IN THE CORONERS COURT OF VICTORIA

AT MELBOURNE

COR 2021 003810

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

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

Amended pursuant to section 76 of the* ***Coroners Act 2008* *on 29 July 2024*

INQUEST INTO THE PASSING OF XY

Findings of:	Coroner Simon McGregor
Delivered on:	19 June 2024
Delivered at:	Coroners Court of Victoria
Hearing dates:	23 – 26 October 2023 at Bendigo 30 October – 1 November 2023 at Melbourne

Proceeding Suppression Orders have been made in this matter pursuant to section 18(2) of the *Open Courts Act 2018.* The names of the deceased, her family members, other children, frontline workers and child protection practitioners have been replaced with pseudonyms or redacted.

*The finding was amended on 29 July 2024 to correct a referencing error at footnotes 124 and 125.

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ACKNOWLEDGEMENT & CULTURAL WARNING

Aboriginal and Torres Strait Islander readers are advised that this Finding contains the name of a deceased Aboriginal person.

Readers are warned that there may be words and descriptions that may be culturally distressing.

I acknowledge the Traditional Owners of the land where the Coroners Court of Victoria sat in this matter, the Wurundjeri and Dja Dja Wurrung peoples of the Kulin nations. I acknowledge their longstanding connection to Country, and I pay my respects to their Elders past and present.

Much of what this inquest has revealed is confronting and traumatic. I would like to acknowledge all the First Nations people who gave their time, evidence, and insights to my investigation. This process has benefited profoundly from their participation, and I acknowledge the emotional toll of their engagement in the coronial process.

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INTRODUCTION

1. XY was born on 31 March 2004 and passed on 18 July 2021 at the age of 17. Although she had grown into a proud young Wemba Wemba woman, XY was, at the time of her passing, disconnected from her family, her culture and her community.

2. XY had a voice, and it was articulate. Sadly, it was not heard in time. There are, however, many other young people in our community who share similar vulnerabilities, who may not feel able to give voice to their experiences, so this inquest has examined XY's life in detail, looking for prevention opportunities that might assist those who remain.

3. At the time of her passing, XY was under the care of the Victorian Department of Families, Fairness and Housing ('DFFH'),[1] having been removed from her family home at the age of 13 by Child Protection. From shortly thereafter, the Secretary stood *in loco parentis*, with a well-recognised statutory and common law responsibility to act in her best interests.

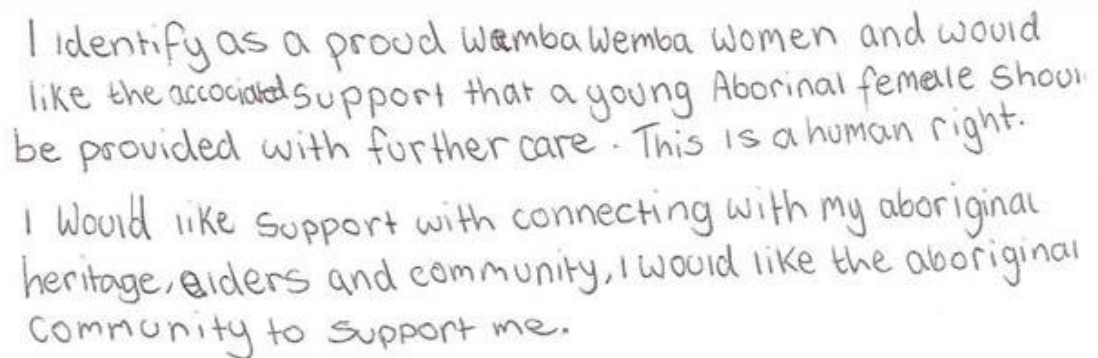
4. In the four years that XY was out of her family home, she had seven different care placements, many of which were short-lived and inappropriate for her needs. At the time of her passing, XY lived at Maison House, a residential care unit operated by Anglicare Victoria ('Anglicare') and was being case managed by Anglicare's Intensive Case Management Service ('ICMS').

5. From the time of her removal from the family home, XY had complex mental health needs. Her mental health further deteriorated as XY disclosed alleged sexual offending by her stepfather and other men, which XY reported to Victoria Police from 2018 onwards. In the months leading up to her passing, XY was actively suicidal, regularly expressing suicidal ideation, engaging in self-harm and attempting suicide.

6. Following XY's removal from her family, and despite her deteriorating mental health, XY was disconnected from her Aboriginal culture and lacked the protection and support

[1] For convenience, this Finding refers to DFFH and its predecessor departments holding responsibilities for Child Protection (including the Department of Health and Human Services and Department of Human Services) as DFFH.

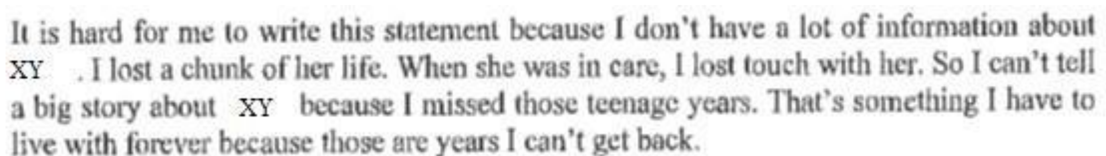
that her culture and community could provide. As XY herself stated in her letter dated 17 December 2020:[2]


I identify as a proud Wamba Wemba women and would like the accociated support that a young Aborinal femeale shoul be provided with further care. This is a human right.

I would like support with connecting with my aboriginal heritage, elders and community, I would like the aboriginal community to support me.

7. After being removed from her family home, XY did not have a relationship with her mother, nor with her siblings. To a significant extent, this was due to XY's Mother not believing XY's allegations of sexual offending by XY's Mother's partner (XY's stepfather), and to the DFFH's failure to facilitate contact between XY and her family at appropriate opportunities despite that obstacle. XY did not have any contact with her siblings, although she had frequently expressed her desire to do so.

8. After XY's passing, XY's Mother captured the event's extended impact in a statement dated March 2022:[3]


It is hard for me to write this statement because I don't have a lot of information about XY . I lost a chunk of her life. When she was in care, I lost touch with her. So I can't tell a big story about XY because I missed those teenage years. That's something I have to live with forever because those are years I can't get back.

9. XY's Mother remembers XY as a 'beautiful, bright young spirit who was taken too soon'.[4] Her memories of XY are of a child who loved to 'sing, dance and dress up', who was artistic, adventurous and close to her family.[5] She described XY as 'a talented, beautiful, happy and giggly girl', who would light up a room, a 'bushy' who loved to go camping with her Uncle ████ ████.[6]

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[2] Coronial Brief – Medical Records Volume, 6665. ('MR')
[3] Statement of XY's Mother, Coronial Brief – Coronial Brief Volume, 33 [4]. ('CB')
[4] Statement of XY's Mother, CB 33 [5].
[5] Ibid [9], [11], [13] and [15].
[6] Ibid [5]-[14].

10. XY's kinship carer Jacquii Jackson spoke of her spirit as follows:

> XY had many wonderful qualities and was a beautiful child and also, she had so many struggles on a daily basis, she always tried her hardest to push through.[7]

CONTEXT

11. Before I turn to address some of the circumstances relevant to XY, it is important to acknowledge the broader social and historical context within which XY’s passing occurred.

12. Aboriginal and Torres Strait Islander people have lived in Australia for more than 60,000 years, displaying sophisticated ways of living and caring for Country and each other. Suicide was virtually unknown in Australia prior to colonisation. [8] In stark contrast, between 2018 and 2022 in Victoria, Aboriginal and Torres Strait Islander people died by suicide at a rate nearly three times higher than non-Indigenous people.[9] Professor Pat Dudgeon, an Aboriginal expert in suicide prevention, gave evidence that in 2021, suicide accounted for 5.3% of Aboriginal and Torres Strait Islander deaths while for non-Indigenous Australians suicide accounted for 1.8% of deaths. [10]

13. The rate of self-harm for Aboriginal youths is also approximately three times higher than for non-Indigenous youths. This is a significant concern not only because self-harm behaviours in themselves can cause distress and injury, but also because intentional self-harm is a strong predictor of future suicide attempts.[11]

14. Recent reports prepared by the Coroners Aboriginal Engagement Unit and the Coroners Prevention Unit as part of this court’s prevention functions demonstrate that this alarming public health trend amongst First Peoples is continuing.[12]

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[7] Coronial Impact Statement of Jacquii Jackson (1 November 2023) 4; T 722:11-14.
[8] Statement of Pat Dudgeon, CB 3654.
[9] Coroners Court of Victoria, ‘Suicides of Aboriginal and Torres Strait Islander people in Victoria, 2018-2022’ (22 February 2023), 8.
[10] Statement of Pat Dudgeon, CB 3655.
[11] Statement of Pat Dudgeon, CB 3655.
[12] See Coroners Court of Victoria, ‘Suicides of Aboriginal and Torres Strait Islander people in Victoria, 2018-2022’ (22 February 2023).

15. In addition, Aboriginal children and young persons are grossly overrepresented in Victoria's child protection system. This is despite multiple reports and inquiries into the child protection system in Victoria over the last decade which have made recommendations directed towards improving the plight of Aboriginal children and young people in state care.

16. Since XY's passing there have been two commissions undertaken in Victoria which have directly confronted some of the systemic issues raised by the investigation into XY's passing.

Royal Commission into Victoria's Mental Health System

17. In March 2021, the Royal Commission into Victoria's Mental Health System ('RCVMHS') delivered its final report. Implementation of the recommendations made by the RCVMHS is currently underway in Victoria, with substantial reforms being implemented with the aim of improving the capacity of Victoria's mental health system, including by:

    a. improving supports available to support children, young people and families;

    b. redesigning bed-based services for young people;

    c. improving supports available to address trauma;

    d. providing culturally safe suicide prevention responses; and

    e. supporting Aboriginal Social and Emotional Wellbeing.[13]

18. To avoid unnecessary duplication of inquiries and investigations, [14] and because implementation of the substantial recommendations made by the RCVMHS is currently underway, I directed that the mental health supports that were in place for XY be examined only to the extent that they fell within the scope of the inquest due to their interaction with the child protection system.[15]

[13] Statement of Paul Flowerdew, CB 2021-1 – 2021-12.
[14] *Coroners Act 2008* (Vic), s 7. ('*Coroners Act*')
[15] Transcript of Directions Hearing (29 March 2023), 5-6.

19. I was fortified in taking this course by the opinion of the court-appointed expert psychiatrist, Associate Professor Robert Parker, who advised me that, following his review of XY's treatment, and as at the time of her passing, the mental health services made available to her, primarily through Bendigo Health, were reasonable and appropriate given her complex presentation and the broader system's contemporaneous design and resourcing. [16] Given that those systemic parameters have changed significantly since the Royal Commission, I decided in the course of setting the scope for this investigation that there was no utility in examining the operation of the mental health system *as it was at the time of XY's passing*, although understanding aspects of that system would shed light on the reasonableness and appropriateness of the child protection system's interactions with it.

20. It was with this limited goal in mind that I received evidence about the operation of the mental health system.

Yoorrook Justice Commission

21. On 4 September 2023, the Yoorrook Justice Commission ('Yoorrook') delivered its second interim report, *Yoorrook for Justice: Report into Victoria's Child Protection and Criminal Justice Systems* ('Yoorrook Report').[17]

22. The Yoorrook Report recommended that the Victorian Government 'transfer decision-making power, authority, control and resources to First Peoples, giving full effect to self-determination in the Victorian child protection system', and recommended that negotiations to facilitate such change occur through the Treaty process, including through potential interim agreements. [18] In addition, Yoorrook recommended wide-ranging, urgent reforms be made to Victoria's child protection system.[19]

23. These Findings are informed by the contents of the Yoorrook report and its recommendations, some of which are already in the early stages of implementation.

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[16] Expert report of Robert Parker, CB 3050, especially at 3062–3065.
[17] Yoorrook Justice Commission, *Yoorrook for Justice: Report into Victoria's Child Protection and Criminal Justice Systems* (Interim Report No 2, August 2023). ('Yoorrook Report')
[18] Yoorrook Report (fn 17) 26, Recommendation 1.
[19] Ibid 29-34 Recommendations 7-26.

Again, Yoorrook's important work represented an opportunity to avoid unnecessary duplication of inquiries and investigations.[20]

24. The Yoorrook report is also a rich source of statistical evidence regarding the experiences of First Peoples children and young people in Victoria's child protection system. It confirmed that First Nations children and young people are overrepresented in Victoria's child protection system and in out-of-home care. As at 30 June 2022, Aboriginal children in Victoria were, when compared to non-Aboriginal children:

    a. 5.7 times as likely to be the subject of a report to child protection services;

    b. 8.5 times as likely to be found to be 'in need of protection' by child protection services; and

    c. 21.7 times as likely to be in out-of-home care.[21]

25. In addition, as of 31 March 2023, 29 per cent of children in state care in Victoria were Aboriginal. [22]

26. Evidence before Yoorrook also showed that a very high proportion of Aboriginal children and young people in out-of-home care have a mental health diagnosis. Among other research, the Yoorrook report cited a 2019 report of the Victorian Auditor General's Office that found that children in out-of-home care had more than five times the rate of mental health problems and double the rate of suicide attempts compared to the general population.[23]

27. These sombre statistics are a stark reminder that XY's experience within the Victorian child protection system was unfortunately not unique. There are historic and ongoing systemic issues for Aboriginal children and young people in protective care of the state which require urgent resolution.

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[20] *Coroners Act* s 7.
[21] Yoorrook Report (fn 17) 18-19 (citations omitted).
[22] Ibid 178.
[23] Yoorrook Report (fn 17) 191, citing Victorian Auditor-General's Office, *Child and Youth Mental Health* (June 2019) 15.

28. In their April 2024 response to the Yoorrook report, the Victorian Government indicated either support, in principle support, or consideration of a number of Yoorrook's recommendations that have relevance to this investigation, including those relating to self-determination, cultural plans, kinship placements, family reunification and the role of siblings.[24] The overlap of those recommendations with matters within the scope of this investigation means that the Victorian Government will have the opportunity to map any further progress in their consideration and implementation of reforms into their formal responses to the recommendations I make in these Findings.

National Agreement on Closing the Gap

29. This year also saw the publication of the Productivity Commission's first *Review of the National Agreement on Closing the Gap* ('*Closing the Gap Review*').[25]

30. The Commission explained the purpose of the project as follows:

> In 2020, all Australian governments, along with the Coalition of Aboriginal and Torres Strait Islander Peak Organisations, signed the National Agreement on Closing the Gap (the Agreement). They committed to mobilising all avenues available to them to achieve the objective of the Agreement – which is 'to overcome the entrenched inequality faced by too many Aboriginal and Torres Strait Islander people so that their life outcomes are equal to those of all Australians'.[26]

31. Aside from its deep dive into progress (or otherwise) in specific outcome areas, the report generally confirmed that governments around Australia still retain power over decision making in partnerships with First Nations people, and still require First Nations people to fit into mainstream approaches to design and implementation.[27] The Commission's 'overarching finding' was that 'a paradigm shift' and 'fundamental change' is required.[28]

32. The Commission further stated:

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[24] Victorian Government, 'Response to the *Yoorrook for Justice* report' (April 2024). See responses to recommendations 1, 5, 7, 9-10, 13-18, 20, 22, 25-26 and 29.
[25] Australian Government Productivity Commission, *Review of the National Agreement on Closing the Gap* (February 2024). ('*Closing the Gap Review*')
[26] *Closing the Gap Review* (fn 25) (Vol 1, Study Report) 3.
[27] Ibid 34.
[28] Ibid 3, 79.

> It remains too easy to find examples of governments making decisions that contradict their commitments in the Agreement, that do not reflect Aboriginal and Torres Strait Islander people's priorities and perspectives and that exacerbate, rather than remedy, disadvantage and discrimination.[29]

33. This year, the Commission looked specifically at the performance of the child protection sector, and concluded that our governments are 'not on track' to close this gap:

> Socio economic outcome 12 (SEO 12) of the Agreement is about Aboriginal and Torres Strait Islander children and young people being able to grow up safe and cared for in family, community and culture. The target of SEO 12 is to reduce the over representation of Aboriginal and Torres Strait Islander children in out of home care by 45% by 2031.
>
> The SEO 12 target remains off track, and is worsening nationally. At 30 June 2022, the rate of Aboriginal and Torres Strait Islander children aged 0–17 years in out-of-home care was 56.8 per 1,000 children in the population. This is an increase from 54.2 per 1,000 children in 2019 (the baseline year). The average annual change was an increase of 0.91 per 1,000 children, with an average annual decrease of 2.03 per 1,000 children required to meet the target (PC 2023d, p. 66).
>
> Progress against this target varies across jurisdictions. Victoria and South Australia have the highest rates of Aboriginal and Torres Strait Islander children in out-of-home care (102.2 and 92.7 per 1000 children respectively) and these rates have increased substantially since 2019. [30]

34. Nationally, there were 22,243 Aboriginal and Torres Strait Islander children in out-of-home care as at 30 June 2021, representing one in every 15.2, and making Aboriginal and Torres Strait Islander children approximately 10 times more likely to be in out-of-home care than non-Indigenous children. [31] As at 30 June 2022, First Nations children represented just over 40% of all children aged 0-17 years in out-of-home care across Australia, despite comprising just 6% of the population in this age group.[32]

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[29] Ibid 79.
[30] *Closing the Gap Review* (fn 25) (Vol 2, Supporting Paper) 316.
[31] Ibid 316.
[32] Ibid 317.

35. The trigger for XY's removal from her family was disclosure of abuse. On this front, the Commission reported that, nationally:

> …in 2021-22, 39.8 per 1,000 Aboriginal and Torres Strait Islander children aged 0–17 years were the subject of substantiated abuse, with emotional abuse the most common type, and the only type to increase from 2018-19. All other types (physical and sexual abuse and neglect) recorded decreases.[33]

36. Further, in 2021, 6 out of 10 First Nations children in out-of-home care across Australia were not living with culturally related carers, although Victoria was among the jurisdictions that were able to report improved numbers of placements with a First Nations relative or kin from 2017.[34]

37. First Nations children subject to child protection reunification orders were only reunited with their families in 16.4% of all cases, whereas 21.5% of non-indigenous children were reunified.[35]

38. As will become apparent below, XY had the misfortune to be on the wrong side of all these statistics.

39. Several of the recommendations made in these Findings relate to innovations and reforms that have already been introduced, or sometimes just foreshadowed, but so recently that there has understandably not been time to assess their effectiveness. While I have noted the existence of those reforms in those instances, as an aid to better monitoring and future accountability I have nonetheless made the recommendations in their originally proposed forms, so as to enable the interested parties, in their mandated responses, to have an additional three months to assemble evidence as to the effectiveness of the reforms targeted to those recommendations.

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[33] Ibid 317.
[34] Ibid.
[35] Ibid.

The Secretary's role *in loco parentis* and the Court's *parens patriae* jurisdiction

40. It is uncontroversial that once a Care by Secretary Order[36] was made in relation to XY on 30 September 2019,[37] the Secretary of the Department of Health and Human Services (as it then was) had 'parental responsibility'[38] for her, to the exclusion of all others, for two years.

41. The common law has long described this legal standing, and its consequential obligations, with the Latin phrase *in loco parentis*, meaning 'in place of the parent' and describing 'a person who looks after another's child for and on behalf of the parent and acts as a substitute parent and assumes responsibility for providing for the child in the parent's absence'.[39]

42. There is authority for the proposition that the phrase 'parental responsibility,' used in the *Children, Youth and Families Act 2005* ('*CYFA*'), carries with it even more comprehensive powers and obligations than a common law actor standing *in loco parentis*.[40]

43. So, while this means the DFFH was responsible for XY's care, wellbeing and all decisions concerning her, the chain of responsibility does not end there. A Court's ordinary jurisdictional powers are buttressed by the common law doctrine of *parens patriae* once the welfare of a child is at stake. Garde J held in *Secretary to the Department of Justice and Regulation v McIntyre*:[41]

> The doctrine of parens patriae is foundational and … is now incorporated by legislation into family law, guardianship, child welfare and child protection jurisdictions across Australia.

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[36] *Children, Youth and Families Act 2005* (Vic), s 289. ('*CYFA*')
[37] Coronial Brief – Protection Records Volume, 5726. ('PR')
[38] *CYFA* s 3(1).
[39] *Butterworths Australian Legal Dictionary* (1997) 'in loco parentis'.
[40] For instance, see *Habib v QBE Insurance (Australia) Limited* [2022] NSWPICMR 73 at [71]: '…the term 'parental responsibility' which requires the claimant to have 'all' of the duties of the parents on a continuing basis and not just some of those duties on a transient basis.'
[41] (2019) 56 VR 526; [2019] VSC 105, [54]

44. Thus, it has fallen to this court to now exercise its statutory jurisdiction with these responsibilities in mind.

THE CHARTER IN CORONIAL INVESTIGATIONS

45. Human rights law protects children in Australia. The key instrument is the United Nations *Convention on the Rights of the Child* [42] ('*CRC*'), which Australia ratified in 1990. The *CRC* outlines a comprehensive set of civil, political, economic, social and cultural rights for children. Some key child rights protected under the *CRC* include the right to life, health, education, play, freedom from violence and abuse, and overarchingly, having their best interests taken as a primary consideration in all actions that concern them. The *CRC* also recognizes the rights and responsibilities of parents in raising children.

46. Within Australia, the protection of children's human rights extends into the laws of the State of Victoria. The key instrument is the *Charter of Human Rights and Responsibilities Act 2006* ('*Charter*'), which protects twenty civil and political rights derived from the *International Covenant on Civil and Political Rights* ('*ICCPR*').[43] In addition to rights of generic application to all individuals, the *Charter* includes specific rights for children under section 17(2), which states:

> Every child has the right, without discrimination, to such protection as is in his or her best interests and is needed by him or her by reason of being a child.

47. As I will unpack below, the *Charter* requires all statutory provisions to be interpreted compatibly with human rights. It also requires Victorian public authorities to act in way that is compatible with human rights and to give proper consideration to human rights when making decisions – obligations that equally apply to the specific human rights of children. In considering compatibility with human rights, the reasonableness and demonstrable justifiability of any limitations on those rights can be evaluated in Victorian court proceedings. Complaints about potential breaches can be made to the Victorian Ombudsman.[44]

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[42] Opened for signature 20 November 1989, 1577 UNTS 3 (entered into force 2 September 1990). ('*CRC*')
[43] Opened for signature 19 December 1966, 999 UNTS 171 (entered into force 23 March 1976). ('*ICCPR*')
[44] Bronwyn Naylor, Julie Debeljak and Anita Mackay, 'A Strategic Framework for Implementing Human Rights in Closed Environments: A Human Rights Regulatory Framework and its Implementation', (2015) 41 *Monash University Law Review* 218-70.

48. While Australia has implemented many of the *CRC* obligations through domestic laws, the Committee on the Rights of the Child has raised concerns about the treatment and wellbeing of certain groups, including First Nations children.[45] The Federal Government has committed to upholding these rights and addressing violations through policies, programs and independent monitoring bodies like the National Aboriginal and Torres Strait Islander Children's Commissioner.[46]

49. In summary, even though international human rights treaties like the *CRC* have been ratified by Australia and legally oblige the government to protect and promote the rights of all children inside the country, their domestic implementation remains an ongoing challenge in some areas.

50. Perhaps for this reason, recommendation 5 of the Yoorrook Report emphasised the importance of upscaling Victorian Government capability, competence and support in relation to human rights:

> … including Aboriginal cultural rights, of all persons appointed to work or working in:
>
> a) the child protection system
>
> …
>
> e) Victoria police
>
> …
>
> to ensure that they have the capability, competence and support necessary for them to carry out the obligations under [the *Charter*] and other human and cultural rights laws, and in particular for this purpose the government must:

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[45] Committee on the Rights of the Child, *Concluding Observations on the combined fifth and sixth Periodic Reports of Australia* (Doc No CRC/C/AUS/CO/5-6, 1 November 2019); and see also the immediately previous report: Committee on the Rights of the Child, *Consideration of reports submitted by States parties under article 44 of the Convention : Convention on the Rights of the Child : concluding observations : Australia* (Doc CRC/C/AUS/CO/4, 28 August 2012).

[46] See Attorney-General's Department (Cth), 'Australia's response to the Committee on the Rights of the Child List of issues in relation to the combined fifth and sixth reports of Australia' (3 July 2019); Department of the Prime Minister and Cabinet (Cth), 'Next Steps on Closing the Gap: delivering remote jobs' (Media Release, 13 February 2024).

g) review and revise all relevant policies, procedures, protocols, administrative directions, guidelines and like documents

h) review all relevant training courses and programs; and

i) ensure that Victorian First Peoples businesses or consultants participate on a paid basis in the review and revision of training courses or programs, and the delivery of these, wherever possible.

51. It will be clear from what follows that I consider human rights mechanisms to be a useful lens through which to view the multitude of interactions that the state and its delegates have with individuals within its jurisdiction. When one is considering whether a death was preventable, it is useful to have the human rights of the person in mind, and to consider:

    a. whether one or more of the person's human rights were engaged during the interactions that person had with the state;

    b. if so, whether those rights were limited by the state during such interactions; and,

    c. if so,

        i. whether the limitations are reasonable and can be demonstrably justified; or

        ii. whether alternative pathways were available, that more effectively balanced the right and the limit, both in terms of assessing compatibility with rights and considering future prevention opportunities.

52. Those alternative pathways may identify future prevention opportunities, even if the alternatives themselves did not form part of the factual circumstances that actually occurred in this particular case, nor formed part of any chain of actual causation in the present death under investigation.

53. The *Charter* sets out the twenty civil and political rights the Victorian Parliament seeks to protect and promote by ensuring that when laws are enacted, and their provisions interpreted, this is done so far as is possible to do so in a way that is compatible with

those rights.[47] The *Charter* also obliges public authorities (including courts and tribunals when acting administratively)[48] to act compatibly with human rights and give proper consideration to rights when making decisions.[49] Human rights may only be limited to the extent that a limitation is reasonable and can be demonstrably justified in a free and democratic society taking into account all relevant factors.[50]

54. The *Charter* influences coronial proceedings due to:

    a. the application of the *Charter* to the Coroners Court itself;

    b. the application of the *Charter* to public authorities (other than the Coroners Court); and

    c. the *Charter* rights engaged by the factual events within the scope of the inquest.

The application of the *Charter* to the Coroners Court itself

55. Pursuant to section 4(1)(j) of the *Charter*, a court or tribunal is not a public authority except when it is acting in an 'administrative capacity'. That expression is not defined in the *Charter* and there is no direct Australian judicial authority to my knowledge on whether the Coroners Court is a public authority under the *Charter* when conducting an inquest and exercising the powers in the *Coroners Act 2008* (Vic) ('*Coroners Act*') to make findings, comments and recommendations. Whilst many coronial functions are administrative, a Victorian coroner is exercising judicial power when they preside over an inquest hearing, as distinct from an investigation on the papers.[51]

56. That said, the Coroners Court is acting administratively when investigating a reportable death and is therefore a public authority at those times and so is required to act compatibly with human rights and give proper consideration to relevant human rights when making those administrative decisions pursuant to section 38 of the *Charter*.

[47] *Charter* ss 1, 28, and 32.
[48] Ibid s 4.
[49] Ibid s 32.
[50] Ibid s 7.
[51] *Cemino v Cannan* [2018] VSC 535, [92] ('*Cemino v Cannan*'). See also Coroners Court of Victoria, *Inquest into the Passing of Veronica Nelson* (COR 2020 0021, 30 January 2023) Appendix A. An appeal against this decision on a different point was subsequently dismissed: *Runacres v The Coroners Court of Victoria* [2024] VSC 304 (11 June 2024).

57. Irrespective of whether it is a public authority, section 6(2)(b) of the *Charter* applies directly to the Coroners Court to the extent that it has functions under Part 2 (that is, relating to particular *Charter* rights), and Division 3 of Part 2 (interpretation of laws, including the *Coroners Act* itself). The most consistently accepted construction of section 6(2)(b) is that the function of the court is to enforce directly only those rights enacted in Part 2 of the *Charter* that directly relate to court proceedings.[52]

58. The Coroners Court most evidently has functions under the right to life (s 9 of the *Charter*), namely, to conduct an effective investigation into a reportable death. In addition, and in common with other courts, the Coroners Court has functions relating to the way matters are conducted, including the rights to a fair hearing and to equality before the law (ss 24 and 8 of the *Charter* respectively).[53]

59. Finally, section 32(1) of the *Charter* provides that so far as it is possible to do so consistently with their purpose, all statutory provisions must be interpreted in a way that is compatible with human rights. Relevantly, I am satisfied that a compatible interpretation of the power conferred by section 67(1) of the *Coroners Act* is one that includes investigating breaches of human rights that might have caused or contributed to XY's passing. Consistent with that view, interpretation of the powers to comment and make recommendations pursuant to sections 67(3) and 72 of the *Coroners Act*, respectively, encompasses powers to make recommendations and comments in relation to human rights issues connected with the death.[54]

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[52] *Cemino v Cannan* (fn 51) [110]; *De Simone v Bevnol Constructions* (2009) 25 VR 237, 247 [52] (Neave JA and Williams AJA); *Kracke v Mental Health Review Board* (2009) 29 VAR 1, 63 [250] (Bell J); *Victoria Police Toll Enforcement v Taha* (2013) 49 VR 1, [247]-[248] (Tate JA); *Matsoukatidou v Yarra Ranges Council* [2017] VSC 61 ('*Matsoukatidou'*) [32] and references cited in footnote 12; *DPP v SL* [2016] VSC 714, [6]; *Application for bail by HL* [2016] VSC 750, [72] (Elliot J); *DPP v SE* [2017] VSC 13, [12] (Bell J); *Harkness v Roberts; Kyriazis v County Court of Victoria (No 2)* [2017] VSC 646 [21].

[53] If a right applies directly to a court via section 6(2)(b), when assessing whether the court has acted compatibly with the right, section 7(2) should be applied: *Matsoukatidou* (fn 52) [58]; *Victoria Police Toll Enforcement v Taha* (2013) 49 VR 1, [250].

[54] I note that in the *Inquest into the death of Tanya Day*, Coroner English made a Ruling on the scope of the Inquest. At [19] of the Ruling, Coroner English stated that for her to rule on the scope of that inquest it was not necessary to address the question of whether the Coroners Court is a public authority when conducting an inquest and exercising the powers in the *Coroners Act* to make findings and recommendations on matters connected with a death. Accordingly, Coroner English did not rule on this issue.

The application of the *Charter* to public authorities (other than the Coroners Court)

60. Section 4 of the *Charter* defines a 'public authority', relevantly, to include certain individuals and entities having functions of a public nature or that exercise functions on behalf of the state or a public authority (whether under contract or otherwise).[55] This means that with the exception of the Senior Next of Kin and Dr Thileepan Naren, the remainder of the interested parties in this inquest are public authorities for the purposes of the *Charter*.

61. As mentioned above, section 38(1) of the *Charter* imposes two distinct obligations on a public authority. It makes it unlawful for a public authority to act in a way that is incompatible with a human right (the so called 'substantive obligation') and, in making a decision, to fail to give proper consideration to a relevant human right (the so called 'procedural obligation'). These obligations do not apply if the public authority cannot reasonably act differently or make a different decision under law under section 38(2), for example where a public authority is giving effect to an express statutory provision that is incompatible with human rights.[56]

62. Section 7(2) of the *Charter* applies to a public authority's obligation to act compatibly with human rights (the 'substantive obligation'). Where an action of a public authority limits a right, but the limit is reasonable and demonstrably justified, the restriction on the human right is not unlawful. This means there is no contravention of the obligations under section 38 of the *Charter*. Whether a limitation of a right is reasonable and demonstrably justified is an assessment made by reference to the inclusive list of factors contained in section 7(2), which includes the nature of the right, the importance of the purpose of the limitation, the nature and extent of the limitation, the relationship between the limitation and its purpose, and any less restrictive means reasonably available to achieve the purpose sought to be achieved by the limitation. Section 7(2) of the *Charter* embodies a proportionality test.[57]

63. Even if a limitation on a human right arising from an act of a public authority is ultimately found to be reasonable and demonstrably justified, if the public authority has made a

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[55] *Charter* s 4.
[56] *Charter* s 38(2), and example provided in the *Charter*.
[57] *Momcilovic v R* (2011) 245 CLR 1, 39 [22] (French CJ).

decision, it is still required to give proper consideration to human rights in making that decision (the 'procedural obligation'). This procedural component of a public authority's obligation is additional or supplementary to any obligation imposed under the primary legislation governing the operations of the public authority. [58] The content of this procedural obligation is now settled in Victorian law[59] such that proper consideration, while it may be discharged in a manner suited to the particular circumstances,[60] cannot be satisfied by merely invoking the *Charter* 'like a mantra'.[61] Rather, it requires 'that review by the Court be of the substance of the decision-maker's consideration rather than the form'.[62] The two obligations under section 38 are independent and cumulative, which means both obligations must be met.[63]

64. Jurisprudence of the Supreme Court of Victoria then guides the questions to ask when determining unlawfulness under section 38(1): [64]

    (a) is any human right relevant to the decision or action that a public authority has made, taken, proposed to take or failed to take? (the relevance or engagement question);

    (b) if so, has the public authority done or failed to do anything that limits that right? (the limitation question);

    (c) if so, is that limit under law reasonable and is it demonstrably justified having regard to the matters set out in s 7(2) of the *Charter*? (the proportionality or justification question);

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[58] *Colin Thompson (in his capacity as Governor of Barwon Prison) & Anor v Craig Minogue* [2021] VSCA 358 [80].

[59] *Castles v Secretary of Department of Justice* (2010) 28 VR 141 ('*Castles*'), 184 [185]-[186]; *De Bruyn*, 669-701 [139]-[142]; *Bare*, 198-199 [217]-[221] (Warren CJ), 218-219 [277]-[278] (Tate JA), 297 [534] (Santamaria JA) (each of the three Justices of Appeal applied the 'Castles test' for proper consideration by way of *obiter dicta*); *Colin Thompson (in his capacity as Governor of Barwon Prison) & Anor v Craig Minogue* [2021] VSCA 358 [83].

[60] *PJB v Melbourne Health (Patrick's Case)* (2011) 39 VR 373 [311] (Bell J).

[61] *Castles* (fn 59) 184 [186].

[62] *De Bruyn v Victorian Institute of Forensic Mental Health* (2016) 48 VR 647, 701 [142].

[63] *Certain Children by their Litigation Guardian Sister Marie Brigid Arthur v Minister for Families and Children (No 2)* [2017] VSC 251, [177] and [225]-[226] ('*Certain Children (No 2)*').

[64] *Certain Children (No 2)* (fn 63) [174]; *Minogue v Dougherty* [2017] VSC 724 at [74]. These questions build on the three-step approach articulated in *Sabet* at [108] which was applied by the Court of Appeal in *Baker v DPP* [2017] VSCA 58 at [56].

(d) even if the limit is reasonable and demonstrably justifiable, if the public authority has made a decision, did it give proper consideration to the right? (the proper consideration question);

(e) was the act or decision made under an Act or instrument that gave the public authority no discretion in relation to the act or decision, or does the Act confer a discretion that cannot be interpreted under s 32 of the *Charter* in a way that is consistent with the protected right (the inevitable infringement question).

65. It appears that paragraphs (a) to (c) address the substantive obligation under section 38(1), paragraph (d) addresses the procedural obligation under section 38(1), and paragraph (e) addresses the exception to unlawfulness under section 38(2).

66. Focusing on the procedural obligation, the Supreme court has explained that, whilst there is 'no strict formula' and the decision-making process should not be scrutinised 'over-zealously', a decision maker must undertake a number of steps to 'give proper consideration'. The decision maker must:[65]

a. understand in general terms which are the rights of the person affected by the decision may be relevant and whether and if so how those rights will be interfered with by the decision;

b. seriously turn their mind to the possible impact of the decision on a person's human rights and the implications there of for the affected person;

c. identify the countervailing interests or obligations; and

d. balance competing private and public interests as part of the exercise of justification.

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[65] *Ibid* [185]-[186]. See also *Certain Children (No 2)* (fn 63) [174]; *Minogue v Dougherty* [2017] VSC 724 at [74]. These questions build on the three-step approach articulated in *Sabet* at [108] which was applied by the Court of Appeal in *Baker v DPP* [2017] VSCA 58 at [56]. See also Pound A & Evans K, *Annotated Victorian Charter of Rights* (2nd Ed) (2019) Thompson Reuters, Sydney, Australia at p.304.

The Content of the Rights of a Child in Victoria

67. The overarching nature of the human rights protections afforded to children makes this particular right the most relevant lens through which to review whether XY's human rights were adequately honoured.

68. In section 17 of the *Charter,* the Victoria Parliament gave domestic effect to Australia's *CRC* obligations [66] to ensure that the best interests of the child shall be a primary consideration in all actions concerning children. The inclusion of this right recognises the special vulnerability of children, so it is a right they hold in addition to all other *Charter* rights.[67]

69. While the terms of section 17(2) do not specify who it is that is required to protect children, the *Charter* only applies to Parliament, courts and tribunals, and public authorities to the extent specified by section 6(2) of the *Charter*. While other entities (such as the child's family or society generally) may have a social responsibility to protect children, for current purposes the section 17(2) obligation to protect children rests on the government through the performance of functions by public authorities using the mechanisms I have set out above.

70. Australian courts have acknowledged the relevance of the *CRC* at a domestic level. [68] In *Northern Territory v GPAO* (1999) 196 CLR 553, per Gleeson CJ and Gummow J at 584, Their Honours held that the best interests of the child was an 'important and salutary principle of substantive law, adopted by courts exercising *parens patriae* jurisdiction for more than a century'.

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[66] Article 3 of the *CRC* requires that '[i]n all actions concerning children… the best interests of the child shall be a primary consideration'. See also Article 12.

[67] Other *Charter* rights are also engaged by the factual matrix of this inquest, such as Sections 8 Equality, 9 Right to Life, and 19 Cultural Rights.

[68] *Minister of State for Immigration and Ethnic Affairs v Teoh* [1995] HCA 20; (1995) 183 CLR 273, 287, 288, 291 (Mason CJ and Deane J), 302 (Toohey J); 305-6 (Gaudron J). See also *Certain Children by their Litigation Guardian Sister Marie Brigid Arthur v Minister for Families and Children* [2016] VSC 796 [146] (*'Certain Children (No 1)*'); see also *Application for Bail by HL* [2017] VSC 1 [121]-[123]; *Certain Children (No 2)* (fn 63) [260]-[262].

71. In *Secretary to the Department of Human Services v Sanding* [2011] VSC 42, a case involving Aboriginal children in the child protection system, in the context of sections 17(2) and 24, Bell J pointed out that:

> It is unquestionably important for the voice of a child to be heard in matters affecting them. As I have said, children bear rights personally, and are entitled to respect of their individual human dignity. The views of children should therefore be obtained and given proper consideration.[69]

72. Garde J described the 'best interests of the child' as the central element of the right recognised by section 17(2), adding that 'by reason of ss 17(2) and 38 of the Charter, the best interests principle is … imported to the acts and decisions of a public authority that engages Charter rights'.[70]

73. While the *Charter* does not define 'best interests', the phrase has been subjected to substantial analysis in different contexts. Courts, public authorities and legislators could refer to a number of different sources, both international and domestic, in considering what meaning to attribute to 'best interests' in the *Charter* context.[71]

74. In particular, the Supreme Court has indicated that the *CRC* is relevant to interpreting the meaning of 'best interests' in the *Charter*, and the scope of section 17(2) more generally. Sections 10(2) and 10(3) of the *CYFA* set out matters that must be considered when deciding what is in the 'best interests' of a child. These matters provide guidance on the content of section 17(2) of the *Charter*.[72] Those considerations include, among other things:

    a. the need to protect the child from harm;

    b. the need to protect the child's rights;

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[69] At [209].
[70] *Certain Children No 1* (fn 68) [145]. This is consistent with how the equivalent right in art 24(1) of the *ICCPR* has been interpreted. See *Human Rights Committee, Views: Communication No 1069/2002 (Bakhtiyari v Australia),* 79th sess, Doc CCPR/C/79/D/1069/2002 (6 November 2003) [9.7]).
[71] *A & B v Children's Court of Victoria* [2012] VSC 589 [109]; *Certain Children No 1* (fn 68) [146].
[72] *Re HL (No 2)* [2017] VSC 1 [123].

c. the need to promote the child's development (taking into account the child's age and stage of development);

d. the child's views and wishes;

e. that intervention into the relationship between parent and child is limited to that necessary to secure the safety and wellbeing of the child;

f. the need to strengthen, preserve and promote positive relationships between the child and the child's parent, family members and persons significant to the child; and

g. that a child is only to be removed from the care of his or her parent if there is an unacceptable risk of harm to the child.[73]

75. There is a comforting analogue between these criteria and those expressed in the international jurisprudence, where the Committee on the Rights of the Child has suggested that the following indicia may be taken into account when assessing the child's best interests:

a. the child's views;

b. the child's identity;

c. preservation of the family environment and maintaining relationships;

d. care, protection and safety of the child;

e. situation of vulnerability;

f. the child's right to health; and

g. the child's right to education.[74]

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[73] *CYFA* ss 10(2), 10 (3).

[74] Committee on the Rights of the Children, *General Comment No. 14 (2013) on the right of the child to have his or her best interests taken as a primary consideration (art 3, para 1)*, 62nd sess, Doc CRC/C/GC/14 (29 May 2013) [52]–[79]

76. Saliently in this proceeding, the international jurisprudence leaves no doubt that the child's own views about what is in their best interests are to be 'given due weight in accordance with their age and maturity',[75] a principle that has been accepted and affirmed by the Victorian Supreme Court: indeed, Dixon J has stated that it would not be possible to make such an assessment without meeting those requirements.[76]

77. I will return to this analysis in the 'XY's Voice' section, towards the end of this Finding.

Cultural rights

78. Since XY identified with her Wemba Wemba heritage, she also has an additional source of human rights protection.

79. Section 19 of the *Charter* protects cultural rights and distinct Aboriginal cultural rights. In the absence of any detailed consideration of the scope of the cultural rights protected by section 19 in Victorian law, international jurisprudence suggests that positive measures may be necessary to protect against the denial or infringement of the right to culture.[77] Further, the denial of the right to culture must meet a certain threshold to be considered a violation. Whether 'interference' becomes 'so substantial' that it amounts to a 'denial' of the right[78] is a question of degree.

