although much was done for Krisinda during her time under the DHS' care, it is apparent that a point had been reached where the DHS was reactive rather than proactive. The DHS made significant efforts to address the cumulative harm manifested by Krisinda's experiences of sexual abuse, neglect and trauma that she suffered as a young child, the transgenerational trauma and associated difficulties and her damaging relationship with her mother.

93. After Krisinda's death, the DHS engaged in reflective hindsight of its management of her and I acknowledge the concessions made by Mr Ross in his evidence about some of the opportunities that were missed in having a strategic approach to her case management. The key concessions made by Mr Ross pertained to the fact that consideration could have been made to a guardianship order being issued rather that a Custody to Secretary Order, that there could have been earlier involvement of the Principal Child Protection Practitioner; that there might have been a benefit in obtaining earlier and more detailed information regarding childhood and family history and there might have been earlier initiation of family therapy. Whilst these concessions were made by the DHS, it should be understood that given Krisinda's complex needs and high-risk behaviours, there were no guarantees that the adoption of one or all of the options conceded would have resulted in a different outcome.

94. I note the submissions made by counsel for Mr Jackson about the failure to re-engage Krisinda with a structured education program. A coronial investigation, including an inquest, cannot be used as a general inquisition into the practices and policies of the DHS and it is impossible to know what might have changed Krisinda's trajectory

95. I do not intend to make any recommendations in relation to this issue, but note Ms Garner's submissions on behalf of the DHS that "*the criticism concerning the education of Krisinda made on behalf of Mr Jackson, really in some senses is a refusal to acknowledge the imperfect world in which the Department of Human Services operates. There were, according to the evidence of Ms Tulloch, legitimate and valid reasons as to why Krisinda wasn't in formal education... It's also*

[84] Transcript, p. 554.

observed, Your Honour, that at all times guardianship of Krisinda remained with her parents, and accordingly it was open to either of her parents to enrol her in school, had they felt that to be necessary. And that there has been no record produced on behalf of the family to suggest that in 2006 or 2007 anybody was advocating for a different approach to be taken with respect to Krisinda's education."[85]

Victoria Police Training in relation to Youths At Risk

96. I agree with the submissions made by counsel assisting that it appears from the evidence of Mr Naisbitt and Constable Anderson that very little time is devoted to training police members to deal with young people and children. In particular, the evidence suggested that the training provided to them was focused on children who are at risk as a result of their parent's behaviour and who may need to be removed from their families.

97. According to the evidence of Inspector Glenn Jackson, police are trained in matters specific to youths at risk.[86] This training is provided in Foundation Training conducted by the Centre for Law and Operational Duties, Youth Affairs Unit, where they are trained to identify risk and protective factors and their police role and responsibilities as protective interveners under the *Children, Youth and Families Act 2005.*

98. Police recruits, in their first 12 weeks, are provided with their first face-to-face session on youths at risk by an external office, the Youth Affairs Unit, the Community Engagement Support Team. The session is approximately 65 minutes long.[87]

99. The recruits are also provided a 65 minutes training session by the Centre for Law and Operational Duties which, relevantly, defines protective intervener powers under the *Children, Youth and Families Act 2005.*

100. Inspector Jackson also detailed two further sessions (65 minutes each) which focus on family violence and protective intervention for children. Whilst Inspector Jackson conceded that these training sessions were "*fairly broad*"[88] and included case studies where the recruits engage in role playing, none were relevant to the circumstances that involved Krisinda. He agreed that the

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[85] Transcript, p. 592
[86] Statement of Inspector Glenn Jackson, dated 8 March 2013 at [11]-[16].
[87] Transcript, p. 494.
[88] Transcript p. 494.

circumstances of Krisinda's death is something that had been considered[89] and the prevailing circumstances of Mr Naisbitt and Constable Anderson's interaction with her would be used in future training.[90]

101. I note that the DHS does not provide any training to police recruits and it is not proposed to invite them to do so. Inspector Glenn Jackson's evidence, at inquest, provided the following explanation:

> *"Probably based on the whole philosophy that we have reduced our face to face component of training and the whole training methodology is, as I said before, about not loading up the students with too much information, giving them sufficient information and then providing different mediums of learning, as in probably understanding that 70 per cent of the learning of policing craft is done in the field and only about 10 per cent is achieved through theory based training. So once again there's a movement away from loading up too much face to face training and ensuring that we, as I say, we provide sufficient foundation training which is supported with the practical application of that training."*[91]

102. Ongoing training in the form of professional development is also provided as part of the Probationary Constable's training.[92]

Warning Flags for 'At Risk' Children in the LEAP System

103. The LEAP system was described by police witnesses as the primary information tool available to them. A LEAP search for an individual contains as a front page the "Master Name Summary" which can contain numerous warning flags and links to more detailed information. At present, there is no flag to indicate that a young person is a client of the DHS.

