Media Release

Coroners Court of Victoria

Aboriginal and Torres Strait Islander readers are advised that this content contains the name of a deceased Aboriginal person. Readers are warned that there may be words and descriptions that may be culturally distressing.

Wednesday 19 June 2024

Coroner calls for increased cultural connection for First Nations children in out-of-home care

Victorian Coroner Simon McGregor has today made 17 recommendations to government and service providers aimed at improving outcomes and cultural safety for First Nations children and young people in out-of-home care following the suicide of a 17-year-old Aboriginal woman in Bendigo in July 2021.

At the time of her passing, XY – a proud young Wemba Wemba woman – was under the care of the Department of Families, Fairness and Housing (DFFH) and living in a residential care unit operated by Anglicare Victoria.

XY was removed from her family home in 2017 at the age of 13 following reports to child protection services beginning when she was 22 months old. While in out-of-home care, XY disclosed she had experienced serious physical and sexual abuse at home – these allegations were reported to police for investigation.

In the four years after her removal from her home until the time of her passing, XY had seven different care placements, including kinship care and residential unit placements, ranging from 2 weeks to 12 months.

During this time, XY's mental and physical health was of concern. She suffered from disordered eating, self-harm, substance misuse and chronic suicidal ideation – all of which became more severe proximal to her passing.

XY received medical and mental health care through the Bendigo and District Aboriginal Co-Operative (BDAC) and Bendigo Health's Child and Adolescent Mental Health Service. She had numerous hospital admissions, including inpatient admissions at the Bendigo and Austin Hospitals, and at the Youth Prevention and Recovery Care service in Bendigo.

Coroner McGregor's investigation centred on the adequacy of care XY received – including case planning and management, supervision and monitoring, risk assessment, the impact of housing instability on XY, available supports, the police response to her disclosures of sexual assault, and the extent to which XY's care was culturally competent.

An inquest was held from 23 October to 1 November 2023. The coroner heard evidence from a range of experts including an Aboriginal independent expert panel, a medical stakeholder panel and a child protection stakeholder panel. His Honour's findings were also informed by recommendations made in the Yoorrook Justice Commission's second interim report and the recent Royal Commission into Victoria's mental health system.

His Honour found that while in care, XY was disconnected from her Aboriginal culture and potential cultural supports from her community. She also had a limited relationship with her mother and no contact with her eight siblings, despite her expressed desire to do so.

The coroner concluded that due to systemic issues existing at the time of XY's passing – such as systemic racism and inadequate consideration of cultural safety – the policies and practises applicable to Aboriginal children in the child protection system did not align with the principle of self-determination.

Furthermore, His Honour found that elements of XY's care – including child protection case management practices, drug and alcohol services, mental health first aid and housing options provided to XY, along with aspects of the police investigation into her alleged sexual assaults, were not tailored towards the needs of First Nations children and young people.

Additionally, the coroner determined that DFFH did not adequately take into account XY's wishes with respect to her care. His Honour stressed the importance of engaging with children in care regarding their needs by both listening to their voice and acknowledging their lived experiences in subsequent decision making. In failing to do so in these circumstances, His Honour found that XY's human rights were breached.

The coroner's 17 recommendations, directed to organisations including DFFH, Department of Health, Victoria Police, BDAC and Bendigo Health, focus on increasing cultural safety and competency across the child protection system for First Nations children and young people. Themes in the recommendations include:

- That DFFH work towards transitioning all Aboriginal and Torres Strait Islander children and young people in the Victorian child protection system to the care of an Aboriginal Community-Controlled Organisation (ACCO) as recommended by Yoorrook.
- In the interim, the DFFH implement a relational case management approach to First Nations children and young people under their care, supported by appropriate staffing and retention policies.
- That DFFH and other organisations providing services to Aboriginal and Torres Strait Islander children and young persons in out-of-home care review their current policies and practices and implement changes to enhance their capacity to provide culturally connected care.
- That kinship carers for vulnerable children and young people be better supported by DFFH.
- That work is undertaken to ensure organisations involved in child protection provide cultural and anti-racism training for the workforce as well as ensuring the availability of and free access to Aboriginal liaison staff and advisors to provide culturally competent advice and care – including during police investigations.
- That support services, including supports for medical and mental health, drug and alcohol services and residential care models are reviewed and updated to reflect an Aboriginal-led approach, with an emphasis on cultural safety and taking into account the child's views and experiences when making care decisions.

A copy of the finding into XY's passing including the full list of recommendations can be accessed here: https://www.coronerscourt.vic.gov.au/sites/default/files/Form%2037%20-%20Finding%20into%20the%20passing%20of%20XY%20-%20COR%202021%20003810%20%2819%20June%202024%29%20Redacted.pdf

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