80. XY's Aboriginal identity raises for consideration the cultural competence of those who interacted with her proximate to her passing, especially whether the treatment and care she received was culturally safe. Care and treatment that is culturally safe for Aboriginal people and delivered by staff who are culturally competent is likely to promote the rights of Aboriginal people to enjoy their identity and culture by incorporating Aboriginal cultural practices and holistic understanding of health, as well as social, emotional, spiritual and cultural wellbeing, and allowing Aboriginal people to safely express their culture and identity when seeking and receiving care.[79]

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[75] *CRC* article 12; see also *Human Rights Committee General Comment 20*, [3].

[76] *Certain Children (No 2)* (fn 63) [262]; see also *Department of Human Services v Sanding* (2011) 36 VR 221; [2011] VSC 42 [209]; *Certain Children (No 1)* (fn 68).

[77] *Poma Poma v Peru*, United Nations Human Rights Committee, Views: Communication No 1457/2006, Doc.

[78] Ibid.

[79] See Martin Laverty, Dennis McDermott and Tom Calma, 'Embedding Cultural Safety in Australia's Main Health Care Standards' (2017) 207(1) *Medical Journal of Australia* 15; Judy Atkinson, 'Trauma-informed

81. Accordingly, I also applied this lens when reviewing XY's interactions with those charged to act in her best interests. For the purposes of this Finding, I have proceeded on the basis that enabling, engaging, renewing and or maintaining XY's access to her own culture was in her best interests, even where aspects of her relationship with her own family from within that culture were at times problematic for her.

82. With this framework in mind, I now turn to my statutory tasks under the *Coroners Act*.

THE CORONIAL INVESTIGATION

Jurisdiction

83. XY's death constituted a 'reportable death' pursuant to section 4 of the *Coroners Act* because her death occurred in Victoria, was unexpected and unnatural, and immediately before her passing, XY was a person deemed to be 'in care' by virtue of being under the care of the Secretary of the DFFH.[80]

Purpose of a coronial investigation

84. The jurisdiction of the Coroners Court is inquisitorial. [81] The specific purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the medical cause of death and the circumstances in which the death occurred.[82]

85. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the investigation findings and by the making of recommendations by coroners. [83] This is generally referred to as the coroner's prevention role.

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services and trauma-specific care for Indigenous Australian children', Resource sheet no. 21, 23 July 2013, http://earlytraumagrief.anu.edu.au/files/ctg-rs21.pdf; *Finding into the death of Harley Robert Larking* (Coroners Court of Victoria, Deputy State Coroner English, 18 September 2020).

[80] *Coroners Act* ss 4(1), 4(2)(a), 4(2)(c).

[81] Ibid s 89(4).

[82] Ibid s 67(1).

[83] Ibid s 1(c).

86. Coroners are empowered to:

a. comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice;[84] and

b. make recommendations to any Minister or public statutory authority or entity on any matter connected with the death, including public health or safety or the administration of justice.[85]

87. These powers are the mechanisms through which the coroner's prevention role can be advanced.

The holding of an inquest

88. As XY was a 'person placed in custody or care' immediately before her passing,[86] the investigation into her passing must include an inquest, pursuant to section 52(2) of the *Coroners Act*.[87]

Findings pursuant to section 67(1)

89. The matters regarding which a coroner investigating a death must, if possible, make findings are set out in section 67(1) of the *Coroners Act*. They are:

a. the identity of the deceased; and

b. the cause of death; and

c. the circumstances in which the death occurred.

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[84] Ibid s 67(3).
[85] Ibid s 72(2).
[86] Ibid s3(c). XY was 'a person for whom the Secretary to the Department of Human Services has parental responsibility under the *Children, Youth and Families Act 2005*'.
[87] I note that by s52(3A) of the *Coroners Act 2008*, the coroner is not required to hold an inquest in the circumstances set out in subsection (2)(b) if the coroner considers that the death was due to natural causes. Further that s52(3A) of the Act provides that for the purposes of subsection (3A), 'a death may be considered due to natural causes if the coroner has received a report from a medical investigator, in accordance with the rules, that includes an opinion that the death was due to natural causes.' The circumstances set out in subsection (3A) do not limit the powers of a coroner to hold, adjourn or recommence an inquest.

90. The *Coroners Act 2008* replaced the *Coroners Act 1985* (Vic) ('1985 Act'), which set out the findings a coroner must make at section 19(1). Notably, prior to the *Coroners Amendment Act 1999*, the 1985 Act included at section 19(1)(e) a requirement for the coroner to find 'the identity of any person who contributed to the cause of death'. The *Coroners Amendment Act 1999* removed this subsection and no equivalent to this subsection was reintroduced in the *Coroners Act 2008*.

91. Nevertheless, findings as to the circumstances surrounding a death may relate to the acts or omissions of other persons in important ways, including:

    a. factual findings as to the courses of action that other persons took;

    b. findings as to relevant standard practices in a person's profession or industry; and

    c. findings as to the likelihood that various courses of action, including the one taken, could have prevented the death.

92. Questions about a person or party's 'culpability', in a statutory context where coroners do not assign fault or blame, can be addressed in comments regarding the relationship between the person or party's course of action and either of the latter two categories above.

93. The power to comment arises from section 67(3) of the *Coroners Act*, which states: 'a coroner may comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice'.

94. These powers arise as a consequence of the obligation to make findings. They are not free-ranging. The powers to comment and make recommendations are inextricably connected with, rather than independent of, the power to enquire into a death and the obligation to make findings. They are not separate or distinct sources of power enabling a coroner to conduct investigations for the sole or dominant reason of making comment or recommendation.[88]

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[88] *Harmsworth v The State Coroner* [1989] VR 989 at 996.

95. It is important to stress that coroners are not empowered to determine civil or criminal liability arising from the investigation of a reportable death, and are specifically prohibited from including a finding or comment or any statement that a person is, or may be, guilty of an offence.[89] It is not the role of the coroner to lay or apportion blame, but to establish the facts.[90] A Coroner must, however, report to the Director of Public Prosecutions if they believe that an indictable offence may have been committed in connection with the death.[91]

Standard of proof

96. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[92] The strength of evidence necessary to prove relevant facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[93]

97. In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw*.[94] The effect of this and similar authorities is that a coroner should not make adverse findings against, or comments about, individuals or entities, unless the evidence provides a comfortable level of satisfaction that the individual or entity caused or contributed to the death.

98. Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demand a weight of evidence commensurate with the gravity of the facts sought to be proved.[95] Facts should

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[89] *Coroners Act* s 69(1). However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See ss 69(2) and 49(1) of the *Coroners Act*.

[90] *Keown v Khan* (1999) 1 VR 69.

[91] *Coroners Act* s 49.

[92] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.

[93] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J (noting that His Honour was referring to the correct approach to the standard of proof in a civil proceeding in the Federal Court with reference to s 140 of the *Evidence Act 1995* (Cth)); *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at 170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.

[94] (1938) 60 CLR 336. See also *Lehrmann v Network Ten Pty Limited (Trial Judgment)* [2024] FCA 369 at [96]-[104]; and *NOM v DPP* [2012] VSCA 198; (2012) 38 VR 618 (at 655 [124] where Redlich and Harper JJA and Curtain AJA explained that '[m]ere mechanical comparison of probabilities independent of a reasonable satisfaction will not justify a finding of fact'. Most recently, see *Runacres v The Coroners Court of Victoria* [2024] VSC 304 at [96] –[104].

[95] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336.

not be considered to have been proven on the balance of probabilities by inexact proofs, indefinite testimony or indirect inferences. Rather, such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[96]

99. Where I have arrived at an adverse finding or comment in relation to an individual or entity, I have been satisfied that the appropriate standard of proof has been met.

Causation, proximity and connection

100. The 'cause of death' refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

101. The 'circumstances of the death' do not refer to the entire narrative culminating in the death, but rather to those circumstances which are sufficiently proximate and causally related to the death. Findings as to circumstances will necessarily include findings as to which events caused others, in what combination they played this causative role, and to what degree.

102. The standard for making a finding that matters are 'connected with' the death for the purposes of making comment under section 67(3) or recommendations under section 72(2) of the *Coroners Act* is not the same as the standard for making a finding as to the circumstances, which requires a proximate connection. In *Thales v Coroners Court*,[97] Beach J adopted the interpretation of Muir J in *Doomadgee v Clements*[98] that 'there was no warrant for reading "connected with" as meaning only "directly connected with"', and that the range of matters connected with a death, for the purpose of comments or recommendations, can be 'diverse'.[99]

103. Beach J in *Thales* quoted a number of examples of matters 'connected with' a death from Muir J in *Doomadgee v Clements*, which included 'the reporting of the death' and 'a police investigation into the circumstances surrounding the death'.[100]

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[96] *Briginshaw v Briginshaw* (1938) 60 CLR 336, 362-3 per Dixon J.
[97] *Thales Australia Limited v The Coroners Court of Victoria & Anor* [2011] VSC 133 (11 April 2011), [75].
[98] *Doomadgee v Clements* [2006] 2 QdR 352.
[99] *Thales Australia Limited v The Coroners Court of Victoria & Anor* [2011] VSC 133 (11 April 2011), [75].
[100] Ibid.

104. A comment about non-causative but substandard conduct may therefore still be appropriate as a matter 'connected with' the death. It remains an adverse comment, despite not implying causation of the death, and the standard of proof for making such a comment is appropriately heightened, as I describe below.

Scope of Inquest

105. Although the coronial jurisdiction is inquisitorial rather than adversarial,[101] it should operate in a fair and efficient manner.[102] When exercising a function under the *Coroners Act*, coroners are to have regard, as far as possible in the circumstances, to the notion that unnecessarily lengthy or protracted coronial investigations may exacerbate the distress of family, friends and others affected by the death.[103]

106. In *Harmsworth v The State Coroner*,[104] Nathan J considered the extent of a coroner's powers, noting they are 'not free-ranging' and must be restricted to issues sufficiently connected with the death being investigated. His Honour observed that if not so constrained, an inquest could become 'wide, prolix and indeterminate'.[105] His Honour stated that coroners do not have general powers to conduct open-ended enquiries into the merits or otherwise of the performance of government agencies, private institutions or individuals.[106] Significantly, he added:

> Such an inquest would never end, but worse it could never arrive at the coherent, let alone concise, findings required by the Act, which are the causes of death, etc. Such an inquest could certainly provide material for much comment. Such discursive investigations are not envisaged nor empowered by the Act. They are not within jurisdictional power.[107]

107. In *Lucas-Smith v Coroner's Court of the Australian Capital Territory*[108] the limits to the scope of a coroner's inquiry and the issues that may be considered at an inquest were also

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[101] Second Reading Speech, Legislative Assembly: 9 October 2008, Legislative Council: 13 November 2008.
[102] *Coroners Act* s 9.
[103] *Coroners Act* s 8(b).
[104] [1989] VR 989
[105] Ibid 995.
[106] Ibid.
[107] Ibid 996.
[108] (2009) 166 ACTR 42; [2009] ACTSC 40.

considered. As there is no rule that can be applied to clearly delineate those limits, 'common sense' should be applied. In this case, Higgins CJ noted that:

> It may be difficult in some instances to draw a line between relevant evidence and that which is too remote from the proper scope of the inquiry. […] It may also be necessary for a Coroner to receive evidence in order to determine if it is relevant to or falls in or out of the proper scope of the inquiry.[109]

108. Higgins CJ also provided a helpful example of the limits of a coroner's inquiry, suggesting that factual questions related to cause will generally be within the scope of the inquest.[110]

109. Ultimately, however, the scope of each investigation must be decided on its facts and the authorities make it clear that there is no prescriptive standard that is universally applicable, beyond the general principles discussed above.[111]

Scope of this Investigation and Inquest

110. Having received notification of XY's death, I conducted a site visit on 26 July 2021.

111. The first directions hearing was on 16 August 2021, and an Interim Suppression Order was made on 18 August 2021 which prohibited the publication of the identification of, or information that would tend to lead to the identification of, XY and/or any other child referred to in the proceedings.

112. In this period, I also issued a number of Form 4 requests for production of protected information including medical records, Medicare and PBS records, and Children's Court records. Those records were then collected, considered and on 15 June 2022 the coronial brief was made available to interested parties.

113. On 29 July 2022, the first draft of the scope of inquest was provided to interested parties. The scope provided a framework of relevance against which to examine XY's experience

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[109] Ibid [20].

[110] Ibid [14]. I note that in that matter, Higgins CJ was referring to the cause of a fire. However, I consider this analogous to the cause of death.

[111] *See Inquest into the deaths of Matthew Poh Chuan Si , Thalia Hakin, Yosuke Kanno, Jess Mudie, Zachary Matthew Bryant and Bhavita Patel: Ruling No 2* (COR 2017 0325) [2019] VicCorCOR 26149 (Coroner Hawkins, 23 August 2019).

of the child protection system and its interactions with the mental health and criminal justice systems.

114. On 21 September 2022, I made a proceeding suppression order and pseudonym order which revoked and replaced the 18 August 2021 interim order, and prohibited the publication of the name, image or any information that would identify or tend to identify XY, XY's family members, and/or any children (as at the time of XY's passing or currently) referred to in the proceedings.[112]

115. Having received submissions in response to the draft proposed scope provided on 29 July 2022, a Revised Scope of Investigation [113] was circulated on 12 October 2022, and prevention opportunity reflection statements were requested from the interested parties.

116. By 9 November 2022, the Court had commissioned independent expert opinions from Dr BJ Newton in respect of the child protection system and Associate Professor Robert Parker in respect of the mental health system.

117. In early 2023, those expert opinions were received, the coronial brief was updated and the Scope of Inquest was narrowed, reflecting that as a result of the investigative processes, many narrative facts were not in issue and would not need to be the subject of oral evidence at an inquest.

118. Following a directions hearing on 15 September 2023 at which interested parties were afforded the opportunity to be heard, the Scope of the Inquest[114] was finalised and the listing of the Inquest was confirmed, to commence on 16 October 2023 in Bendigo, XY's home town.

119. On 19 October 2023, I made a proceeding suppression order which prohibited the publication of the name, image or any information that would identify or tend to identify frontline staff of Anglicare and BDAC who were involved in XY's care and/or had given or will give evidence in this proceeding; and DFFH Child Protection Practitioners who

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[112] Appendix A to these Findings
[113] Appendix C to these Findings.
[114] Appendix D to these Findings

were involved in XY's care and had made statements or had statements made on their behalf in this proceeding.[115]

Interested Parties

120. In the course of the investigation and inquest, I granted leave for ten applicants to appear as interested parties in accordance with section 56 of the *Coroners Act*:

    a. XY's Mother, Senior Next of Kin;

    b. Chief Commissioner of Police;

    c. Anglicare Victoria;

    d. Department of Education and Training Victoria;

    e. Bendigo Health;

    f. Bendigo and District Aboriginal Co-operative;

    g. Austin Health;

    h. Department of Families, Fairness and Housing;

    i. Australian Community Support Organisation; and

    j. Dr Thileepan Naren.

Facts Not In Dispute for the purposes of this proceeding

121. As I observed above, many of the factual circumstances relevant to XY's life and the circumstances of her passing were not in dispute in this inquest. The Facts Not In Dispute document ('FNID') [116] comprehensively detailed the facts that the interested parties, within the meaning of the *Coroners Act*, have agreed are not, for the purposes of this inquest, disputed.

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[115] Appendix B to these Findings.
[116] Exhibit A – 'Facts Not in Dispute' (18 October 2023). ('FNID') See the procedural history of the proceeding for an explanation of the FNID process.

122. Use of the FNID process significantly reduced the duration of the oral hearing of the inquest into XY's passing and obviated the need for family, friends, carers, those who worked with XY and others affected by the distressing circumstances of XY's passing to give oral evidence.[117] The FNID process also enabled the inquest into XY's passing to focus on systemic prevention opportunities rather than the granular detail of her dealings with individuals within the child protection and mental health systems.

Witnesses called at Inquest

123. The inquest was structured into three tranches of concurrent evidence: one expert panel and two stakeholder panels.

Aboriginal Independent Expert Panel

124. The Aboriginal Independent Expert Panel comprised the following members, each of whom had provided an expert report:

    a. Dr BJ Newton;[118] and

    b. Dr Jacynta Krakouer.[119]

125. The Aboriginal Independent Expert Panel ('AIEP') members were each provided a briefing pack and questions ('conclave questions') prior to convening to deliberate privately. Conclave panellists were expected to discuss each question and formulate consensus answers as far as possible. No conclave panellist was expected to compromise their opinion for the benefit of agreement. Rather, the process was intended to facilitate collaboration of thought in the development and refinement of opinions, and identify where agreement lay, and where opinions differed.

Medical Stakeholder Panel

126. The Medical Stakeholder Panel comprised:

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[117] *Coroners Act* s 8(b).

[118] Proud Wirajduri woman with a PhD in Social Work/Social Policy and a Bachelor of Social Work/Bachelor of Arts with Honours in Sociology.

[119] Proud Mineng Noongar woman with a PhD in Social Work, Master of Social Work, Master of Social Policy and a Bachelor of Science (Psychology, History and Philosophy of Science).

a. Associate Professor Philip Tune, Clinical Director of Mental Health, Bendigo Health;

b. Mr Julian McNeill, Lead Clinician, Youth Prevention and Recovery Care ('YPARC'), Bendigo Health; and

c. Dr Samuel Robson, Child and Adolescent Psychiatrist, Clinical Unit Head of Child and Adolescent Mental Health Services ('CAMHS'), Bendigo Health.

Child Protection Stakeholder Panel

127. The Child Protection Stakeholder Panel comprised:

a. Mr Nathan Chapman, Executive Director, Loddon Area, DFFH;

b. Ms Kirstie-Lee Lomas, Statewide Principal Practitioner, Office of Professional Practice, DFFH;

c. Ms Simone Corin, Executive Direction, Protection and Care Policy & Aboriginal Initiatives, DFFH;

d. Mr Dallas Widdicombe, Chief Executive Officer, Bendigo & District Aboriginal Co-Operative ('BDAC');

e. AL, Aboriginal Child Specialist Advice and Support Service practitioner, BDAC;

f. Mr Michael Oerlemans, Regional Director North Central Region, Anglicare Victoria;

g. AC, Case Manager, Intensive Case Management Service, Anglicare Victoria; and

h. Superintendent John Kearney, Victoria Police.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity, pursuant to section 67(1)(a) of the *Coroners Act*

128. On 18 July 2021, XY, born 31 March 2004, was formally identified by her friend ZA.

129. Identity was not in dispute and required no further investigation.

Medical cause of death, pursuant to section 67(1)(b) of the *Coroners Act*

130. Forensic pathologist, Dr Melanie Archer performed an external examination on XY's body at the Victorian Institute of Forensic Medicine on 20 July 2021 having reviewed the Police Report of Death Form, scene photographs and post-mortem computer tomography (CT) scan.

131. In her report dated 4 August 2021, Dr Archer confirmed the cause of death was neck compression by hanging, with consistent ligature marks clearly visible. Various other multidirectional incision type wounds were also visible, some sutured and some not. These latter findings were consistent with XY's documented history of self-harm.

132. While the toxicology analysis did not detect the presence of alcohol, it did detect delta-9-tetrahydrocannabinol[120] (~3 ng/mL), venlaxafine[121] (~1.8 mg/L) and its metabolite desmethylvenlaxafine, quetiapine (~0.05 mg/L), diazepam [122] (~0.01 mg/L) and its metabolite nordiazepam, and prazosin[123] (~0.002 mg/L). The substances detected were not present at levels that would have caused or contributed to XY's death.

133. I accept Dr Archer's opinion.

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[120] Cannabis.
[121] An antidepressant medication.
[122] A sedative medication.
[123] An antihypertensive medication.

Findings as to circumstances, pursuant to section 67(1)(c) of the *Coroners Act*

XY's family background

134. XY was born on 31 March 2004 in Bendigo. She was 17 years old when she passed on 18 July 2021.

135. XY was an Aboriginal woman of the Wemba Wemba people through her maternal family. She was the eldest child of XY's Mother and XY's Father.

136. XY's mother is Aboriginal. Her country is Wemba Wemba. XY's Mother's parents (XY's maternal grandparents) are [redacted] [redacted] and XY's Grandmother. [redacted] is Maltese and XY's Grandmother is Aboriginal. XY's Grandmother is originally from Swan Hill.

137. XY's Mother and XY's Father were in a relationship for approximately 10 years. They separated in 2008 when XY was 5 years old. They also had a son, Brother 1, born in 2007, who was aged 1 at the time of the separation.

138. XY's Mother subsequently formed a relationship with XY's Stepfather. XY lived with her mother and XY's Stepfather in a suburb in Bendigo prior to being removed from the family home on 19 October 2017.

139. XY had eight siblings – Brother 1 (born 2007), Brother 2 (born 2011), Brother 3 (born 2015), Sister 2 (born 2016), Sister 1 (born 2018), [redacted] [redacted] (born 2006), [redacted] [redacted] (born 2010) and [redacted] [redacted] (born 2012). Sister 1 is deceased.

140. XY attended California Gully Primary School (from 2010 to March 2012 and April to August 2014) and St Liborious Primary School, Eaglehawk (from June 2012 to April 2014 and August 2014 to February 2017).[124]

141. When XY was little, she loved to sing and dance and dress up. She was also artistic and adventurous, and loved to play outside. She was close to her family and enjoyed spending time with her Nan, cousins and siblings.[125]

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[124] Primary school student records, CB 857. See also Statement of Kylie Hand, CB 1996.
[125] Statement of XY's Mother, CB 33-34.

Early interventions by Child Protection

142. Child Protection case notes contained within the Child Relationship Information System ('CRIS') held by the DFFH indicate that XY was subject to 17 reports to Child Protection between 5 January 2006 and 24 January 2019 and four Community Based Child Protection consultations. Of note:

143. The first report from 5 January 2006 was closed after Protective Intervention phase, with protective concerns substantiated on 21 June 2006;

144. Nine reports were closed at the Intake phase (19 October 2007; 1 September 2010; 12 June 2012; 7 May 2014; 14 April 2015; 29 June 2015; 4 February 2016; 14 August 2016 and 12 April 2017);

145. Five reports were closed after a Child Protection Investigation and not substantiated (20 July 2006, 10 December 2007, 12 January 2015, 31 August 2015 and 6 June 2016); and

146. Two reports proceeded to protection order phase (24 August 2017 and 24 January 2019).[126]

Chronology of relevant events from 2017

147. On 1 February 2017, XY commenced secondary schooling at Catherine McAuley College, Junortoun (also described as Catholic College Bendigo). As an aside, my investigation revealed that the College was a persistent exemplar of the proper form and content of pastoral care.

148. On 27 June 2017, Dr Thileepan Naren, General Practitioner, saw XY at the Bendigo & District Aboriginal Co-operative ('BDAC'), where she attended with her mother. The presenting concern was a suspected eating disorder. Dr Naren prepared a Mental Health Care Plan and referred XY to a psychologist and subsequently to the Child and Adolescent Mental Health Service ('CAMHS') at Bendigo Health.[127]

[126] Statement of AW, CB 2031. See also Timeline prepared by BJ Newton, CB 3133-3132 and Protection Records cited therein.
[127] Statement of Thileepan Naren, CB 3291. See also BDAC Health Summary, CB 651.

149. On 4 July 2017, XY and her mother attended an appointment with Dr Naren, at which XY's Mother expressed some reluctance about proceeding with CAMHS and a preference to go through Headspace instead, due to her understanding of XY's age and her belief as to what these services offered.[128]

150. On 4 August 2017, Amanda Kelly of CAMHS conducted a telephone assessment with XY's Mother as part of the intake process for XY.[129]

151. On 7 August 2017, XY attended her first and only appointment with Dr Candice Boyd, a clinical psychologist with Headspace Bendigo. Dr Boyd advised Dr Naren that XY needed to be referred again to CAMHS eating disorder service.[130]

152. On 17 August 2017, XY's Mother informed CAMHS that they did not wish to pursue CAMHS for XY at that time, although they would continue to see XY's GP.[131]

153. Dr Naren continued to review XY twice weekly throughout 2017 and most of 2018.[132]

154. On 24 August 2017, Child Protection received a notification from XY's school, raising concerns about XY's mental health, refusal to eat, vomiting after meals and cutting her arms.[133] XY's Mother states that at times it was difficult to get XY to go to the doctors and that she also required assistance from BDAC to get XY to those appointments.[134] Child Protection determined that the report required further protective assessment and progressed the matter to the investigation phase.[135] As part of this investigation, on 18 September 2017, Child Protection workers conducted a home visit[136] and XY underwent a mental health assessment by CAMHS at Bendigo Hospital.[137]

155. On 19 September 2017, XY's Mother telephoned the Victorian Aboriginal Child Care Agency ('VACCA') in an upset state about XY. This was reported to Child Protection, who conducted a home visit. During the home visit, XY's Mother expressed that she

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[128] BDAC Health Summary, CB 652.
[129] MR 2372.
[130] Letter from Dr Boyd to Dr Naren dated 7 August 2017, CB 811.
[131] MR 2380.
[132] Statement of Thileepan Naren, CB 3291. See also BDAC Health Summary, CB 651.
[133] Case Note dated 24 August 20217, PR 4258.
[134] Supplementary Statement of XY's Mother, 6 October 2023, [5].
[135] PR 4223.
[136] PR 4196.
[137] PR 4207.

wanted XY to remain in her care and asked for support, specifically, to complete a referral to Stronger Families through BDAC. XY's Mother explained that her call to VACCA was 'a cry for help'. Child Protection interviewed XY, spoke to her school and decided to allow XY to return home that night.[138]

156. On 28 September 2017, Child Protection conducted a home visit. [139] Following consultation with Principal Practitioner AW, Child Protection decided to proceed with a Protection Application in relation to XY.[140]

157. On 4 October 2017, Child Protection telephoned XY's Mother to advise that they would be intervening with a four-week Rapid Response. XY's Mother agreed to the referral occurring.[141] On 6 October 2017 the Rapid Response commenced.[142]

158. On 6 October 2017, Child Protection met with CAMHS and was told the family did not attend two appointments at the Eating Disorder Clinic.[143] XY's Mother concedes she may have missed one appointment.[144]

159. On 16 October 2017, XY attended an appointment with Dr Samuel Robson, Child and Adolescent Psychiatrist, CAMHS. Dr Robson's recommendations included that XY attend CAMHS for case management and treatment (with lead clinician Jane Azul), that CAMHS 'work with DHHS regarding their protective concerns' and that XY attend BDAC daily until her medical condition improved.[145]

160. On 18 October 2017, XY told a staff member at school that she had been physically abused at home. Child Protection were notified of XY's disclosures. XY was allowed to return home that night.[146]

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[138] PR 4177-4189.
[139] PR 4162.
[140] PR 4160.
[141] PR 4152.
[142] PR 4146.
[143] PR 4146.
[144] Supplementary statement of XY's Mother, 6 October 2023, [10].
[145] Letter from Dr Robson dated 23 October 2017, PR 4156.
[146] PR 4132.

161. On 19 October 2017, a professional meeting was held concerning XY. The meeting was attended by representatives from DHHS, CAMHS, Rapid Response, Catherine McAuley College and VACCA.[147]

Removal of XY from her family home

162. On 19 October 2017, Child Protection issued a Protection Application and XY was removed from her family home.[148]

163. Between 19 and 23 October 2017, XY was placed with Sharon Collicoat (an Anglicare respite provider) in Woodend.[149] While in Ms Collicoat's care, XY refused to eat, and Ms Collicoat was very concerned for her welfare.

164. On 19 October 2017, Child Protection contacted BDAC, Mallee District Aboriginal Services in Mildura, Mallee Family Care (regarding possible placement in Swan Hill) and Anglicare about potential placement options beyond 23 October 2017 and was informed that none were available.[150]

165. On 22 October 2017, in consultation with Anglicare's On-Call service, Ms Collicoat took XY to the Kyneton Hospital where XY was assessed by a nurse. XY also spoke to a psychiatrist at CAMHS by phone.[151] On 23 October 2017, XY attended an appointment with CAMHS.[152] Child Protection were notified of these concerns.[153]

166. On 23 October 2017, Child Protection continued to look for placements for XY. BB of Child Protection telephoned XY's Mother, who provided the names of five family members who may be suitable. XY's Mother also said that she had spoken to XY's friend ███'s mother, Jacqueline Jackson, about the situation.[154]

167. On 23 October 2017, XY spent the night in the care of Sally Atkinson.[155]

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[147] PR 4124.
[148] PR 4110.
[149] PR 4105.
[150] PR 4119 (BDAC) and PR 4099 (MDAS Mildura).
[151] PR 4085.
[152] PR 4079.
[153] DHS Client Incident Form, PR 3863.
[154] PR 4057, 4077.
[155] PR 4037.

168. On 24 October 2017, Child Protection records indicate that a phone call took place between Child Protection and VACCA at 10:46am in which VACCA stated they would like XY's maternal grandmother to be assessed as a carer for XY. VACCA also asked if there had been sibling contact and, if not, could this be scheduled.[156]

XY is placed with Jacqueline Jackson

169. On 24 October 2017, XY was placed by Child Protection with Jacqueline and Jason Jackson. Child Protection records note that 'XY continues to not eat or drink and carer is to take XY to BDAC for medical review tonight. If XY requires admission, then carer will contact AHS'.[157]

170. XY's placement with the Jacksons was approved by Nathan Chapman, the Acting Assistant Director Child Protection, who queried whether consultation had occurred with VACCA or ACSASS. An email response from Anthony O'Brien, Deputy Area Manager, states, 'We consulted with Lakidjeka/ACSASS. They also recommended assessment of the maternal grandmother, however, we have deemed her inappropriate'.[158]

171. On 24 October 2017, XY attended an appointment with Dr Naren, accompanied by Ms Jackson. Dr Naren referred XY to the Emergency Department at Bendigo Health.[159] XY was admitted into hospital until 30 October 2017. Ms Jackson stayed with XY while she was in hospital.[160]

172. On 25 October 2017, an Interim Accommodation Order was made placing XY in a declared hospital namely Bendigo Health. Conditions of the order included a condition that 'no family member must have any contact with XY other than agreed by the court'.[161]

173. On 30 October 2017, Child Protection attended Bendigo Hospital for a professionals/discharge meeting. The CRIS notes record that the medical professionals determined there was no need for XY to remain in hospital and that it was appropriate

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[156] PR 4034.
[157] PR 4029.
[158] PR 4023.
[159] BDAC Health Summary, CB 660.
[160] Statement of Jacquii Jackson, CB 121.
[161] PR 5590.

that she be discharged that day.[162] On that day, XY was discharged into the care of Ms Jackson. Ms Jackson's children are Aboriginal and her daughter, ████, was friends with XY at school.[163]

174. Upon discharge from hospital, the plan was for XY to be seen by BDAC twice weekly for monitoring and 4-6 weekly by Paediatrician Dr Rhys Parry, and to continue to have regular CAMHS appointments.[164]

175. Ms Jackson was aware from XY's hospitalisation and medical appointments of XY's eating disorder and self-harming. She provided around-the-clock care to XY, including sleeping on a mattress in XY and ████'s room to ensure that XY didn't do anything overnight, and supervising XY while she showered and toileted. When XY returned to school, Ms Jackson attended school every lunchtime to monitor her eating. Ms Jackson quit her job in order to be able to support XY once she returned to school.[165]

176. On 30 October 2017, a home visit was conducted by Child Protection, during which XY's Mother indicated that she would like for the children to remain in contact with XY. XY's Mother also requested family counselling with XY as she felt that her relationship with XY had been damaged. Child Protection agreed to discuss this with XY.[166] A court report due on 20 November 2017 was also to include an assessment as to the suitability of counselling between XY's Mother and XY.[167]

177. On 31 October 2017, an Interim Accommodation Order was made ordering that XY be placed in the care of Ms Jackson. Conditions of the order included conditions that 'parents must not have any contact with the child other than as agreed to by the child' and 'child may have contact with the child's siblings at times and places as agreed between the child and DHHS'.[168]

178. As of 2 November 2017, Rapid Response were concerned about XY's isolation from her family, especially her siblings. A Child Protection Case Note records that XY made a

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[162] PR 4003.
[163] Statement of Jacquii Jackson, CB 115.
[164] Case Note created by AN, PR 4003.
[165] Statement of Jacquii Jackson, CB 122-125.
[166] PR 3997.
[167] Court Activity Case Note dated 31/10/2017, PR 3995.
[168] PR 5584.

phone call to Brother 2 for his birthday and had a brief conversation with him, and that Brother 1 did not want to speak to XY.[169]

179. On 9 November 2017, Ms Jackson spoke to AN at Child Protection. Ms Jackson advised that XY had taken a step backwards after learning she had put on 7kg. When asked how she was managing, Ms Jackson told AN that things had been hard. AN encouraged her to attend her GP for a Mental Health Plan.[170]

180. On 14 November 2017, XY's Father contacted Child Protection, stating that he had learned through a family friend that XY was in care.[171] On 16 November 2017, XY's Father met with Child Protection. He advised that he wanted contact with his children and was willing to care for them.[172]

181. On 14 November 2017, AN spoke to XY and completed a Kinship Assessment. XY advised that she was not ready to have contact with her family. AN also discussed with XY her mother's desire to have counselling together and advised XY that she could consider this.[173]

182. On 21 November 2017, Rapid Response closed. They recommended another referral be made to support reunification once XY returned home.[174]

183. On 27 November 2017, an extension was made to the Interim Accommodation Order made on 31 October 2017. In relation to family contact, the relevant conditions of the order provided the following:

    a. Parents must not have any contact with XY other than as agreed to by XY.

    b. XY may have contact with her siblings at times and places as agreed between XY and DHHS.[175]

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[169] PR 3991.
[170] PR 3971-5584.
[171] PR 3969.
[172] PR 3955.
[173] PR 3968.
[174] Signs of Safety Assessment and Planning Form, PR 3928.
[175] PR 5565.

184. On or about 29 November 2017, a Part A Kinship Assessment was uploaded to CRIS[176] along with paperwork to support Ms Jackson's application for a carer's allowance.[177]

185. On or about 30 November 2017, responsibility for XY's case was transferred from AN to another Child Protection Practitioner, ultimately AP.[178]

186. During December 2017, Ms Jackson expressed to Jane Azul at CAMHS that she felt inadequately supported by Child Protection. Also, XY reported that she was missing her siblings and wanted to visit her siblings and cousins.[179]

187. Ms Jackson states that sometime before Christmas 2017, XY disclosed to her that she had been raped by an adolescent male, ██████.[180] Ms Jackson reported the matter to Child Protection.[181] XY also disclosed to CAMHS that she had been raped by an adolescent male, ██████. These matters were notified to Child Protection in January 2018.[182]

188. On 29 January 2018, XY's Father informed Child Protection that he would like XY placed in his care.[183]

189. On 31 January 2018, a Conciliation Conference was held. The Court extended the Interim Accommodation Order made on 27 November 2017 on the same conditions.[184]

190. On 5 February 2018, a Family Reunification Order was made. The order noted that the protective concerns did not relate to the biological father, XY's Father. Conditions of the order included the following:

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[176] PR 3907.
[177] PR 392.
[178] PR 3901.
[179] MR 2459-2464.
[180] Statement of Jacquii Jackson, CB 1636-7.
[181] Statement of Jacquii Jackson, CB 1637 and CB 1187.
[182] BDAC Health Summary, CB 669; PR 3894; and the name '██████' appears in a later case note PR 3855.
[183] Case Note created by AP, PR 3890.
[184] PR 5558.

a. Mother, father and stepfather may have contact with the child at times and places as agreed between the child, parents and DHHS. DHHS or its nominees will supervise contact unless DHHS assesses that supervision is not necessary.

b. The child may have contact with the child's siblings at times and places as agreed between the child and DHHS and the parents.[185]

191. At court on 5 February 2018, XY's Mother's solicitor informed Child Protection that XY's parents would not be allowing XY to see her siblings.[186]

192. On 20 March 2018, XY's school contacted Child Protection to advise that XY's Mother had contacted them saying she refused to receive any information from the school about XY.[187]

193. On 6 April 2018, XY's Mother telephoned Child Protection crying, saying she missed XY and wanted to see her. AP said this would be up to XY and informed XY's Mother that XY would like to see her siblings, to which XY's Mother agreed.[188] On 12 April 2018, AP informed Ms Jackson that XY's mother wanted to see her and was happy for XY to see her siblings. AP explained that Child Protection could organise a supervised contact between the family. Ms Jackson stated that she did not think that XY would like to see her mother, but would ask.[189] Later that morning, AP spoke to XY's Mother and informed her that XY was not ready to see her yet but would like contact with her siblings. XY's Mother stated that she would not allow this.[190]

194. On 20 April 2018, Ms Jackson told Child Protection that XY told her XY's Stepfather had sexually abused her on multiple occasions and that XY's Mother was at home when some of the abuse occurred. Ms Jackson also told Child Protection about XY disclosing to her that an adolescent male, [redacted], had raped her.[191] XY and Ms Jackson spoke to the Central Victoria Sexual Offences and Child-Abuse Investigation Team ('SOCIT')

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[185] PR 5550.
[186] PR 3881; Supplementary statement of XY's Mother, 6 October 2023, [12].
[187] PR 3870; Supplementary statement of XY's Mother, 6 October 2023, [12].
[188] PR 3860.
[189] PR 3858.
[190] PR 3857.
[191] Statement of Jacquii Jackson, CB 1186-1187; Case Note dated 20 April 2018 created by AP, PR 3855 and related Case Notes, PR 3848-3854.

about these matters and XY was referred to the Centre Against Sexual Assault ('CASA').[192]

195. On 26 April 2018, Jane Azul from CAMHS contacted AP of Child Protection by email seeking respite for Ms Jackson and her family. The contents of Ms Azul's email included the following:

> Jacquii is experiencing carer fatigue.
>
> The provision of respite would help to prevent placement breakdown.
>
> I am aware that this placement has been fundamental to the progress that XY has made in the last 6 months in dealing with the eating disorder. She has other mental health issues which appear to be related to her experiences in her family prior to her removal. I am concerned that break down of this placement will have a negative impact on her mental health.[193]

196. On 30 April 2018, AP wrote to Ms Azul advising that Ms Jackson had said respite could be tricky because of XY's high needs and asked whether Ms Azul could recommend any clinical respite placements for XY. Ms Azul responded that she was not aware of any clinical settings XY could attend for respite other than hospital, which she did not require at that time.[194]

197. On 21 April 2018, Bendigo SOCIT received a report from DHHS that XY had disclosed that she had been raped by her stepfather on two occasions and by a family friend, [redacted].[195]

198. On 23 April 2018, Detective Senior Constable Ben Manning ('DSC Manning') from the Bendigo SOCIT contacted Ms Jackson. XY was reluctant to speak to Police so it was agreed that it would be arranged for XY to speak to a counsellor from CASA prior to

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[192] BDAC Health Summary, CB 679-680. See also Case Note dated 20/4/2018 created by AP, PR 3855 and related Case Notes, PR 3848-3854.
[193] MR 2702.
[194] MR 2701-2701.
[195] Operation Tramless-2018 Investigation Notes, CB 1263.

making a statement to police.[196] Police confirmed with CASA that Ms Jackson made contact that day.[197]

199. On 26 April 2018, Ms Jackson took XY to the Bendigo Multi-Disciplinary Complex ('MDC') to meet with CASA. [198] DSC Manning confirmed that XY attended the appointment with Ms Jackson and her school Aboriginal Liaison Worker, that very limited information was provided to the CASA counsellor and XY was on the list to receive follow up from CASA.[199]

200. Following XY's disclosure of alleged sexual abuse by XY's Stepfather, on 30 April 2018 Child Protection contacted SOCIT regarding XY's disclosure.[200] Child Protection states that SOCIT advised that they could not investigate XY's Stepfather until XY had made a statement about him and until then, Child Protection would need to proceed with their own investigation.[201]

201. On 1 May 2018, following a consultation with the Principal Practitioner, Child Protection undertook investigations in relation to XY's Stepfather. As part of this investigation, XY was interviewed by Child Protection Practitioners ████ ████ and AP concerning her disclosures made in relation to XY's Stepfather and ██████. During the interview, XY said that she did not want to tell workers about what she had disclosed about her stepfather.[202]

202. On 2 May 2018, as part of Child Protection's ongoing investigations into the alleged sexual abuse by XY's Stepfather, a home visit was conducted with police officers, during which XY's Stepfather agreed to leave the family home voluntarily.[203] Child Protection told XY's Mother and XY's Stepfather that there had been a report made in relation to a sexual assault at the property but did not reveal who had made the allegations.[204]

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[196] Operation Tramless-2018 Investigation Notes, CB 1263; Statement of Jacquii Jackson, CB 1188, [26].
[197] Operation Tramless-2018 Investigation Notes, CB 1264.
[198] Statement of Jacquii Jackson, CB 1190, [27]; Tramless 2018.
[199] Operation Tramless-2018 Investigation Notes, CB 1264.
[200] PR 3851.
[201] Ibid.
[202] PR 3842-3843.
[203] PR 3840.
[204] PR 3838, 3840.

203. On 3 May 2018, Child Protection met with SOCIT and provided a copy of the transcript of XY's interview on 1 May 2018.[205] Also on that date, Child Protection met with CASA and was told XY had attended an initial CASA appointment but would need to wait three months before she would be allocated a CASA worker.[206]

204. On 3 May 2018, ████ █████ provided SOCIT with contact numbers for Child Protection workers AP and AY.[207] That same day, Detective Sergeant Hallinan of SOCIT made contact with AY about XY and suggested to her that a case conference be convened later that day between Child Protection and DSC Manning.[208]

205. On 3 May 2018, DSC Manning and AY had a case conference in relation to XY's complaints of sexual assault.[209]

206. On 4 May 2018, DSC Manning consulted with ████ ████ in relation to XY. Child Protection records state that DSC Manning advised Child Protection that due to the three-month waiting period for CASA counselling, 'he would likely try to get out to the home to meet XY in person as he does not want to retraumatise her 3 months from now when she is effectively engaging with CASA'. █████ advised DSC Manning that she believed XY had issues speaking with male professionals due to her trauma past, however she was unsure how XY would engage with SOCIT.[210]

207. On 4 May 2018, XY's Mother and XY's Stepfather were served with a Protection Application.

208. On 7 May 2018, DSC Manning again spoke with Ms Jackson who said that XY was warming to the idea of engaging with police and was willing to attend for preliminary discussion and information about the police process.[211]

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[205] PR 3839.
[206] PR 3839.
[207] PR 3839.
[208] Operation Tramless-2018 Investigation Notes, CB 1264.
[209] Operation Tramless-2018 Investigation Notes, CB 1264.
[210] Case Note dated 4/5/2018 created by Darcy Gordon, PR 3837.
[211] Operation Tramless-2018 Investigation Notes, CB 1265.