104. Inspector Jackson's evidence was that a warning flag for "High Risk Youths" in principle merited further investigation/enquiries. However, he noted that such a flag was not without its issues, such as how it was to be structured, the lack of an IT link between the DHS' database and the Victoria Police database, how the integrity of data could be maintained and the criteria around

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[89] Transcript p. 496.
[90] Transcript p. 537.
[91] Transcript, pp. 504 and 505.
[92] Evidence reveals that Constable Anderson definitely received this training in 2003 and following. Records of Mr Naisbitt's training in 1995 could not be located.

what would fall under that particular flag. Whilst he acknowledged the implementation issues, his evidence was that if such a flag was ever to be implemented, it would operate consistent with the other flags, in that it alerts the police officer that there is an associated risk or something they need to explore further.[93]

105. Despite the identified practicalities (technical and financial) with a flag for High Risk Youths, there is real merit that there should be a flag to indicate that a DHS client has been placed on the High Risk Youth Schedule. Such an alert would immediately alert police not only to the true age range of the young person, but of their 'high risk' status.

106. Commendably, the submissions on behalf of the Chief Commissioner of Police are that they will continue to work with the DHS to consider the merits of warning flags being placed on the LEAP system for youths at risk. I note the DHS did not support a LEAP flag on the basis that the systems in place at the time of Krisinda's death, had they been activated, were sufficient. The DHS is also concerned that the inclusion of sensitive information onto the LEAP database could result in stigmatisation of a young person, and have adverse consequences to the effect of drawing young people who are on the register to greater scrutiny by the police. I do not consider these concerns to displace the need for children at risk to be given a higher profile by police.

Communications between Victoria Police and DHS

107. The evidence reflects that the DHS and Victoria Police have a well established and good working relationship with each agency continually engaging in initiatives to promote child safety and improved communication. The recent June 2012 Protecting Children Protocol between the Victoria Police and the DHS is one example of this. I note that the Victoria Police also has dedicated Youth Resource Officers, programs to assist children in need of protection and who are involved with the DHS's High Risk Youth Program.[94] Evidence of this can be seen where Victoria Police Youth Resource Officer, Senior Constable James Ridsdale, had spoken to Krisinda in secure welfare as requested by the DHS.[95]

108. Since the interaction between Senior Constable McPhee and Mr Vose on 20 January 2008, the St Kilda Police Station has introduced new procedures to enhance and promote a better working

[93] Transcript, pp. 510-511.
[94] Statement of Robert Ross, Exhibit 28 at [3].
[95] Statement of Robert Ross, Exhibit 28 at [8].

relationship between the DHS and the St Kilda police,[96] which includes the introduction of a new form that is completed when the DHS or the SOS report a matter to the St Kilda police. This has resulted in an improved system of information collection and recordkeeping and enhanced the distribution of information to police members where relevant. The DHS or SOS worker is seen by the section Sergeant upon attendance at the St Kilda Police Station. Depending on the information received, the section Sergeant is able to initiate relevant police action, such as conducting LEAP checks and distributing information to patrolling police units with instructions to KALOF (keep a lookout for) the youth at risk The cover note for the new procedure states:

> "*Police and DHS working in partnership dealing with children, young persons in St Kilda. St Kilda Police and DHS street workers regularly have meetings to discuss the following: young persons prostituting in St Kilda, young persons who regularly go missing in St Kilda, ways in which intelligence and information can be shared and ways in which improvements can be made to enhance the relationship between police and DHS. As part of the St Kilda Police prostitution strategy 2009 the aim of this booklet is to provide a log of interactions with DHS street workers regarding safe custody and at risk children and young persons, gather any additional information and/or intelligence of DHS street workers have involving the exploitation of children and young persons. Streetworks through their outreach work are the eyes and ears out on the street. Information they have given to the police in the past has been investigated and offenders charged. However, a lot of information intelligence has gone nowhere.*"[97]

109. The new procedure also provides:

> "*Procedure when Streetworks attend the station. The section sergeant is to speak to them in private if other persons are in the reception area, record who you have spoken to and a contact number. Ascertain from them children, young persons of interest and record them. Record your action taken, for example, if given to the van crew. Ascertain if there is any additional information and/or intelligence. If the information intelligence is urgent complete an IR. This booklet will be regularly checked and the information intelligence will be collated at a later date.*"[98]

110. In light of the new procedure, I do not intend to make any recommendations relating to this issue.

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[96] Transcript pp. 251 -252.
[97] Transcript, p. 558.
[98] Transcript, pp. 558-9.