209. On 8 May 2018, Ms Jackson took XY to the MDC, and DSC Manning showed XY around and explained what would happen if she made a report to police. [212] Ms Jackson described DSC Manning as 'fantastic' and said he explained to XY she could make a statement.[213] DSC Manning explained XY's options, investigation and court processes, provided information pamphlets, and confirmed XY was on the waiting list to receive follow up from CASA. No offending was discussed on that occasion. DSC Manning noted that XY was very shy and further rapport and confidence was required before attempting a Visual and Audio Recording of Evidence ('VARE').[214]

210. On 14 May 2018, Ms Jackson contacted DSC Manning to arrange a time for a VARE.[215]

211. On 16 May 2018, XY made a VARE statement to DSC Manning at the Central Victoria SOCIT in relation to the alleged sexual offending by XY's Stepfather. During the VARE, XY described seven incidents of rape alleged to have been committed by her stepfather between 2016 and 2017 at the family home. [216] At the conclusion of the VARE, XY requested that the matter not yet be investigated. It was determined that, given XY's Stepfather was aware of the allegations, he would be interviewed, with further investigative considerations to follow.[217] DSC Manning told XY that she did not have to do anything right now with her interview, but it was there now and if she ever wanted to press charges she could.[218]

212. Ms Jackson supported XY in making her VARE. She describes XY as being very conflicted about whether or not she wanted to press charges. XY was worried that if XY's Stepfather went to jail her mother would be by herself with the kids. XY also told Ms Jackson that she stopped eating because of the sexual abuse perpetrated by XY's Stepfather.[219]

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[212] Operation Tramless-2018 Investigation Notes, CB 1265; see also Statement of Jacquii Jackson, CB 1190, [28].
[213] Statement of Jacquii Jackson, CB 128, [84].
[214] Operation Tramless-2018 Investigation Notes, CB 1265; see also Statement of Jacquii Jackson, CB 1190, [28].
[215] Operation Tramless-2018 Investigation Notes, CB 1265.
[216] SOCIT Investigation Brief - Tramless 2018, CB 1176.
[217] Operation Tramless-2018 Investigation Notes, CB 1266.
[218] Statement of Jacquii Jackson, CB 128, [86].
[219] Statement of Jacquii Jackson, CB 128.

213. On 17 May 2018, DSC Manning issued a family violence safety notice ('FVSN') on XY's behalf against XY's Stepfather.[220]

214. Also on 17 May 2018, XY's Stepfather was interviewed by police. He denied the alleged offending.[221] DSC Manning served the FVSN on XY's Stepfather that day.[222]

215. On 22 May 2018, an interim intervention order was issued against XY's Stepfather naming XY as the affected family member.[223]

216. On 22 May 2018, XY's Mother provided a statement to police as part of their investigation into the alleged sexual offending by XY's Stepfather. In her statement XY's Mother said that she did not believe the allegations were true.[224]

217. On 21 June 2018, XY's Stepfather had supervised contact with XY's Mother and the children.[225]

218. On 28 June 2018, Ms Jackson met with AT and AP and told them that she could no longer care for XY.[226] Ms Jackson states that she told Child Protection workers that they needed to find somewhere for her to go before the school holidays as she needed to take her kids away for the holidays to reconnect and get some respite.[227]

219. Child Protection attempted to obtain a placement for XY through various agencies without success.[228]

220. On 29 June 2018, an emergency placement was obtained for one week in Mildura.[229] Ms Jackson states that when she was told by Child Protection of the Mildura placement, she told them that it was not suitable, including because XY would be unable to attend her various medical appointments in Bendigo.[230]

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[220] CB 1153, 1236.
[221] SOCIT Investigation Brief - Tramless 2018, CB 1177.
[222] SOCIT Investigation Brief - Tramless 2018, CB 1266.
[223] CB 1226.
[224] SOCIT Investigation Brief - Tramless 2018, CB 1201.
[225] PR 3826.
[226] PR 3824; Statement of Jacquii Jackson, CB 130.
[227] Statement of Jacquii Jackson, CB 131.
[228] PR 3799-3824.
[229] PR 3796.
[230] Statement of Jacquii Jackson, CB 131.

221. Child Protection ultimately decided not to send XY to Mildura, and XY remained with Ms Jackson while Child Protection commenced discussions with XY's Father.[231]

222. From 2 July 2018, Child Protection attempted to make contact with XY's Father. On 5 July 2018, Child Protection spoke to XY's Father and told him that XY's carer was no longer able to look after her. XY's Father said that he would care for XY. Child Protection asked him whether there was anyone else he could nominate to care for XY, and XY's Father suggested his mother, , or his brother and his wife.[232]

223. Child Protection approached , who was not able to care for XY, but said that he and his wife would like to have contact with XY.[233]

224. On 9 July 2018, a 12-month intervention order applied for by DSC Manning was granted to XY against her stepfather, XY's Stepfather.[234]

225. On 16 July 2018, AP sent a text message to Ms Jackson informing her that Child Protection were looking at all available family options for XY.[235] On 23 July 2018, a further text message was sent informing Ms Jackson that Child Protection were possibly looking at reunifying XY with her father.[236]

226. On 8 August 2018, XY made a second VARE statement to DSC Manning at the Central Victoria SOCIT in relation to the alleged sexual offending by XY's Stepfather. During this VARE, XY disclosed that her stepfather had made her perform oral sex on an unknown male in a car while XY's Stepfather was at his drug dealer's house. XY alleged that her stepfather returned to the vehicle to collect XY and the money she had been given for sex, before walking home.[237] During this VARE, XY also disclosed that she had been raped by in her bedroom at home.[238] Police chose to prioritise their investigation into the allegations made against XY's Stepfather, rather than those made against , as the allegations against XY's Stepfather were more serious and

[231] PR 3795.
[232] PR 3789.
[233] PR 3783-3785.
[234] CB 1226; 1228.
[235] PR 3786.
[236] PR 3770.
[237] SOCIT Investigation Brief - Tramless 2018, CB 1177.
[238] SOCIT Investigation Brief – Modra 2018, CB 1618.

committed within the family environment.[239] Police determined not to investigate the allegations against ██████ simultaneously with those against XY's Stepfather so as to minimise the anxiety experienced by XY, who remained unsure about the extent to which she wanted police to respond to her complaints.[240]

227. On 10 August 2018, Child Protection decided to place XY with her father and his wife, ████ ███.[241] This decision was communicated to Ms Jackson on 13 August 2018, and to XY on 14 August 2018.[242]

228. On 15 August 2018, an office meeting was held for XY and Ms Jackson to meet XY's Father and Ms ███It was the first time XY had seen her father since she was 5 or 6 years old. XY and her father hugged and spoke for about 20 minutes, then XY went for a walk. Ms Jackson, XY's Father and M███hen talked for over one hour about XY's needs, and agreed to become Facebook friends so that they could further communicate about XY. Arrangements were made for XY to move the next day.[243] XY's school was informed of the new care arrangements.[244]

XY is placed with her father, XY's Father

229. On 16 August 2018, XY moved into her father's home, assisted by Ms Jackson.[245]

230. On 20 August 2018, XY's Mother was advised that XY's placement with Ms Jackson had ended, and that XY had been placed with her father. Child Protection records record that XY's Mother 'sounded very upset' and asked if XY was ok.[246]

231. CAMHS records from September indicate that XY was having difficulties transitioning to her father's home and missed Ms Jackson.[247]

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[239] SOCIT Investigation Brief – Modra 2018, CB 1631.
[240] Ibid.
[241] PR 3761.
[242] PR 3757-3758.
[243] PR 3756.
[244] PR 3755.
[245] PR 3753.
[246] PR 3747.
[247] MR 2885, 2901, 2914.

232. On 14 September 2018, XY's Mother gave birth to her daughter Sister 1. [248] Child Protection monitored XY's Mother and Sister 1 closely around the time of the birth and for several months afterwards.

233. On 21 September 2018, XY's Mother contacted Child Protection to ask whether XY had been informed of the birth of her sister Sister 1. XY's Mother requested that XY be asked whether she would like to have contact with XY's Mother and all the children to meet her sister. AP of Child Protection indicated that she would let XY know and get back to XY's Mother.[249]

234. On 29 November 2018, XY's Stepfather was arrested by SOCIT investigators and interviewed for a second time in relation to the allegations made by XY. He denied all allegations and was released without charge.[250]

235. On 18 January 2019, XY commenced with a new CAMHS case manager, Tegan Harrison. XY stated that she had not been eating recently, and wanted more support with meals. Ms Harrison spoke to XY's Father about this and he became defensive, saying XY was lazy and needed to make better choices.[251]

236. On 24 January 2019, Child Protection received a report in relation to XY, following an alleged family violence incident at home the previous day. Child Protection understood that Victoria Police were applying for an intervention order by way of Family Violence Safety Notice against XY's Father.[252] An intervention order was served on XY's Father on 30 January 2019.[253] Child Protection conducted a Protective Investigation into the matter. As part of the investigation, on 11 February 2019 XY was interviewed at school about the incident and her relationship with various family members.[254]

237. On 13 February 2019, Child Protection visited Ms Jackson's home, unannounced, to ask whether she would be prepared to care for XY once again. Ms Jackson explained that she could not assist and reiterated that her family had embraced XY but had not received any

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[248] PR 3743.
[249] PR 3739.
[250] SOCIT Investigation Brief - Tramless 2018, CB 1177.
[251] MR 3076.
[252] PR 3730.
[253] CB 1655.
[254] PR 3631.

help or support from DHHS.[255] On 15 February 2019, Ms Jackson telephoned AZ of Child Protection to express her disappointment for Child Protection's actions in 'trying to guilt her into taking on the care of XY'.[256]

238. On the evening of 13 February 2019, XY disclosed physical violence by her father, claiming that her father had punched her in the eye causing bruising. On 14 February 2019, XY attended a doctor's appointment in relation to her eye. She told the doctor that she'd been in bed and got up to take her phone off the charger at 11:30pm when an argument occurred with her dad. She said her dad had a short temper and they quite often argued, but this was the first time he had hit her.[257]

239. Also on 13 February 2019, Constable Jacinta Morrissey interviewed XY about the incident. XY did not want to make a statement and did not consent to police taking photographs of her eye.[258] On 5 March 2019, Constable Morrissey spoke with XY again and asked whether she had thought about the incident some more and whether she would like to make a statement, but XY declined to do so do and stated that she did not want the matter to go any further.[259] That same day, Constable Morrissey interviewed XY's Father in relation to the alleged assault and breach of intervention order; XY's Father denied hitting XY.[260] Police also took a statement from XY's stepsister, who stated that XY had told her that she had slipped and hit her eye on a chair and that she did not believe that XY's Father had hit XY.[261] On 7 March 2019, XY made a formal statement of no complaint to police in relation to the incident.[262]

XY is placed with Peta Thompson

240. On 13 February 2019, as a result of the alleged assault by XY's Father, XY was placed with Peta Thomson. Ms Thompson was a family friend, and XY and her daughter were school friends. XY's Father agreed to this voluntary placement.[263] A Commence Care

[255] PR 3617.
[256] PR 3583.
[257] PR 3601.
[258] Statement of Jacinta Morrissey, CB 1683.
[259] Ibid.
[260] Statement of Jacinta Morrissey, CB 1683 – 1684.
[261] Statement of [redacted], CB 1679.
[262] Statement of XY, CB 1706.
[263] PR 3614.

Allowance application form for funding was made for Ms Peta Thompson to care for XY as a home-based kinship carer.[264]

241. On 14 February 2019, DHHS filed a Protection Application in relation to XY.[265]

242. On 14 February 2019, Child Protection met with XY's Mother and informed her of XY's move from XY's Father' house.[266] During the visit, XY's Mother stated that XY's Father had always been a violent man and she never wanted XY in his care. XY's Grandmother was present and advised that she was willing to have XY enter her care. Both XY's Mother and XY's Grandmother agreed that an Aboriginal Family-Led Decision Making ('AFLDM') meeting was needed for XY and they stated that they were happy to participate. XY's Mother agreed that sibling contact would be beneficial for both XY and her siblings and said that she would like to see XY if XY wanted to pursue this.[267]

243. XY was informed that her mother would like XY to have contact with her siblings and with her if XY wanted it. XY seemed very surprised and said she would think about it.[268]

244. On 15 February 2019, Child Protection visited the home of XY's Father to collect XY's belongings. XY's Father advised that he and his family wanted no further contact with XY or DHHS.[269]

245. Also on 15 February 2019, XY's Father spoke to CAMHS and said he found a notebook/diary while cleaning out XY's room which contains significant details about sexual abuse. CAMHS advised him to report this to police.[270]

246. On 18 February 2019, an AFLDM Referral was made. Under the heading 'Purposes of AFLDM' the following is stated:

> To begin discussion with family to explore options for XY which will provides stability and respite.

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[264] PR 3554.
[265] PR 5775.
[266] PR 3588.
[267] PR 3588.
[268] PR 3587.
[269] PR 3585.
[270] MR 3098.

XY needs to feels she is believed and supported by her family to work with police and psychological services to begin to address the trauma.

To explore with family options for long term placement. – If no family options what will be required to maintain the placement and stabilise XY's life to allow her to achieve her identified goals and address the trauma while being supported by family.

Support for regular sibling contact between XY and her siblings, both in the care of XY's Mother and XY's Father.

How do we repair relationship between parents and XY.

Educational options[271]

247. On 18 February 2019, DSC Manning contacted Child Protection to find out where XY was living so that he could visit her regarding the allegations made against XY's Stepfather.[272]

248. Also on 18 February, XY's Mother contacted Child Protection to get an update on XY. XY's Mother was told about a consultation for an AFLDM and was pleased that this was occurring.[273] On 19 February 2019, XY's Mother contacted Child Protection for more information about the consultation for the AFLDM. XY's Mother became angry and said she wanted an AFLDM when XY was first taken out of her care, not now. She told Child Protection she wanted nothing to do with XY.[274]

249. On 20 February 2019, Detective Manning contacted Child Protection wanting to make a time to meet with XY.

250. On 26 February 2019, XY's Mother told Child Protection she would attend the AFLDM but was not sure if it would be useful.[275]

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[271] PR 3576.
[272] PR 3571.
[273] PR 3572.
[274] PR 3567.
[275] PR 3540.

251. On 1 March 2019, XY's Mother contacted Child Protection and advised she wanted no responsibility for her child and was not prepared to attend court.[276]

252. Also on 1 March 2019, XY's school counsellor informed Child Protection that XY's Father had refused to give parental consent for XY to attend a school camp and that he did not want to be contacted by the school about XY.[277]

253. On 4 March 2019, the Protection Application was adjourned to enable XY to provide instructions to her lawyers, for Registrar's letters to be sent to XY's parents notifying them of the next mention, and for AFLDM to occur.[278] The Magistrate made a notation that, '1. The mother is opposed to the child being placed with the maternal grandmother'; and '2. The mother does not wish to be a party to the proceeding on an ongoing basis.'[279]

254. Also on 4 March 2019, XY fainted at school.[280]

255. On 6 March 2019, BA of Child Protection made a referral to ACSASS in a document entitled 'Areas of Concern.'[281] A Commence Care Allowance form was also completed in respect of Peta Thompson as XY's carer for XY for home-based care, kinship care – placement long term.[282]

256. On 7 March 2019, a Kinship Care Preliminary Part A assessment was completed by BA in respect of Peta Thompson.[283]

257. On 12 March 2019, Child Protection contacted XY's Mother who said she would not be attending the AFLDM.[284]

258. On 13 March 2019, the AFLDM meeting was held, convened by ███ █████ of BDAC and attended by XY, XY's Grandmother, BA, AX (AFLDM Convenor from Child Protection), Aunty Lyn Warren (Aboriginal Elder) and ███ █████ (XY's cousin). Both of XY's parents declined to attend the meeting and expressed to Child Protection that

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[276] PR 3505, 3506.
[277] PR 3507.
[278] PR 5767.
[279] PR 5766.
[280] PR 3504. See also CAMHS notes at MR 3119.
[281] PR 3481.
[282] PR 3492.
[283] PR 3456.
[284] PR 3426.

they did not want XY to live with them. During the meeting, XY's Grandmother offered to have XY live with her in Swan Hill, and XY expressed that she would prefer to remain where she is in Bendigo. It was agreed that XY would remain living with Ms Thompson, while having contact with her grandmother and cousins. A further AFLDM was to be held in 3 months' time to review family contact.[285]

259. In mid-March 2019, XY's case was transferred from BA to another Child Protection Case Manager, ultimately AR.[286]

260. On 20 March 2019, XY's Grandmother contacted AX, AFLDM convenor from Child Protection, wanting to have XY stay with her over Easter. [287] This placement was approved, with arrangements made for them to stay at a cabin in a caravan park.[288] XY's Grandmother requested that Aunty Lyn Warren not be involved in future AFLDMs. AX asked about XY's Grandmother and XY's Country. XY's Grandmother stated she believed her mother was Nari Nari and father Muthi Muthi however she would ask some of the people in her family to confirm.[289]

261. On or about 25 March 2019, a welfare worker at XY's school spoke to Child Protection about an incident of alleged family violence in which XY had been pushed by Ms Thompson's partner. XY was on school camp at the time of the call.[290]

262. On 29 March 2019, XY spent the weekend at a caravan park with XY's Grandmother, funded by Child Protection, as XY's Grandmother was living with XY's Mother at the time and could not accommodate XY.[291]

263. On 2 April 2019, Child Protection met with Ms Thompson to discuss the complaint regarding her partner having pushed XY, her housing situation, and the terms of her kinship care of XY.[292]

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[285] PR 3391 and MR 1150. See also PR5783 regarding communications with XY's Mother and XY's Father prior to the meeting.
[286] PR 3393-3403, 3357.
[287] PR 3393.
[288] PR 3378-3381.
[289] PR 3378-3381.
[290] PR 3387.
[291] PR 3377-3386.
[292] PR 3373.

264. On 8 April 2019, Detective Acting Sergeant Sarah Miller spoke with XY in the presence of her carer Peta Thompson about a further disclosure interview and options in relation to the alleged sexual offending being investigated by police. Acting Sergeant Miller discussed options with XY and advised XY that given the new disclosures she had made since her original VARE interview, if they were proceeding with the investigations a further VARE would need to be obtained. XY told police she was struggling with the pressure/stress the police investigation was causing her and was considering making a statement of no further police action in relation to all matters currently under investigation. XY was to discuss options with Ms Thompson at home over the next few days and police would contact her on 11 April to ascertain how she wanted to proceed.[293]

265. On 11 April 2019, Detective Acting Sergeant Miller called Ms Thompson and Ms Thompson advised that she had attempted to speak with XY about whether she wanted the investigation to proceed but XY disengaged when she tried to talk about it with her.[294]

266. Following Child Protection consulting with ACSASS, [295] on 12 April 2019, XY and Ms Thompson met with AR. AR explained to XY and Ms Thompson that XY had to stay with her grandmother on the weekend and begin the transition to live with her grandmother.[296] Later that day, Ms Thompson telephoned AR and told her that XY did not want to spend the weekend with her grandmother. Child Protection told Ms Thompson that it was important that weekend contact with the grandmother went ahead and that on Monday Child Protection would discuss it with XY again.[297]

267. Also on 12 April 2019, AR spoke to Tegan Harrison at CAMHS. Ms Harrison advised they were unsure whether CAMHS was the right service for XY, and that CASA may be better. Ms Harrison advised that XY and Ms Thompson often cancelled CAMHS appointments. Ms Harrison also advised that XY's mood had improved since staying with Ms Thompson.[298]

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[293] SOCIT Investigation Brief – Modra 2018, CB 1620.
[294] SOCIT Investigation Brief – Modra 2018, CB 1620.
[295] PR 3359.
[296] PR 3353.
[297] PR 3350.
[298] PR 3349.

268. On 15 April 2019, XY told AR that she did not enjoy being with her grandmother on the weekend. XY said that when she talked to her Nan about some things she changed the subject, those things being 'stuff that's gone on'. Child Protection explained to XY that staying with Ms Thompson was not a long-term option and if there is a willing family member, children must be placed with them.[299]

269. On 15 April 2019, Ms Thompson telephoned SOCIT and told Detective Sergeant Grigg that XY had decided that she wanted to proceed but did not want to make a further VARE until after the school holidays.[300]

270. Also on 15 April 2019, [redacted] [redacted], a Kinship Care Worker from BDAC, contacted Child Protection to advise she was to be XY's worker for the First Supports Program.[301]

271. On 17 April 2019, Ms Harrison at CAMHS telephoned Child Protection and advised that XY had not attended her appointment. Ms Thompson had apparently called CAMHS and stated that XY did not wish to attend anymore. Ms Harrison advised that CAMHS were ok with his and recommended XY continue with counselling at CASA, Headspace or a private psychologist.[302] A discharge letter was sent to Dr Naren.[303]

272. On 18 April 2019, during the Easter weekend, XY told Ms Thompson that she did not want to stay at her uncle's house as he was an ice user. This was reported to Child Protection, who made a phone call to XY's Grandmother, who said that XY was fine and XY's uncle would not be returning home that weekend.[304] That night, XY left her grandmother's house with her cousins [redacted] and [redacted][305] XY did not return to her grandmother's house and was reported missing to police. XY was staying with her cousins.[306]

273. On 23 April 2019, XY got a job at KFC.

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[299] PR 3344.
[300] SOCIT Investigation Brief – Modra 2018, CB 1621.
[301] PR 3342.
[302] PR 3341.
[303] PR 3298.
[304] PR 3334-3337.
[305] PR 3321.
[306] PR 3313 and PR 3319.

274. Also on 23 April 2019, Child Protection met with Ms Thompson regarding XY's long-term care. Ms Thompson indicated that she would support XY living with her cousins, but not her maternal grandmother.[307]

275. Also on 23 April 2019, Child Protection received a CAMHS closure letter dated 16 April 2019. The closure rationale included improvement in XY's mood, stable weight, not attending the last three appointments, and Ms Thompson's opinion that the service was no longer needed. XY's overall risk was assessed as 'low'.[308]

276. On 1 May 2019, AR of Child Protection referred XY to CASA for crisis care.[309]

277. On 4 May 2019, XY attended the Bendigo MDC with Ms Thompson and met with Detective Acting Sergeant Miller about her options. XY made further disclosures in relation to her stepfather, XY's Stepfather, alleging that she fell pregnant after being raped by him and that he hit her in the stomach with a brick and killed the baby. During the meeting it was discussed that XY had never had any counselling with CASA and was currently on their waiting list. XY said she was making statements to protect her siblings. XY indicated that she wanted to get some counselling prior to making a further statement, and that at that stage she wanted no further police action in relation to all other matters.[310] Detective Acting Sergeant Miller obtained a statement from XY, in which XY stated that she did not want to make another statement to police about XY's Stepfather and did not want police to investigate her first two statements any more at that stage because she was not 'in the right head space' and wanted to get some counselling. XY further stated that she understood she could come back and see police at any time to make another statement and have the matters investigated.[311]

278. On 6 May 2019, an interim accommodation order was made. In relation to sibling contact the order stated 'XY may have sibling contact regularly. In the case of Brother 1, contact is subject to his wishes. DHHS or its nominee will supervise contact'.[312] XY's Mother's

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[307] PR 3308.
[308] PR 3298.
[309] PR 82.
[310] SOCIT Investigation Brief – Modra 2018, CB 1622; Statement of XY dated 4 April 2019, CB 1404-1406.
[311] Statement of XY dated 4 April 2019, CB 1404–1406.
[312] PR 5760.

solicitor advised the Court that she wanted the order to have the following notation: 'The Mother does not wish to be a party to the proceedings on an ongoing basis'.[313]

279. On 7 May 2019, AR of Child Protection visited XY and Ms Thompson and informed XY about the court order and that the hearing had been adjourned for two months to allow a Cultural Support Plan to be completed. AR advised XY that the Court made an order for XY to have contact with her siblings and that Child Protection would work with the parties to arrange this. XY was happy about this. AR advised XY that they had referred her to CASA, but there was a six-month waiting list, so Child Protection would pay for a private counsellor to see XY. Ms Thompson advised that XY had met with BDAC First Supports that day, who were going to arrange a maths tutor for XY.[314]

280. On 8 May 2019, a consultation occurred between Child Protection and ACSASS. ACSASS advised that they would not support XY being placed with her maternal grandmother, and advised it would be preferable that XY remain where she was and have contact with the family she chose (her cousins). Notes of the meeting recorded that XY was excited about seeing her family.[315]

281. On 21 May 2019, XY's school counsellor, Chantel White, emailed Child Protection advising that XY has mentioned that her GP was wanting to change/cease her medication and indicated that she wanted to talk to a counsellor. Ms White stated this was a 'big step for XY' and recommended a clinical psychologist undertake the role.[316]

282. On 27 May 2019, XY overdosed on medication at home. She was found by her carer Peta Thompson and transported to Bendigo Hospital by ambulance. The Enhanced Crisis Assessment Team ('ECAT') assessed XY as depressed and recommended a priority referral to CAMHS be accepted and her medication reviewed. ECAT expressed concern with the current involvement of CASA, given the work involved and XY's current mental state and recommended XY's current state and depression should be the primary focus.[317]

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[313] PR 3268.
[314] PR 3265.
[315] PR 3263; MR 1144.
[316] PR 3260.
[317] MR 4911.

283. On 28 May 2019, Child Protection contacted ACSASS practitioner AL about XY overdosing on medication and being admitted to Bendigo Health hospital overnight.[318] AR of Child Protection visited XY at home. XY agreed that she was feeling depressed and said it was worse than before and said she wanted to speak to a psychologist. AR also spoke to XY about family contact. XY said she had been speaking to her cousins and wanted to have contact with her siblings.[319]

284. On 28 May 2019, CAMHS advised Dr Naren and Child Protection of the following recommendations for XY's care:

   a. XY to commence therapy with a private psychologist.

   b. XY to remain on the CASA waiting list until allocated.

   c. XY to continue to attend her GP for medication review and prescriptions, with Dr Naren able to consult with a CAMHS Psychiatrist to discuss medication.

   d. 'Nil ongoing CAMHS involvement at this time'.[320]

285. Also on 28 May 2019, Child Protection advised XY's father that XY had been taken to hospital overnight following an overdose, that she had been medically cleared by ECAT, and that they had re-referred XY to CAMHS. XY's Father was angry that XY had not been going to CAMHS, as she had when she lived with him. XY's Father advised he wanted to be kept up to date about XY but did not want contact with her yet.[321] Child Protection tried unsuccessfully to contact XY's mother.[322]

286. On 5 June 2019, XY's school counsellor Chantel White emailed AR at Child Protection. Ms White said she had completed a risk assessment on XY today and she was moderate/high risk, with suicidal thoughts still present, ongoing lowered mood and eating moderate amounts.[323]

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[318] PR 3250.
[319] PR 3247.
[320] PR 3240. See also PR 3244, 3246; MR 3216.
[321] PR 3243.
[322] PR 3242.
[323] PR 3233.

287. On 11 June 2019, Child Protection spoke to XY's GP, Dr Naren, who said he was hoping to have XY's medications reviewed by a CAMHS psychiatrist. Child Protection suggested XY be referred to private psychiatrist Dr Laura Barbosa at Sternberg Clinic.[324] Child Protection worker AR emailed XY's school counsellor Chantel White to update her on this development and advised that she would be on leave for two weeks and to contact AO in her absence.[325]

288. On 17 June 2019, Ms White sent a further email to Child Protection (to AO as AR was on leave). Ms White advised that XY continued to present as at risk, with current suicidal ideation, conflict with one of Ms Thompson's children at home and at school, and being significantly behind at school. Ms White further stated that she spoke to XY about possible placements and the only one she could identify were her cousins, however, also indicated that she knew that would not be suitable due to their current situation. Ms White also asked when Child Protection could recommence regular care team meetings.[326]

289. On 18 June 2019, [redacted] [redacted] of BDAC emailed Child Protection to advise that he was XY's new First Supports Worker, replacing [redacted] [redacted] and that he had been unable to reach XY's carer 'at this stage'.[327]

290. On 19 June 2019, XY was missing from fifth period, and her school was concerned about her mental health. She was subsequently found.[328]

291. On 25 June 2019, Ms White sent a third email to Child Protection (AO) highlighting concerns about her safety and urging an immediate assessment of XY by Dr Barbosa, to whom XY had been referred. Ms White asked Child Protection to advise when a care team meeting could occur .[329]

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[324] PR 3231; MR 625.
[325] PR 3229–3230.
[326] PR 3227.
[327] PR 3225.
[328] PR 3223-3224.
[329] PR 3221.

292. On 1 July 2019, an Interim Accommodation Order was made, with the same conditions in relation to sibling contact as were made on 6 May 2019.[330] The Court noted that Child Protection was to consider whether the Family Reunification Order was viable or not.[331]

293. On 4 July 2019, CASA emailed Child Protection indicating that they would be closing XY's file due to an inability to get in contact with XY and her carer. Contact with CASA was ultimately made by Ms Thompson at Child Protection's request.[332]

294. On 10 July 2019, DSC Manning of SOCIT consulted with Lauren Wright of CASA about XY. DSC Manning advised that he believed XY would get a lot out of counselling at CASA.[333]

295. On 17 July 2019, Ms White emailed Child Protection seeking an update about XY. She said XY found it upsetting to think about placement. Ms White's concerns about XY's risk continued, with XY having disclosed continued and increased frequency of suicidal ideas and deliberate self-harm over the holidays. Ms White also advised that XY had engaged in risky sexual activity.[334]

296. Also on 17 July 2019, XY attended an intake meeting with CASA. XY reported that she found it difficult to find a counsellor that matched well, and that she often felt anxious when having counselling and in the lead-up to attending.[335]

297. On 22 July 2019, Child Protection met with XY at school, with Ms White present. AR showed XY her Cultural Support Plan, which XY was happy with. AR told XY her mum had given Child Protection a ring for XY. XY did not want to see the ring and did not want to take it.[336]

298. As of 25 July 2019, XY was on CASA's allocation list.[337]

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[330] PR 5748-5749.
[331] PR 5753.
[332] PR 3212-3216.
[333] CASA Case Notes, PR 8419.
[334] PR 3209.
[335] PR 8419.
[336] PR 3203.
[337] PR 3199.

299. On 30 July 2019, Child Protection sought feedback and endorsement from BDAC on XY's Cultural Support Plan, noting that XY was happy with the plan.[338]

300. On 12 August 2019, XY's carer, Ms Thompson, reported to Child Protection that XY was, 'Really great actually. She's really happy.'[339]

301. Also on 12 August 2019, ███ ████ of BDAC emailed Child Protection to advise that ████ ███, XY's First Supports Worker, was no longer working at BDAC, and that he would be looking after 'the XY Family' until they were allocated to a new worker.[340]

302. On 22 August 2019, Child Protection were given a letter that XY had written to her mother. In the letter, XY asked her mother to acknowledge the abuse by her stepfather, which she said would end up in court. XY also asked why her mother would not let her see her siblings. Child Protection determined not to provide the letter to XY's Mother. Child Protection stated its rationale as follows: XY's Mother 'has expressed feeling anxious and depressed and is frequently upset when speaking about XY'. XY's Mother 'has expressed that she does not believe XY and that XY's lies are the reason that [Child Protection] are involved with her family'. Child Protection considered that providing the letter to XY's Mother would therefore be detrimental to XY's Mother's mental health at that stage.[341]

303. On 28 August 2019, XY self-harmed with a razor. The following day, AR made a home visit to XY and Ms Thompson. Ms Thompson said she was 'really angry' at XY for self-harming, and believed she was doing this for attention. XY told Child Protection she did not feel comfortable staying with Ms Thompson over the weekend as she did not want her to be angry at her all weekend. XY agreed to spend the weekend with her cousins.[342]

XY is in the care of ██ and ███ ███

304. XY was happy with her cousins over the weekend and remained with them for the following week to attend her uncle's funeral. Her uncle ████ passed over the weekend

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[338] PR 3197.
[339] PR 3196.
[340] PR 3194.
[341] PR 3191.
[342] PR 3188.

and XY was able to visit him in hospital before he passed. XY saw XY's Mother and XY's Grandmother at the hospital. XY also saw Sister 1 at the hospital.[343]

305. On 4 September 2019, Child Protection consulted with AL of ACSASS. AL advised Child Protection to have minimal contact with the family while they had Sorry Business. Child Protection sought endorsement of a change in XY's disposition from a Family Reunification Order to a Care by Secretary Order. AL advised that as XY's parents had both said they didn't want her back and XY had said she did not want to return to their care, then this decision was endorsed as it was in the best interests of XY. [344]

306. On 9 September 2019, an Interim Accommodation Order was made placing XY with Peta Thompson, with the same conditions in relation to sibling contact as were made on 6 May 2019.[345]

307. On 10 September 2019, Child Protection spoke with ███ ████ who advised that she and her sister ████ would be willing to have XY permanently. Arrangements were made for XY to remain with her cousins, and her belongings collected from Ms Thompson's house by Child Protection.[346] Ms Thompson stated that she was shocked and surprised when XY was taken from her care, and that she and her family wanted XY to stay with them permanently. She says DHHS did not provide her with any explanation as to why XY was taken from her care.[347]

308. On 12 September 2019, Child Protection made a Safe Custody Application to the Children's Court on the grounds that new facts and circumstances had arisen since the making of the Interim Accommodation Order on 9 September 2019. The Application was made noting:

- Child and Carer had disagreement and Child was placed with family for respite.
- CP assessed that the Carer was no longer suitable for Child to be placed with.

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[343] PR 3148.
[344] PR 3144.
[345] PR 5743.
[346] PR 3115.
[347] Statement of Peta Thompson, CB 160.

- Child placed with Maternal Cousins in an Aboriginal Placement.
- Child wishes to remain in this placement with Cousins.
- Cousins wishing for Child to remain with them.
- ACSASS endorsing this Aboriginal placement.[348]

309. On 13 September 2019, a new Interim Accommodation Order was made placing XY with ██ ███. In relation to sibling contact the order stated: 'XY, subject to her wishes, may have sibling contact regularly. In the case of Brother 1, contact is subject to his wishes. DHHS or its nominee will supervise contact.'[349] A notation on the court order states:

> The department is committed to making best endeavours to progress sibling contact on this IAO, however notes that the current family dynamics may pose difficulties for this occurring regularly.[350]

310. On 17 September 2019, Child Protection contacted Goldfields Psychology in relation to the Mental Health Care Plan from XY's GP, Dr Naren.[351]

311. On 18 September 2019, a Care Planning Meeting for XY was held with XY, AR of Child Protection and AL from BDAC ACSASS in attendance. The meeting noted recent developments and a plan was made for Child Protection to apply for a Care by Secretary Order for XY.[352]

312. On 23 September 2019, Child Protection booked in appointments with a psychologist for XY at Goldfields Psychologist, with the first appointment scheduled for 12 November 2019.[353]

313. On 26 September 2019, XY's Cultural Plan was given to her.[354] The plan was already out of date, not reflecting her move from Ms Thompson's care.

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[348] PR 175-176.
[349] PR 5737.
[350] PR 5732.
[351] PR 3090.
[352] PR 3051.
[353] PR 3020.
[354] PR 3054.

314. On 30 September 2019, a Care by Secretary Order was made. The order was to remain in force until 29 September 2021 or until XY turned 18 or married, whichever occurred first, with a review in 12 months' time.[355] The order was made in the absence of XY's parents.[356]

315. On 3 October 2019, Child Protection arranged XY's first counselling appointment with CASA, scheduled for 28 October 2019.[357]

316. On 7 October 2019, told Child Protection that things were going okay but they were unsure if they could provide care for XY long term.[358]

317. On 8 October 2019, Child Protection contacted Ms White, XY's school counsellor, to update her on XY's current care arrangement and the Care by Secretary Order, as well as the appointments arranged with CASA and a private psychologist for XY. Ms White advised Child Protection that XY had disclosed her interactions with her mother and her stepfather at her uncle's funeral and that XY stated, 'if Mum had of [sic] believed me I would still have a home and a family.'[359]

318. On 9 October 2019, Child Protection became aware (through Ms White, the school counsellor) that XY had taken a pregnancy test which returned a positive result (her GP subsequently confirmed a negative test). XY disclosed that she had been intoxicated at a party during the school holidays and passed out. When XY woke up a male said they had had sex.[360] Child Protection reported the matter to Central Victoria SOCIT and liaised with Dr Naren and AL of BDAC.[361]

319. On 10 October 2019, AR of Child Protection met with and . AL from ACSASS was present. and said they loved having XY there but that they were struggling. They identified various concerns. Child Protection agreed to complete a First

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[355] PR 5726.
[356] PR 3013–3014.
[357] PR 3016.
[358] PR 3015.
[359] PR 3011.
[360] PR 3004. See also PR 2996 regarding GP appointment and follow up.
[361] PR 2999.

Supports Referral and assist with new glasses and a dental referral for XY. A respite referral was also to be made.[362]

320. On 11 October 2019, Leading Senior Constable Fiona Whitty from Central Victoria SOCIT met with XY at school (with Ms White present) in relation to the alleged rape by an unknown male at a party. XY stated that she had attended a party on 27 September 2019 and had been told by an unknown male that they had sex but she did not remember the event. XY told police she did not want the police to investigate the matter and signed a statement to this effect.[363] Ms White informed Child Protection that XY was upset later that day and was concerned about going home because her cousins did not know about the recent situation.[364]

321. On 14 October 2019, during a telephone conversation between AR and Ms White, Ms White suggested that XY would benefit from a psychiatric review as she felt XY may have a personality disorder. Child Protection agreed that a psychiatric review would be of benefit to XY and agreed to follow up. [365]

322. On 15 October 2019, a Principal Practitioner Case Consultation was undertaken with AW and XY's Child Protection Practitioner, AR and Supervisor AO. Outcomes of the consultation included the Child Protection Sexual Exploitation Practice Leader ('SEPL') meeting XY, referring her to CASA, and identifying a counsellor who could provide XY with long-term support.[366]

323. On 16 October 2019, a SEPL Consult was undertaken by BD, which recommended a Take 2 file review.[367]

324. On 17 October 2019, a Targeted Care Package Consultation was held between AR, her Team Manager and the Targeted Care Planner. The action items from that consultation were:

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[362] PR 3002.
[363] SOCIT Investigation Brief – Refeeding DHHS 2019, CB 1722.
[364] PR 2993.
[365] PR 2992.
[366] PR 2989.
[367] PR 2986.

- Explore if suitable for a kinship targeted.
- Can have tailored care support- May be able to pay for the mentoring.
- Consult to be sent to contracting to assess if XY is suitable for Kinship Target.
- First supports to be further explored.[368]

325. On 23 October 2019, Detective Sergeant Matthew Gildea consulted with CASA about XY. Detective Sergeant Gildea advised that XY had reported that she had been raped at a party in September, that a SOCIT investigation had been going ahead but XY had requested no further police action, and that he was going to consult with XY's carer before closing the file.[369]

326. Later that day, Detective Sergeant Gildea spoke with Ms ██ ███ who advised that she supported XY's decision to make a statement of no further complaint about the allegation that she had been raped by an unknown male at a party and that she would continue to work with CASA and DHHS to support XY.[370]

327. On or about 28 October 2019, Child Protection cancelled XY's scheduled appointment with CASA due to XY's referral to Take 2.[371]

328. On 5 November 2019, Child Protection cancelled XY's first appointment with Goldfields Psychology which had been scheduled for 12 November 2019.[372] On 8 November 2019, Child Protection cancelled the remainder of XY's scheduled appointments.[373]

329. On 11 December 2019, AR forwarded a completed Take Two Referral for XY to AW, Principal Practitioner.[374] Arrangements were made for Berry Street and Child Protection to meet in early January to discuss the referral.[375]

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[368] PR 2984-2985.
[369] CASA Case Note, PR 8425.
[370] SOCIT Investigation Brief – Refeeding DHHS 2019, CB 1723.
[371] PR 8427.
[372] PR 2970.
[373] PR 2968.
[374] PR 2951.
[375] PR 2948.

330. On 17 February 2020, the Berry Street Take Two Healing Childhood Trauma service ('Berry Street') accepted XY as a client.[376] On 2 March 2020, Berry Street informed Child Protection that XY's anorexia had returned and recommended immediate treatment by General Practitioner Dr Naren. [377] The Child Protection Practitioner undertook to arrange an appointment.[378]

331. On 2 March 2020, Child Protection completed a 15+ Transition Care Plan for XY.[379]

332. On 3 March 2020, another consultation occurred with SEPL BD regarding XY's risk of sexual exploitation.[380]

333. On 11 March 2020, Child Protection picked XY up from school and conducted a home visit. a advised things were going really well, they had no concerns and wished for XY to keep living with them.[381]

334. On 30 March 2020, a Kinship Care Assessment (Part A) for XY was completed by AR.[382] On around 31 March 2020, a Kinship Care Assessment (Part B) for XY was completed by BE and uploaded on CRIS.[383] On the same date, BE followed up on enquiries about kinship brokerage funding for items such as a washing machine, bedroom furniture and tutoring for XY and in view of the developing COVID-19 health crisis and the stress that may have on the carers.[384]

335. On 16 April 2020, XY's case worker, AR, submitted an endorsed Kinship Brokerage Package and Kinship Supports Referral for XY to , Kinship Engagement Co-ordinator (DHHS) for further funding for XY's kinship care with and .[385]

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[376] PR 5413.
[377] PR 2887.
[378] PR 2887-2888.
[379] PR 2890–2901.
[380] PR 2886.
[381] PR 2883.
[382] PR 2922–2946.
[383] PR 2853–2880.
[384] PR 2851–2852.
[385] PR 2830–2848.

336. On 17 April 2020, Child Protection approved XY's one-on-one tutoring to be conducted online during the pandemic closures.[386]

337. On 23 April 2020, XY's school provided Child Protection with XY's Specific Learning Plan.[387]

338. In May 2020, Child Protection continued to negotiate funding for XY through Kinship Care Placement Support Brokerage and obtaining and submitting quotes for necessary items.[388] On 25 May 2020, the Brokerage application was approved.[389]

339. On 13 May 2020, XY's case management was allocated to BDAC, from Child Protection.[390]

340. On 20 May 2020, BDAC case workers AM and ███ ███ attended ██ and ███ ███'s home to conduct a welfare check on XY, following concerns raised by Catherine McAuley College that XY had not been completing schoolwork or attending online classes for the previous six weeks (during COVID-19 lockdowns). XY was not present during the visit, as BDAC were informed that she was visiting with her grandmother.[391]

341. Between May and June 2020, XY's personal journal entries discuss, at length, her declining mental health, desire to self-harm and suicidal ideation.[392]

342. On 3 June 2020, Take Two (Berry Street) provided an edited version of their Take Two Assessment of XY to Child Protection, requesting that an earlier version be deleted.[393]

343. On 11 June 2020, AQ (Child Protection) and BDAC exchanged phone calls. BDAC requested Child Protection conduct a welfare check on XY, and Child Protection responded that it was BDAC's responsibility to do so as her case manager, unless the

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[386] PR 2825-2826.
[387] PR 2814.
[388] PR 2792–2807.
[389] PR 2765.
[390] Statement of AW, CB 2032.
[391] PR 2788, 2785.
[392] CB 622.
[393] PR 2754.

matter was urgent.[394] There is no record of any welfare check being carried out following this conversation.

344. On 12 June 2020, Child Protection spoke with ███ ███ to arrange delivery of new bedroom furniture and informed her of the school's concerns.[395]

345. On 15 June 2020, Melissa Urquhart from Take Two contacted AM of BDAC regarding XY. AM responded on 16 June 2020 that she wanted XY to begin counselling ASAP, as XY had 'noticed a slip in herself recently.'[396]

346. On 16 June 2020, AM of BDAC contacted Catherine McAuley College to advise that XY had reported a deterioration in her mental health and anxiety about returning to school. On 19 June 2020, XY attended school but walked out of class following an outburst. Attempts were made to contact her to conduct a welfare check. Colin Hogan of Catherine McAuley College estimated that XY's school attendance for the year was at 59.4%, however he expressed doubt over the accuracy of this number due to difficulties with calculating attendance due to COVID.[397]

347. On 14 July 2020, XY (accompanied by ██ ███) presented to the Bendigo Health Adult Acute Unit. ██ brought XY in after finding a suicide note in XY's journal. XY was admitted to the unit and remained there until 16 July 2020.[398] Her clinical notes include a statement by ██ that 'When CAMHS closed they said they would refer her to a Psychologist but it never happened. She has not had counselling since CAMHS closed a year ago. She needs a counsellor or maybe group support'.[399]

348. On 16 July 2020, XY was placed at the Bendigo Health Youth Prevention and Recovery Centre ('YPARC') for the first time.[400] She would return to YPARC a number of times before her death. XY's initial YPARC stay concluded on 4 August 2020. On 3 August 2020, XY was informed that ██ ███ was relinquishing care as ██ could no longer

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394 PR 2752 – PR 2753.
395 PR 2742.
396 PR 2736.
397 PR 2735.
398 MR 1489 – MR 1596.
399 MR 1531.
400 PR 2723.

monitor XY. XY was released the following day into her grandmother's care.[401] AM advised Child Protection that, 'XY is happy to go to her grandmother's XY's Grandmother tonight, but I feel this is not a long term solution as it may not be sustainable depending on XY's relationship with her grandmother, and the fact that her grandmother has contact with XY's mother and uncles who XY herself has a poor/negative relationship with'.[402]

349. On 5 August 2020, in an Aboriginal Family Led Decision Making meeting with BDAC and Child Protection, the prospect of XY moving in with her Aunty ██████ ██████ was discussed.[403] On 6 August 2020, Ashlee Lougoon of CAMHS informed AQ of Child Protection that XY was apprehensive about moving in with her Aunty because she did not really know her. XY remained 'not super enthusiastic' about remaining with her grandmother.[404] AQ also spoke to AL of ACSASS, who expressed concern that XY's Grandmother may have been exercising control over XY to convince her to stay.[405]

350. On 6 August 2020, XY consulted with Ashlee Lougoon of CAMHS. XY reported that generally, her mental health was poor.[406] Child Protection liaised with CAMHS[407] and AL of ACSASS regarding XY's views. Child Protection and ACSASS agreed that they would allow XY to stay with her grandmother and not move to her aunt's for the time being, provided her grandmother liaised with Child Protection, BDAC and CAMHS.[408] On 12 August 2020, XY again met with CAMHS and reported an interest in attending an Aboriginal Girl's group at BDAC, so that she could attempt to connect more with culture.[409]

351. On 13 August 2020, BDAC, as contracted case managers, provided a quarterly report to Child Protection regarding XY. The report recorded that the next three months would focus on, *inter alia*:

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[401] PR 2711.
[402] PR 2711.
[403] MR 1083.
[404] PR 2686.
[405] PR 2685.
[406] MR 3256.
[407] PR 2686.
[408] PR 2685 and 2682.
[409] MR 3300.

- Establishing connections with XY's extended family and exploring respite options through holding an AFLDM.
- Referral to Better Futures to be completed.
- XY's cultural support plan to be updated to reflect current placement etc.
- Establishing care team meetings with professionals involved, i.e. CAMHS/school to address needs/concerns.[410]

352. On 18 August 2020, XY ingested paracetamol in what was described as an 'impulsive paracetamol overdose'. XY was admitted to the Child and Adolescent Ward at Bendigo Health and remained there until 21 August 2020.[411] On that date, she was transferred to the Marion Drummond Adolescent Unit at the Austin Hospital. On 22 August 2020, XY self-harmed using razor blades from a pencil sharpener that she smuggled into the unit. XY was briefly restrained while the blades were confiscated.[412]

353. On 26 August 2020, XY was discharged from hospital and commenced a stay at YPARC.[413] During that stay, XY reported to a YPARC worker that she had received phone calls from her mother.[414]

354. Also on 26 August 2020, AQ recorded in XY's CRIS file under subject 'Rationale for Placement (ACPP)', that ACSASS were consulted and endorsed XY to be placed with XY's Grandmother.[415]

355. On 27 August 2020, a Care Team Meeting was held regarding XY with representatives from BDAC, Child Protection, CAMHS and Catherine McAuley College. It was noted in the meeting that, 'XY has expressed difficulties living with her nan, including concerns around nan's frequent contact with XY's mother. XY is willing to live with her nan, as

[410] PR 2676.
[411] MR 3328.
[412] PR 2637.
[413] PR 2627.
[414] PR 2602; PR 2613; Supplementary statement of XY's Mother, 6 October 2023, [22].
[415] PR 2630.

she believes there are no other options. XY has expressed interest in living independently'.[416]

356. On 28 August 2020, XY remained in XY's Grandmother' care. On this date, Emma Botheras of YPARC disclosed to AQ of Child Protection that during her earlier stay, XY informed YPARC that her mother and stepfather visited XY's Grandmother, and that XY found this distressing and tried to ensure she was out when they visited. XY also disclosed to YPARC that approximately one month prior, she was sexually assaulted at a house party by three unidentified males.[417]

357. Prior to 27 August 2020, SOCIT contacted Child Protection again and advised that they wished to speak with XY about whether she wished to pursue charges.[418]

358. On or around 28 August 2020, Detective Acting Sergeant Miller contacted YPARC and advised that police were hoping to visit XY in person to discuss what she wanted to do in relation to her allegations against her stepfather.[419]

359. Sometime between 28 August 2020 and 1 September 2020, XY spoke with SOCIT and decided that she wished to provide a new statement in relation to the allegations against her stepfather and have the matter investigated further.[420]

360. On 1 September 2020, AM of BDAC informed Child Protection that XY had informed Victoria Police (SOCIT) that she was willing to co-operate in its investigation of her stepfather. XY also expressed concerns with continuing to live with her grandmother, given her close relationship with XY's mother and stepfather. [421] Also on that date, YPARC emailed BDAC and Child Protection to inform them that XY had been receiving phone calls from her mother that day and that XY believed they were due to her recent disclosures.[422]

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[416] PR 2605 – 2609.
[417] PR 2611.
[418] PR 2609.
[419] PR 2611.
[420] PR 2600; CB 1530.
[421] PR 2600.
[422] PR 2602; Supplementary statement of XY's Mother, 6 October 2023, [22].

361. On 8 September 2020, Detective Acting Sergeant Miller again referred XY to the Central Victoria CASA in respect of the allegations of sexual assault involving her stepfather.[423] The next day, on 9 September 2020, SOCIT re-opened the Tramless-2018 investigation.[424] On 10 September 2020, XY participated in a further VARE statement with Victoria Police (SOCIT), in which she recounted her allegations and provided new information that was not previously disclosed.[425] Victoria Police conducted a further interview with XY's stepfather.

362. On 11 September 2020, Child Protection emailed ACSASS (following a phone consultation) noting XY's Grandmother had not been supportive of XY's decision to press charges against her stepfather and that XY had decided she did not wish to return to living with XY's Grandmother. Child Protection noted it supported this decision. The email also noted that XY did not want to live with her aunt ████ and that BDAC had spoken to ████ who was willing to send XY regular texts in the hope that this may build the relationship between them.[426]

363. On 18 September 2020, at a Case Planning meeting, XY expressed a wish to be granted an independent living arrangement at Solomon Street Residential Care, for a period of 12 months. XY also expressed interest in being linked with an Aboriginal mentor in the community who was not a member of her family.[427] Notes from the meeting include that XY's cousins, ██ ███ ███, no longer wanted contact with XY.[428] Prior to the meeting AM spoke to XY to gain her views on her case plan.[429]

364. On 22 September 2020, a further care team meeting was held with representatives of YPARC, Catherine McAuley College, BDAC and Child Protection in attendance. The meeting notes record that, 'XY has appeared more happier/settled at YPARC and her mood has improved since knowing she has been accepted into Solomon Street'.[430]

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[423] PR 8428.
[424] CB 1530.
[425] CB 1531-1532.
[426] PR 2581.
[427] PR 2561.
[428] PR 2552.
[429] PR 2561.
[430] PR 2547.

365. On 30 September 2020, a case plan was made for XY, with actions table setting out significant decisions for care and wellbeing including XY's views in the areas of care arrangements, contacts, cultural support, education, health care, and other significant decisions, with each domain noting the cultural considerations.[431]

366. Also created on 30 September 2020 was a 'Child and Family Cultural Details' document, which noted (among other things) that XY would benefit from having an Aboriginal mentor, that she was engaged with CAMHS on a weekly basis and attended BDAC medical clinic to support her health needs, and that her GP Dr Naren had recommended seeing XY on a monthly basis to support her health needs and review medication.[432]

367. On 12 October 2020, XY moved to Solomon Street.[433]

368. On 18 October 2020, XY informed Grace Owen of Solomon Street that she was actively suicidal and that she had a plan to end her life on a walk. XY was assessed by 'Psych triage', but not admitted.[434]

369. On 20 October 2020, XY consulted with CASA, reporting that she used drugs to 'not feel numb' and to forget the memories of her sexual assaults.[435] The following day, XY disclosed an incident of self-harm by cutting to Solomon Street staff, which was triggered by an argument that XY had with her grandmother.[436]

370. On the evening of 21 October 2020, XY left Solomon Street and was uncontactable by staff. She was located later that night under the influence of alcohol, with some superficial self-harm cuts. XY remained at hospital overnight for observation.[437]

371. On 30 October 2020, XY spoke with Ashlee Lougoon of CAMHS. XY informed Ms Lougoon that she was travelling to Daylesford with a friend.[438] The following day,

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[431] PR 2567 – 2574.
[432] PR 1907-1910.
[433] PR 2525.
[434] PR 2422, 2510.
[435] PR 8433, 8438.
[436] PR 2503.
[437] PR 2499-2500.
[438] MR 3604.

XY presented to Bendigo Health Emergency Department reporting an overdose of 10 doxycycline tablets. She was discharged the following day.[439]

372. On 3 November 2020, XY ingested caffeine pills, in a 'spur of the moment' decision to self-harm. XY presented herself via ambulance to Bendigo Hospital Emergency Department.[440] On 4 November 2020, XY was again admitted to YPARC amidst ongoing concerns of her self-harming.[441]

373. On 4 November 2020, XY was moved again, this time back to YPARC.[442] Her stay involved one instance of self-harm on 15 November 2020.[443] On 16 November 2020, Ashlee Lougoon of CAMHS notified AQ of Child Protection that XY threatened suicide to YPARC's staff psychiatrist if she was moved to Aunty ████'s residence. YPARC informed CAMHS that they could not support her relocation to Aunty ████, but also held concerns about returning XY to Solomon Street as it was not staffed 24 hours a day.[444]

374. On 6 November 2020, a care team meeting was held with representatives of YPARC, BDAC, CAMHS, Child Protection and Solomon Street present. It was recommended that XY stay at YPARC for a week, but not for longer than two weeks, and a more specific safety plan to be developed if XY is to return to Solomon Street on discharge.[445]

375. On 12 November 2020, the Child Protection worker consulted with the Team Manager, AS regarding XY. AS recommended a consultation with ACSASS, to facilitate contact between XY and her aunt to promote their connection, and for XY to be added to the HRY (High Risk Youth) pre-panel.[446]

376. On 13 November 2020, a quarterly report by BDAC was completed which noted XY's mental health had deteriorated significantly due to a number of factors including COVID-

[439] MR 5603-5609.
[440] PR 2452; MR 5611.
[441] PR 2430 – 2437.
[442] MR 6383.
[443] MR 6469.
[444] PR 2402 & 2413.
[445] PR 2431.
[446] PR 2422.

19, placement breakdown, SOCIT involvement, and family dynamics/relationship breakdown.[447]

377. On 17 November 2020, Child Protection made a phone call to XY's paternal grandmother, ████ ████, to discuss concerns about XY's wellbeing and a possible kinship placement. ████ stated she would like to provide care for XY but was concerned how she would care for her whilst she was still working full time. She had not had contact with XY for approximately 3 years due to not wanting to cause conflict with XY's Father. She said she would like to commence contact with XY, and also provided a list of other kin but noted she did not believe any of them had capacity to care for XY.[448]

378. On 18 November 2020, Child Protection put out a request for a one-week placement for XY to a number of residential care providers. The Summary of Important Requirements for this Placement included close monitoring of XY (including regular overnight checks) to watch for self-harm episodes, sharp objects to be locked away, and support for XY during the Victoria Police (SOCIT) investigation. [449] A number of organisations, including the Mallee District Aboriginal Service (including Swan Hill and Mildura), the Njernda Aboriginal Corporation and Anglicare (Bendigo and Northern Metro) all replied that they were unable to accept XY. [450] Due to the uncertainty regarding XY's accommodation, and the stress this apparently placed upon her, Ashlee Lougoon of CAMHS emailed Child Protection on 20 November 2020 with her concerns that it was her 'impression that XY is now at far greater risk than she ever has been at Solomon Street'.[451]

379. On 19 November 2020, XY was taken to the Bendigo Hospital Emergency Department by her friend '███ due to XY experiencing suicidal ideation.[452]

380. On 20 November 2020, XY stated she did not want to stay with her friend '███' and did not want to go to any other placement other than Solomon Street and that not having somewhere to go was making her want to kill herself. Child Protection explained that she

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[447] PR 2192-2199.
[448] PR 2392-2393.
[449] PR 2383.
[450] PR 2352.
[451] PR 2276.
[452] PR 2333 – 2341.

couldn't go to Solomon Street overnight at the moment but could go for day programs and that Child Protection were doing their best to find her someone at the moment.[453]

381. On 24 November 2020, XY took acid with a fellow resident of Solomon Street. She was transported to hospital and stayed until the following day.[454]

382. On 26 November 2020, AQ of Child Protection met with XY and advised that she and AX (AFLDM) were considering holding an AFLDM meeting regarding having more contact with family members. XY stated she did not wish to attend. AQ asked whether XY wanted to engage in cultural activities or be engaged with a cultural mentor, which she declined. XY said she was interested in her culture but didn't want to participate in anything at that time. XY also said she did not want to engage with BDAC and wanted to be case managed by Anglicare.[455]

383. On 27 November 2020, Solomon Street provided Child Protection with an updated detailed safety plan for XY residing at Solomon Street including doubling staff numbers at certain times, which Child Protection approved.[456]

384. Also on 27 November 2020, XY attempted suicide or self-harm by cutting. She was admitted to Bendigo Health Emergency Department, where she was treated. Either during her admission or the following day, she disclosed to 'MIND Staff' (presumably YPARC staff) that she had been raped by a 35-year-old male, posing as a 17-year-old, that day, who she met on Snapchat approximately two to three months earlier. The alleged rape occurred at the male's house, and he used handcuffs to restrain her during the assault. ASCO staff case notes indicate that XY was advised to report this to Victoria Police.[457] Upon releasing her, XY returned to Solomon Street where she learned that her friend ███ █████ had died by suicide. XY then cut herself. Police were called and attended, and XY resisted until Police produced handcuffs, which caused her distress and she complied with their directions. XY was conveyed to hospital by ambulance pursuant to

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[453] PR 2332.
[454] PR 2239 – 2253.
[455] PR 2221.
[456] PR 2213 – 2214.
[457] MR 6541-6542.

section 351 of the *Mental Health Act 2014*.[458] In the Emergency Department, XY told her attending nurse about the rape, however no rape kit was offered to her.[459]

385. On 30 November 2020, another SEPL consultation occurred with BD regarding XY's risk of sexual exploitation. [460] A further safety plan was made for XY by Child Protection.[461]

386. On 1 December 2020, XY moved from the Bendigo Hospital Adult Acute Unit ('AAU') to YPARC on advice by the treating psychiatrist.[462]

387. Between 1 December 2020 and 3 December 2020, AQ of Child Protection spoke with XY's Grandmother regarding XY returning to live with her. XY's Grandmother refused to agree to Child Protection's 'bottom line' that XY's Grandmother not allow XY's mother and stepfather to visit, and said that she could not manage XY's self-harming behaviours.[463]

388. On 4 December 2020, AW of Child Protection prepared a case note in which he floated the possibility of XY's admission to an adolescent psychiatric unit, which was supported by YPARC's staff psychiatrist. AW noted that CAMHS psychiatrists had 'admission rights', and that CAMHS would need to initiate this process.[464]

389. On 8 December 2020, AQ from Child Protection met with XY at YPARC. YPARC staff Emily McDonnell and 'Dev' were present. AQ initially discussed XY's allegation of rape perpetrated by the 35-year-old male. XY would only tell AQ his first name ███'). When AQ asked XY to accompany her for a drive to the area where XY suspected the rape occurred, XY refused. After being advised that Child Protection considered ███ to be a risk to her (and others') safety, XY became visibly distressed and began to shake. AQ then changed topic, and informed XY that her paternal grandmother ███ ███ had agreed to take her into her home. XY again became upset, and refused to live with

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[458] Victoria Police ePDR Form dated 27 November 2020 at 20:10, CB 1760.
[459] MR 6541-6542.
[460] PR 2169.
[461] PR 2151-2155.
[462] PR 2159.
[463] PR 2125.
[464] PR 2099.

█████, saying she wanted 'nothing to do with that side of the family'.[465] On 11 December 2020, █████ texted AX of Child Protection, informing him that she was reneging her agreement to accommodate XY due to 'family issues and stress over it'.[466]

390. On 10 December 2020, AQ applied for an interim intervention order, on behalf of XY, against █████ ██████, in respect of her allegations of rape against him. XY provided the necessary information to AQ the day prior. [467] The interim order was subsequently granted[468] and although it was delivered to XY at YPARC, clinicians did not provide it to her as she was not in a mental state to receive it.[469] A final order was made on 11 January 2021.[470]

391. Also on 10 December 2020, XY was taken to the Bendigo Hospital Emergency Department by YPARC staff who were concerned for her wellbeing. [471] She was medically assessed and cleared for return to YPARC but YPARC were concerned about her escalating risk which required one-on-one support.[472]

392. On 15 December 2020, XY's YPARC stay was extended due to the unavailability of a suitable residence for her to move into, and due to observations by YPARC's staff psychiatrist that this uncertainty was causing XY distress.[473]

393. Also on 15 December 2020, a Kinship Engagement File Review was undertaken by Child Protection which looked at previous attempts to identify placements and respite placements, and to identify additional family. [474] This Review was updated on 17 December 2020.[475]

394. On 17 December 2020, BDAC case worker, AM spoke to XY to advise her that BDAC would be no longer case contracted for XY from 18 December 2020 and XY reported

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[465] PR 2057.
[466] PR 2039.
[467] PR 2050.
[468] PR 2040.
[469] PR 2037.
[470] PR 1710.
[471] PR 2047.
[472] PR 2041.
[473] PR 1994.
[474] PR 1975 – 1991.
[475] PR 1945.

that she was happy for BDAC to close.[476] Prior to closure of XY's management, AM completed a Better Futures Referral for XY.[477]

395. Between 16 December 2020 and 18 December 2020, Child Protection made attempts to find XY accommodation with her Aunty ████, and ████'s son ████ and his wife. Neither attempt was successful.[478] Child Protection, including the AFLDM convenor as well as BDAC, explored other family members as options for placements, but these were also unsuccessful.[479] These efforts were made in consultation with ACSASS worker AL.[480]

396. On 17 December 2020, XY wrote a letter to Child Protection, Solomon Street and BDAC. The letter appears in XY's medical records,[481] but not on her contemporaneous Child Protection case file. It read as follows:

> Dear Child Protection, Solomen [sic] St, BDAC
>
> I would like to be treated as a mature minor. I am writting [sic] this letter out of frustration as I do not feel I am being properly validated, supported or cared for by your services. I would like this letter to be viewed as feedback on my behalf.
>
> I identify as a proud Wemba Wemba women [sic] and would like the accociated [sic] support that a young Aboriginal female should be provided with further care. This is a human right.
>
> I would like support with connecting with my aboriginal [sic] heritage, elders and community, I would like the aboriginal [sic] community to support me. My family connections with BDAC which has impacted my access to services which has resulted of disconnection to my people and community.
>
> (Regarding Solomen [sic] St)
>
> I would like another chance please. I feel I am being punished for acting on my feelings. I feel restricted by some of the rules, like having to get police checks

[476] PR 1942.
[477] PR 1932.
[478] PR 1849.
[479] PR 1940.
[480] PR 1917.
[481] MR 6665

> everytime I stay overnight somewhere and being restricted to a certain amount of days or hours which I'm aware is not fully in your control but I would like to be treated like I'm independent as for from my understanding that's what we're working towards? I would be 100% open to making a new safety plan to try and reduce my risks and so I have a say in what supports me best.
>
> (Regarding child protection)
>
> I don't feel supported by you, I don't feel you have my best interest at heart, all of your options with housing Solomen [sic] Street was the most supportive, and place of least risk, you removed me from there which has only created more unnecessary stress on me and has taken a toll on my mental health, I just very much feel like you are providing unclear directions. I would like to be treated as a mature minor, I believe I have the capacity regarding my accommodation and lifestyle choices.
>
> Regards,
>
> XY

397. The letter was later acknowledged as 'being registered on FMS but not on CRIS'. The subsequent report that was generated noted that 'Young person has been spoken to on numerous occasions regarding her feedback. Young person reminded of the importance of attending their care team meeting so that their voice can be heard. Young person informed of child protection procedures and practice in regards to decision making.' 'No system or organisational changes or action' was noted as the Actions Taken, and the 'key lessons learnt for the service' were:

- Explaining child protection procedures and process in a child friendly manner.
- Including young person in care team.
- If young person doesn't attend care team how information is passed onto young person.
- Listening to young person voice.[482]

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[491] PR 1673.

398. On 23 December 2020, XY's case management responsibilities returned to Child Protection.[483]

399. Also on 23 December 2020, short-term kinship accommodation at a schoolmate's home was organised. XY resided in a caravan during this placement.[484] XY then moved to the home of the schoolmate's grandparents. XY was initially resistant because she did not know the grandparents. XY remained there until 31 December 2020, when a suicide note was found in XY's room.[485] XY was then admitted to Bendigo Hospital's Adult Acute Unit, where she remained until 14 January 2021.

400. Upon XY's release from hospital on 14 January 2021, XY was placed at Anglicare Victoria, Maison House.[486] On 13 January 2021, XY expressed a preference to remain in hospital when Child Protection visited her with an Anglicare worker in hospital to discuss the placement, [487] however Child Protection case notes state that she 'transitioned reasonably smoothly to the house and was engaging positively with staff and another [young person] in the house'.[488] On 15 January 2021, AB of Anglicare visited XY at Maison House. XY expressed that she was feeling numb over the 'unknown', as this placement only lasted seven days and she did not know what would happen to her afterwards. Accordingly, XY could not enjoy herself at Maison House or feel a sense of belonging because she knew she would be moved. XY told AB that she would use drugs and possibly self-harm to relieve the stress.[489]

401. On 15 January 2021, CAMHS reported to Child Protection that they had caught up with XY and she presented as bright, chatty and humorous and more future focussed than she had been in months.[490]

402. On 21 January 2021, XY's stay at Maison House was extended a further seven days.[491] Also on this date, AQ of Child Protection and Ashlee Lougoon of CAMHS emailed each

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[483] Statement of AW, CB 2032.
[484] PR 1809, 1821.
[485] PR 1762-1767.
[486] PR 1718.
[487] PR 1720, MR 2008.
[488] PR 1715.
[489] PR 1708.
[490] PR 1706.
[491] PR 1673.

other regarding XY's desire to have contact with her younger siblings. AQ noted that XY's parents had previously denied such requests, but that she would follow up as it 'would be in XY's best interests'.[492]

403. On 22 January 2021, XY's placement at Maison House was extended to 28 January 2021.[493] Anglicare Care Team Meeting Minutes for 21 January 2021 state that XY was enjoying her time at Maison House, and that 'Containment at Maison is similar to what [XY] gets at YPARC – [Ms Lougoon] has advised that this is the best that she has seen XY and has been able to communicate with her around other options'.[494]

404. On 25 January 2021, Maison House staff contacted Child Protection regarding concerns about XY's self-harm and drug use. On the same day, Maison House staff liaised with CAMHS worker Ms Lougoon regarding XY's presentation, following Child Protection's advice to do so.[495]

405. Also on 25 January 2021, Louise Gillman of CASA called AQ of Child Protection, and left her a voicemail. Ms Gillman then sent a text message to XY, stating that she was 'just following up as [she] had not heard back from [XY]'. Ms Gillman asked XY if she would like to make an appointment for counselling.[496] On 28 January 2021, XY's CASA file was closed, due to her 'Ceased contact with service'. The record indicates that XY attended two sessions with the service. Under Goals Achieved, the report stated 'YES'.[497]

406. On 28 January 2021, Child Protection sent out an email seeking a placement for XY that day. Eight residential care providers, from all over Victoria, responded that they did not have capacity to accept her.[498] That afternoon, AQ of Child Protection contacted XY to inform her that she had been approved to stay an additional night at Maison House. XY expressed her distress and frustration at Child Protection and AQ regarding the lack of certainty about her placement. XY told AQ that she did not understand why she could not

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[492] PR 1667-1668.
[493] PR 1664.
[494] PR 1664.
[495] PR 1648 – 1653.
[496] PR 8440.
[497] PR 8441.
[498] PR 1597.

stay at Maison House long term, that she did not believe Child Protection and AQ were doing anything to help her and that 'This is making me want to kill myself'.[499]

407. Also on 28 January 2021 ████ █████, Program Manager Residential Services Anglicare contacted Child Protection asking for XY to remain at Maison House.[500] On 4 February 2021, Child Protection confirmed that XY could remain at Maison House.[501]

408. On 2 February 2021, XY was still at Maison House. She left briefly that afternoon and returned, telling a staff member on her arrival that she had stood on the train tracks waiting for a train to arrive. XY expressed that the uncertainty regarding her placement was making her feel this way.[502]

409. On 8 February 2021, XY self-harmed by cutting. She bandaged the wounds herself and would not allow workers at Maison House to help her. Eventually, paramedics were called and arrived after 10pm. XY refused to accompany paramedics to Bendigo Hospital. Victoria Police was called and arrived 30 minutes later. Police 'convinced XY to go with the paramedics to hospital with no fuss'. At Bendigo Hospital, XY was assessed by the Enhanced Crisis Assessment Team. Early the following morning, XY returned to Maison House.[503]

410. On 10 and 11 February 2021, XY disclosed to AB of Maison House additional details of sexual exploitation and sexual assault. Specifically, XY disclosed that she had been in the bush with a male named ███' who she believed to be 17 years old███ touched XY's leg, and 'stuff happened but I let it I went along with it because I don't know how to say no'.[504] XY did not report this to Victoria Police. Further, XY disclosed that she had sex with an unknown male in Castlemaine in exchange for drugs. XY did not provide details of the male.[505] This incident was reported to police on 11 February 2021 by Child

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[499] PR 1596.
[500] PR 8058.
[501] PR 5902.
[502] PR 1565.
[503] PR 1555-1557.
[504] CB 633; PR 1405, 1541.
[505] PR 1404.

Protection, AQ, who was advised there was no action police could take without the dealer's name.[506]

411. On 15 February 2021, XY told Maison House workers that her mother had left her messages on TikTok in which she called XY a liar and that she had a good childhood. Later in the day, XY was observed in her room with cutting wounds to her left arm. Maison House staff helped XY clean her wounds. Hospital triage and the Anglicare Victoria After Hours service were notified. Hospital triage advised Maison House staff that there was no immediate need for medical attention and that they should continue to check on XY regularly and call back later if needed. Later again, XY was found unresponsive on the hallway floor. She was roused by Maison House workers and an ambulance was called. Paramedics took XY to hospital.[507] On the same day, AQ of Child Protection referred XY to Youth Support and Advocacy Service Bendigo ('YSAS'), with her consent.[508]

412. On 16 February 2021, XY received a phone call from 'Tegan' of CAMHS, who informed her that she had secured a placement at YPARC. Upon arrival at YPARC, XY told staff that she was doing okay, but did not understand why she was still feeling suicidal after knowing that she had a stable placement.[509]

413. On 21 February 2021, XY was admitted to Bendigo Hospital under an assessment order after absconding from Bendigo Hospital on 20 February 2021.[510] She spent time in the Intensive Care Area / Adult Acute Unit and spoke to a psychiatrist. On 22 February 2021, the assessment order was revoked.[511] XY then called staff at Maison House and told them that she wanted to return to that residence.[512] On 23 February 2021, Maison House staff picked up XY from Bendigo Hospital and took her back to the residence. That evening, XY became upset again after receiving news that another (unidentified) friend had died by suicide. However, there was no incident of self-harm that night.[513]

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[506] PR 1534.
[507] PR 1512-1513.
[508] PR 1519, 1521.
[509] PR 1507.
[510] MR 2099.
[511] MR 2135.
[512] PR 1479.
[513] PR 1473.

414. On 27 February 2021, XY told Maison House staff that she wanted to kill herself that evening. XY was taken to Bendigo Hospital, administered medication and sent home. AB of Maison House noted that XY appeared frustrated by the hospital's decision to send her home, and that the nurse at Bendigo Hospital told XY that as she had not hurt herself, the nurse did not believe that XY was at risk.[514]

415. On 28 February 2021, XY spoke with residential staff about XY's Mother's comments to her on TikTok. XY also discussed the abusive messages she has received from XY's Father.[515]

416. On 1 March 2021, ████ ███ of Maison House emailed AS, BC and AQ of Child Protection, informing them that XY indicated to Maison House staff that the previous day, she had had sex with an unidentified male, that she felt she had no connection or control, that the male seemed to be in it for himself and that she felt as if she had been raped, but had not asked him to stop. Later that day, XY disclosed to Maison House staff that she was becoming increasingly frustrated with health professionals disregarding her feelings and telling her that her self-harm was only superficial. XY revealed additional self-harming abrasions which she said she did with a broken shampoo lid. XY also disclosed to Maison House staff that she 'just wants to die' and that she planned to overdose. After refusing to accompany staff to Bendigo Hospital, XY made small cuts in her arms. Victoria Police were called and attended. Police accompanied XY in an ambulance to Bendigo Hospital. A doctor raised the prospect of XY transferring to the Austin Hospital, which agitated XY. She told the doctor that the last time she was at the Austin Hospital, she was made to strip search by a male with no female present.[516] There is no record of any strip search of XY having been conducted at the Austin Hospital.

417. On 15 March 2021, XY met with Stephen Turner of YSAS. XY rejected his offer to assist her with reducing her substance use. No further appointments were made.[517]

418. On 16 March 2021, XY returned to Maison House after going out. She told staff that she had taken the drug, acid.[518] Staff later found XY in her room with a very deep cut to her

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[514] PR 1470.
[515] PR 1471.
[516] PR 1458-1459.
[517] PR 1395.
[518] Lysergic acid diethylamide, commonly known as LSD, PR 1410.

wrist. XY refused attempts to treat her wound or attend hospital. After some time, Victoria Police were called and attended the residence. Attending police were aware that XY had returned to the residence in a very heightened state after being out all day and stated that she had tried Ice and a short time later had been located in her bedroom with severe self-harm cuts and had stated to workers that she wanted to kill herself.[519] Two male police members spoke with XY, in what the staff member (unidentified) describes as 'firm, clear voices'. XY was asked repeatedly if she had any blades and she refused to answer. Police told XY that if she did not hand over the blades they would have to restrain her. XY did not reply. Maison House staff encouraged XY to hand over any blades so the police did not have to search her, which XY refused. The members then restrained XY with handcuffs, at which point she told them where the blades were located. A female member then arrived and searched XY, locating more blades.[520] XY was taken to Bendigo Hospital, where she absconded and was picked up again by Victoria Police. Maison House staff attended Bendigo Hospital, and eventually XY was discharged back to Maison House, telling the staff member accompanying her that she felt the mental health team at Bendigo Hospital did not listen to her, and that 'It's like I have to kill myself to show them I'm sick'.[521]

419. XY returned to Bendigo Hospital on 18 March 2021 after she ingested 20 Panadol Rapid tablets and collapsed. She was discharged that day.[522]

420. On 19 March 2021, XY spoke to AB of Maison House (via telephone) and told her she planned to kill herself by going to the train tracks or hanging herself at the 'old gillies building'. AB placed 15-minute welfare checks on XY, with a direction to follow her if she left the residence.[523] AB also sent an email to Ashlee Lougoon of CAMHS and AQ of Child Protection stating that Maison House was single-staffed, having difficulty filling shifts, and that staff were not trained to deal with XY's self-harming and Bendigo Hospital were turning her away when she wanted to be admitted. [524] The same day, Ms Lougoon reported to AQ that she had met with XY that day, and XY had asked to be

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[519] CB 1134.
[520] PR 1410.
[521] PR 1410-1411.
[522] PR 1392-1393.
[523] PR 1388.
[524] PR 1383.

admitted to Bendigo Hospital Adult Acute Unit. Ms Lougoon informed XY that it was not an appropriate or therapeutic environment for XY, and instead CAMHS would look for an adolescent inpatient unit bed. XY was offered treatment options including discharge to Maison House with her input regarding safety planning, admission to the Austin Hospital which XY refused, or short-term treatment team follow up, which XY also declined.[525] XY opted for Maison House.[526]

421. On 20 March 2021, XY was found in Maison House hanging by a shoelace or hoodie cord. She was unresponsive but conscious. She was taken to Bendigo Hospital, with Maison House staff also attending, and she absconded and was located by Victoria Police early the following morning. She was admitted to Bendigo Hospital, with a plan to move her to an adolescent inpatient unit in Melbourne later that morning.[527]

422. On 21 March 2021, XY remained in Bendigo Hospital. Child Protection notes indicate that Bendigo Hospital staff would not tell Anglicare whether XY would be admitted. The Child Protection On Call service contacted Bendigo Hospital to give consent for information to be shared with Anglicare.[528] On 23 March 2021, XY was placed at the adolescent inpatient ward at Austin Hospital. She was upset by this. AU of DFFH suspected that XY was upset because of her previous disclosure concerned an alleged strip search during a previous admission.[529] On 26 March 2021, ██████ ████ of Maison House, Ashlee Lougoon of CAMHS, and others in XY's extended care team met to discuss her stay at Austin Health. AU of DFFH asked whether XY could be placed in accommodation in Melbourne, specifically with mental health supports, following her discharge. Ms Lougoon noted that she was not aware of any therapeutic long-term residences available within the mental health service system that could accommodate XY.[530]

423. On 26 March 2021, XY's case management was contracted to Anglicare Victoria's Intensive Case Management Service ('ICMS'). This decision was made after she was assessed as requiring more intensive case management support. This involved 'an

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[525] PR 1379.
[526] PR 1379.
[527] PR 1372-1373; MR 5700.
[528] PR 1365.
[529] PR 1360.
[530] PR 1358-1359.

assertive case management approach that was integrated with other multidisciplinary services, including residential care'.[531]

424. On 30 March 2021, ██ █████ of Child Protection emailed AB, whose role as Residential Care Team Leader included responsibility of ICMS, seeking accommodation for XY at YPARC upon her imminent discharge from Austin Hospital. The importance of XY being given some certainty about her accommodation was raised.[532] Later that day, an ICMS worker picked up XY from hospital and drove her to YPARC. Visits to Maison House during that stay were also discussed.[533]

425. 31 March 2021 was XY's 17th birthday. AC of ICMS emailed Child Protection and CAMHS, informing them that ICMS staff took XY out to dinner for her birthday, where XY expressed regret over upsetting Maison House staff during her recent suicide attempt. XY described it as a 'BPD moment' (borderline personality disorder moment).[534]

426. On 8 April 2021, AC of ICMS emailed AQ of Child Protection and AL of ACSASS, inviting AL to conduct a joint visit with XY.[535] Principal Practitioner AW requested the Aboriginal State-wide Principal Practitioner, Ruby Warber, attend the upcoming AFLDM meeting.[536]

427. On 23 April 2021, a 'Kinship Engagement / Closure Summary' was uploaded to CRIS which noted that 'CP advised that XY declined to engage with family and relevant services for any relationship building, cultural [connections], etc'. Follow up required included: 'CP to re-consider the potential kinship respite carer (willing to consider long-term placement) that the Loddon Kinship Engagement team found, once relationships and connections with XY and relevant family members have been carefully planned, supported and successful over time', and 'CP to consider further AFLDM consults, liaison with BDAC ACSSAS Worker to reconnect with the potential kinship carers and liaise between them and XY. CP may re-refer to Loddon Kinship Engagement team once XY and family members agree to further explore kinship options and for any relevant

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[531] Statement of AW, CB 2032.
[532] PR 1350.
[533] PR 1347-1348.
[534] PR 1328-1329.
[535] PR 1292.
[536] PR 1206.

carer supports'.[537] In an email from ██████ ██████ (DFFH) to AQ (DFFH) on 24 April 2021, Ms ██████ stated 'You or anyone from CP may re-refer to us in future once CP assesses further kinship finding is recommended and/or XY is agreeing to reconnect with family'.[538]

428. On 29 April 2021, in an AFLDM consult meeting, participants from Child Protection, ACSASS and Anglicare discussed slowly reintroducing XY to culture and family. A tentative plan was set to reconvene in late May 2021.[539]

429. On 4 May 2021, XY had a phone consult with Ashlee Lougoon of CAMHS. XY reported that she had abstained from self-harm for two weeks, but had relapsed and felt that she was back at 'square one'. Ms Lougoon discussed the possibility of a circuit-breaker stay at YPARC, which XY agreed to consider.[540] On 7 May 2021, XY spoke with Ms Lougoon again and disclosed that she had spent almost all of the money in her bank account on, and then taken a number of Xanax and, although her memory of the episode was blurry, she believes she went to a park and cut herself deeper than she had intended. XY was picked up by Victoria Police and taken to hospital, where ECAT assessed her. The ECAT assessor made a comment to XY that her cuts 'weren't the worst they've seen', which XY reported made her feel unvalidated.[541]

430. Between 7 May 2021 and 10 May 2021, XY had her 'circuit breaker' stay at YPARC.[542]

431. On 11 May 2021, residence workers (believed to be Maison House) picked up XY from a park where she was intoxicated. When back at the residence, XY self-harmed with blades. Victoria Police were called to attend in response to a suicidal female harming with a razor blade. Members directed XY to surrender her blade, and she refused. XY then self-harmed in front of the members by cutting into her right arm, drawing blood. Police then tried to take the blade from XY, without success. Police then deployed capsicum spray on her and restrained her with handcuffs. XY was provided with

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[537] PR 1136-1137.
[538] PR 1133.
[539] MR 958-959; PR 1095-1096.
[540] MR 4488-4492.
[541] MR 4512.
[542] PR 6638-6646.

aftercare.[543] Paramedics then arrived.[544] ECAT assessed XY at Bendigo Hospital as not being at imminent risk and discharged her with a plan for CAMHS continued management[545] as it would be 'counterproductive' to keep her overnight.[546] On 12 May 2021, Child Protection consulted with AL of ACSASS regarding this incident.[547]

432. On 25 May 2021, XY and AC of Anglicare met with AL of ACSASS at the offices of BDAC. Participants discussed culture, including the Wemba Wemba people and XY's totem, the Nightjar Bird. Plans were made to continue to engage XY with culture.[548]

433. On 26 May 2021, XY informed Maison House staff that, the night before, her ex-boyfriend '█' held a gun to her head. XY self-harmed later that evening and did not go to hospital. AB, in her capacity as Residential Care Team Leader responsible for Maison House, wrote to AQ of Child Protection that she had instructed staff to report the gun issue to Victoria Police, and XY was advised to photograph her injuries as evidence.[549] A few days later, in a disclosure made to Ashlee Lougoon of CAMHS, XY provided more information about her interaction with █. Ms Lougoon noted that while XY described █ as an ex-boyfriend, Ms Lougoon noted that he was more likely a person in an 'illegal, exploitative relationship' with XY. XY reported that █ hassled her until she relented and went to his place where 'not good things' happened. XY was resistant to involving Victoria Police, fearing it would make it worse.[550]