Protective Interveners powers under the Children Youth and Families Act 2005

111. I found Ms Rogers to be a very credible witness who clearly demonstrated immense respect for Krisinda and took her role in relation to her seriously. However, despite this, she did not have the power of a protective intervener.

112. A police interview that requires the DHS to send an independent third person necessitates that the independent third person also have protective intervener powers. The circumstances involving Ms Rogers at St Kilda Police Station highlights the serious consequences of the lack of such powers.

113. Counsel assisting submitted that consideration should be given to expanding the circumstances which require mandatory reporting under section 184 of the *Children Youth and Families Act 2005* (as outlined in section 8 of the Protecting Children Protocol) to include a child who has suffered or is likely to suffer significant harm as a result of drug taking, self-harm, or other high risk behaviours. Such expansion would have 'caught' the situation, which confronted officers Mr Naisbitt and Constable Anderson on 16 January. I agree.

114. Similarly, consideration should be given to the expansion of non-mandatory reporting practices pursuant to paragraph 8.2 of the Protecting Children Protocol to include children at risk of significant harm from their own behaviour rather than at the hands of another person.

115. The definition of the phrase "significant harm" in section 162 of the *Children Youth and Families Act 2005* should be broadened to include a child who is classified as High Risk, including a high-risk child who is not necessarily at 'immediate' risk. A child who is considered high-risk at the present time and has a history of high-risk behaviours should equate to a significant risk, which would in turn justify the use of protective intervener powers in circumstances where a child is away from his or her residence.

116. Section 172(3) of the *Children Youth and Families Act 2005* provides that "The Secretary may detain without warrant any child who is in the custody or under the guardianship of the Secretary." Counsel for Mr Jackson submitted that whilst it could not be any plainer that there is a right to detain without warrant, the evidence given in the inquest was that in the absence of a warrant, a situation which occurred on Saturday, 19 January 2008, Krisinda, could not be detained.

117. I note, and agree with the submissions of the DHS that the power, to detain without a warrant, is not mandatory but discretionary; and that as a matter of policy, the uncontested evidence of Mr

Ross, Ms Rogers and Ms Tulloch more particularly, was that the provisions are not employed in the circumstances such as what occurred in front of St Kilda Police Station on 19 January, and that there were salient policy reasons for not seeking to physically detain children such as Krisinda in those circumstances.

118. This policy approach is premised on the foundation that to do so would be destructive to the worker and child relationship; that it might be unsafe for the child and the worker; that it represents additional trauma to a young person in circumstances where they already have a background of trauma; and that protective interveners such as Child Protection Workers are empowered to take the child into safe custody without any warrant if they are satisfied on reasonable grounds that the child is in need of protection. In practice, they would only exercise that power in circumstances where a child was at immediate and extreme risk of harm. The power is not utilised to keep children in placement.

119. I acknowledge the submissions on behalf of the DHS that "*even when protective intervener provisions permit physical restraint by child protection workers, such restraint is not exercised for reasons of safety and in order to preserve therapeutic relationships with young people. Thus, it is submitted that the Protective Intervener recommendation should not be made.*"[99]

120. I also acknowledge the DHS's desire to preserve therapeutic relationships with young people. However, the circumstances of Krisinda's death are compelling and I have determined that there is a need to broaden the powers of DHS workers who manage and supervise High Risk Youths (see Recommendation 1).

Influence of mother

121. Krisinda's relationship with her mother and her mother's associates were a very damaging influence on her. This was well known to the Secretary from 2005.[100] Robert Ross acknowledged that, albeit with hindsight, an opportunity may have been missed in 2006 to pursue guardianship of Krisinda through the Children's Court[101] and thereby regulate Krisinda's relationship with her mother.[102] Whether through that mechanism or an early application to

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[99] Submissions on behalf of the DHS dated 5 April 2013 at paragraph 10.3
[100] Transcript pp. 324-5, 327, 445.
[101] Transcript pp. 328 and 443.
[102] Transcript pp. 444-5, and see Transcript 314; cf Transcript 405.

impose supervision of contact with her mother, a stronger line on this issue should have been taken at a much earlier stage.