434. On 30 May 2021, Maison House staff found a suicide note in XY's journal. XY was not at the residence. After engaging Victoria Police, XY was located at a playground, hanging by a shoelace and unconscious (police and medical records indicate XY called police herself).[551] Police arrived at the scene around 6:19pm and XY was immediately cut down by police and after a few seconds she commenced breathing but remained unconscious. Police requested an ambulance attend the scene as soon as possible and monitored XY's

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543 Victoria Police LEAP Incident Report, CB 1138; PR 996-997.
544 PR 996.
545 MR 5103.
546 PR 997.
547 PR 989.
548 MR 942; PR 935.
549 PR 922-923.
550 MR 4615.
551 MR 4621.

pulse and breathing until an ambulance arrived. [552] XY was transported to Bendigo Hospital Emergency Department.[553] The following day, XY reported to Ashlee Lougoon of CAMHS that she was 'pissed off' that her suicide attempt did not succeed.[554] On the same day, CAMHS and Maison House discussed line-of-sight monitoring for XY, but it was agreed that would only be reasonable when her mental state appeared lowered (she had presented in good spirits earlier in the day).[555]

435. On 1 June 2021, ACSASS, ICMS, Child Protection and a number of other participants met to discuss XY's recent suicide attempt, the possibility of XY re-engaging with culture and her mother. AL of ACSASS suggested unpacking this with XY to determine if, at this time, this would do more harm than good.[556] Another meeting occurred the next day between Child Protection, Anglicare, CAMHS and the Department of Education.[557] On 5-6 June 2021, during a stay at YPARC, XY told CAMHS staff that her mother had contacted her, and she got 'lured in' with a phone call with her siblings.[558] On 9 June 2021, XY reported to Ashlee Lougoon of CAMHS that the messages from her mother started off 'nice' but descended into denials of XY's trauma when her mother told her that she was not raped.[559]

436. On 9 June 2021, the Care Team Meeting notes record that 'AFLDM booked for this Friday'.[560]

437. On Saturday 12 June 2021, Maison House staff found XY in the bathroom with several deep cuts. XY reluctantly agreed to go with paramedics to Bendigo Hospital for stitches.[561] While there, Maison House staff and XY spoke with ECAT and were told that because XY was engaged with CAMHS, XY was better off 'holding out' until her meeting with CAMHS on Tuesday. XY expressed frustration at this, and said, 'What if I do something before then? I could easily kill myself in that time'. XY and Maison House

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[552] Statement of Senior Constable Todd Deason, CB 257 – 258.
[553] PR 887, 889; MR 4627
[554] MR 4632.
[555] MR 4633.
[556] MR 931-932.
[557] MR 926-928; PR 861-862.
[558] MR 4678.
[559] MR 4696.
[560] PR 791.
[561] PR 504-505, 6791.

staff continued to express concerns to ECAT and were told again to 'hang on till Tuesday'.[562]

438. On 16 June 2021, Child Protection, ICMS, CAMHS met with Tim McCormick of Better Futures, in part to discuss XY's transition to life outside care as she approached her 18th birthday.[563]

439. On 18 June 2021, XY self-harmed again. As she was blocking the door and not letting Maison House staff in, Victoria Police were called and attended. When members were talking with XY, Maison House staff saw her try to pick up a blade. A female member restrained her. Paramedics arrived and sedated XY. She was taken to Bendigo Hospital, with a Maison House staff member also attending, where her wounds dressed and then she was discharged. Later that evening, XY disclosed to a Maison House worker that it was the three-year anniversary of her miscarriage, after the rape by her stepfather.[564]

440. On 21 June 2021, XY and a Maison House worker drove past a house in Eaglehawk. XY said she was raped in that house when she was 14 years old, from which XY suffered vaginal tears and an STI. XY stated that it was the first time she was sexually abused by someone outside her family. XY told the Maison House worker that she had not reported the rape because the person who raped her had assaulted a number of other girls, and that 'There were people doing a run through of [his] house with shovels, baseball bats and guns anyway'. The Maison House worker reported the rape disclosure to Victoria Police.[565]

441. Between 25-26 June 2021, XY went to Melbourne to visit a friend. When she returned to Maison House, she complained of drug withdrawal having gone off her medication during her trip. After a self-harming episode on 28 June 2021, paramedics and Victoria Police were called. XY self-harmed again in the ambulance trip to Bendigo Hospital and was restrained both in the ambulance and again at the hospital.[566] The Maison House worker reported that Victoria Police told them that XY had become aggressive in the ambulance and that she had to be restrained, which the worker was surprised to hear

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[562] PR 6791.
[563] PR 748.
[564] PR 6819.
[565] PR 6834.
[566] PR 6870.

because there was no history of violence, by XY, towards people. [567] AQ of Child Protection again consulted with AL of ACSASS regarding this incident.[568] On 29 June 2021, XY requested a circuit breaker stay at YPARC, as advised by CAMHS to Anglicare and Child Protection. This was arranged[569] and XY stayed at YPARC until 1 July 2021.[570]

442. On 3 July 2021, XY self-harmed again at Maison House. Paramedics and Victoria Police attended,[571] and XY willingly accompanied them to Bendigo Hospital. XY received 19 stitches and spent the night in the Adult Acute Unit[572] and was discharged back to Maison House.[573]

443. On 5 July 2021, an across-agency monthly clinical meeting was held. Participants included CAMHS psychiatrist Dr Patrick Johnson, CAMHS case manager Ashlee Lougoon (and her manager, Belinda Crossley), ███ █████ from BDAC and AW from Child Protection. They discussed whether XY may have been leaving clues before her suicide attempts, such as her leaving her diary open for staff to find suicide notes, or her calling Victoria Police to let them know she was going to make a suicide attempt. Participants also discussed the prospect of XY participating in traditional healing practices and ceremonies. An action item was made for Anglicare to follow this up with ACSASS.[574] On the same date, AQ consulted with AL of ACSASS, who asked that Anglicare be reminded to contact ACSASS when there was an incident after hours, which was then done.[575]

444. On 11 July 2021, XY attempted suicide by attaching a library bag cord to her neck and leaning forward, while in the bathroom. Staff heard the attempt and intervened. XY was subject to 10-15 minute checks at the time, due to her ongoing suicide attempts and reports of poor mental health. When paramedics and Victoria Police attended, XY was uncooperative about attending the emergency department to be checked and attempted to run away. She was handcuffed by Victoria Police members, ‘sectioned and sedated’. She

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[567] PR 6870.
[568] PR 641 -648.
[569] PR 624 – 627.
[570] PR 606.
[571] CB 1146–1147; MR 5753.
[572] MR 4841.
[573] PR 582.
[574] PR 574.
[575] PR 573 and 571.

was then taken to Bendigo Hospital.[576] Upon her release the following day, Maison House staff report expressing their frustration with Bendigo Hospital for continuing to release XY when she is brought in. An unidentified person involved in XY's care at the hospital told Maison House staff that 'Sadly one day XY will be successful in killing herself'.[577] This was subsequently reported to ACSASS.[578]

445. On 13 July 2021, XY went to stay at YPARC. She remained there until 16 July 2021, self-harming the night before her release.[579] On 16 July 2021, XY had planned to visit with friends but that was cancelled due to COVID lockdowns. XY complained that she wanted to remain at YPARC, but there was no capacity for her. CAMHS consulted with YPARC and was content for XY to return to Maison House, as she would be well supported there.[580]

446. Also on 13 July 2021, CAMHS (participant unidentified) and Child Protection (AW) met to discuss the possibility of admitting XY to the adolescent inpatient care at Austin Health. CAMHS did not support this idea, as it was unlikely to reduce her medium- to long-term risk, and because exposure of young people with borderline personality disorder to mental health facilities 'can establish a pattern to dependency into adulthood'.[581]

Events of 18 July 2021 (date of death)

447. On 18 July 2021, XY met her friend ZA outside Maison House. XY returned ZA's bong to her.[582]

448. Later that afternoon, XY told Maison House worker AA that she was going on a walk. AA noted that XY was allowed to go on unsupervised walks as long as she checked in every 30 minutes.[583]

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[576] PR 444.
[577] PR 441-442.
[578] PR 434.
[579] PR 391.
[580] MR 4901.
[581] PR 408.
[582] Statement of ZA, CB 87.
[583] Statement of AA, CB 2012.

449. CCTV obtained during the course of the coronial investigation captured XY on foot, travelling south.[584]

450. At 5.27pm, XY sent a text message to AA of Maison House, in which XY said 'I'm sorry it was none of your guys fault it wasn't anyone's fault I just can't do it'.[585] AA made multiple, unsuccessful attempts to reach XY by phone, save for one successful attempt where XY informed AA that she was at the Golden Square primary school. AA did not know if XY meant the abandoned school or the actual school, so she directed Victoria Police to both. AA states that Victoria Police told her that there was a fence around the abandoned school and they could not immediately gain access.[586]

451. At the time, there were three primary school sites in close proximity in Bendigo – the former Golden Square Primary School on Laurel Street, the operating Golden Square Primary School on Maple Street and the Violet Street Primary School.[587]

452. At 5:32pm, ESTA received a 000 call from AA reporting XY missing.[588]

453. At 5:40pm, Sergeant Mick McCrann was dispatched in relation to 000 calls made by AA.[589]

454. At 5:48pm, Senior Constable Paul Lethlean ('SC Lethlean') and Leading Senior Constable William Edwards ('LSC Edwards') left the police station to search for XY.[590]

455. At 5:49pm, Sergeant McCrann contacted SC Lethlean and LSC Edwards by radio to co-ordinate the search and asked the members to call AA and get an update on where XY may be.[591]

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[584] CCTV photographs, CB 385 – 386.
[585] Further statement of AA, CB 2012; PR 6948.
[586] Further statement of AA, CB 2012-2013.
[587] This information is available through Google; see also, references to three school sites in Statement of Mick McCrann, CB 220; Statement of Paul Lethlean, CB 225; Statement of William Edwards, CB 229.
[588] CB 551.
[589] CB 551; statement of Mick McCrann, CB 220.
[590] Statement of Paul Lethlean, CB 225.
[591] Ibid; see also Statement of Mick McCrann, CB 220.

456. At 5:53pm, SC Lethlean called AA for information. AA told SC Lethlean that a carer was out looking for XY but they did not know which school she was at.[592] SC Lethlean spoke with AA again on the phone at 5:54pm.[593]

457. SC Lethlean and DSC Edwards patrolled around the Laurel Street primary school site (i.e. the former Golden Square Primary School) and then the Maple Street school site. SC Lethlean and DSC Edwards spoke with Sergeant McCrann at the Maple Street school site. After speaking with Sergeant McCrann, they returned to the Laurel Street school site (i.e. the former Golden Square Primary School) to search for XY.[594]

458. Sergeant McCrann patrolled what he refers to as the Vine Street (presumably Violet Street) and Maple Street schools on foot and in his vehicle for some time.[595]

459. Shortly after 6:04pm, SC Lethlean jumped the 6ft high chainmesh fence surrounding the Laurel Street primary school and conducted a search of the premises, without success.[596] SC Lethlean walked around to every building around the property and looked in the windows where he could and in the bushes between the buildings and checked every doorway. He observed that the only building that he could gain entry to was a shelter shed type building which was fitted with a roller door, but the door was not open enough for him to climb through.[597] There were big glass windows he could shine a torch through but he could not view anyone inside. At 6:09pm, SC Lethlean received another call from AA while he was still searching the school yard.[598] At around 6:18pm, SC Lethlean completed his search and advised ESTA of this.[599]

460. Between 6:18pm and 6:21pm, Sergeant Mick McCrann called XY's phone three times.[600]

461. At 6:21pm, Sergeant McCrann made phone contact with XY. Sergeant McCrann asked XY questions about her whereabouts, welfare and whether he could help her. Sergeant McCrann said words to the effect that he really wanted to try and help XY, that he was

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[592] Statement of Paul Lethlean, CB 225.
[593] Ibid.
[594] Ibid.
[595] Statement of Mick McCrann, CB 220.
[596] Statement of Paul Lethlean, CB 225.
[597] Ibid.
[598] Ibid.
[599] Ibid.
[600] Statement of Mick McCrann, CB 221.

not going to arrest her and that he just wanted to talk to her. XY replied, ‘No it’s done’ and ‘I’m not going to be alive’ in response to his questions. XY then ended the phone call.[601]

462. At 6:22pm, Sergeant McCrann called Sergeant Michael Pain, regarding the possibility of triangulating XY’s mobile phone in an effort to locate her. Sergeant Pain suggested calling the police station to obtain assistance including from the PACER (Police, Ambulance, Clinician, Emergency Response mental health clinician) at the station.[602]

463. At 6:24pm, Sergeant McCrann spoke with Sergeant Michael Delaney about his conversation with XY and PACER possibly calling XY to make contact. Sergeant Delaney undertook to ‘contact PACER to establish contract/build information with a view to phone triangulation’.[603]

464. At 6:28pm, Sergeant McCrann spoke with Acting Senior Sergeant Peckham. The pair discussed that XY’s suicide threats may not meet the criteria to obtain phone triangulation, however it was agreed that they would wait for further information from Sergeant Delaney and PACER to determine this.[604]

465. At 6:35pm, Sergeant Delaney spoke with Jan McNeil, PACER Clinician. Ms McNeil informed Sergeant Delaney that she was familiar with XY, specifically that she knew of XY’s suicide attempt at the playground on 30 May 2021.[605]

466. At 6:49pm, Constable James Dempsey, performing watchhouse keeper duties at Bendigo police station, received a call advising that Supervising Sergeant Michael Pain had instructed him to begin preparing missing person reports in respect of XY.[606]

467. Shortly after 6:49pm, Constable Dempsey called AA, who provided him with a description of what had happened with XY and a physical description of what she was wearing. Constable Dempsey asked AA if they would be applying for a safe custody

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[601] Ibid.
[602] Statement of Mick McCrann, CB 221.
[603] Ibid CB 222.
[604] Ibid.
[605] Statement of Michael Delaney, CB 250.
[606] Statement of James Dempsey, CB 243.

warrant and AA advised they were not.[607] Constable Dempsey started preparing the missing person reports.[608]

468. Sometime around 7:00pm, Constable Dempsey received information that XY had sent a Snapchat to her friend ZA standing on some train tracks and saying sorry. Constable Dempsey rang ZA and sought further information from ZA but she could not provide any.[609]

469. At 7:00pm, Sergeant Delaney contacted the Senior Sergeant, Online Supervisor at the Police Communications Centre. He detailed his concerns for XY and was instructed to complete a triangulation request and forward it to 'Our 265, then 150 for approval'.[610]

470. At 7:30pm, Sergeant Delaney forwarded a completed triangulation request to Acting Senior Sergeant Peckham (the Bendigo 265). The two then spoke, and Peckham confirmed he would forward the request 'onto the 150 for approval'.[611]

471. At 7:38pm, Acting Senior Sergeant Peckham emailed the Triangulation Request to Inspector Bruce Thomas (the 150 on duty).[612]

472. At 7:43pm, Inspector Thomas emailed Acting Senior Sergeant Peckham and advised the request had been authorised and sent off to D24.[613]

473. At 8:09pm, the triangulation was activated and Sergeant Delaney received a call from the Online Supervisor at the Police Communication Centre, advising that the triangulation request was approved but 'unfortunately [XY's] phone was switched off'. The Online Supervisor said they would keep trying and continue to keep Sergeant Delaney informed of the results of the triangulation.[614]

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[607] Ibid CB 244.
[608] Ibid.
[609] Ibid.
[610] Statement of Michael Delaney, CB 251.
[611] Ibid.
[612] Email from Acting Senior Sergeant Peckham to Inspector Thomas, CB 584.
[613] Email from Inspector Thomas to Acting Senior Sergeant Peckham, CB 584.
[614] Statement of Michael Delaney, CB 252.

474. At 8:13pm, AA located a suicide note in XY's room, with an empty blister pack of Oxycodone.[615] The suicide note read 'I'm sorry, I wish things could be different but I'm done'.[616]

475. At 8:24pm, Constable Dempsey contacted AA again enquiring about the signing of a media release and providing a photo of XY for the release. AA told Constable Dempsey about the suicide note and the missing Oxycodone.[617]

476. A short time later, AF of Maison House attended the police station to sign the media release and provided two photos of XY to Constable Dempsey. Constable Dempsey asked about the status of applying for a safe custody warrant and was told it had not been applied for.[618]

477. At or around 8:46pm, AF signed the media release authority.[619]

478. At 9:00pm, Sergeant Delaney directed Constable Dempsey to create a media release with the information about XY that Victoria Police had obtained from AA and other Maison House staff.[620]

479. At 9:03pm, Sergeant Delaney liaised with the Online Supervisor at the Police Communications Centre again and was told that XY's phone was still switched off and they were not having any luck but that they would continue trying and notify Sergeant Delaney of any changes.[621]

480. At approximately 9:05pm, Constable Dempsey sent off the information for the media release to the Police Media Unit. [622] Sergeant Delaney states that this occurred at 10:25pm.[623]

481. At approximately 10:13pm, AF and XY's friend ZA arrived at the abandoned Golden Square primary school (Laurel Street site). The two had been driving around for some

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[615] PR 6949.
[616] CB 383.
[617] Statement of James Dempsey, CB 245, [13].
[618] Ibid [15].
[619] CB 578.
[620] Statement of Michael Delaney, CB 252.
[621] Ibid.
[622] Ibid CB 245, [16].
[623] Ibid CB 252.

time before then, attending the places XY was known to frequent. ZA led AF through a hole in the fence, near the train tracks. They went to the building where ZA had, earlier that evening, heard what she thought was a man snoring while searching for XY.[624] ZA opened the door and told AF that XY was inside, dead. The time was 10:31pm.[625]

482. At 10:46pm, paramedics arrived at the abandoned Golden Square Primary School. First Constable Hicks took off his police vest and managed to fit through the gap in the door and, along with a paramedic, cut XY down from the rope. XY was confirmed deceased.[626]

483. At about midnight, police attended XY's Mother's home in Huntly to inform her of XY's death, but she already knew. XY's Mother had found out about XY's death on Facebook, when she saw a post by Victoria Police stating that they had found XY deceased. A few days later, a member of Victoria Police visited XY's Mother and apologised for the way she found out about XY's passing. The police officer told XY's Mother that they were busy, and someone had wrongly put it up on Facebook.[627]

484. In closing submissions, Counsel on behalf of the Chief Commissioner of Police advised that after becoming aware that XY's passing had been published on social media in error, the Victoria Police Media, Communications and Engagement Department took a number of steps to prevent such an error occurring again, namely:

    a. The day after the post was published, on 19 July 2021, an email was sent to all Victoria Police media staff to remind them of the correct practice around promptly taking down such notifications.

    b. On 20 July 2021, a further email was sent to the Victoria Police social media team reminding them Victoria Police should not post anything when a missing person has been located without express permission from their manager.

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[624] Statement of ZA, CB 92.
[625] Statement of AF, CB 180.
[626] Statement of Lachlan Hicks, CB 233; Statement of Troy Allan, CB 266.
[627] Statement of XY's Mother, CB 38.

c. Discussions were held with media staff and the social media team to ensure that the policy was understood, with specific reference to the post regarding [XY's] passing.

CONSIDERATION OF SYSTEMIC ISSUES

Self-Determination[628]

485. The inquest heard that there was broad acceptance from both the experts and the interested parties that the legislative framework, policies and practises applicable to Aboriginal children in the child protection system needed to continue to evolve toward effecting the principle of self-determination.[629]

486. The fulcrum of that legislative framework is found at section 18 of the *Children, Youth and Families Act 2005* (Vic) ('*CYFA*'). That section empowers the Secretary of the DFFH to delegate certain functions and powers with respect to children who are the subject of Children's Court protection orders to the principal officer of an Aboriginal agency, with the agreement of the Aboriginal agency and the principal officer, and having regard to the views of the child and their parent if they are able to be reasonably obtained. This is known as the Aboriginal Children in Aboriginal Care program ('ACAC').

487. By way of background, Bendigo & District Aboriginal Co-operative ('BDAC') is an Aboriginal agency able to receive delegations under section 18, as is the Victorian Aboriginal Child Care Agency ('VACCA'). Njernda Aboriginal Corporation is currently in the process of being authorised to receive section 18 delegations, referred to as the 'pre-authorisation phase'.[630]

488. Many benefits accrue to Aboriginal children and young people being cared for by the Aboriginal community through organisations such as BDAC. According to BDAC, these include an increased reunification rate compared to mainstream child protection services,

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[628] See Scope of Investigation at [3] & [7] and Scope of Inquest at [3] & [6].
[629] See T 49-50, 168, 181-182, 354-355, 460-461, 500-503.
[630] T 457. See also Yoorrook Report (fn 17) 116.

a higher closure rate, a holistic and culturally sensitive approach and no contended matters with regard to reunification.[631]

489. Previous reports, including the Commission for Children and Young People's *Always was, always will be Koori children* report from 2016[632], have recognised the benefits and improved outcomes for Aboriginal children cared for by Aboriginal community-controlled agencies and the Aboriginal community more generally.[633] Dr Krakouer also referred to research from 2016 which identified the difference between non-indigenous workers seeing cultural connections as one of many hierarchical needs, compared to Aboriginal agencies and workers seeing cultural connection as a fundamental primary need for Aboriginal children in out-of-home care.[634]

490. The Yoorrook Report acknowledged previous reports which showed that services 'designed, controlled and delivered by the Aboriginal community' have the greatest potential to produce the best outcomes. In particular, Yoorrook found that 'the transfer of child protection case management and service functions to the Aboriginal Children in Care program has also led to better outcomes for those children and families compared to DFFH management'.[635] Significantly, according to the Yoorrook Report, 83% of First Peoples children are reunified with their parents or family when case managed by an Aboriginal Community-Controlled Organisation ('ACCO') under a section 18 authorisation compared to 64% when case managed by DFFH Child Protection.[636]

491. In relation to XY, BDAC was offered a section 18 delegation, but did not accept the authorisation due to XY's 'particularly high acuity of care needs' and BDAC having inadequate resources or capacity to meet those needs at that time.[637] Dr Krakouer gave evidence that, in her opinion, had the section 18 authorisation been accepted by BDAC

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[631] Statement of Raylene Harradine, CB 978.

[632] Commission for Children and Young People, *Always was, always will be Koori children – Systemic inquiry into services provided to Aboriginal children and young people in out-of-home care in Victoria* (October 2016).

[633] T 50.

[634] T 50.

[635] Yoorrook Report (fn 17) 80, citing Commission for Children and Young People, *Our Youth, Our Way: Inquiry into the Over-Representation of Aboriginal Children and Young People in the Victorian Youth Justice System* (Report, 2021) and State of Victoria, Response to Yoorrook Justice Commission Issues Paper 2: Call for Submissions on Systemic Injustice in the Child Protection System, 17 March 2023.

[636] Yoorrook Report (fn 17) 24, citing State of Victoria, Response to Yoorrook Justice Commission Issues Paper 2: Call for Submissions on Systemic Injustice in the Child Protection System, [46].

[637] Statement of Raylene Harradine, CB 979.

and had BDAC been resourced appropriately to be able to care for XY's needs, expanded service provision from BDAC could have been provided to XY, and XY's cultural needs would have been given greater attention.[638]

492. Dr Krakouer said that the inability to appropriately resource complex cases is not an issue that is unique to BDAC. She said that, despite the policy objective of section 18, 'when the resourcing isn't available to an Aboriginal community-controlled organisation it can then impact practice outcomes and outcomes for Aboriginal and Torres Strait Islander children and families'. Dr Krakouer described this as 'a systemic issue that really warrants further attention'.[639]

493. Mr Widdicombe, the current CEO of BDAC, gave evidence that at the time BDAC was considering a potential section 18 authorisation for XY, BDAC's program was in its infancy and lacked the capability, rather than necessarily the financial resources, to handle a case of XY's complexity. Mr Widdicombe said that now, or even 12 months ago, BDAC would have been able to accept such an authorisation.[640]

494. There was evidence before this inquest as to various initiatives that are already being undertaken by the Victorian Government through DFFH to transition children in the child protection system into the care of Aboriginal Community-Controlled Organisations ('ACCOs'). For example, Ms Corin of DFFH described a range of services which are in the course of being implemented under *Wungurilwil Gapgapduir*.[641] Established in 2018, which I note is prior to XY's passing, *Wungurilwil Gapgapduir* is a tripartite partnership between the Victorian Government, Victorian Aboriginal community and community service organisations directed to improving outcomes for Victorian Aboriginal children and families. Key objectives of *Wungurilwil Gapgapduir* include a commitment to ensuring 'culturally competent and culturally safe services for staff, children and families'

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[638] Statement of Jacynta Krakouer, CB 3721; T 59.
[639] T 59.
[640] T 450.
[641] Attachment SC -5 to statement of Simone Corin (4 November 2022): DFFH, '*Wungurilwil Gapgapduir*: Aboriginal Children and Families Agreement and Strategic Action Plan An agreement and strategic plan' (April 2018), CB 2339-2394. ('*Wungurilwil Gapgapduir*').

and a commitment to have all Aboriginal children and young people in out-of-home care under the care of an ACCO.[642]

495. In addition, Ms Corin gave evidence that through the Aboriginal Children in Aboriginal Care initiative ('ACAC'), which operationalises section 18 of the *CYFA*, DFFH is providing resources to support ACCOs to gain the skills and capability to become authorised for the purposes of section 18 in a self-determined way. Ms Corin also gave evidence of the 'pre-authorisation process' whereby ACCOs have the ability to supervise a lesser number of children pending full authorisation.[643]

496. Recently, in October 2023, the Community Protecting Boorais pilot commenced, which allows ACCOs to conduct investigations of reports made in child protection cases, therefore becoming involved and supporting Aboriginal children and families as soon as a report to Child Protection is made.[644] BDAC and VACCA have received funding to undertake this pilot.[645]

497. In addition, new positions have been created in Loddon Child Protection, including an Aboriginal Cultural Advisor and a Child Protection Specialist. The role of the Child Protection Specialist is to support BDAC and other ACCOs to improve their practice capability in relation to section 18 authorisations as a 'critical friend'.[646] In Loddon, the position manages the Transfer of Aboriginal Children ('TAC'), being those subject to case contracting, such as XY, and the ACAC (or section 18) children.[647] Mr Chapman

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[642] CB 2339. See also statement of Simone Corin, CB 2050-2051 and Appendix A; Yoorrook Report (fn 17) 83.
[643] T 451-452.
[644] Exhibit E - DFFH, 'Table of changes in relation to Child Protection policy and legislation since Simone Corin's witness statement 4 November 2022 (20 October 2023) 5. ('Exhibit E - Table of changes in relation to Child Protection policy and legislation')
[645] Yoorrook Report (fn 17) 198.
[646] Statement of AW, CB 2036. See also T 456-461 (Chapman and Widdicombe).
[647] T 457:5-11. The distinction between the programs is detailed in Ms Lomas's responsive report at CB 3615-3616 (definitions omitted): 'The Aboriginal Children in Aboriginal Care (ACAC) program and the Transitioning Aboriginal Children (TAC) are two (a legislative and a policy) mechanisms supporting the transfer of responsibility and decision-making for Aboriginal children in Child Protection and care to ACCOs. The ACAC program is a priority for the Department and is the first program of its kind in Australia. The Act under section 18 enables the Secretary of the Department to authorise the principal officer of an Aboriginal agency to preform (sic) specific functions and powers conferred to the Secretary in relation to an Aboriginal child subject to a protection order [ACAC]… TAC is the transfer of case management and case contracting of Aboriginal children on contractible orders in care to ACCOs. Case contracting is a policy approach whereby Child Protection contract a funded agency to perform the case management tasks and functions within an identified case plan, except for the case plan decision making, which remains with Child Protection.'

confirmed that there is a planned evaluation of the program likely to commence in 2024-25.[648]

498. For completeness, Mr Chapman added that there are currently two AFLDM conveners within the Loddon Area, who report to the Aboriginal Children in Aboriginal Care Specialist position. The latter represents a 'central point' to coordinate AFLDM work and the case planning function for Aboriginal children in the local Child Protection team.[649] He also identified the Reunification Panel as a related initiative: a collaborative forum in which BDAC participates, depending on the location of the child who is the subject of the meeting.[650] As Mr Chapman explained, the panel provides Child Protection with an opportunity to hear feedback and criticism from cross-sectoral practitioners, including ACCOs. [651] The ACAC position-holder is a 'key' member of the panel, and brings together the various aspects of case planning under one 'umbrella', in order to see the 'connections and alignments between the work that we're trying to achieve'.[652] The position also performs an internal function, in that it connects with the Office of Professional Practice and draws on central practice guidance.[653]

499. While it is positive to note the progress that is currently being made to improve the experience of Aboriginal children and families within the Child Protection system, and to move towards a self-determined model, it is too early for me to make any assessment as to the effectiveness of these programs, most of which are in their infancy.

500. A self-determined system cannot be built instantly; it requires continual resourcing, gradual capacity building, and sustained knowledge transfer to develop the confidence of ACCOs to accept authorisations to care for children such as XY. As Mr Widdicombe affirmed in evidence, if the process is rushed, 'we may not do it right'. Mr Widdicombe also reflected on the 'vast improvements' in this space since XY's passing, attributing

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[648] T 459:16-19.
[649] T 458:3-9.
[650] T 458:10-19.
[651] T 458:25-29.
[652] T 458:30 - 459:6.
[653] T 459:7-15.

these to the 'willingness of the Department' and to the expansion of capability within BDAC.[654]

501. Yet the best interests principle and the human rights of the child in question must necessarily drive individual decision-making, even while the system itself is transformed. Mr Chapman eloquently drew a distinction between a child's 'eligibility for authorisation and their suitability'.[655] While some children might be eligible for transfer to an ACCO, they might not be suitable, due, for instance, to the complexity of the child's case or to the fact that they are out of area. However, Mr Chapman noted that the reasons for unsuitability have reduced over time as section 18 programs have 'matured'. [656] Mr Chapman described the process for identifying suitable children as a 'rigorous, line-by-line, child-by-child discussion', which draws upon information from the DFFH and the ACCO, and which 'take[s] into account the views of the child and family as well'.[657]

502. It is readily apparent that this process would present risks for the child if it were not managed carefully, although this must be also balanced against the immediate risk the child is experiencing. This tension encapsulates the difficult balancing exercises continually required within the child protection system.

503. As noted in the Yoorrook Report, Victoria is currently 'less than halfway towards meeting the *Wungurilwil Gapgapduir* 2021 target for all First Peoples children in care to be transferred to the ACAC program'.[658] In addition, as the Yoorrook Report pointed out, the rate of Aboriginal children in state care in Victoria remains the worst in Australia, currently 102.2 per 1,000.[659] Therefore, there remains a long way to go in improving the experience of Aboriginal children and young people in Victoria's child protection system.

504. Closing submissions made on behalf of XY's Mother, Senior Next of Kin, pointed out that delegating to ACCOs the functions of the current child protection system will not in itself realise self-determination, because that system is itself is 'a deeply flawed product

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[654] T 393:15-25.
[655] T 453:12-13.
[656] T 453:18-22.
[657] T453:30 - 454:5.
[658] Yoorrook Report (fn 17) 200.
[659] Ibid 117.

of colonisation practices of 'protection' and child removal […] which is by its nature fundamentally at odds with culturally appropriate care'.[660]

505. While the concept of culturally appropriate care will be explored in the next section, Dr Krakouer linked the two concepts as she explained the need for further and profound devolution of child protection to First Nations communities:

> So when we think about the child's best interests in many ways we actually can't divorce them from the interests of the community and the interests of the family. That's quite a Western construct to see the child in isolation.[661]

506. While certain Western cultures such as Denmark, Belgium and Sweden utilise 'family support' models of child protection,[662] Dr Krakoeur's point is well made in relation to the child protection systems operating in former English colonies, such as Australia.

507. For this reason, having investigated XY's case and heard from First Nations experts and other stakeholders, I endorse Yoorrook's Recommendation 1 regarding self-determination within child protection. While ultimately, standalone legislation will be required to enable at-risk Aboriginal children to be properly cared for by their communities without losing access to their culture, it would be premature in this transitionary phase to make any more specific comment than that.

508. Nonetheless, in this transitionary context, it is obviously vital that the current initiatives in place and the ACCOs responsible for overseeing them (including BDAC in this case) are adequately funded and resourced now and into the future to have the capability and capacity to accept case management responsibilities for First Peoples children and families, particularly in light of the ACCOs' increased responsibilities within Victoria's child protection system as it moves towards a self-determined model. As the Yoorrook report noted:

> ACCOs need the workforce and resources to scale up. This becomes more urgent as ACAC organisations also take on the role of the State in investigating child

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[660] XY's Mother, Senior Next of Kin, 'Final Submissions on behalf of XY's Mother', 9 February 2024, [43], [53]. ('XY's Mother Final Submissions')
[661] T 49:6-10.
[662] Price-Robertson, Bromfield & Lamont, *International approaches to child protection: What can Australia learn?*, CFCA Paper 23 of 2014, Australian Institute of Family Studies, Australian Government, 1 and 3.

protection cases. While investment has occurred in recent State budgets, if ACCOs are to become simultaneous investigator, case manager and carer, significant resources will need to flow to ensure the sector does not take on the State's broken child protection system without the resources to deliver better outcomes.[663]

Recommendation 1

509. *That DFFH:*

   a. *work towards transitioning all Aboriginal and Torres Strait Islander children and young people in the Victorian child protection system to the care of an ACCO, pending the transfer of decision-making power, authority, control and resources to First Peoples communities as recommended by Yoorrook.*

   b. *in collaboration with ACCOs including BDAC, ensure that ACCOs are adequately funded and resourced to have the capability and resources to accept section 18 authorisations, including in cases involving Aboriginal and Torres Strait Islander children and young people with complex needs.*

Cultural Connection[664]

510. Legal representatives on behalf of XY's Mother, Senior Next of Kin, prefaced their submissions on this topic by noting that any attempt to maintain a First Nations child's connection to culture, when they are removed from their family by the State, is fundamentally flawed.[665] They said that family is the key source of culture for First Nations children, and that the predominant focus should therefore be on measures designed to avoid removal from family in the first place. They further submitted that 'any discussion of the State facilitating the culturally connected care of a child whom the State has removed from their family, and therefore their culture, should not lose sight of the fundamental cruelty and high risk of failure involved in that proposition'.[666]

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[663] Yoorrook Report (fn 17) 200.
[664] See Scope of Investigation at [1(d)], (e)], [2(i)(iii)], [3], [4] & [7]; and Scope of Inquest at [2(h)(iv)], [3], [4] & [6].
[665] XY's Mother Final Submissions (fn 660) [12]; citing evidence of Dr Newton at T 48.
[666] Ibid [13].

511. While it must be acknowledged that XY's own attitude towards active engagement with her culture fluctuated and was influenced by a range of factors, this needs to be understood as a common and normal response from a young person beginning to make choices about their life, in response to their own lived experiences.

512. The Aboriginal Independent Expert Panel expressed the view that the specific details of care provided to XY through DFFH and its contracted providers (other than BDAC) was not culturally connected and failed to recognise culture as a protective factor against suicide.[667] None of the interested parties disputed this opinion, although the DFFH made submissions on this point that I have set out below.

513. The expert reports of Dr Newton and Dr Krakouer contained many examples of ways in which the care provided to XY through DFFH and service providers was not culturally connected. Some examples include:

    a. failing to prioritise XY's relationships, connections and contact with her family and the Wemba Wemba community;

    b. neglecting XY's relationship with her mother and siblings;

    c. underutilisation of the Aboriginal Family Led Decision Making process;

    d. failing to provide XY with a timely and up to date cultural plan;

    e. failing to provide XY with a cultural mentor, despite her request;

    f. failing to identify XY's social and emotional needs (including her cultural needs) as essential and synonymous with meeting XY's physical, psychological and emotional needs; and

    g. failing to ensure that return to Country visits were organised and took place.[668]

514. Legal representatives on behalf of XY's Mother submitted that a fundamental barrier to XY maintaining connection to culture was the tendency by caseworkers to only consider

[667] T 46.
[668] Statement of BJ Newton, CB 3086-3087 & 3107-3109; Statement of Jacynta Krakouer, CB 3720-3728.

XY as an individual, rather than the need to strengthen her relationships to community, culture and family.[669] They submitted:

> [A]n aspect of the failure by DFFH and service providers to meaningfully engage with and support XY's family was the failure to recognise and respond appropriately to their experience of intergenerational trauma. This failure can be attributed in part to what the AIEP described as 'a parent-deficit, parent-blaming approach by child protection systems, as opposed to how families can be supported in these contexts'.[670]

515. BDAC witnesses gave examples of occasions where the cultural expertise and advice provided by XY's Aboriginal Child Specialist Advice and Support Service ('ACSASS') case manager, was misunderstood, ignored or misrepresented by DFFH and other service providers.[671] They also gave evidence that meetings between care team professionals were often culturally inappropriate.[672] Unfortunately, it appears that there has been little improvement in this regard. According to BDAC:

> The ongoing challenges of peer-to-peer cultural safety, and the respectful consideration of cultural advice persists. BDAC are yet to witness any discernible positive systemic changes addressing these concerns since XY's passing.[673]

516. Rather than asserting any *mala fides* on the part of the DFFH and service providers for this ongoing trend, BDAC inferred that the inadequate utilisation by decision makers of ACSASS is primarily due to its scarcity and the high demands on ACSASS workers. Currently, the ACSASS service at BDAC has funding to resource only two full-time ACSASS workers, who provide advice and support in relation to decisions to be made, and about culturally appropriate intervention and service delivery for all Aboriginal children within the child protection catchment area of Bendigo.[674] Further, ACSASS provide information to the family regarding what their rights and responsibilities are, and

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[669] XY's Mother Final Submissions (fn 660) [18].
[670] Ibid [20], citing T 43.
[671] Statement of Raylene Harradine, CB 1870; Statement of AL, CB 3261-3263; T 392.
[672] Statement of Raylene Harradine, CB 1870-1871; Statement of AL, CB 3263-3264; T 391-392
[673] Exhibit N – Dallas Widdicombe, 'Responses to questions taken on notice on behalf of the Bendigo and District Aboriginal Corporation (BDAC)', 10 November 2023, [2].
[674] BDAC witness AL, a former ACSASS practitioner, stated that she was responsible for up to 500 Aboriginal children at a time across the Loddon catchment area where ACSASS is delivered by both Njernda Aboriginal Corporation and BDAC: CB 3264. See also T 398:9-25.

what services are available to them. The service is collaborative, and workers are available 24 hours per day, 7 days per week, according to a rotating roster. Given that there is only funding for two full-time ACSASS workers, all after hours consultation must be overtime, and this service becomes very limited where ACSASS workers take their entitled leave.[675]

517. Addressing this issue requires a substantial increase in ACSASS workers and service capacity.[676] As set out above, the inquest was assisted by, and did not seek to duplicate, the work of Yoorrook. Relevantly on this topic, with regard to the use and resourcing of ACSASS, the Yoorrook Report found the following:

    a. ACSASS is not consulted on all matters in which it should be involved;[677]

    b. There is significant under-utilisation of ACSASS at the intake phase of child protection interventions, where consultations occurred in only 17% of cases in the 2021-22 period,[678] as well as at the investigation phase, where consultations occurred in only 63% of cases in the same period;[679]

    c. Identification of Aboriginality is crucial to meeting legal obligations for consultation with ACSASS on child protection decisions; and[680]

    d. There is a large-scale failure to consult with ACSASS and hold Aboriginal Family Led Decision Making meetings.[681]

518. Additionally, Yoorrook heard evidence that:

    a. ACSASS is underfunded and cannot keep up with demand; and[682]

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[675] The roles and responsibilities of the ACSASS worker are outlined in the statement of Raylene Harradine, CB 1867-1869.

[676] T 397-398; Exhibit N - Dallas Widdicombe, 'Responses to questions taken on notice on behalf of the Bendigo and District Aboriginal Corporation (BDAC)', 10 November 2023, [9].

[677] Yoorrook Report (fn 17) 136.

[678] Ibid, see footnote 90, 45.

[679] Ibid 160.

[680] Ibid 156.

[681] Ibid 160.

[682] Ibid 160.

b. Critical information from ACSASS is not directly presented to decision-makers in reports. Instead, it is summarised in Child Protection's account of the advice in its report. Magistrates have expressed frustration about not receiving ACSASS advice directly.[683]

519. A case plan with an attached cultural plan is required for all Aboriginal children in out-of-home care who are subject to a Children's Court order.[684] Under section 176 of the *CYFA*, the cultural plan must be aligned with the child's case plan, which in turn must 'reflect and be consistent with the child's cultural support needs', so as to:

> (a) maintain and develop the child's Aboriginal identity; and
>
> (b) encourage the child's connection to the child's Aboriginal community and culture.[685]

520. Section 176 further specifies that a child's cultural support needs may vary, depending on, among other things, how connected they are to their Aboriginal identity and whether they are placed within their own Aboriginal community, with another Aboriginal community or with non-Aboriginal carers.[686] Yoorrook found that as at the end of March 2023, only 67 percent of Aboriginal children in care for more than 19 weeks had a cultural plan.[687]

521. While acknowledging that the care provided to XY was not sufficiently culturally connected, the DFFH submitted that it would be 'overly simplistic to characterise the actions of Child Protection as devoid of awareness of the importance of culture'.[688] With respect, the evidence of the Aboriginal Independent Expert Panel ('AIEP') was never so absolute, but rather amounted to a reasonably long list of specific deficiencies that they identified upon review of the case materials.

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[683] Ibid 163.
[684] *CYFA* ss 166(3)(b), 176.
[685] *CYFA* s 176.
[686] Ibid.
[687] Yoorrook Report (fn 17) 114, 123 [endnote 29], noting that the requirement to have a cultural plan within 19 weeks is not a legislative requirement.
[688] DFFH, 'Responsive submissions on behalf of the Secretary to the Department of Families, Fairness and Housing, 9 February 2024, [29]. ('DFFH Responsive Submissions')

522. The DFFH further submitted that, while Counsel Assisting probed the Child Protection Stakeholder Panel witnesses about the extent to which, and the ways in which, XY's care was culturally responsive, no precise definition of 'culturally connected care' was put to the witnesses and, accordingly, I should be cautious in attributing weight to any inference of concurrence to be drawn from Counsel Assisting's submission that the witnesses did not dispute the opinion.[689]

523. I am not persuaded by the DFFH submission here, and note that their witnesses had both permission to be in court during the evidence given by the AIEP, and access to the transcript of that evidence, when Dr Krakouer referred to and paraphrased part of her expert statement,[690] which provides the following cogent explication:

> Best-practice culturally connected care for Aboriginal and Torres Strait Islander children and young people who are subject to Child Protection involvement in Victoria and/or placement in out-of-home care **requires active efforts to be demonstrated by providing ongoing opportunities for, and linkages to facilitate, meaningful cultural connections for the child or young person**.
>
> **Best-practice requires a relational approach to support Aboriginal and Torres Strait Islander children and young people's journeys of culturally connecting while living in out-of-home care, or subject to Child Protection involvement.** A relational approach to culturally connected care prioritises, and includes, relationships, connections and contacts with Aboriginal and Torres Strait Islander people, particularly family and people from the child or young person's mob group.[691] [My emphasis]

524. Having had the benefit of that opinion, and not proffering any different opinion or evidence, the DFFH acknowledged that attention must be paid to shortcomings in the cultural attunement of the care provided to XY, and to opportunities for improvement in this respect. I accept the DFFH's submission that those oversights within XY's case were a symptom of a far broader, long-standing government-wide trend, which must be

[689] Ibid [30].
[690] T 46-49.
[691] Statement of Jacynta Krakouer, CB 3716, [32]-[33]. (Original emphasis included)

holistically addressed. This is also the spirit of the Yoorrook Justice Commission's Findings.

525. Ms Kirstie-Lee Lomas, Statewide Principal Practitioner from the DFFH Office of Professional Practice, eloquently articulated the multifactorial complexities associated with improving the DFFH's offerings of culturally connected care. She began by acknowledging in her evidence that the care provided to XY was, on the whole, not sufficiently culturally connected; [692] had it been, the Court would have heard 'an experience of her living out her… very proud identity as a… Wemba Wemba Aboriginal young person in all aspects of her life'.[693]

526. As Ms Lomas identified, 'systemic racism' represents a structural impediment to the realisation of culturally connected care,[694] and this must be combatted not only within Child Protection, but at a 'much broader State and population level'. [695] By way of example, Ms Lomas emphasised the importance of dismantling systemically racist patterns of thinking within the education system, as these necessarily inform how all adults, including Child Protection practitioners, ultimately approach their work. [696] Notwithstanding the prevalence of unconscious biases, Ms Lomas affirmed her reflection from her written statement about the noble intentions of Child Protection practitioners, stating they 'come to the work to do their very best'. [697] She added that the Child Protection Practitioner workforce is principally social-work qualified, and they seek to work with families in a manner which is consistent with that training.[698]

527. Relatedly, Ms Lomas reiterated the centrality of the need for a 'relational approach' in achieving culturally connected care for First Nations children. [699] In this respect, the DFFH's evidence echoed that given by the AIEP. As Dr Krakouer explained, underpinning the relational model is an 'understanding that people are the conduits of culture and people hold cultural knowledge to impart to other people'.[700] According to

[692] T 362:10-12.
[693] T 362:14-17.
[694] T 362:27-29.
[695] T 363:5-11.
[696] T 363:14-15.
[697] T 363:25-29.
[698] T 363:29-364:3.
[699] T 364:6.
[700] T 47:20-24.

Ms Lomas, Child Protection practitioners grapple with a 'real, live tension' between investing in families and developing 'relationships, genuine engagement, partnership, all of those things which are foundational to culturally connected care', on the one hand, and discharging their plethora of other responsibilities and functions, on the other.[701] Ms Lomas's reflection was that resourcing constraints and the inclination towards 'compliance-driven casework'[702] can compromise the quality of the relationships practitioners are able to craft with families. As Ms Lomas observed, Child Protection Practitioners 'do their very best in a very complex, very pressured system'.[703] A corollary of these observations was that, in practice, Child Protection Practitioners require more time with all families, including Aboriginal families, in order to develop relationships which lead to better outcomes.[704] Ms Lomas also agreed with the proposition I put that enhancing 'staffing levels and the retention rates and experience of those staff' would foster the adoption of relational approaches, and would in turn, counteract compliance-driven casework.[705]

528. Further, while it did not always manifest in XY's case, there is evidence elsewhere of adoption of best practice culturally connected care for Aboriginal Children in Victoria.[706] In this sense, Child Protection is already equipped with some strong practices: the challenge they face is standardising the uptake of such models throughout Victoria in order to achieve 'consistency'.[707]

529. The inquest considered whether there was a disjuncture between the DFFH's theoretical or ideal position in respect of culturally connected care, the realisation of which Child Protection strives towards, and the empirical, real-world landscape in which the various policies are to be implemented, which is a multifactorial - and a far more complex and nuanced - question. Ms Lomas affirmed as follows:

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701 T 364:12-26.
702 T 364:17.
703 T 365:22-23.
704 T 365:16-19.
705 T 365:24-366:1.
706 T 366:10-15.
707 T 366:16-24. BDAC witness AL concurred at [22] in her statement at CB 3263.

a. The Department is statutorily bound to provide 'ongoing opportunities and linkages to facilitate cultural connections' for children and young people.[708]

b. Child Protection's policies, including those set out in the Child Protection Manual, stipulate that cultural engagement must be prioritised — even if this was not always XY's experience.[709]

c. It is Child Protection's 'intent' to adopt a relational approach to culturally connected care which foregrounds relationships with members of the child's community, even if this objective is not always wholly realised.[710] As Ms Lomas acknowledged, at points, XY did not enjoy the benefit of this relational approach; however, a number of contextual factors and 'barriers' influenced this outcome.[711]

d. The reconceptualisation of culture as something which is produced and reproduced through *people*, and the allied recognition that people hold and transmit cultural knowledge, is not uniquely a task for Child Protection, but is a shift which must be achieved by the 'broader system and population'.[712] According to Ms Lomas, 'we need an understanding of culture in the way that's described through Yoorrook, that's described by the AIEP', which is shared across society — both within Child Protection and across the State.[713]

e. Cultural plans are 'part of… the fabric of Child Protection' and a key component of the way it does its work.[714] While these need to be attended to in a timely manner, Child Protection Practitioners contend with the challenge of balancing this priority against all other work they are required to undertake.[715]

f. Similar constraints apply in respect of return to country visits: while the Child Protection Manual and other Departmental literature underscore the importance

[708] T 367:25-27.
[709] T 367:29-368:2.
[710] T 368:4.
[711] T 368:5-9.
[712] T 368:10-13.
[713] T 368:14-18.
[714] T 368:22-24.
[715] T 369:2-8.

of these, and prescribe 'vehicles' for their realisation, such as AFLDM meetings, they are not always accorded the highest priority in 'a very busy and pressured system.' [716] This does not, however, derogate from Child Protection's understanding of their importance to Aboriginal children and young people.[717]

g. ACCOs are acquiring increasing involvement in the care of Aboriginal children who would otherwise be engaged with Child Protection. By virtue of amendments to the *CYFA*, and specifically the conferral of investigative powers upon Aboriginal agencies under section 18, 'the system is headed in the right direction'.[718]

h. Legislation governing Child Protection conceives of cultural connection as a fundamental and primary need for children in out-of-home care, even if the significance afforded to culture in XY's case was not always consistent with what Child Protection 'would have expected to see'.[719]

530. Ms Lomas also confirmed, in direct response to my questioning, that 'more staff would mean… that our practitioners didn't need to work with as many families at… once'; this, in turn, would have the effect of increasing their capacity for meaningful and effective work, including undertaking cultural planning, and adopting a culturally informed and relational approach to case work.[720]

531. There was broad agreement among the Aboriginal Independent Expert Panel and interested parties that systemic improvements were feasible and were already in train.

532. In response to the AIEP's enumerated 'tangible' ways in which culture could find expression in the care of Aboriginal children and young people, Ms Lomas set out the ways in which these concrete expressions of culture already feature in the Child Protection's practices:

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[716] T 369:9-14.
[717] T 369:15-19.
[718] T 369:26-29.
[719] T 370:16-17.
[720] T 370:29-371:16.

a. The DFFH displays Aboriginal and Torres Strait Islander flags, as well as Aboriginal artwork in reception areas. As part of their cultural planning activities, Aboriginal children enjoy culturally appropriate music and television, and experience traditional food, holidays, and other cultural events, such as NAIDOC Week.[721]

b. The conceptualisation of culture manifested by the DFFH is inevitably and intrinsically informed by dominant social discourses. As such, Ms Lomas explained that developing a recognition of the 'deeper' aspects of culture will require high-level, structural change, as well as a commitment to 'partnering… incredibly closely with' ACCOs: a dynamic which has been successfully achieved in the Loddon Area.[722]

c. While the DFFH employs Aboriginal cultural mentors, this practice could be expanded, particularly as mentoring can usefully facilitate the relational approach to case work.[723] In this case, AL often performed the role of being XY's cultural mentor;[724] it was also proposed at one stage that XY be mentored by Fiona Gray.[725]

d. Participation in public cultural events, such as NAIDOC Week and the National Aboriginal and Torres Strait Islander Children's Day is 'preferenced… for a lot of children.'[726]

e. Opportunities for Aboriginal children and young people to connect with community comprise part of the cultural planning undertaken by Child Protection. These are increasingly accessible, in part due to the advent of reliance on new technologies, as necessitated by the pandemic.[727]

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[721] T 373:24-374:20.
[722] T 374:22-375:1.
[723] T 375:2-8.
[724] FNID (fn 116) [294].
[725] PR 2433, 2552.
[726] T 375:9-11.
[727] T 375:12-23.

533. Anglicare Victoria has also already taken steps toward improving the provision of culturally connected care for young people in their residential care houses and under its case management. Those steps include:

   a. the adopting of a Cultural Safety Policy;

   b. the establishment of the Cultural Safety Executive Committee;

   c. prominent displays of Aboriginal art and the Aboriginal flag in all residential care houses;

   d. the building and maturing of relationships with ACCOs through joint endeavours such as the Care Hub and in section 18 matters;

   e. the employment of cultural mentors;

   f. the BY leadership program;

   g. the dedicated cultural space Darrango yan-dhan; and

   h. participation in NAIDOC week and other cultural events.[728]

534. While the DFFH submitted that certain aspects of the recommendation below were unnecessarily duplicative of existing policy, BDAC's closing submissions highlighted the continuing gaps between theory and practise in this area with sufficient strength to persuade me that the best course is to make the recommendation as I had foreshadowed, and expose the adequacy of the responses to the ongoing scrutiny provided by the mapping of the interested parties' responses against recommendations. This course will enable future scrutiny in subsequent inquests, commissions or other reviews, should the deficits identified by the AIEP persist.

Recommendation 2

535. *That DFFH, Anglicare and other organisations providing services to Aboriginal and Torres Strait Islander children and young persons in out-of-home care (other than*

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[728] See the evidence of Michael Oerlemans at T 376, 415, 430-432.

ACCOs) review their current policies and practices and implement any changes that are needed to enhance their capacity to provide culturally connected care, including by:

a. *implementing aspects of culture (that can easily be accessed by non-Aboriginal people) such as displaying the Aboriginal and Torres Strait Islander flags, displaying Indigenous artwork, engaging with Aboriginal music and TV, learning about Aboriginal food/holidays/language etc;*

b. *recognising the deeper levels of culture that are not accessible by non-Aboriginal people and being guided by Aboriginal and Torres Strait Islander people about these – by taking on board advice from ACCOs, Aboriginal practitioners within your organisation and building relationships with the wider Aboriginal community;*

c. *employing Aboriginal cultural mentors and having them available to both staff and young people in their care (particularly in residential care);*

d. *developing a close relationship with, and being led by the child or young person about their own levels of cultural connection and how they would like to further connect to culture, and providing those opportunities;*

e. *having a presence at, and taking children and young people to, public events such as NAIDOC week and National Aboriginal and Torres Strait Islander Children's day; and*

f. *providing opportunities for Aboriginal children and young people to connect with community online (for example, via Facebook).*

536. Further, in response to the evidence I heard about the limitation of ACSASS resources, combined with the willingness of BDAC to evolve those services and make them more readily available to stakeholders,[729] I make the following recommendation.

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[729] Exhibit N – Dallas Widdicombe, 'Responses to questions taken on notice on behalf of the Bendigo and District Aboriginal Corporation (BDAC)', 10 November 2023; BDAC, 'Bendigo and District Aboriginal Co-Operative Closing Submissions, 9 February 2024, [28]-[38]. ('BDAC Closing Submissions')

Recommendation 3

537. *That ACSASS be sufficiently funded by the Victorian Government to:*

   a. *enable full compliance with sections 10, 11 and 18 of the CYFA, so that all decision makers at all critical points in time have full and frank access to Aboriginal specialist advice; and*

   b. *ensure all service providers who have contact with Aboriginal children have free and reliable access to Aboriginal specialist advice, so that no Aboriginal child is placed in a position where they do not have cultural supports around them.*

538. As I have set out above, the Aboriginal Independent Expert Panel was clear that a relational approach by child protection workers towards children and their families is a crucial precursor to providing culturally connected care.

539. The AIEP also recommended that all staff providing case management or residential care services to Child Protection clients undertake cultural awareness and antiracism training. In her evidence, Dr Krakouer highlighted the importance of going further than superficial cultural awareness training modes, where there may be an implication that 'someone who is not of that culture, can simply develop an awareness of somebody else's culture in a one-off training session and then walk away with expertise'.[730] Dr Krakouer preferred the term 'cultural humility', which 'ensures that people understand that they are lifelong learners, and that you can never really develop expertise in someone else's culture'.[731] Dr Krakouer also emphasised the importance of antiracism training to unlearn the harmful stereotypes that are perpetuated about Aboriginal and Torres Strait Islander people.[732]

540. Yoorrook recommended that DFFH ensure that:

   a. all incoming Child Protection staff complete, as part of their pre-service training, cultural awareness and cultural rights training;

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[730] T 193:10-14.
[731] T 193:15-18.
[732] T 193:19-30.

b. all Child Protection staff and DFFH executives undertake regular, mandatory cultural safety training; and

c. completion rates for training be published by DFFH annually.[733]

541. Evidence was given as to current training provided by DFFH to Child Protection Practitioners and planned improvements to be introduced as part of its induction program from April 2024.

542. The DFFH has established an Aboriginal Cultural Advisor ('ACA') role[734], which is an *identified position* for Aboriginal applicants only. There are 17 or 18[735] positions across Victoria, located in the various catchment areas. Mr Chapman described these as 'inward-facing' positions, as distinct from the 'outward-facing' Aboriginal Children in Aboriginal Care positions, which are established only in those areas which have authorised section 18 ACCO providers.[736] The objective of the ACA role is to 'improv[e] cultural safety within the Child Protection workforce and their practice'. [737] They provide education as to some of the 'mistakes' which non-Aboriginal people are at risk of making, and about how to engage in a culturally appropriate way with Aboriginal families.[738] In the Loddon Area, the ACA position now also provides an oversight and coordination function in relation to the development of cultural plans for Aboriginal children living in care services. An initiative developed by the ACA position in the Loddon Area is the Yarn About Practice series, a series of 'internal practice reflections' which 'create a culturally safe place to share knowledge and ideas and improve practice with Aboriginal children and families.'[739] Those sessions, some of which were held on country and others, in the office, [740] were said to be well-attended. [741] In addition, the ACA position-holder accompanies Child Protection Practitioners on select home visits to support dialogue with

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[733] Yoorrook Report (fn 17) Recommendation 14, 31. Noting that Yoorrook's recommendation regarding training does not apply to other service providers within the child protection system, such as Anglicare.
[734] CB 2036, at paragraph 37.1.
[735] T 425:1-2.
[736] T 421:25-30.
[737] T 422:4-6.
[738] T 423:30-424:4.
[739] T 424:5-15.
[740] T 427:23-24.
[741] T 427:18.

families,[742] acting 'as a bridge between practitioner…, and family and community'.[743] Mr Chapman gave evidence that a position of this nature would have been instrumental in fostering XY's connection with the Wemba Wemba community, stating 'this role would assist us to do that much better, and in a much more… systemic way as well.'[744]

543. In addition, DFFH's Child Protection learning hub now contains resources to assist practitioners working with Aboriginal children and families.[745]

544. Local initiatives designed to increase cultural literacy and humility are also underway in the Loddon Area, including:

    a. Child Protection staff have undertaken cultural reflection sessions, which deal with issues including white privilege and unconscious bias.[746]

    b. On-country sessions with Child Protection Practitioners, facilitated by the Senior Cultural Advisor, and offering an experience designed to 'challenge' staff in relation to their practice and their engagement with Aboriginal children and families.[747]

    c. Participation in cultural events, such as Aboriginal Children's Day, p providing an opportunity for staff to be 'immersed with community'[748]

    d. The Wirrigirri (Messenger) Program: an inter-Departmental, 'opt-in' initiative with local teams, including in Loddon, which delivers a series of culturally informed and reflective programs throughout the year. [749] The program underscores the 'importance of non-Aboriginal people taking ownership of, and responsibility for, reconciliation and a commitment to ongoing cultural learning.'[750]

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[742] T 423:1-5.
[743] T 423:16-17.
[744] T 422:27-28.
[745] T 409:13-22.
[746] T 411-412.
[747] T 412:28-413:6.
[748] T413:21-28.
[749] T414:6-12.
[750] CB 3634.

545. Anglicare employees undergo a one-off online cultural awareness training program, developed by First Nations people, as part of their induction training, which is in addition to any training undertaken as part of an employee's TAFE studies.[751] BDAC provides its employees with local cultural awareness training, as well as being a provider of face-to-face training for external stakeholders. [752] Victoria Police has had mandated cultural awareness training for sworn officers since May 2022, which approximately 12,000 (of approximately 16,000) sworn officers have undertaken to date. There is currently no requirement for refresher training, although this may be considered once all sworn officers have completed their initial training.[753]

546. On this point, both DFFH and Anglicare submitted that certain aspects of the recommendation below were unnecessarily duplicative of existing programs. I will, however, make the recommendation as I had foreshadowed, which will in turn engage the interested parties' obligation to respond. The adequacy of the responses can thereby be more efficiently scrutinised in subsequent inquests, commissions or other reviews, should the deficits identified by the AIEP persist.

Recommendation 4

547. *That DFFH engage with its stakeholders to review their existing training programs so as to ensure that:*

   a. *all frontline and executive staff employed by agencies that provide child protection, case management and/or residential care services under DFFH's auspices, including but not limited to Anglicare, provide their staff with regular, mandatory cultural awareness and antiracism training covering issues including:*

      i. *the history of colonisation and in particular the impact of 'protection' and assimilation policies;*

[751] T 415:19-25.
[752] T 417:23-418:7.
[753] T 419.

ii. *the continuing systemic racism and paternalism inherent in child protection work today that must be identified, acknowledged and resisted;*

iii. *the value of First Peoples family and child rearing practice;*

iv. *upholding human rights including Aboriginal cultural rights; and*

v. *the strength of First Peoples families and culture and culturally appropriate practices; and*

b. *such training includes mandatory refresher training; and*

c. *such training is designed and delivered by a First Peoples business or consultant on a paid basis.*[754]

Cultural Planning[755]

548. When done properly, the formulation, implementation and ongoing review of an Aboriginal young person's cultural plan provides perhaps the most tangible tool for engagement and connection with their culture. Sadly, the inquest heard evidence that these plans were missing in many cases, often delayed, template driven and formulaic, and frequently out of date. The latter characteristics were, unfortunately, all features of XY's plan, which was dated 15 September 2019.

549. As discussed above, the *CYFA* requires a cultural support plan to be prepared for each Aboriginal child in out-of-home care that is aligned with the case plan for the child.[756] The statutory purpose of a cultural plan is to (a) maintain and develop the child's Aboriginal identity, and (b) encourage the child's connection to the child's Aboriginal community and culture.[757]

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[754] The wording of this recommendation adopts the language of Yoorrook's Recommendation 14, Yoorrook Report (fn 17) 31.
[755] See Scope of Investigation at [1(d)], [1(e)], [2(a)], [2(i)(iii)] and [7] and Scope of Inquest at [2(h)(iv)] & [6].
[756] *CYFA*, ss 166(3) & 176.
[757] *CYFA*, s 176(3).

550. DFFH policy requires a cultural plan be in place within 19 weeks following a child entering out-of-home care.[758] XY's cultural plan[759] was provided to XY on 26 September 2019, almost two years after XY's removal from her family home. It had not been reviewed or updated prior to XY's passing.

551. The Aboriginal Independent Expert Panel was critical of the cultural plan prepared in relation to XY. In particular, they noted that XY's cultural plan:

    a. was not prepared in a timely manner;

    b. was out of date by the time it was provided to XY, in that it focused very much on Peta and the placement with Peta Thompson (despite that placement having ended shortly prior to XY being provided with her cultural plan);

    c. the genogram was difficult to read;

    d. the list of goals and tasks did not include any accountability, milestones or review dates to ensure their implementation; and

    e. the plan inappropriately described XY's cousins as her cultural mentors. A senior Aboriginal woman or elder would have been a more appropriate cultural mentor for XY.[760]

552. By contrast, Dr Krakouer's evidence was that best practice requires the use of cultural support plans in out-of-home care 'to indicate *how* relational approaches to culturally connected care can be enacted' for Aboriginal and Torres Strait Islander children and young people.[761] Dr Krakouer added that best practice requires cultural plans to:

    a. involve the child or young person and their family in their creation and review;

    b. be updated regularly (at a minimum, annually or when placement or other significant circumstances change); and

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758 T 435:27-30.
759 CB 503.
760 CB 503; T 55-58.
761 Statement of Jacynta Krakouer, CB 3717, [35].

c. provide 'an individual plan to (re)establish or maintain cultural connections, such as contact arrangements with family members, plans for Return to Country with Elders and family members from the same mob group as the child or young person'.[762]

553. The cultural support plan that DFFH prepared in relation to XY failed to meet all of these best practice measures.

554. The Department accepted that XY's cultural plan was not prepared in a timely fashion but noted that XY's cultural plan was in the process of being updated at the time of her passing.[763] Further, while Mr Widdicombe 'expressed concern that cultural support plans were still 'not good enough',[764] he himself attributed this outcome, in part, to time and procedural pressures, stating 'I am the person that signs them off, but… it is a [tick-a-]box. I'm… pressured to sign them off for court'.[765] This evidence highlights the importance of adequate staffing and resourcing in a system which says that it aspires to provide culturally attuned and relational case management to the children in its care.

555. In relation to the DFFH's policy of providing Aboriginal children with a cultural plan within 19 weeks, Ms Corin gave evidence that compliance with that requirement is currently at 67% and conceded that there is therefore 'still clearly room for improvement there.'[766] Certain new approaches, especially those piloted in the Southwest, have seen an uplift in compliance to 89%.[767]

556. Ms Corin confirmed in her evidence that the DFFH monitors compliance with cultural planning requirements through both internal reporting and through reporting to the Aboriginal Children's Forum. [768] The Forum convenes the ACCOs across Victoria involved in delivery of children and family services, Community Service Organisations,

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[762] Statement of Jacynta Krakouer, CB 3718 [36]-[39].
[763] T 544.
[764] T 389:27-29.
[765] T 389:30-390:1-4.
[766] T 436:1-4. See also Yoorrook Report (fn 17) 24.
[767] T 436:5-12.
[768] T 435:5-8.

and the DFFH, and is responsible for overseeing the realisation of *Wungurilwil Gapgapduir*.[769]

557. *Wungurilwil Gapgapduir* is anchored by five objectives, the first of which is to '[e]nsure all Aboriginal children and families are strong in culture and proud of their unique identity'.[770] Ms Corin gave evidence that cultural plans comprise one of the action items within that objective, and that since XY's passing the Forum has established 'improvement targets to increase compliance.'[771] At the September 2023 meeting of the Aboriginal Children's Forum, participants agreed that the approach to cultural plans should be reconsidered through the Aboriginal-led Statewide Cultural Planning Forum (to be held in 2024), to consider how the current model can be improved and redesigned to increase quality and compliance of initial and review plans and support culturally appropriate implementation.[772]

558. In XY's case, her cultural support plan contained a genogram, [773] which, though potentially a valuable component of the plan, was 'not particularly readable'. Dr Krakouer remarked that she struggled to be able to see the different names and wondered 'whether XY would have struggled to make sense of [it] as well'.[774] Ms Corin explained that the DFFH is currently adopting 'new software that will give greater functionality in preparation of those genograms' and will enable additional storage, and more detailed components, such as images, contacts, places, and education history, to be recorded within the genogram.[775]

559. In reference to the discrete action items within cultural plans, Ms Lomas explained that, although she is not aware of any changes to the way in which these are enumerated *within* the cultural plans, the introduction of the SAFER children framework[776] has promoted

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[769] T 435:9-14.
[770] *Wungurilwil Gapgapduir* (fn 641) 8.
[771] T 435:15-26.
[772] T 437:1-11; Exhibit E - Table of changes in relation to Child Protection policy and legislation (fn 644) 12.
[773] CB 506-507, a graphic representation of a family tree.
[774] T 56:6-9.
[775] T 436:12-20.
[776] Exhibit H – DFFH, 'SAFER Children framework guide: The five practice activities of risk assessment in child protection (October 2021) 7, figure 3. ('Exhibit H – SAFER guide') The SAFER children framework is the risk assessment approach for Victorian child protection practitioners. When it commenced on 20 November 2021, the five SAFER children framework activities of risk assessment replaced the four Best interests case practice model risk assessment activities. Child protection practitioners use the SAFER children framework to guide their risk assessment and risk management.

the use of — and enhanced the dynamism of — the actions table, which is attached to a child's case plan.[777] Ms Corin stated that the goals and tasks that are associated with cultural planning should also be reflected in a child's actions table,[778] which is embedded within the CRIS[779] system and is far more easily updated than the cultural plan.[780] She added that 'within the actions table there are review dates for certain goals and tasks and the accountability within the actions table is also very clear.'[781] The DFFH also gave evidence that while there was an actions table in relation to each version of XY's case plan,[782] the actions table now occupies a separate tab in the CRIS system, and so 'works more effectively as a "live" document'.[783] That is, since SAFER commenced, actions tables have been presented in a more accessible and easily updateable format, a development which answers some of the concerns about XY's cultural plan.

560. The establishment of the ACA role also evidences progress in this space since XY's passing. The position-holder represents the 'central point'[784] of supervision over cultural support plans, and works with Child Protection Practitioners in the Loddon Area to strengthen both their rigour and quality.[785] They also oversee compliance, assist with identifying children who require a cultural plan, guide practitioners as to the content of the plan, and facilitate connections with ACCOs.[786] By ensuring cultural plans are continually updated and kept relevant, the ACA role guards against the kind of obsolescence which XY's plan suffered from as a result of her transitions between placements.[787]

561. Loddon Area has also introduced a number of practice improvements to cultural planning for Aboriginal children. Its 'learning lunch' series, which comprised five hour-long sessions, examined both the 'development and… implementation' of cultural support

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[777] T 440:6-10.
[778] T 440:16-17.
[779] Client Relationship Information System, the client information and case management data system used by Child Protection.
[780] T 440:27-441:20.
[781] T440:19-25.
[782] For example, see actions table related to version 5 of XY's case plan at PR 1883.
[783] Exhibit M – DFFH responses to question on notice, 3 November 2023, [6]-[7].
[784] T 425:11.
[785] T 422:7-15.
[786] T 422:16-23.
[787] T 439:6-12.

plans.[788] The sessions were 'very well-attended', with each drawing an audience of approximately 15 to 20 practitioners.[789] Separately, the Loddon Area hosted one session on compliance for Child Protection managers, which 20 staff attended, [790] and three sessions for case management practitioners, with 33 in attendance.[791]

562. Mr Chapman also affirmed the indispensability of the Loddon Area's practice of co-locating with Aboriginal staff from BDAC and Njernda Aboriginal Corporation to the quality of cultural planning. As he explained, 'every week… one of the ACCOs is in our office… for ACSASS consults [and] also… cultural support plan consults,… and other pieces of work that relate to case planning.'[792] This program manifests an 'experiential' approach to learning and development: staff benefit from a 'co-located, embedded experience', and enjoy a unique opportunity to work with their colleagues at ACCOs 'in a way that maybe they otherwise wouldn't have.'[793]

563. Finally, the DFFH submitted that any recommendations here should be cognisant of the considerable work already underway, and the additional resources which have been procured and allocated - within both the DFFH and the ACCO sector - to improve cultural planning practices within Child Protection. Consistently with the approach I have taken above in relation to new initiatives the efficacy of which has not yet been assessed, I intend to make the recommendation as foreshadowed in the draft form circulated, and create a footprint of accountability through the formal response mechanism, which will assist evaluation of all the initiatives in any future inquest or other inquiry.

Recommendation 5:

564. *That DFFH:*

   a. *review and revise all relevant policies, procedures, guidelines and like documents; and*

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[788] T 426:28-30.
[789] T 427:2-4.
[790] T 427:12-13.
[791] T 427:14.
[792] T 443:6-12.
[793] T 443:16-21.

b. review and revise all relevant training courses and programs:

to improve its workforce's understanding of the importance of cultural plans and improve the quality, timeliness, implementation and monitoring of cultural plans for Aboriginal and Torres Strait Islander children in out-of-home care. In particular, DFFH should ensure that cultural plans:

c. are individually tailored;

d. involve the child or young person and their family in their creation and review;

e. are updated regularly (at a minimum, annually or when placement or other significant circumstances change);

f. provide a plan to (re)establish or maintain cultural connections, such as contact arrangements with family members, plans for Return to Country with Elders and family members from the same mob group as the child or young person;

g. include SMART goals with clearly defined accountabilities, either as part of the cultural plan or an actions table supporting the child or young person's case plan; and

h. include a legible genogram.

565. XY's Mother supports this recommendation, as well as Yoorrook's call for legislative reform with respect to cultural plans.[794] She has also persuaded me that there would be merit in exploring the viability and utility of the Children's Court holding additional powers to require that cultural plans be developed and to oversee the implementation of these plans through requirements for regular reporting and case management.[795]

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[794] XY's Mother Final Submissions (fn 660) [34]; see also Yoorrook Report (fn 17) 'Recommendation 22', 33.
[795] Ibid citing Victorian Aboriginal Legal Service, 'Submission to the Yoorrook Justice Commission, Child Protection', November 2022, 28, 45 (VALS' Submission to Yoorrook).

Recommendation 6

566. *That the DFFH, in consultation with the Attorney General, explore the viability and utility of granting the Children's Court supervisory powers over Aboriginal young people's cultural plans.*

Culturally appropriate mental health supports[796]

567. As discussed above, in formulating the scope of inquest I was conscious of the need to avoid duplicating the work of the Royal Commission into Victoria's Health System and to avoid cutting across reforms that are currently being implemented in its wake. I did, however, wish to explore the interface between Child Protection and the mental health system where relevant in XY's case, because where the DFFH is in a position of parental responsibility,[797] it is part of that role to understand any mental health services that the young person is engaging with, to form a view about whether those services are fit for purpose, and, where necessary, to advocate or arrange for the young person to receive better care.

568. Concerning the management of XY's mental health, I accept that the dynamism of XY's case must be borne in mind, and that it would be an oversimplification to accept or suggest that DFFH was always passive or inactive in responding to her needs.[798] However, as a generalisation, the coronial brief revealed many instances where Child Protection practitioners did not understand the purpose, or the limitations, of the available mental health care, or if they did understand its shortcomings, they did not thereupon revisit their primary obligation to act in XY's best interests and pursue other pathways toward getting her appropriate care.

569. For this reason, the Aboriginal expert witnesses were asked to review XY's access to mental health treatment through a cultural lens. In her report, Professor Pat Dudgeon explained that Aboriginal people require, at the very least, culturally safe mental health care.[799] She considered that XY did not receive culturally safe and appropriate mental health treatment and noted that XY 'was not provided the necessary cultural supports and

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[796] See Scope of Investigation at [2(d)], [2(i)(i)], [8], [9], [10] and Scope of Inquest at [2(h)] [7], [8].
[797] *CYFA*, s 3(1).
[798] See annexure to DFFH Responsive Submissions (fn 688), 'Summary of psychological supports for XY'.
[799] Statement of Pat Dudgeon, CB 3657.

the care was not provided under a social and emotional wellbeing lens which we know and understand to be effective for optimal health and reducing risk for suicide'.[800]

570. Professor Dudgeon explained that social and emotional wellbeing ('SEWB') is a collectivist, comprehensive and holistic approach to health care, and is widely accepted to be more culturally appropriate for Aboriginal peoples.[801] The features of effective and culturally grounded SEWB measures that guard against Aboriginal youth suicide include:

    a. a strength-based approach - that is, being Aboriginal is seen as a strength;

    b. cultural safety;

    c. holistic care, which addresses both psychosocial supports and the influences of social determinants of health, including unemployment, education, poverty, and racism; and

    d. the inclusion and empowerment of Aboriginal knowledges and community in suicide prevention efforts.[802]

571. Regarding the SEWB concept, Dr Krakouer agreed that it 'is a more culturally appropriate way of understanding Aboriginal health including mental health'.[803] She considered that SEWB prioritises 'the strength and resilience of Aboriginal and Torres Strait Islander people' in a way that was 'quite distinct' from Western understandings of mental health.[804]

572. Dr Newton added that it is important to recognise culture as a safeguard for children's mental health and wellness, and that the absence of culture as a safeguard increases the risk of children's mental health and wellbeing deteriorating.[805] She noted that this is seen in many children in care.[806] That 'cultural discontinuity and lack of access to culture

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[800] Ibid CB 3669. See also generally statement of Pat Dudgeon, CB 3669-3673.
[801] Ibid CB 3658.
[802] Ibid CB 3662-3664, 3680.
[803] T 125:29-126:3
[804] T 126:5-12.
[805] T 126:14-21.
[806] Ibid.

(cultural exclusion) are associated with negative psychosocial outcomes for Aboriginal and Torres Strait Islander peoples' was also raised by Professor Dudgeon in her report.[807]

573. In regard to culturally specific approaches in the Emergency Department ('ED'), Mr McNeill and Associate Professor Tune gave evidence that an Aboriginal health liaison officer is available and is very frequently engaged either at a patient's request or if staff feel they may be helpful.[808] Patients are asked if they identify as Aboriginal as a standard question when registering on arrival at the ED.[809] XY's Aboriginal background was reasonably well known in the ED.[810] However, Exhibit C (being a further statement by Associate Professor Tune addressing the extent to which XY had contact with an Aboriginal Hospital Liaison Officer during her presentations at Bendigo Health) revealed that there are only three such recorded contacts, despite XY's many visits there.[811] Although it is noted in the statement that the practice would be for XY to be offered such contact on each admission, this is the extent of the contact recorded in the records.[812]

574. AL suggested that it may be possible, either before going into hospital or at least when *en route*, for Child Protection practitioners to make suggestions, foster support, or directly contact an Aboriginal health liaison worker at the hospital on behalf of the child they are protecting.[813]

575. Ms Lomas reflected that while the Child Protection system 'had a good understanding of [XY's] mental health in the context of the Western sense,' it did not understand her health in a holistic, culturally grounded way.[814] Ms Lomas also expressed the view that pathologising XY was 'not helpful',[815] and posited that the application of a Social and Emotional Wellbeing framework, as articulated by Aboriginal mental health expert guidance, would have resulted in a different conceptualisation of XY's needs.[816] In

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[807] Statement of Pat Dudgeon, CB 3657.
[808] T 249:20-250:24.
[809] T 250:15-17.
[810] T 251:1-3.
[811] Exhibit C – Supplementary Statement of Associate Professor Philip Tune, 30 October 2023, [2.1]. XY attended the Emergency Department at Bendigo Hospital on approximately 28 occasions in the period 3 August 2020 until her passing (see MR 1283-1296).
[812] Ibid [2.3].
[813] T 554:29-555:4.
[814] T 639:24-640:6.
[815] T 640:7-8.
[816] T 640:11-26.

response to questioning as to whether the DFFH had shifted away from adopting Western medical health approaches to children and young people with presentations like XY's, Ms Lomas stated that she doubted that such was 'all within the Department's control.'[817] She continued: 'I think it… relates to… the evidence that I've already given in terms of the whole system and population understanding… culture… and addressing systemic racism'.[818] While Ms Lomas explained that she had witnessed that type of care provided by ACCOs, she stated that she did not believe it features within mainstream services.[819]

576. As to the role of Child Protection in ensuring XY had access to culturally safe supports during her hospital attendances and other interactions with mental health services, Mr Chapman adverted to the natural limits of the DFFH's ability to control the way external service providers engaged with XY and her cultural needs, stating 'We've heard evidence that YPARC felt that their services were culturally safe… [T]here are complexities associated with after hour admissions and the fact that the hospital has carriage of its own resources and how they're deployed.' [820] While Mr Chapman acknowledged that the DFFH 'potentially' could have 'advocated' for the service providers to use their resources to meet XY's needs, he added, 'that is a shared responsibility across… the whole of the system that had supported XY', including the DFFH, the practitioners, and 'everybody who had contact with XY in many respects.'[821]

577. Mr Chapman also outlined some of the new developments in the Loddon Area, which have improved cohesion between the DFFH and health providers, stating 'the Principal Practitioner of the Area… has actively worked to strengthen the relationships at that senior level with the clinical staff at Bendigo Health.'[822] For this reason, Mr Chapman expressed confidence that 'these sorts of issues, if escalated… to that level, would be looked at and hopefully resolved in a timely… way'.[823] In relation to whether internal changes have been made within the DFFH to ensure that Child Protection practitioners or subcontracted carers presenting with children to health services identify their unique

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[817] T 642:18-19.
[818] T 642:21-27.
[819] T 642:30-643:8.
[820] T 552:2-9.
[821] T 552:10-17.
[822] T 552:18-25.
[823] T 552:26-28.

needs, Mr Chapman explained that it is 'just standard practice'. [824] Relevantly, the Medical Stakeholder Panel witnesses gave evidence that XY was 'well-known' by CAMHS, Bendigo Health Emergency Department, and YPARC to be an Aboriginal young person,[825] which tells against any notion that communication about XY's cultural background was deficient.

578. In terms of improvements to the DFFH's advocacy for children and young people as they access health services, Mr Chapman reiterated earlier evidence about the critical role of the Senior Multi-Agency Panel and the Better Connected Care initiative in ensuring cross-sectoral integration in the Loddon Area, stating 'these are opportunities for us to intervene on the first front… earlier and at a more senior level… on the second front in a more systems… response.'[826] Mr Chapman also acknowledged the impact of COVID-19 during the period in which XY presented frequently to Bendigo Health, explaining that 'it shifted everything that happened around us and… was a very dynamic time'.[827] Ms Lomas observed in her statement that, from April 2020, COVID-19 restrictions meant that XY was often alone during hospital attendances.[828] Mr Chapman further referred me to the various recommendations for the Loddon Area that have flowed from the DFFH's Office of Professional Practice Review[829] of XY's case, including that the Loddon Area senior leadership group prioritise '[e]ngagement of specialist and other support services through joint planning, care teams and client advocacy.'[830] This recommendation was included in the Loddon Area's practice priorities for 2023.[831]

579. In relation to questioning about whether Child Protection considered 'institutionalising' XY, Mr Chapman reflected that the issue was 'complicated… in some respects… because that gateway to those sorts of settings are through the mental health system. They're not through us.'[832] As Mr Chapman explained, Child Protection 'take[s] guidance' from mental health practitioners. [833] Additionally, in response to evidence given by

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[824] T 554:3-15.
[825] T 246:19-21; 251:1-3.
[826] T 559:9-12.
[827] T 559:13-16.
[828] CB 3602.
[829] As described in the statement of Kirstie-Lee Lomas, CB 3593-3607.
[830] CB 3603, [48].
[831] CB 3603, [49].
[832] T 560:30-561:4.
[833] T 561:6-7.

Mr Oerlemans of Anglicare about consideration given to private inpatient facilities, Mr Chapman explained that he was of the understanding that there was only one inpatient adolescent unit in Victoria but that it did not cater for high acuity children such as XY[834] — this being the Albert Road Clinic.[835] As Mr Chapman affirmed in evidence, 'there was really no facility that could have assisted XY at the time.'[836] In this connection, Ms Corin made reference to the new statewide child and family centre, while noting that this will provide care for children aged zero to eleven at a sub-acute level,[837] and thus would not have been of assistance to XY during adolescence, though may have been during childhood.

580. Adopting a prospective lens, Ms Corin gave evidence about a program currently being considered, which would involve 'embed[ding] mental health advisors within the Department… to be able to advise and support Child Protection Practitioners' both in terms of identifying and responding to their mental health needs, and in navigating and accessing the mental health system. [838] Such a team would avail Child Protection Practitioners — who 'aren't mental health clinicians' — of specialised, expert advice.[839] Ms Corin also confirmed that the Department is 'actively' working with Department of Health colleagues to identify 'opportunities… for reform' to support children and young people in care.[840]

581. In response to a draft of the recommendation that follows (Recommendation 7), the DFFH submitted that such recommendations would be more appropriately directed to the Department of Health.[841] While I accept that government departments have specific areas of remit, I consider that this points to the very issue that the scope was exploring: that a person standing in the shoes of a parent cannot bureaucratically sidestep their

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[834] T 564:1-4.
[835] T 564:11.
[836] T 564:15-19.
[837] T 564:28-565:7.
[838] T 562:27-563:3.
[839] T 563:5-6; see also Exhibit E – 'Further table of initiatives in relation to Child Protection, relevant to mental health and wellbeing, following the evidence of the AIEP and Mental Health Panel, not previously included in Simone Corin's witness statement 4 November 2022 or table dated 20 October 2023', item (C). ('Exhibit E – Further table of mental health and wellbeing initiatives')
[840] T563:7-13; Exhibit E – Further table of mental health and wellbeing initiatives (fn 839), item (B).
[841] DFFH Responsive Submissions (fn 688) [124].

responsibility by pointing to another department with an overlapping responsibility. People will fall between the cracks this way.

582. The DFFH did however, make the persuasive closing submission that it could, together with the Department of Health, clarify the role of Child Protection and care services in relation to mental health support, especially where culturally safe mental health services are urgently required. It must be recognised that, in order to meet the needs of children in care who have chronic mental health conditions,[842] multiple systems and departments must work together to deliver appropriate supports.