122. The DHS' recognition in late 2007 of the need to contain contact with her mother coincided with a more insightful recognition of the potential for reunification with her father.[103] These developments were contributions of the State Principal Practitioner Robyn Miller[104] and supported by Monica Tulloch.[105]

123. At the time of Krisinda's death, much constructive and fruitful effort had been put into planned reunification with her father.[106]

FINDINGS

I accept and adopt the conclusions of Dr Michael Burke AND I find that Krisinda Carmen Smart died from heroin toxicity.

In the days leading up to her death, Krisinda came into contact with members of the Victoria Police and was in the care of the DHS.

I find that police contact with Krisinda on 17 January 2008, in particular in relation to Mr Naisbitt, was an opportunity lost to detain her and implement protective measures. Furthermore, it was nothing short of poor policing. There was nothing in Mr Naisbitt's actions on that day that demonstrated any concerns for the welfare of Krisinda.

There is no doubt that the DHS and other professionals in Krisinda's life had made concerted efforts to encourage lifestyle changes and mitigate the risks it posed to her. However, Krisinda was a girl with quite significant problems. At the same time, the DHS was trying to move Krisinda forward; to develop a rapport with her, improve her self esteem; develop her life skills; to connect her with her culture; and to countermand the very, very significant damage she had suffered before she first came into the care of the DHS.

It must be acknowledged that Krisinda's early family relationships, in particular with her mother, and experiences were a key factor that affected her development and the life path she took. Whilst her lifestyle and drug-taking choices posed an ongoing significant risk to her own wellbeing, her death was a true tragedy. It was also a preventable tragedy. Whilst it is not

[103] Transcript pp. 314, 330, 332-6, 409-10, 449.
[104] Transcript p. 447-9.
[105] Transcript p. 313; Ex 25.
[106] Transcript p. 330-5.

possible to say, with certainty, whether any or all of the contacts with these agencies would or could have prevented Krisinda's tragic death, there were lost opportunities to provide critical intervention to address her high risk taking and complex needs. Children with complex needs such as Krisinda are resource and labour intensive, but this must never be an excuse or reason for failing to intervene.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation(s) connected with the death:

Recommendation 1

I recommend that the Department of Health and Human Services ensure all of their workers, including Residential Care Workers, who have management and supervision of high-risk children be given Protective Intervener Powers to detain them when it is considered that they are at risk of immediate and extreme risk of harm..

This power would apply to situations such as the one in which Ms Roger's was faced with at the St Kilda Police station on 19 January 2008.

Recommendation 2

I recommend, with the aim of supporting the Department of Health and Human Services to undertake more informed risk assessments for High Risk Youth, that the Chief Commissioner of Police and the Department of Health and Human Services, if they have not already done so, establish a 'working party' between the two organisations to undertake a feasibility study to determine whether a warning flag for 'high risk' children under the care of the Department of Health and Human Services can be included on the LEAP database. Consideration must include, but not be limited to:

a. the criteria and name of the flag for 'high risk' children;
b. whether to do so would breach any privacy legislation and if so, whether the perceived risk(s) to the child outweighs privacy rights/principles.

c. how the information relevant to the flag would be maintained and updated;
d. the situations in which Victoria Police would be required to notify the Department of Health and Human Services if a 'High Risk Youth' is checked on LEAP; and
e. training of Victoria Police members and Department of Health and Human Services workers in relation to the flag.

Recommendation 3

I recommend, if it has not already been done, the Chief Commissioner of Police provide Academy based training that includes the circumstances of Mr Naisbitt and Constable Anderson's interaction with Krisinda on 17 January 2008 to help prevent Victoria Police members from making the same or similar mistakes in the future such as those made by Mr Naisbitt.

Recommendation 4

I recommend that the Minister for Health review section 162 of the *Children Youth and Families Act 2005* with the view to amending the provision to include circumstances where a child has suffered, or is likely to suffer, significant harm as a result of drug taking, self-harm or other high risk behaviours. Such a review should include circumstances where a child is classified by the Department of Health and Human Services as a High Risk Youth. Consequences, of this amendment would expand the mandatory reporting requirements under section 184 of the *Children Youth and Families Act 2005* and would have 'caught' the situation which confronted officers Mr Naisbitt and Constable Anderson on 16 January, 2008.

Pursuant to section 73(1) of the **Coroners Act 2008**, I order that this Finding be published on the internet.

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

- Jason Jackson
- The Secretary to the Department of Health and Human Services
- The Chief Commissioner of Police
- Counsel for Darren Naisbitt, Constable Mark Anderson and Senior Constable Victoria McPhee
- Detective Senior Constable Hallinan, coroner's investigator.

Signature:

AUDREY JAMIESON, CORONER

DATE: 7 MAY 2015