Recommendation 7

583. *That DFFH:*

   a. *in consultation with the Department of Health and Bendigo Health, develop and implement more focused Social and Emotional Wellbeing approaches to the treatment of Aboriginal and Torres Strait Islander young people requiring mental health diagnosis and treatment, and do so in consultation with Aboriginal Community-Controlled Organisations such as BDAC, and that appropriate and ongoing training be provided to clinical and Child Protection staff to support these approaches;*

   b. *in consultation with the Department of Health and Bendigo Health, develop and implement systems for the cultural support of Aboriginal and Torres Strait Islander young people admitted to hospital for acute and other mental health episodes, to ensure that Aboriginal health liaison officers are actively made available to the young person at the time of admission and that that cultural connection is available beyond crisis admissions;*

   c. *in consultation with the Department of Health and Bendigo Health, take appropriate steps to ensure that its practice of offering contact with an Aboriginal Health Liaison Officer upon admission is effected on each occasion*

[842] Ibid [123], also citing annexure to DFFH Responsive Submissions (fn 688), 'Summary of psychological supports for XY'.

that a young Aboriginal or Torres Strait Islander person is admitted with mental health issues.

d. *develop and implement systems to ensure that young Aboriginal and Torres Strait Islander people with acute and/or chronic mental health conditions are provided prompt and ongoing mental health assessment and treatment, and ensure that this is done in ongoing consultation with appropriate Aboriginal input, such as ACCOs like BDAC, and take all steps open to ensure these ACCOs are appropriately funded to enable that work to occur.*

584. This recommendation was broadly endorsed by XY's Mother, BDAC and Bendigo Health.[843]

Risk assessment and risk management[844]

585. In relation to DFFH's risk assessment and management processes, Ms Lomas accepted the propositions drawn from the Department's written statements that the risk assessments conducted in XY's case by Child Protection were 'commonly superficial and episodic' and did not adequately consider the cumulative harm experienced by XY throughout her life or the impact of cumulative harm on her emotional, psychological and physical health.[845]

586. In speaking to the improvements made by DFFH since XY's passing in this respect, Ms Lomas gave an in-depth explanation of the Department's new SAFER children framework,[846] which commenced on 20 November 2021.[847] Ms Lomas described the key features of the SAFER children framework, as follows:

a. The outer layer, being the Child Protection Role and Mandate: this includes statutory obligations and the Multi-Agency Risk Assessment and Management Framework ('MARAM'), which emerged from the Royal Commission into

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[843] XY's Mother Final Submissions (fn 660) [66]-[68]; BDAC Closing Submissions (fn 729) [1]; Bendigo Health, 'Closing submissions on behalf of Bendigo Health', 9 February 2024, [11]-[12].
[844] See Scope of Investigation at [2(b)] and Scope of Inquest at [2(c)].
[845] T 651:1-4; Statement of Kirstie-Lee Lomas, CB 3595-3596; Statement of AW, CB 2033.
[846] See Exhibit H - SAFER guide (fn 776).
[847] T651:12.

Family Violence.[848] Ms Lomas reflected on how XY's case, and in particular, the position of XY's Mother, would likely be conceptualised differently applying the MARAM lens, as it is understood now, stating 'the system would likely have responded to them different in relation to them being identified as victim/ survivors of family violence.'[849]

b. The next layer, Supporting Our Practice: this includes the Child Protection Manual, case recording system, the role of Principal Practitioners, and reflective practice.[850]

c. The third layer, Professional Judgement: this contemplates a 'recommitment to professional judgment as the model for how we undertake risk assessment in Victoria'. Ms Lomas observed that, unlike some jurisdictions, Victorian Child Protection 'has never subscribed to structured decision-making… We've always believed that professional judgment and… allowing and enabling, empowering our practitioners to bring their knowledge, skills and experience to the work that they do, including risk assessment, and the decisions they make is really important'.[851]

d. The central layer, SAFER, is the 'new' aspect of the framework that commenced on 20 November 2021: 'they are the five practice activities of risk assessment… and management in Child Protection'.[852]

587. Ms Lomas also took the Court to a 'roadmap' which delineates each of the five practice elements:[853]

a. 'S', being seek, share, sort, and store information and evidence: factors which prompt concern within Child Protection are reduced to 'essential information categories'. Ms Lomas confirmed that in XY's case, drug and alcohol use would have been one such factor: relevant information would have been captured in

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848 T 652:18-26.
849 T 653:10-12.
850 T 653:16-22.
851 T 653:23 – 654:1-4.
852 T 654:14-17.
853 Exhibit H - SAFER guide (fn 776) 7, figure 3.

the CRIS system, which would then be supplemented by further, similar data, to enable Child Protection to 'build the picture of… evidence across the course of time, which is a really important point when we think about the building of information as it relates to cumulative harm.'[854]

b. A, being analyse information and evidence to determine the risk assessment: guided by the Best Interests Case Practice Model,[855] actions under the analysis component of the Framework involve interrogation of the vulnerability of the child…[,] severity of harm, likelihood of harm and safety'.[856] The consequent judgment then requires an evaluation of the consequence and probability of harm to the child.[857] Ms Lomas stated that the application of this dimension may have resulted in improved outcomes in XY's case: 'we would have seen a much different articulation of XY's experience of that harm and the severity…[and] we would've seen an indication of what that harm meant for XY in terms of impact on her.'[858]

c. F, being formulate a case plan; and

d. E, being enact the case plan: Ms Lomas explained that Child Protection seeks to link case planning and associated actions with the risk assessment.[859] In this connection, Ms Lomas referred to the expert evidence about the importance of having an 'action focused approach' in a case like XY's.[860] She elucidated how Child Protection uses actions table as 'a very tangible… live way of working, not only with children and families themselves, but other… care teams.'[861]

e. R, being review: Ms Lomas explained that risk assessment is reviewed at least annually for children on protection orders, and more frequently when considering the prospect of reunification.[862]

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[854] T656:25-657:3.
[855] T 658:26; Exhibit H – SAFER guide (fn 776) 8, figure 4.
[856] T 659:12-17.
[857] T 659:25-26.
[858] T 660:8-19.
[859] T 661:22-23.
[860] T 661:29.
[861] T 662:11-13.
[862] T 661:3-13.

588. Further, in relation to XY's eating disorder, Ms Lomas concurred with the conclusion of the Office of Professional Practice that this condition 'was not well understood'.[863] She went on to observe that 'the symptom may have been acknowledged but the seeking of information and assessments regarding what may have been the cause or what sat behind that particular disorder could have been very different.'[864] Ms Lomas explained that, because Child Protection practitioners are not clinicians, their role extends to identifying 'signs, factors of concerns (*sic*), other issues that might require specialist advice, assessment or treatment'.[865] She considered that XY's eating disorder was 'one of the signs that we would ask of our practitioners, expect of them, to pick up as flags, call them red flags if you like… that should prompt one to be curious' about whether there is a 'need to seek further information or advice that's outside the expertise and the knowledge that a practitioner may hold.'[866] While these 'flags' were identified at certain points, Ms Lomas accepted that they 'possibly' were not at others.[867] Ms Lomas also noted that the Child Protection Manual contains advice about management of mental health concerns, including 'prompts around eating disorders'.[868]

589. In response to questioning from Counsel Assisting as to the prominence of culture in the SAFER framework, Ms Lomas stated that 'this is not the be-all, end-all… of what we provide Child Protection',[869] and noted that the document is 'a dynamic framework' which will be revisited over time.[870]

590. In closing submissions, the DFFH also drew my attention to the following aspects of the SAFER children framework, which they submitted reflect a 'cognisance of the significance of culture, particularly in respect of Aboriginal children and young people':[871]

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[863] T 648:26-30.
[864] T 649:1-4.
[865] T 649:15-18.
[866] T 649:18-24.
[867] T 649:25-27.
[868] T 650:9.
[869] T 670:13-14.
[870] T 671:3-8.
[871] DFFH Responsive Submissions (fn 688) [129].

a. An artwork by Dixon Patten, titled Man Yeann Lidj (‘Embrace a Child’ in Gunnai/Jurnai Language), which was specifically designed by Mr Patten for SAFER, is featured on page i of the SAFER guide.[872]

b. Cultural needs are factored into the ‘F’ component of the rubric, with a view to having these integrated in case planning.[873]

c. The guide articulates the ‘shared vision’ of *Wungurilwil Gapgapduir*, being a commitment to ensuring that ‘all Aboriginal children and young people are safe, resilient, thriving and living in culturally rich, strong, Aboriginal families and communities’, and sets out the seven principles developed as part of *Wungurilwil Gapgapduir* to inform the work of Child Protection.[874]

d. The SAFER framework contains targeted instructions for interacting with Aboriginal children and families, including that observations about their circumstances should ‘always be culturally sensitive and informed, respect Aboriginal people and the historical context of harm caused while making observations with child safety in mind as the priority, and be informed by cultural advice from the ACSASS, ACCOs and Aboriginal people themselves.’[875]

e. Culture is regarded as one of the three domains in which children live their lives, interposing family and community.[876]

Sexual Assault Supports and Subsequent Referrals[877]

591. An issue that arose during the coronial investigation and inquest was the appropriateness of a non-female, non-Aboriginal police officer leading the Victoria Police Sexual Offences and Child Abuse Investigation Team (‘SOCIT’) investigations and taking XY’s

[872] Exhibit H – SAFER guide (fn 776) i.
[873] Exhibit H – SAFER guide (fn 776) 7, figure 3.
[874] Ibid 9.
[875] Ibid 30.
[876] Ibid 23, 40.
[877] See Scope of Investigation at [1(f)], [2(i)(ii)] and [6], and Scope of Inquest at [2(h)(iii)] and [5].

Video-Audio Recordings of Evidence ('VARE') in connection with the sexual offending she disclosed.[878]

592. Dr Krakouer gave evidence that it would have been appropriate in XY's circumstances to have an Aboriginal person working with the police to be there at the time of the SOCIT investigations and for a female SOCIT officer to have taken the VAREs.[879]

593. AL agreed, stating, 'this is clearly women's business,' being interviewed by a white male may have affected XY's ability to ongoingly engage with the process.'[880] She concluded, 'it's culturally unsafe'.[881]

594. Mr Widdicombe's evidence on this topic was as follows:

> I think it's really important to have culture at the forefront…any proper cultural awareness training would say that it would be common sense to have a female deal with women's business and a male deal with men's business. I think that…the alleged offender being a white male, having a white male [police officer] probably wouldn't make much sense to me.[882]

595. Superintendent Kearney gave evidence of the practical limitations of Victoria Police human resources. He said that 'SOCITs are extremely busy…If we were to try and defer half the work to the female workforce, we might not get our job done in an efficient manner'.[883] He later gave evidence that 30% of sworn police members in Victoria Police are female, approximately 50% of SOCIT detectives are female and over 90% of sexual assault complainants are female.[884] Within a workforce of 19,000, only 139 employees identify as Aboriginal or Torres Strait Islander.[885]

596. On an interpersonal level, Detective Senior Constable Benjamin Manning ('DSC Manning') conducted the SOCIT investigations and VARE processes with as much

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[878] T 108:13-20; T 589:25 – 591:29.
[879] T 208:29 - 209:20.
[880] T 590:3-10
[881] T 590:15.
[882] T 589:24-30.
[883] T 588:21-25.
[884] T 713:5-17.
[885] T 718:6-8.

sensitivity, dignity and respect as was possible in those difficult circumstances.[886] There were delays in the process, but these were explicable judgement calls when consideration was given to prioritising particular investigations among the various allegations, XY's welfare at various moments in time and her fluctuating willingness to proceed with the complaints.[887] Further, while DSC Manning took the lead in the investigative work, some of the other investigators who worked with XY were female.[888]

597. While the Chief Commissioner acknowledged and accepted the expert evidence that it is generally preferrable for female police officers to deal with 'women's business', Victoria Police already have a general policy (albeit not specific to Aboriginal females) that sexual offence complainants should be interviewed by a police member of the same gender where practicable and unless the complainant requests otherwise.[889]

598. The Chief Commissioner also acknowledged the importance of having an Aboriginal liaison officer available to Aboriginal sexual assault complainants. This is already reflected in Victoria Police policy.[890] Finally, the Commissioner acknowledged that there was no evidence of an Aboriginal liaison officer being present with XY during the SOCIT investigations, nor of one being requested but being operationally unavailable.[891]

599. In short, while the Chief Commissioner closed the inquest submitting that the organisation already had in place sufficient policies and procedures to deal with a vulnerable female Aboriginal child such as XY,[892] those procedures did not in XY's case deliver the culturally safe and gender-appropriate resources she needed. Further, this failure could not be fully explained by human resource limitations, given that the majority of SOCIT investigations are logistically as well as emotionally complex, and so need a

[886] Jacquii Jackson, who was XY's carer at the time she made her VAREs, described DSC Manning as 'fantastic' in his conduct of the investigations and interactions with XY; see statement of Jacquii Jackson, CB 128.
[887] T 586:20-21, T 585:29-586:3, T 585:13-21, T 586:4-8, T 588:12-17.
[888] Constable Jacinta Morrisey; Detective Acting Sergeant Sarah Miller and Leading Senior Constable Fiona Whitty: see e.g. FNID (fn 116) [102], [127], [140], [183], [225].
[889] Chief Commissioner of Police, 'Submissions of the Chief Commissioner of Police' (9 February 2024) [13] ('CCP Closing Submissions'); citing Victoria Police Manual – Sexual Offence Investigations, CB 2855 [2.5].
[890] T 595:5-12; CCP Closing Submissions (fn 889) [17], citing Annexure 1 to CCP Closing Submissions, Victoria Police, 'Code of Practice for the Investigation of Sexual Crime' (2016), 15 [6.1.1].
[891] CCP Closing Submissions (fn 879) [18].
[892] Ibid [23] – [24].

pre-arranged resource allocation rather than being spontaneous and therefore limited to the available resources on hand.

Recommendation 8

600. *That Victoria Police:*

    a. *make every effort to increase the number and availability of Aboriginal and Torres Strait Islander people it employs;*

    b. *make every effort to employ Aboriginal and Torres Strait Islander people in SOCITs;*

    c. *increase the number and availability of Aboriginal liaison staff in its dealings with young Aboriginal sexual assault complainants;*

    d. *as a matter of policy, when dealing with female Aboriginal sexual assault complainants, make available a female police officer to conduct VAREs and lead contact with the complainant, unless the complainant requests otherwise or it is not practicable;*

    e. *improve its cultural awareness training as it relates to dealing with female Aboriginal sexual assault victims, including by incorporating reference to 'cultural humility' as described by Dr Krakouer.*

601. The inquest also considered whether the DFFH, *in loco parentis*, should have more actively supported XY during and after her complaint processes. In response to questioning about this, Mr Chapman acknowledged that 'Child Protection should have coordinated with police more strongly' and that Child Protection has a role in advocating for children in their interactions with police; however, he noted that Child Protection was not 'the lead agency' in that setting. [893] Mr Chapman also drew my attention to the Protecting Children Protocol, which establishes principles for Child Protection's engagement with Victoria Police. As Mr Chapman explained,[894] while the AIEP levelled some criticism at the DFFH for being absent during the VARE, this course was dictated

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[893] T 575:4-11.
[894] T 575:17-30.

by the Protecting Children Protocol, which, at the relevant time, stated: [895] 'Child protection practitioners should be present to view the interview and take notes *from the monitoring room*.'[896] Child Protection practitioners or ACAC case managers are also not permitted to view the VARE recording after the interview is completed.[897]

602. More generally, and adopting a state-wide lens, Ms Lomas described the relationship between Victoria Police and Child Protection as 'a partnership that works well' and one that is 'collaborative'[898] in nature.

603. Dr Robson's evidence was that XY was reluctant to disclose the true nature and extent of her sexual abuse to CAMHS[899] and also to CASA.[900] Psychological appointments for XY with CASA and Goldfields Psychology were cancelled by Child Protection in October and November 2019.[901] Child Protection referred XY to the Take Two Berry Street service, which Dr Robson described as 'a collaboration of services that is designed for young people in out-of-home care' [902] suitable 'for people with more complex presentations'[903] compared with private psychology referral in the community.[904]

604. Dr Newton observed that DFFH's response to XY's allegations of sexual assault lacked urgency and an appreciation for the seriousness of XY's declining mental health and untreated child sexual abuse trauma. She considered that the referrals were made too late and were inadequate.[905] She opined that there were 'large gaps in XY's continuity of care for her mental health which were caused by casework decision-making'.[906]

605. Dr Newton gave further evidence that upon XY's disclosure of sexual assault it would have been best practice to consult ACSASS workers 'in how to manage that disclosure,

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[895] T 575:23-28.
[896] Attachment 10 to Exhibit M - DFFH responses to questions on notice (3 November 2023): DFFH, 'Protecting Children – Protocol between Department of Human Services – Child Protection and Victoria Police' (June 2012) 20 [1.6.10] (emphasis added). The updated protocol (January 2023, Attachment 9 to Exhibit M) extends this requirement to ACAC case managers at 36 [E.4].
[897] Ibid.
[898] T577:26-27.
[899] T 234:21-31.
[900] T 235:1-2.
[901] See FNID [191]-[192].
[902] T 302:1-3.
[903] T 302:6-7.
[904] T 302:7-11.
[905] Statement of BJ Newton, CB 3102 [117]; T 72:9-73:8.
[906] Statement of BJ Newton, CB 3102 [118].

particularly with…XY's family…as they would have been able to provide…[a] culturally responsive…approach to how to…how to deal with that.[907] Dr Newton stated that DFFH should also have supported Jacquii Jackson in how to respond in a way that was best for XY,[908] and should have supported XY's access to sexual education, supports or other intervention.[909]

606. Mr Chapman agreed with Dr Newton that there was a lack of urgency in the DFFH's response.[910] In closing submissions, DFFH also accepted that ACSASS could have been consulted, [911] albeit that this would have fallen outside of the usual advisory role of ACSASS.[912] Mr Chapman recalled the Principal Practitioner's desire to 'make sure that the right service was involved with… XY from a mental health perspective.'[913] However, he acknowledged that Child Protection should have placed greater priority on procuring a referral for XY, sought specialist advice about managing the disclosures, and should have explored appropriate Aboriginal services.[914]

607. Looking to the future, Mr Chapman reiterated the benefits of a 'relational case practice', and spoke of an appetite within the DFFH to embrace that approach, so as to enable Child Protection practitioners to develop more meaningful relationships with children.[915] In terms of specific systems improvements designed to enhance the DFFH's ability to respond to children who have experienced sexual abuse, Mr Chapman referred to the following:

    a. The introduction of 'senior clinical liaison meetings with CASA', which involve the Principal Practitioners and the Child Protection Director in the area, and commenced in late 2021 or early 2022;[916]

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[907] T 67:28-68:5.
[908] T 69:23-70:2.
[909] T 70:19-28.
[910] T 579:11-12.
[911] DFFH Responsive Submissions (fn 688) [106].
[912] At T 335:2-6, AL described ACSASS as a 'consultatory service… that consult with the Department in regards to any significant decisions…[and] in making recommendations regarding those significant decisions.'
[913] T 579:21-23.
[914] T 579:23-27.
[915] T 579:15-18.
[916] T 579:29-580:3.

b. The Framework for Trauma-Informed Practice, which is a 'whole of system framework' which embodies a 'shared vision of what trauma-informed practice looks like for service users… and those who deliver it.' [917] Mr Chapman explained that the Framework articulates 'principles and practice domains… associated with trauma, contains practical advice on working with children and young people, individuals and families.'[918]

c. The establishment of Aboriginal Sexual Assault Healing Services across five areas, which are being delivered by ACCOs. These, Mr Chapman explained, 'provide a culturally… responsive and safe sexual assault support service… based on holistic healing principles.'[919]

d. Consideration is being given to the integration of mental health advisers within the DFFH. They would work closely with Child Protection Practitioners to advise and guide them in relation to mental health considerations.[920]

608. Within Bendigo Health, Mr McNeill's evidence was that there is already access to an Aboriginal Health Liaison Officer in YPARC, the Emergency Department and the Adult Acute Unit,[921] albeit that in this case, there were very few recorded contacts by such persons with XY. Bendigo Health records indicate that XY had contact with an Aboriginal Health Liaison Officer ('AHLO') on 25 October 2017 during an Emergency Department presentation and on 18 August 2020 upon admission to the Child and Adolescent Ward. On 4 July 2021, a referral to an AHLO was made after an overnight stay in the Adult Acute Unit, but it is not apparent from the records whether contact was made prior to her discharge.[922]

609. Looking to the future, Associate Professor Tune's evidence addressed initiatives underway across Victoria to address Recommendation 33[923] of the report of the *Royal Commission into Victoria's Mental Health System*, which focuses on the social and

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[917] T 580:3-9.
[918] T 580:10-13.
[919] T 580:21-28; Exhibit E – Further table of mental health and wellbeing initiatives (fn 839), item (E).
[920] T 581:1-7.
[921] T 247:19-28.
[922] Exhibit C – Supplementary Statement of Associate Professor Philip Tune (30 October 2023) [2.1]-[2.2].
[923] See *Royal Commission into Victoria's Mental Health System* (Final Report: Summary and recommendations, February 2021) Recommendation 33, 69.

emotional wellbeing of Aboriginal peoples requiring and seeking mental health support and treatment.[924] He also explained that:

a. The Aboriginal mental health traineeship program involves the introduction of ten Aboriginal Mental Health Traineeships across eight Area Mental Health and Wellbeing Services, including Bendigo Health. 'Bendigo Health has already supported one trainee to complete the traineeship, and the staff member is now an ongoing member of the mental health workforce';[925] and

b. The Koori Mental Health Liaison Officer ('KMHLO') Program - Bendigo Health has employed a KMHLO working across mental health inpatient services. It has recently received funding to establish a KMHLO in child and youth community services. That person will be based in the CAMHS service but will also have capacity to support youth services.[926]

610. As the majority of these initiatives are at best embryonic, or as yet unproven, with the support of BDAC,[927] I make the following recommendations.

Recommendation 9

611. *That:*

a. DFFH, in consultation with the Department of Health, clarify respective roles, fund and ensure facilitation of early, intensive and culturally appropriate mental health intervention for young Aboriginal people in its care presenting with complex mental health problems and allegations of sexual assaults.

b. DFFH continue to fund and develop Aboriginal sexual assault healing services delivered by ACCOs.

c. DFFH implement practices for appropriately urgent action and follow up with the Department of Health, and/or its service providers, to ensure young

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[924] Statement of Philip Tune, CB 2886, [11.4]-[11.8].
[925] Ibid [11.7]; also T 228:31-229:7 and T 265:3-16.
[926] Ibid [11.8]; also T 228:26-30 and T 256:19-31.
[927] BDAC Closing Submissions (fn 729) [1].

Aboriginal people in its care presenting with allegations of sexual assault are receiving culturally appropriate mental health intervention.

d. DFFH develop and implement processes for appropriate support for out-of-home carers who are dealing with young people suffering the mental health effects of sexual assault.

e. Bendigo Health consider developing and implementing integrated Aboriginal and Torres Strait Islander worker and lived experience workers within the Bendigo health system itself.

Drug and Alcohol Support[928]

612. In February 2021, XY was referred by Child Protection, with her consent, to Youth Support and Advocacy Service Bendigo ('YSAS'), a specialised drug and alcohol support service. [929] She met with Stephen Turner of YSAS on 15 March 2021, but declined his offer to assist her with reducing her substance abuse. [930] No further appointments with YSAS were made.[931]

613. Ms Lomas's gave evidence as to the role of the SAFER framework in assisting Child Protection to respond to drug and alcohol risk. Ms Lomas explained that under the new framework, drug and alcohol use would be considered a 'factor', signifying a potential indicator of adverse outcomes,[932] increasing the likelihood of harm to a child.[933] That factor would then be reflected in CRIS, along with the Child Protection Practitioner's analysis of the risk landscape. Ms Lomas explained: 'we require our practitioners to actually articulate... what is the information we hold about that?... is it that… XY has started to experiment with marijuana use, and that's the first piece of information we hold about that factor?' [934] Ms Lomas went on to explain how the system enables Child Protection to 'add additional information' in order to 'build the picture of… evidence

[928] See Scope of Investigation at [2(e)] and [7] and Scope of Inquest at [2(d)].
[929] FNID (fn 116) [273].
[930] FNID (fn 116) [279].
[931] Ibid.
[932] T 656:6-7.
[933] T 656:15-20.
[934] T 656:23-27.

across the course of time'.[935] The DFFH submitted that this approach produces more holistic insight, which is critical in assessing cumulative harm and also assists Child Protection to recognise problematic and harmful behaviours.[936]

614. Ms Lougoon's evidence was that XY resisted referrals to drug and alcohol support. She considered that XY was aware that substance abuse was harmful to her mental state overall but viewed it as an effective coping strategy to escape her distress.[937]

615. Associate Professor Tune's evidence was that he believed Bendigo Health had adequately cared for and treated XY's alcohol and substance misuse, noting that several discussions were had with XY regarding substance abuse,[938] and active attempts were made to engage XY with drug and alcohol services. [939] Associate Professor Tune added that, from a medical perspective, substance misuse is a serious concern for any patient – and of particular concern in a case like XY's[940] – and is actively screened for when patients engage with health services.[941] He considered XY to be between the 'pre-contemplative' and 'contemplative' phases of willingness to consider she had a substance abuse problem and being able to choose to address her concerns.[942]

616. A 'natural barrier for engagement' noted by Associate Professor Tune is that drug and alcohol treatment requires the engagement of a separate additional service provider.[943] He also considered that XY may have had a more positive outcome if she had access to Aboriginal-based services, whether that was a peer worker of an Aboriginal background who had overcome substance misuse, or a drug and alcohol service run by Aboriginal people.[944] In this regard, Associate Professor Tune stated that there a number of initiatives now underway or planned as a result of the *Royal Commission into Victoria's Mental Health System*, including the establishment of a Koori Mental Health Liaison Officer in

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[935] T 656:27-657:3.
[936] DFFH Responsive Submissions (fn 688) [139].
[937] Statement of Ashlee Lougoon, CB 3275 [6.4].
[938] Statement of Philip Tune, CB 2881 [3.10].
[939] Ibid [3.11]-[3.12]; T 227:25-228:19.
[940] T 227:15-19.
[941] T 227:10-15.
[942] T 228:6-10.
[943] T 228:10-13.
[944] T 228:13-19.

child and youth community services, and a commitment to expanding the mental health workforce through Aboriginal mental health traineeships.[945]

617. The DFFH advised me that the Department of Health has carriage of or control over the provision of many of these services, although obviously, where the person in need is a child, this does not absolve the DFFH of its responsibilities.

618. It is apparent from the evidence I heard at inquest that, while services do exist to address drug and alcohol use, and they were offered to XY, none of those services are yet tailored towards the special needs or vulnerabilities of Aboriginal people. In other areas of social work, services have more successfully been provided when they have been designed and delivered by Aboriginal organisations on behalf of the communities they represent,[946] and this appears to be a gap in the current treatment offerings.

Recommendation 10

619. *That the Department of Health, DFFH and Bendigo Health coordinate culturally appropriate drug and alcohol support for young Aboriginal and Torres Strait Islander people who present with drug/alcohol misuse, including by adequately funding and liaising with appropriate ACCOs such as BDAC and/or suitable family/community supports.*

Suicide Prevention, Safety and Planning[947]

620. It was often the case for XY that the people best placed to notice and monitor her 'symptoms' of poor or declining mental health were non-medically trained Child Protection staff and service providers.

621. In her report, Dr Krakouer noted that '[t]here is no indication that residential care workers possess mental health first aid training, such as Applied Suicide Intervention Skills Training, and are trained or capable of engaging in conversation about suicidal ideation

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945 Statement of Philip Tune, CB 2886, [11.4]-[11.8]; also T 228:22-229:9, T 256:19-31 and T 265:3-16.

946 See evidence of Dallas Widdicombe at T 358:11-21, T294-21; see also Commission for Children and Young People, *Our Youth, Our Way: Inquiry into the Over-Representation of Aboriginal Children and Young People in the Victorian Youth Justice System* (Report, 2021) Finding 1.

947 See Scope of Investigation at [1(b)], [2(a), (b), (d), (i), (j)], [8], [9], [10] and Scope of Inquest at [2(b), (c), (h), (i)], [7], [8].

with XY as a form of suicide prevention.'[948] Dr Krakouer considered that Child Protection 'had a responsibility to ensure that residential care workers possessed Applied Suicide Intervention Skills Training ('ASIST') so that an immediate response to suicidal ideation, concern or risk could be undertaken by residential care workers on-site when XY needed help, support and de-escalation immediately.'[949]

622. The DFFH explained that once mental health issues become acute, provision of services and service options fall within the remit of the Department of Health,[950] but this raises the question of how any emerging mental health issues might be managed before they become acute.

623. Dr Krakouer's evidence was that all of XY's carers should have undertaken some form of mental health first aid training.[951] Associate Professor Tune agreed that residential workers 'should have the capacity to convey a compassionate human response',[952] and they should definitely have some form of mental health first aid training.[953] He noted, however, that it would not be fair and reasonable to expect someone at the level of responsibility of residential care workers 'to have the capacity to apply the sorts of skills provided by Applied Suicide Intervention Skills Training',[954] which is aimed at people from a clinical background.[955]

624. BDAC and Anglicare strongly supported their staff, not just at the coalface, but also those in case management positions, having some level of mental health first aid training.[956]

625. The DFFH witnesses gave evidence of the various initiatives designed to support children in out-of-home care with suicidal ideation. Ms Corin confirmed that the DFFH funds 'CALM Conversations' training for residential care workers, which is delivered by the Centre for Excellence in Child and Family Welfare ('Centre for Excellence').[957] Training

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[948] Statement of Jacynta Krakouer, CB 3736 [100].
[949] Ibid [102].
[950] DFFH Responsive Submissions (fn 688) [146(a)].
[951] T 159:10-16.
[952] T 289:22-23.
[953] T 290:4-5, 290:11-18.
[954] T 289:26-29.
[955] T 290:9-10.
[956] BDAC Closing Submissions (fn 729) [1-2]; Anglicare, 'Submissions on behalf of Anglicare Victoria' (13 February 2024) [40]-[41] ('Anglicare submissions').
[957] T 680:17-26.

courses were held in July, September, and October 2023.[958] Ms Corin added that the Department of Health also provides ASIST, which was offered to residential care workers, and that the Centre for Excellence is currently examining how ASIST might be integrated within the broader Residential Care Learning and Development Strategy for residential care workers.[959]

626. For kinship and foster carers, the DFFH offers training through the Carer KaFÉ, a consortium program overseen by the Centre for Excellence, Kinship Carers Victoria, and VACCA.[960] The platform offers training for trauma-informed care and responses to self-harm, and it has previously included suicide prevention training. It also contains links to online resources, including Federal Government and Emerging Minds mental health resources, and referrals to remote and in-person training. The platform makes mental health first aid training available, though Ms Corin acknowledged that this would be at carers' 'own cost or costs supported by Department allowances.'[961] Ms Corin indicated that the consortium is currently considering the future training schedule and acknowledged that there was an opportunity to consider whether mental health first aid might be provided as part of that program going forward.[962]

627. Additionally, Ms Corin referred to the further table of mental health initiatives filed on behalf of the DFFH, and specifically to roundtables which have been held as part of the development of Victoria's new suicide prevention and response strategy, ('the new strategy')[963] one of which focussed on children and young people at increased risk of suicide.[964] Separately, she added, as part of the consultations informing development of the new strategy, consideration has been given to the unique needs of Aboriginal children and young people in consultation with Aboriginal organisations, and these findings will

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[958] T 680:27-28.
[959] T 681:4-16.
[960] T 681:22-682:3.
[961] T 682:7-20.
[962] T 682:21-25.
[963] A Victorian Government initiative to develop a 'comprehensive whole-of-government, community-wide, evidence-informed, systems-based approach […] to effectively prevent and respond to suicide in the Victorian community: see https://engage.vic.gov.au/the-victorian-suicide-prevention-and-response-strategy.
[964] T 687:19-688:5; Exhibit E – Further table of mental health and wellbeing initiatives (fn 839), item (D).

inform the DFFH's future practices and policies for suicide prevention in respect of this cohort.[965]

628. Without repeating my reasons for excising the purely medical or mental health related issues from the scope of this inquest, it remains within scope to consider what level of mental health first aid training is required to ensure that non-medically trained Child Protection staff, residential care staff and other carers are able to meet the immediate needs of the vulnerable children in their care. The following recommendation around mental health first aid is intentionally expressed with a level of generality, with the intention of giving stakeholders the opportunity, recognising their separate remits, to make sure that children in out-of-home care are not falling between the cracks of interlocking systems, for lack of knowledge about when and how a child needs to move between the spheres. Further, while the DFFH has helpfully explained a number of initiatives currently in train, those initiatives have not yet crystallised, so I will make the following recommendations in order to help track those responses into the future.

Recommendation 11

629. *That DFFH:*

  a. *in association with its ACCO partners, the Department of Health and Bendigo Health, urgently consider how existing mental health services and new mental health service options could be developed to provide care that is accessible to and culturally appropriate for Aboriginal and Torres Strait Islander young people with complex mental health needs;*

  b. *offer funded mental health first aid training for all out-of-home carers, or, at minimum, for out-of-home carers caring for children and young people with mental health concerns, and make such training available in accessible locations in regional Victoria.*

630. In a similar vein, with respect to mental health crisis management, the AIEP considered that a better coordinated response between the hospital, the Aboriginal community (including people working at BDAC), medical and mental health services in the

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[965] T 688:5-11.

community (including CAMHS), and those providing direct care to XY should have been in place, so that all members of XY's care team understood how to implement the safety plan and support XY when she was experiencing suicidal ideation or a desire to self-harm.[966]

631. While both XY's Mother and BDAC endorsed the following recommendation,[967] it was XY's Mother's position that, given XY's recent history and presentation on the day of her passing, it was inadequate for residential care staff to have allowed her to leave Maison House unaccompanied.[968] XY's Mother submitted that the 'line of sight monitoring' policy in place on 18 July 2021 was inadequate, in that it left to the discretion of residential care staff whether to follow XY when she left the residence. The policy stated, 'If XY leaves placement and has not voiced where she is going or what she is doing staff to maintain line of sight with XY. This is not required if XY has stated where she is going and what time she will be back'.[969] On the day of XY's passing, she left Maison House, telling staff that she would be back in two hours and was going for a walk.[970] XY's Mother submitted that I should consider making a recommendation that DFFH and service providers ensure that any 'line of sight monitoring' policies mandate consideration of compelling surrounding circumstances, such as patterns of escalation in suicidality risk, risk of exposure to identified triggers of a self-harm event, and the young person's recent behaviour and affect.[971]

632. I am persuaded that there is merit in making this recommendation.

Recommendation 12

633. *That*

   a. *DFFH develop measures to improve coordination between stakeholders in the development and implementation of safety plans, with a particular cultural*

[966] T 130:15-25.
[967] BDAC Closing Submissions (fn 729) [1]-[2]; XY's Mother Final Submissions (fn 660) [69].
[968] XY's Mother Final Submissions (fn 660) [70].
[969] PR 388.
[970] PR 6948.
[971] XY's Mother Final Submissions (fn 660) [73].

emphasis where safety plans concern Aboriginal and Torres Strait Islander young people; and

b. *DFFH and service providers ensure that any 'line of sight monitoring' policies mandate consideration by carers of compelling surrounding circumstances, such as patterns of escalation in suicidality risk, risk of exposure to identified triggers of a self-harm event, and the young person's recent behaviour and affect.*

Better Support for Carers[972]

634. The Aboriginal Independent Expert Panel was critical of the adequacy of support provided by Child Protection to XY's kinship carers, Peta Thomson and Jacquii Jackson. In a coronial impact statement which she read aloud to the Court at inquest, Ms Jackson gave a heartfelt account of the difficulties she faced in caring for XY while juggling her own family's needs, stating:

> I had this little girl living in my home, needing a loving family and I loved her so much but it wasn't enough to save her.
>
> […]
>
> The highly stressful life we all lived for almost 12 months, blindly navigating our way through the best we could, would have been so much better for all of us if we had support from the department. I believe had we have gotten the help I so desperately requested on so many occasions that XY would still be alive today and living in my home as another member of my family.[973]

635. The AIEP's evidence referred to many specific examples where inadequate support was provided to XY's carers by DFFH, including:

a. for Ms Thomson, assistance with transportation to appointments;[974]

b. for Ms Jackson, access to BDAC for supports;[975]

[972] Scope of Investigation at [2(g)] and Scope of Inquest at [2(g)].
[973] Jacquii Jackson, Coronial Impact Statement (1 November 2023); T 723:24-26, 724:29-725:6.
[974] T 153:6-13.
[975] Ibid.

c. DFFH not responding, or not responding in a timely way to attempts by carers to contact Child Protection, including at times of crisis;[976]

d. mental health training and therapeutic supports for carers;[977]

e. support for carers specifically focusing on managing XY's disclosures of alleged sexual abuse;[978]

f. provision of respite, including improved processes for approval of extended family members to provide respite;[979] and

g. follow up with carers following XY's hospital admissions.[980]

636. The AIEP expressed the opinion that, had appropriate support been provided to XY's kinship carers, this could have prevented breakdown of the carer relationships and may have led to carers maintaining an ongoing relationship with XY following breakdown of the placement. Instead, XY's carers felt so unsupported by DFFH that they felt unable to sustain a relationship with XY after the placement came to an end.[981]

637. DFFH witnesses accepted that Child Protection and the broader system could have provided more supports for XY's carers and agreed with the AIEP's comments in this regard.[982] Mr Chapman offered an apology to XY's kinship carers for the DFFH's lack of support.[983]

638. Previous reviews have identified the need for improved supports to be provided to kinship carers, and for DFFH to more actively monitor kinship placements to ensure their stability. In 2016, the Commission for Children and Young People found that 'kinship carers require increased advocacy, support, assistance, training and education to provide culturally safe and trauma informed care to Aboriginal children requiring out-of-home

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[976] T 154:9-155:2.
[977] T 141:11-23, 151:7-18.
[978] T 71:10-74:5.
[979] T 74:27-75:10, 80:15-20.
[980] T 119:3-120:2.
[981] T 150:5-24, 153:14-27.
[982] Responsive statement of Kirstie-Lee Lomas, CB 3624 [51]; T 623:15-18, 631:12-20.
[983] T 631:12-20.

care'.[984] Despite changes following the 2016 report, the Commission for Children and Young People found again in 2019 that many kinship carers do not receive adequate levels of support.[985] More recently, in June 2022, the Victorian Auditor-General's Office report on the performance audit of the kinship care model made twelve recommendations directed to DFFH, including in relation to improving its monitoring of kinship placements and enhancing access by carers to financial support.[986] DFFH has accepted the recommendations and is currently 'working on addressing' them.[987]

639. The Yoorrook Report recommended that the Victorian Government address barriers to First Peoples becoming carers for First Peoples children in the child protection system, including by 'ensuring kinship carers have appropriate access to training, support, and services at a level that is at least equivalent to the training, support and services offered to foster carers.'[988]

640. DFFH witnesses gave evidence of several initiatives that have been introduced since XY's passing. These include the introduction in October 2022 of a Care Support Help Desk[989] and increased funding to improve respite support.[990] I note also the significant Victorian Government investment in these initiatives in the 2021-22 and 2022-23 State Budgets.[991] In relation to a young person with high acuity needs like XY, Mr Chapman acknowledged that there remains a lack of clinical respite options, and it would still be challenging to find a respite carer, although he believed that the improvements now in place would make the identification of a respite placement more likely.[992] There is also now funding available for additional training for kinship carers through the Carer KaFÉ.[993] These programs are still in their infancy, and I accept it is too early to make any

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[984] Commission for Children and Young People, 'Always Was, Always Will be Koori Children: Systemic Inquiry into Services Provided to Aboriginal Children and Young People in Out-of-Home Care in Victoria' (Inquiry Report, 2016)13, Finding 7; cited in Yoorrook Report (fn 17) 183.
[985] Commission for Children and Young People, 'In Our Own Words: Systemic Inquiry into the Lived Experience of Children and Young People in the Victorian out-of-Home Care System' (Report, 2019) 44, Finding 31; cited in Yoorrook Report (fn 17) 184.
[986] Victorian Auditor-General's Office, 'Kinship Care' (Independent Assurance Report to Parliament, June 2022), available at www.audit.vic.gov.au/report/kinship-care.
[987] Statement of Simone Corin, CB 2048-9 [28].
[988] Yoorrook Report (fn 17) 33, Recommendation 20.
[989] T 624:8-21.
[990] T 625:11-20.
[991] Statement of Simone Corin, CB 2048 [24]-[25].
[992] T 628:22 - 629:12.
[993] T 681:22 - 682:20.

assessment as to whether they are likely to improve the supports provided to kinship carers.

Recommendation 13

641. *That DFFH ensure that kinship carers:*

   a. *have access to training, support, and services that are appropriate to their circumstances;*

   b. *are aware of and receive assistance accessing financial supports; and*

   c. *are aware of the existence of the Care Support Help desk and how to access it.*

Accommodation Instability and other Residential Services issues[994]

642. Uncertainty regarding her accommodation was an issue that XY often expressed concern about and which she had indicated caused her significant distress.[995] Ms Lomas described the period following the breakdown of XY's two kinship placements in 2019, when the 'pressure on practitioners to find placements was immense', and acknowledged that '[p]rofessionals and XY herself said not knowing where she would live and be cared for was the source of significant distress for her'.[996]

643. Dr John Cooper, XY's treating psychiatrist during YPARC admissions, opined that 'accommodation and carer instability had a profound impact on XY's mental health'.[997] Similarly, Ms Lougoon's evidence was that in her experience, 'XY's lack of permanent and stable accommodation had a significant detrimental impact on her mental health'.[998] She stated that 'XY explained to me that she was often distressed at the thought of having no stable accommodation' and '[her] accommodation instability was often a barrier to her being able to engage in a therapeutic way as she was often in crisis'.[999]

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[994] Scope of Investigation at [2(a), (f), (g), (h)] and Scope of Inquest at [2(a), (e), (f), (g)].
[995] See, e.g., FNID (fn 116) [241], [258], [270].
[996] Statement of Kirstie-Lee Lomas, CB 3600 [37].
[997] Statement of Dr John Cooper, CB 3268 [3.10].
[998] Statement of Ashlee Lougoon, CB 3272 [3.2].
[999] Ibid.

644. Dr Robson's evidence was that providing safe and stable accommodation would have been a very important part of XY's care,[1000] and that the difficulty in finding adequate kinship accommodation was a setback in the provision of care.[1001] Dr Robson noted that mental health services do not provide residential facilities for young people and the only potentially available service was Solomon Street (where XY had briefly stayed).[1002] Dr Robson's evidence was that it was 'quite clear' that if XY had more stable and consistent accommodation and carers, that would have led to an improved outcome.[1003] He stated that there had been no changes to the provision of accommodation since XY's death and that mental health services are never going to provide accommodation.[1004] While the provision of safe accommodation is an important factor in discharge from an in-patient unit or step-up/step-down facility, the responsibility of finding that accommodation and sustaining it resides with Child Protection.[1005]

645. This is because it is accepted medical practice that although a person presenting in an acute phase of suicidality might be admitted as an inpatient or subject to orders under the *Mental Health Act 2014* (now enacted as the *Mental Health and Wellbeing Act 2022),*[1006] if a person is experiencing ongoing and long-experienced chronic symptoms, it is usually not appropriate for them to reside long-term in an inpatient setting such as a hospital. Sadly, at the time of XY's interactions with mental health services, there were no therapeutic long-term residences available within the mental health system that could accommodate her.[1007]

646. Dr Krakouer summarised the complex interaction between carer supports, XY's mental health and accommodation instability as follows:

> The lack of support provided to XY's carers by Child Protection, in my opinion, exacerbated XY's mental health conditions because this lack of support contributed

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[1000] T 230:11-13.
[1001] T 230:13-15.
[1002] T 230:28 - 231.8
[1003] T 231:11-15.
[1004] T 231:16-25.
[1005] T 232:15-233:14.
[1006] And noting that, when necessary, appropriate orders were made, such as the Temporary Treatment Order (MR 7395) and Inpatient Assessment Order (MR 7391) made on 21 March 2021.
[1007] See FNID (fn 116) [284]; PR 1358.

in no small measure to multiple placements ending and the period of placement uncertainty and instability.'[1008]

647. Ms Lomas agreed with that analysis, albeit caveating her evidence with a reminder that she was not a clinician.[1009] Ms Lomas also clarified that XY would have experienced a fear of abandonment purely by virtue of the fact that she was in out-of-home care, although in her case this was also compounded by the complexity of her family dynamic.[1010] More generally, the profound personal impact of placement instability on XY was acknowledged by the DFFH witnesses in their statements.[1011]

648. In oral evidence, BDAC highlighted the importance of case workers having a 'plan B' in the event that a child's current placement is unsuccessful. Mr Widdicombe explained that BDAC's practice when case managing children aged around ten or above is to discuss the 'plan B' with the child, so as to provide a sense of stability from knowing where they are to live next if their current placement doesn't work out.[1012] Such discussions generally occur within the AFLDM process.[1013] This does not appear to be an approach used by DFFH, whose focus remains on 'stability for long-term arrangements' for children, [1014] but in his oral evidence, Mr Chapman accepted that this type of contingency planning made common sense.[1015]

649. In relation to expanding placement options, Ms Corin confirmed in her evidence that the 2023-24 State budget allocated funding to continue placements in 19 homes and fund six additional homes across the State which adopt a two- and three-bed therapeutic residential care model.[1016] Three of those are led by ACCOs.[1017] According to Ms Corin, the therapeutic homes engage educational, vocationalist, specialist skills coaches, as well as Aboriginal cultural support as guided by the ACCO in the non-ACCO led homes.[1018]

[1008] Statement of Jacynta Krakouer, CB 3732 [91].
[1009] T 639:3-13, T 641:28.
[1010] T 639:15-23.
[1011] Responsive report of Kirstie-Lee Lomas, CB 3624 [51]-[52]; Statement of Nathan Chapman, CB 3632 [46].
[1012] T 485:2-20.
[1013] T 485:22 – 486:1.
[1014] T 486:27-28.
[1015] T 486:25-26.
[1016] T 510:7-18; Exhibit E - Table of changes in relation to Child Protection policy and legislation (fn 644) 6.
[1017] T 510:17-18.
[1018] T 510:27 - 511:3.

The design takes into account the complex needs of children and young people in residential care and their experiences of trauma.[1019]

650. Ms Corin also affirmed that the Victorian Government will invest $100.4 million over four years to provide all children in residential care with access to therapeutic supports by 2025/26, thereby providing young people with more options for comprehensive support.[1020] While these therapeutic residential homes are *not* designed specifically to address mental health concerns, the KEYS (Keep Embracing Your Success) model is so intended.[1021] KEYS residences are homes for adolescents across the state with challenging behaviours or emotional or mental health issues, who are in or are likely to move into residential care.[1022] There are six such homes across in Victoria, one of which is ACCO-led, by VACCA.[1023] These are designed to 'provide culturally safe, trauma-informed… responses',[1024] and feature a 'multidisciplinary' team including a 'mental health worker, psychiatrist, drug and alcohol worker… community… and family engagement worker'.[1025]

651. As a service provider, Anglicare made the observation that the KEYS model of residential care service was useful but that access to resources and expertise, and a limited workforce, were issues in regional areas.[1026]

652. These improvements are vital because, as the weight of the evidence in this matter has confirmed, when a person experiences continual states of crisis due to a lack of stable accommodation, that person is unlikely to be able to engage with or benefit from psychological treatment that might otherwise assist in addressing the underlying trauma or conditions giving rise to distress and suicidality.[1027]

[1019] T 511:4-9.
[1020] T 512:16-23; Exhibit E - Table of changes in relation to Child Protection policy and legislation (fn 644) 6.
[1021] T 511:11-25.
[1022] T 511:20-25.
[1023] T 511:18-20; 513:7.
[1024] T 511:26-27.
[1025] T 511:26 - 512:3.
[1026] T 514:22-27, 515:7-17.
[1027] Statement of Ashlee Lougoon, CB 3272 [3.2]; Statement of John Cooper, CB 3269 [4.3]; Statement of Matthew Large, CB 3232 [309].

653. On these topics, BDAC was able to assist me with valuable lived experience insights. In closing submissions, BDAC endorsed[1028] the Yoorrook findings that:

a. the current residential care model is not culturally appropriate;[1029]

b. residential care staff are often ill-equipped to respond to the complex needs of children and young people with a history of trauma;[1030] and

c. Aboriginal-led services provide better holistic care to First Peoples children in out-of-home care and mitigate harms of child removal.[1031]

654. BDAC's Chief Executive Officer, Mr Widdicombe, elaborated:

> ...the missing link for us is a residential care model, not a residential care home. I have some experience with an ACCO led residential care model in Mildura, and the hardest part of that was there was one home. I think that it needs to be a model, so it can be balanced, and we can find where young people are suitable, rather than trying to put everyone in the one home.[1032]

655. In response to questions relating to improvements in residential care design going forward, he added:

> I think co-design's important, but I just want to emphasise that it's got to be Aboriginal-led. These are our children and a lot of the times our complexities that we need to work through. I think over particularly the last five years we've proven that we can do it, so I think it's really important for it to be Aboriginal-led. But also, I understand that it's hard to fund us for everything straight away and it takes a while for us to gather momentum, so where we can't be funded, I think co-design's super important.[1033]

656. Accordingly, I make the following recommendation.

[1028] BDAC Closing Submissions (fn 729) 3-5 [8].
[1029] Yoorrook Report 194.
[1030] Yoorrook Report 194-5; citing Commission for Children and Young People, 'Out of Sight: Systemic Inquiry into Children and Young People Who Are Absent or Missing from Residential Care' (Report, 2021) 94.
[1031] Yoorrook Report 197.
[1032] T 515:21-28.
[1033] T 358:11-21.

Recommendation 14

657. *That:*

   a. *the KEYS or like model of residential care services continue to be rolled out in regional Victoria and that such services for young Aboriginal and Torres Strait Islander people be developed in consultation with ACCOs such as BDAC;*

   b. *ACCOs be prioritised as the preferred organisation to deliver residential care in the tender process for allocating funding, with quality of care and best practice outcomes given a higher priority than economic rationalisation in the tender process.*

Towards more effective 'relational' case management[1034]

658. The Aboriginal Independent Expert Panel was highly critical of DFFH's case planning, case management and transition planning in relation to XY. They concluded it did not address XY's relational, cultural, therapeutic or wellbeing needs. Dr Newton said:

> DHHS's approach to XY's care was reactive, and placement-centred. As such the focus was always on solving the problem of XY having a placement, doing minimal active casework with XY, her family or carer in between, and then waiting for XY's 'complex needs' to become too much before requiring another placement. This approach took precedence over relationship focused practice which invested in the network of care to support XY in an ongoing way.[1035]

659. Dr Newton and Dr Krakouer expressed the opinion that DFFH's case management of XY was not in her best interests in the following specific ways:

   a. DFFH did not respond to early significant concerns for the family;

   b. did not provide any opportunities for XY to attend family counselling and did not re-establish contact with her mother or siblings while XY was in out-of-home care;

[1034] Scope of Investigation at [2(a), (g)], [7] and Scope of Inquest at [1], [2(a), (g)], [6].
[1035] Statement of BJ Newton, CB 3084 [46].

c. did not address XY's therapeutic needs for trauma relating to child sexual abuse;

d. did not prioritise XY's connection to culture and family while she was in care;

e. did not forward plan for XY's long-term stability and wellbeing;

f. did not adequately use the AFLDM model;

g. did not adequately support XY's carers; and

h. did not ensure that XY had access to culturally safe and sensitive supports throughout her admissions to hospitals and interactions with police.[1036]

660. In addition, Dr Krakouer opined that the 'best interests principles' and the 'decision-making principles' enshrined in sections 10 and 11 of the *CYFA* as it was at the time of XY's passing [1037] were not effectively upheld in XY's case. [1038] Dr Krakouer also expressed the opinion that the DFFH applied a narrow understanding of the Aboriginal and Torres Strait Islander Child Placement Principle (ATSICPP)[1039] by restricting its application only to placement decisions, thus ignoring the remaining four elements of prevention, participation, partnership and connection.[1040] Dr Krakouer acknowledged that this understanding of the ATSICPP reflected the narrow focus of sections 13 and 14 of the *CYFA* as it was at the time of XY's passing.

661. In closing submissions, the DFFH acknowledged that the Department's 'internal guidance has long recommended consideration of the other four principles'[1041], and noted that the new section 14 of the CYFA,[1042] which will commence on 1 July 2024, makes statutory provision for the four additional principles at the core of the ATSICPP:[1043]

[1036] Statement of BJ Newton, CB 3088-3098; Statement of Jacynta Krakouer, CB 3729-3730, [82].
[1037] Version No. 125, Version incorporating amendments as at 26 April 2021.
[1038] Statement of Jacynta Krakouer, CB 3722-3723 [52]-[55].
[1039] A framework designed to promote policy and practice to reduce the over-representation of Aboriginal and Torres Strait Islander children in the child protect system. See Australian Institute of Health and Welfare, https://www.aihw.gov.au/reports/child-protection/atsi-cppi-2018-19/summary. See also Clare Tilbury, 'The Aboriginal and Torres Strait Islander Child Placement Principle: aims and core elements' (June 2013) at https://www.snaicc.org.au/wp-content/uploads/2015/12/03167.pdf.
[1040] Statement of Jacynta Krakouer, CB 3722-3724 [52]-[59].
[1041] DFFH Responsive Submissions (fn 688) [79].
[1042] Amended by s 5 of the *Children and Health Legislation Amendment (Statement of Recognition, Aboriginal Self-Determination and Other Matters) Act 2023*, which received Royal Assent on 27 June 2023.
[1043] DFFH Responsive Submissions (fn 688) [78]; T 517:19-28.

> *Prevention principle*
>
> (1A) An Aboriginal child has a right to be brought up within the child's family and community.
>
> *Partnership principle*
>
> (1B) The Aboriginal community to which the child belongs and other respected Aboriginal persons have a right to participate in the making of a significant decision in relation to an Aboriginal child under this Act.
>
> (1C) Representatives of the Aboriginal community have the right to participate in the design and implementation of child protection and community services relating to Aboriginal children and their families under this Act.
>
> *Participation principle*
>
> (1D) The parents and members of the extended family of an Aboriginal child have a right to participate, and to be enabled to participate in an administrative or judicial decision-making process under this Act that relates to that child.
>
> *Connection principle*
>
> (1E) An Aboriginal child has a right to develop and maintain a connection with the child's family, community, culture, Country and language.

662. Ms Corin stated in her evidence that extensive work is currently underway within the DFFH in relation to 'training and readiness' to ensure that the further principles can be implemented from 1 July 2024.[1044] She added that the Beginning Practice Program's now engages with all five elements of the ATSICPP, as does the CRIS system.[1045]

663. During the inquest itself, the DFFH did not dispute Dr Krakouer's opinions regarding sections 10 and 11 of the *CYFA*, nor did they elicit direct contradictions from their own witnesses. Those witnesses did, however, provide the useful context that I have set out below. For the avoidance of doubt, on my part, I received Dr Krakouer's evidence as

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[1044] T 517:29-518:5.
[1045] T 517:5-18.

expert social work opinion, and not as any 'ultimate issue' legal conclusion on the appropriate statutory interpretation of any aspect of the *CYFA*.[1046]

664. The lack of effective case management and holistic, long-term planning was detrimental to XY.[1047] It was also inconsistent with a Social and Emotional Wellbeing framework, which is a more culturally appropriate approach to health and wellbeing for Aboriginal and Torres Strait Islander people.[1048]

665. In her evidence, Ms Lomas adverted to the possibility of incorporating the Social and Emotional Wellbeing Model, as advocated for by the AIEP witnesses, into the Looking After Children framework: the practice framework applicable to children in out-of-home care in Victoria.[1049] Such a synergy, Ms Corin considered, would accord Child Protection an 'opportunity… to automatically be thinking about the cultural needs of Aboriginal children very differently'.[1050]

666. The Aboriginal Independent Expert Panel was also critical of the 'ritualism' they observed in the manner in which child protection practitioners engaged in XY's case. Dr Newton described ritualism as follows:

> Ritualism is manifest through compliance, where caseworkers are so overwhelmed by performing to system requirements, that critical thinking and intuitive and active casework skills are often sidelined for automatic and 'tick-a-box' processes such as attending and notating meetings, and filling in forms. This extends to … sourcing [out-of-home care] placements reactively to a crisis or emergency removal. This is demonstrated clearly in XY's case.[1051]

667. In relation to XY's case specifically, Dr Newton observed that there were:

> [A] lot of emails back and forth, a lot of box-ticking, a lot of following policy, a lot of filling out forms, doing, you know what you're supposed to do … All of that

[1046] As the Department submitted I should: DFFH Responsive Submissions (fn 688) [81].
[1047] Statement of Jacynta Krakouer, CB 3729 [80].
[1048] Statement of BJ Newton, CB 3092 [74]. See also Statement of Pat Dudgeon on Social and Emotional Wellbeing, CB 3658-3660, 3670.
[1049] T 662:23 - 663:7.
[1050] T 663:2-7.
[1051] Statement of BJ Newton, CB 3080 [16].

> happened without actually deeply engaging in active case work ... specifically ... for the family that you're working with.[1052]

668. Similar observations were made by BDAC in relation to XY's care team. AL, XY's ACSASS worker during 2019, stated:

> I observed that the care team, unfortunately, operated within a confined mindset characterised by a narrow 'ticker' box mentality, placing disproportionate emphasis on assessment, safety and action planning, all while inadvertently neglecting the crucial aspects of cultural understanding or acknowledgement in XY's case. It deeply saddened me to witness how the care team's continuous reactivity and preoccupation with rigid protocols overshadowed the profound significance of incorporating more organic, culturally-rooted interventions and fostering genuine connections for XY.[1053]

669. Dr Krakouer agreed with these observations, adding that, in her opinion 'the bureaucracy and paperwork requirements of caseworkers can interfere with their ability to actually establish relationships with the people that they work with'.[1054] In addition, in her opinion, there was also a tendency by caseworkers to see the child as the primary client, whereas for Aboriginal and Torres Strait Islander children, in order to achieve the best outcomes 'it is crucial that you work with the whole family because children are not detached from their family and community context'.[1055]

670. For instance, when considering the role afforded to XY's mother, the Aboriginal Independent Expert Panel expressed the opinion that DFFH did not adequately consult XY's Mother on key decisions concerning XY, nor provide adequate support to XY's Mother to assist her in reaching decisions about XY's wellbeing, despite the legislative requirements of sections 10 and 11 of the *CYFA*.[1056]

671. For its part, the DFFH acknowledged in its evidence various constraints, including time pressures and statutory reporting requirements, on Child Protection Practitioners' ability

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[1052] T 94:17-26.
[1053] Statement of AL, CB 3264 [28].
[1054] T 96:5-9.
[1055] T 96:16-26.
[1056] Statement of BJ Newton, CB 3105-6 [135]-[139]; Statement of Jacynta Krakouer, CB 3738-3741 [110]-[118] & [123]-[129].

to cultivate and maintain deep relationships with the children in their care and their families.

672. In response to questioning about the prioritisation of and engagement in longer-term strategic planning in XY's case, Ms Lomas discussed the shortcomings of what she described as 'compliance-driven casework', being the 'tension that exists for practitioners in terms of spending the time with children and families, that they come to the work to do, and the administrative requirements… in terms of recording'. [1057] Ms Lomas expressed the view that 'Child Protection Practitioners are… bound by too many procedures'.[1058]

673. Ms Lomas acknowledged the importance of enabling its practitioners to work in a way that is consistent with the relational approach, which, in relation to Aboriginal children and young people, DFFH accepted was key to providing culturally connected care.[1059] However, Ms Lomas also highlighted the importance of ensuring that the administrative and recording components of a caseworker's role are undertaken,[1060] some of which are required by statute. She added that the Client Relationship Information System 'holds part of the life story of… children and young people who are known to Child Protection in Victoria'.[1061]

674. In response to questions I asked, Ms Lomas agreed that better staffing levels, retention rates and experience of Child Protection staff would foster the adoption of relational approaches and would, in turn, counteract compliance-driven casework. [1062] Indeed, increasing staff levels seems to be an obvious way to improve Child Protection Practitioners' capacity to form better relationships with the young people it is manifestly trying to help.

675. Counsel Assisting made the closing submission that there is something fundamentally wrong with the Victorian child protection system if practitioners (however hardworking and well intentioned they are) are so focused on the ritualistic or compliance driven

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[1057] T 467:14-21.
[1058] T468:5-7.
[1059] T 364:4-26; DFFH Responsive Submissions (fn 688) [33].
[1060] T 467:22-25.
[1061] T 467:28-30.
[1062] T 365:24 - 366:1.

aspects of their work, that they are unable to engage in meaningful casework and build relationships with children and their families.[1063] They further submitted that this fundamental problem further highlights the importance of child protection services being provided to Aboriginal and Torres Strait Islander children and families by ACCOs and the Aboriginal and Torres Strait Islander community.[1064]

676. Although the DFFH conceded that there are, at times, limitations which prevent practitioners from developing the kind of rapport which they would establish and nurture in an ideal world, it took issue with the proposition put by Counsel Assisting that there is something 'fundamentally wrong' with the Victorian child protection system. They submitted that the very system, which provides care to some of the most vulnerable children, situated in some of the most complex families in the state, is staffed by a professionally qualified, dedicated group of Child Protection Practitioners who work tirelessly to achieve positive outcomes for the children and the broader community. Without the efforts of these workers, most of these vulnerable children would not be as safe. The submission concluded that while the DFFH accepts, and indeed welcomes, constructive recommendations, it vigorously refutes any unwarranted criticism of the Child Protection Practitioners, who strive to keep Victorian children safe.[1065]

677. From my vantage point, both submissions are correct. My Counsel Assisting were referring to the results being generated by the system itself, and not to the motivation nor performance of any individual Child Protection staff members. For that reason, I have made the recommendation[1066] that the child protection system should be staffed at appropriate levels to allow them to achieve the Department's expressed preference for relational case management with the young people and families they are charged with helping.

[1063] Counsel Assisting the Coroner, 'Counsel Assisting's Closing Submissions' (8 December 2023) [89]. ('Counsel Assisting Closing Submissions')
[1064] Ibid.
[1065] DFFH Responsive Submissions (fn 688) [60].
[1066] See *Recommendation 16* below.

Connection with family and Aboriginal Family-Led Decision Making[1067]

678. The Aboriginal Independent Expert Panel was also highly critical of DFFH for their failure to facilitate connections between XY and her family, and their failure to adequately utilise the Aboriginal Family-Led Decision Making ('AFLDM') model. The Panel was also critical of their treatment of XY's mother.[1068]

679. Despite the complicated relationship that existed between XY and her mother, the Aboriginal Independent Expert Panel identified many missed opportunities for DFFH to have facilitated contact between XY and her siblings, mother and grandmother.[1069]

680. One such occasion was when XY's Mother asked DFFH to provide XY with a ring on her behalf. Approximately one month later, XY wrote a letter to her mother. Despite this clear opportunity for reconnection, the AIEP opined that DFFH took a paternalistic view and decided to ignore the expressed wishes of the family when they decided not to give XY's letter to XY's Mother because it would be too detrimental to XY's Mother's mental health.[1070]

681. Another opportunity for reunification was during the two years from May 2018, when XY's stepfather had moved out of the family home. During this time, XY's Mother made multiple attempts to reconnect with XY despite the sexual abuse allegations.[1071]

682. Mr Chapman conceded that there were missed opportunities to encourage and foster XY's relationships with significant adults in both her maternal and paternal families and that the Department should have worked more strongly to preserve XY's family connections despite the challenges that existed.[1072] Such concessions also featured in his written statement.[1073]

683. In his oral evidence, Mr Chapman went on to describe the challenging context with which the DFFH was confronted. Mr Chapman explained that 'Child Protection needs to

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[1067] See Scope of Investigation at [1(e)], [2(a)] and Scope of Inquest at [2(a)], [2(h)(ii)].
[1068] T 51:14-52:13, T 53:2-26; 85:27-92:28.
[1069] T 85:27 - 92:28; Statement of BJ Newton, CB 3088-3092 [66]-[71].
[1070] T 89:24 - 90:14.
[1071] T 172:19 – 173:5.
[1072] T 519:7-25.
[1073] Statement of Nathan Chapman, CB 3633 [54].

strike… a careful balance… between the competing tensions of XY's connection to family, which is absolutely a protective factors (*sic*),… on many, many fronts but also protecting her from further harm', here referring to evidence concerning her likely feelings of abandonment and the invalidation of her claims of child sexual assault.[1074] The delicate nature of this balancing exercise was also described in Mr Chapman's written statement, where he observed that although 'the Department should have made better efforts to engage XY's family', a 'fundamental distrust of the Department, coupled with complex family dynamics, made this extremely difficult'.[1075] However, Mr Chapman accepted that when XY's mother did seek contact with XY, the DFFH 'should have dropped everything' in order to facilitate this.[1076]

684. Mr Chapman's assessment was that, in managing the 'competing tensions… Child Protection had swung too far in one direction at the expense of another direction and the benefits… that sat at the other end of that spectrum.'[1077] He added that navigating the evolving dynamics in XY's family was far from straightforward, stating 'I think the dynamic was changing… on a very regular basis. So… how that tension was being balanced on one day would probably look very different on another day.'[1078]

685. The only AFLDM meeting held in relation to XY occurred on 13 March 2019,[1079] some 18 months after XY was removed from her family home. Child Protection case notes indicate that XY's Mother told Child Protection that she wanted an AFLDM when XY was first taken out of her care, not in early 2019.[1080] This led to the first AFLDM going ahead without XY's Mother. The closing submissions on behalf of XY's Mother reflect that, in her view, this delay set up a wall between her and XY, which she feels made XY think she did not have a mother.

686. A further AFLDM was planned for three months later[1081] but never occurred.

[1074] T 521:2-10.
[1075] Statement of Nathan Chapman, CB 3633 [54].
[1076] T 521:11-15; T 690:7-9.
[1077] T 521:26-30.
[1078] T 522:2-5.
[1079] PR 3391, MR 1150.
[1080] PR 3567.
[1081] PR 3391; MR 1150.

687. The Aboriginal Independent Expert Panel expressed the opinion that, had the AFLDM model been used appropriately, it could have been utilised:

a. prior to XY's removal, to support XY to remain in the family home;

b. following XY's removal, to involve the family in coming up with potential solutions for respite options, multiple carers or provision of carer support;

c. to enlist further support from the Wemba Wemba community;

d. to provide for or establish plans for sibling contact, including by having the siblings attend a meeting;

e. to enable forward planning; and/or

f. to establish family counselling.[1082]

688. In closing submissions, XY's Mother agreed with the AIEP's observation that 'the absence of family for an AFLDM] meeting…signals that the process is not family-led'.[1083] She agreed with BDAC that a more flexible approach should be adopted in terms of how and when AFLDMs take place.[1084] Further, and in line with the evidence of the AIEP,[1085] XY's Mother submitted that I should consider making a recommendation to loosen referral criteria so that other agencies, not just the DFFH, are able to make referrals for AFLDMs, including, most importantly, ACCOs that have been delegated powers pursuant to section 18 of the *CYFA*. I am persuaded that there is merit in making that recommendation.

Recommendation 15

689. *That DFFH extend AFLDM referral powers to organisations providing contracted case management services to DFFH and to ACCOs exercising delegated powers pursuant to section 18 of the CYFA.*

[1082] T 98:1 – 99:4.
[1083] T 105:16-19; XY's Mother Final Submissions (fn 660) [30]-[31].
[1084] T 538:5-11, 540:9 – 541:25; XY's Mother Final Submissions (fn 660) [33].
[1085] T 75:11 – 76:3.

690. With reference to the minutes of the AFLDM meeting held on 13 March 2019,[1086] the Aboriginal Independent Expert Panel also expressed the opinion that the manner in which the AFLDM was conducted, particularly in relation to the opening indication by DFFH as to the Department's 'bottom line', was 'quite culturally inappropriate and insensitive to the family in the spirit of an AFLDM'.[1087]

691. BDAC gave evidence that, in their experience, Child Protection frequently commenced the meeting by referring to DFFH's bottom line, which BDAC agreed was culturally inappropriate.[1088] BDAC also emphasised that AFLDM meetings should be less formal, provide an opportunity for the family to have a yarn and be led by the Elders present.[1089] BDAC highlighted the need for a flexible approach to be adopted in terms of where and how AFLDM meetings take place, in order to encourage young people and families to participate in their own AFLDMs. An example was given of AFLDMs being conducted around the fire pit at BDAC.[1090]

692. Yoorrook also found that AFLDM meetings were often not held, held late or not culturally safe.[1091] Yoorrook recommended that DFFH 'urgently take steps to ensure full compliance with its obligations to convene an Aboriginal Family Led Decision Making meeting before making any significant decision about an Aboriginal child, and record the outcome'.[1092]

693. The DFFH acknowledged in evidence that XY's first AFLDM meeting should have been held much sooner, and that the 18 months which elapsed between the date XY was placed in out-of-home care and the date of the first AFLDM meeting represented a lengthy delay.[1093]

[1086] PR 3391-3392.
[1087] T 100:3-18.
[1088] T 526:21-23.
[1089] T 527:9-30, 528:17-21
[1090] T 538:5-11, 540:9 – 541:25.
[1091] Yoorrook Report158.
[1092] Yoorrook Report 32, Recommendation 16(a).
[1093] T524:19-25.

694. As to whether it is commonplace to have 'bottom lines' in an AFLDM meeting, DFFH supplied the Court with the AFLDM Guidelines of July 2019. [1094] Those Guidelines provide that 'During the consultation, the child protection practitioner will need to provide […]'clarification of minimum requirements that will promote the child's safety, wellbeing and development and key issues that are to be addressed through AFLDM', which are 'often referred to as bottom lines'.[1095] While the phrase could be expressed in a more culturally sensitive way, the material illustrates that the purpose of these 'bottom lines' is to centralise the interests of the child throughout the AFLDM process and to focus participants' attention on the objectives of the process. Relevantly, the Department's responses to questions on notice also confirmed that the Guidelines were developed in consultation with Aboriginal people and organisations. [1096] Further, the Guidelines reflect the DFFH's clear recognition that the role of Aboriginal Elders in the AFLDM process is 'critical and integral' to the design of the AFLDM forum in any particular child's case.[1097]

695. DFFH witnesses gave evidence of several local and State-wide initiatives since XY's passing that are aimed at improving the uptake of AFLDM processes for Aboriginal children and young people. First, Mr Chapman referred to his earlier evidence[1098] about strengthening collaboration between ACCOs and Loddon Area Child Protection, including through co-location.[1099]

696. Second, Mr Chapman referred to the creation of an additional AFLDM practice leader position in April 2022 (which is identified for Aboriginal applicants only).[1100] He added that AFLDM practice leaders now receive automated CRIS alerts when a substantiation of harm is recorded in a case, thereby notifying the practice leader that an AFLDM is required in a 'really timely way'.[1101] Upon receiving the alert, the AFLDM practice leader arranges a consultation with the Child Protection Practitioner and the case planner

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[1094] Attachment 1 to Exhibit M - DFFH responses to questions on notice (3 November 2023): 'Program guidelines for Aboriginal family-led decision making (AFLDM) – Including program requirements and practice guidance (July 2019). ('AFLDM guidelines')
[1095] Ibid 19.
[1096] Exhibit M - DFFH responses to questions on notice (3 November 2023) [10].
[1097] AFLDM Guidelines (fn 1092) 23-24.
[1098] T 442:28 – 443:15.
[1099] T 531:21.
[1100] T 531:27-30.
[1101] T 532:1-6.

to prepare for AFLDM.[1102] Mr Chapman acknowledged that the streamlined CRIS alert system is only activated upon initial substantiation, but explained that AFLDM practice leaders continue to have opportunities for input at later stages in Child Protection's involvement, such as by participating in the reunification collaborative panel, the High Risk Youth Panel, the intensive infant response panel and undertaking reviews of AFLDM activities.[1103] Mr Chapman noted that, additionally, the specialist Aboriginal Children in Aboriginal Care position supervises the 'AFLDM process and the timeliness of it'.[1104]

697. Mr Chapman also agreed with AL's view that the AFLDM process should permeate the life of a case, 'particularly at key decision-making points.' [1105] He confirmed that systematising CRIS alerts throughout the life cycle of Child Protection's intervention, and especially at critical junctures in the case, would be helpful. [1106] On this point, Ms Lomas reflected that careful consideration needs to be given to economising and prioritising alerts, as they are more readily dismissed when too abundant.[1107]

698. Ms Corin outlined a number of statewide strategies aimed at improving uptake of AFLDM procedures. Ms Corin explained that since January 2022, one focus of the suite of *Wungurilwil Gapgapduir* [1108] reporting requirements has been compliance with AFLDM obligations.[1109] Ms Corin stated that DFFH recognises that there is 'work that we need to do' about the consistency of that reporting, and that work commenced in late 2022 to analyse the 'reporting mechanism and also to look at a refresh of the AFLDM guidelines'.[1110] She added that this work has been paused while the Yoorrook Justice Commission is underway.[1111]

[1102] T 532:28 – 533:1.
[1103] T 533:2-14.
[1104] T 532:8-14.
[1105] T 532:21-22.
[1106] T 533:16-26.
[1107] T 534:10-15.
[1108] *Wungurilwil Gapgapduir* (fn 641). Implementation of *Wungurilwil Gapgapduir* is overseen by the Aboriginal Children's Forum which comprises representatives from Victoria's ACCOs, Community Service Organisations and the Victorian Government: Statement of Simone Corin (4 November 2022), Appendix A, CB 2051 [6].
[1109] T 534:25-535:2.
[1110] T 535:3-11.
[1111] Ibid.

699. Ms Corin also outlined how the transfer of decision-making authority to ACCOs, including in respect of AFLDMs, could enhance AFLDM outcomes by providing more opportunity for local decision-making, and added that 'there is some work that is being done at the moment to look at how the… model might be better… considered in an… integrated… manner locally.'[1112] Ms Corin identified Njernda and Goolum Goolum as examples of ACCOs undertaking AFLDM during the intake phase. She stated that this initiative 'is showing promise' in its capacity to divert children from entering out-of-home care. [1113] Ms Corin also confirmed that the Department is considering a recommendation from the Yoorrook Justice Commission Interim Report that AFLDM and ACSASS should be engaged earlier in Child Protection's involvement.[1114]

Early Intervention and Improving Case Management Practices for Aboriginal and Torres Strait Islander Children and Young People

700. Raylene Harradine, who provided a statement on behalf of BDAC as their former CEO, gave the following evidence to the Yoorrook Justice Commission:

> When a First Nations family comes to the attention of the Department, it is crucial to provide wrap-around, supportive services immediately to guarantee a coordinated response that meets their needs. In the initial stages, implementing structured, supportive services pre-emptively can help prevent the need for invoking statutory child protection measures. [1115]

701. Yoorrook, at recommendation 8(a), has called for the Victorian Government to 'work with Aboriginal organisations to develop a consistent definition of early help, early intervention and prevention that aligns with the perspectives of First Peoples'.[1116] This inquest was illustrative of the need for culturally appropriate, resourced and targeted intervention for a Wemba Wemba family.

[1112] T 535:12-25; Exhibit E - Table of changes in relation to Child Protection policy and legislation (fn 644) item (B).
[1113] T 536:3-12.
[1114] T536:17-23; see also Yoorrook Report 32, Recommendation 16.
[1115] Yoorrook Report (fn 17) p. 131; citing Witness Statement of Raylene Harradine to the Yoorrook Justice Commission (29 May 2023) 6 [30].
[1116] Yoorrook Report 29, Recommendation 8(a).

702. The Aboriginal Independent Expert Panel ('AIEP') also identified the need for greater investment in prevention and early intervention responses carried out by Child Protection. This is to ensure that the system is not overwhelmed at the tertiary end of the service spectrum, at which point it operates in a 'crisis mode' like it did when managing XY.[1117]

703. XY's Mother submitted that XY her family were crying out for early intervention and support, but that despite being an at-risk family, they never received it. She further submitted that much of what followed would likely have been avoided with appropriate intervention prior to XY being removed.[1118] It is apparent to me that spending money early on and supporting families to stay together is more likely to avoid tragic outcomes. Pragmatically, it is also more cost-effective than waiting until a child is separated from family and culture, and in crisis.

704. Finally, XY's Mother submitted that I should also explicitly endorse recommendation 8(a) from the Yoorrook Justice Commission, and that any recommendation endorsing it should note that a definitional agreement of 'early intervention' with First Nations communities should be met with concomitant funding. This is to ensure that early intervention services delivered by ACCOs are appropriately resourced to deliver for their communities.[1119]

705. In relation to early interventions, the DFFH submitted that while Child Protection had limited interaction with XY's family in respect of several — especially early — reports, the Department witnesses explained in evidence that this is referable to the design of the Victorian Child Protection system.

706. Mr Chapman explained that Child Protection is the 'statutory part' of a spectrum of services delivered by the Children and Family Service System: [1120] '[i]t's the very… tertiary part of the system, and there's an entire range and suite of other services,… universal or primary services,… that are in place hopefully to prevent families coming into contact with the statutory component of the system.' [1121] In addition to these mainstream supports, Mr Chapman identified that there are 'targeted or secondary

[1117] T 93:18, T 93:25 – 94:1.
[1118] XY's Mother Final Submissions (fn 660) [39].
[1119] Ibid [42].
[1120] T 340:29.
[1121] T 340:29 – T 341:1-5.

services which include parenting and family services, and those that respond to specific needs, including family violence, socio-economic disadvantage, housing disability, alcohol and other drug use, etc.'[1122] Accordingly, responsibility for family support service provision by the Victorian Government 'does not sit entirely' with the DFFH.[1123]

707. Mr Chapman also explained that Child Protection does not have contact with the family the subject of a report[1124] at every phase of its process. He described the six separate phases of intervention:

   a. consultations under section 38 of the *CYFA*, which are conducted through community-based teams;[1125]

   b. intake phase, which is a state-wide 'triaging and assessment phase to decide whether or not further assessment was required', and involves no direct contact with the family;[1126]

   c. investigation, which is where 'the first home visit occurs', and the assessment of the investigation, which involves a determination of whether the risk of harm is substantiated and, if so, potentially the filing of a protective application in the Children's Court (at this stage sections 10-14 of the *CYFA* apply);[1127]

   d. protective intervention, in which the case is transferred to a case management team following the making of an interim or final order by the Children's Court, with the child either remaining in parental care or entering out-of-home care (if the latter, kinship care is preferred);[1128] and

   e. closure, which is a 'case planning activity and often includes the development of a community plan to ensure supports are in place and scaffold around the

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[1122] T 341:9-14.
[1123] T 341:8.
[1124] Under s 28 or 29 of the *CYFA*.
[1125] T 342:24 – T 343:3.
[1126] T 343:16-24.
[1127] T 343:25 - T 345:9.
[1128] T 345:10-20.

family and child… to continue after Child Protection has ceased its involvement.'[1129]

708. Mr Chapman's evidence on this point supplies helpful context to the evidence of the AIEP to the effect that the DFFH should have referred XY's Mother and XY's family to universal services, such as playgroups, earlier in the course of their interactions.[1130] According to Mr Chapman, while it is 'absolutely' a part of Child Protection's role to offer such referrals,[1131] Child Protection was not in 'direct contact with the family' in respect of the nine earliest reports which were closed at intake phase.[1132] Mr Chapman also observed that 'the universal system itself has referral pathways and mechanisms … for families that might be experiencing vulnerability at different points'.[1133] Mr Chapman stated that whereas the Child Protection system sits at the 'crisis end' of interventions, the goals of early intervention and prevention are primarily achieved by the 'entire child and family wellbeing system that sits before it.'[1134]

709. Ms Corin's further table of mental health and wellbeing initiatives[1135] outlined some more recently available supports for children and families, many of which are led by the Department of Health:

   a. Children's Health and Wellbeing Locals, which 'provide access to multidisciplinary paediatric health, mental health and family services for children aged 0-11 years who are experiencing developmental, emotional, relational and behavioural challenges, and their families', and which include group-based parenting programs;[1136]

   b. Group-based parenting programs within Child and Youth Area Mental Health and Wellbeing Services, which seek to 'build the skills and confidence of

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[1129] T 346:23 – T 347:5.
[1130] T 62:4-13.
[1131] T 690:28-29.
[1132] T 691:6-7. The nine reports which were closed at intake phase included the reports of 19 October 2007, 1 September 2010, 12 June 2012, 7 May 2014, 14 April 2015, 29 June 2915, 4 February 2016, 14 August 2016, and 12 April 2017.
[1133] T 691:7-11.
[1134] T 691:15-18.
[1135] Exhibit E – Further table of mental health and wellbeing initiatives' (fn 839).
[1136] Ibid 1, item (A).

parents to support children experiencing mental health and wellbeing challenges';[1137]

c. The Statewide Child and Family Centre, which provides 'subacute, residential services for families with a child aged 0-11 years who is experiencing major behavioural, emotional and relationship difficulties', through 'flexible, family-centred therapy and support from child and family mental health specialists';[1138] and

d. Early Help Family Services, which deploy family services practitioners within universal services, including schools, early childhood services and health services 'to identify and engage families with emerging needs', and involve provision of 'individualised and group-based support such as parenting education and support groups'. Early Help Family Services are delivered in all 17 of the DFFH's areas, including seven sites where ACCOs are providing leadership or partnership to trial programs.[1139]

710. The DFFH also gave extensive evidence about a broad range of other case management improvements that have been initiated since XY's passing.

Child Protection Manual redesign

711. Ms Lomas gave evidence of a proposed redesign of the Child Protection Manual, an outward-facing document which was originally introduced in 2005 and contains statutory requirements, policy, process guidance and support for Child Protection Practitioners. Ms Lomas considered that such a redesign could assist with addressing 'compliance-driven' casework and the concerns expressed by the AIEP around 'ritualism'. Ms Lomas explained that in early 2023, the DFFH engaged an independent contractor to 'design a future blueprint for the manual…. with the aim of clearly defining the role of the Child Protection… practitioner and their functions, to be more accessible and contemporary

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[1137] Exhibit E - Table of changes in relation to Child Protection policy and legislation (fn 644) 2, item (F).
[1138] Ibid item (G).
[1139] Ibid item (H).

and meaningful… to children and their families,'[1140] and with a view to creating a manual 'that is culturally aligned and promotes self-determination for Aboriginal people'.[1141]

712. Ms Lomas confirmed that the redesign process involved consultation with Community Service Organisations through the Centre for Excellence in Child and Family Welfare, and with ACAC providers through the Aboriginal Initiatives Unit within the DFFH.[1142] She also confirmed that the proposed changes are likely to 'reduce the volume of paperwork' which Child Protection Practitioners are obliged to complete, and agreed with my observation that the redesign seeks to 'streamlin[e]' compliance with statutory record-keeping 'without jettisoning its key function'.[1143]

713. At this stage, the business case is being developed and government investment would be required to support the redesign of the child protection manual consistently with the blueprint developed.[1144]

High-Risk Youth Panel

714. In response to questions about the effectiveness of the Child Protection High-Risk Youth ('HRY') Panel, Mr Chapman gave evidence that, in XY's case, the 'panel at that time was operating in the way it's designed'.[1145] Specifically, he stated, it was 'undertaking the type of collaborative role of bringing together… external agencies with the [D]epartment to really look at the risk issues and the planning.'[1146] Mr Chapman went on to explain that the HRY Panel has 'a geared approach', with an 'internal facing conversation to scope which children would go to the external facing panel', and identified that XY's case passed through that process several times.[1147]

Multi-Agency Senior Governance Meetings

715. DFFH witnesses also gave evidence about the introduction, in December 2021, of 'multiagency senior governance meetings' facilitated by Loddon Child Protection, which

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[1140] T 469:1-7.
[1141] T 469:15-17.
[1142] T 470:11-17.
[1143] T 471:14-T472:16.
[1144] T 470:30 – 471:2.
[1145] T 466:30 – 467:1.
[1146] T 466:24-29.
[1147] T 467:2-6.

are able to be convened 'as and when required' in relation to young people living in residential care who present with the most complex and high-risk behaviours. [1148] Mr Chapman stated that these meetings are not a regular process, but a 'mechanism that we initiate… for probably the most top-tier children… where the system is stuck'.[1149] and are able to be initiated 'to bring the most senior people from the sector and government together to really problem-solve some of the wicked issues that the system is grappling with'. Since XY's passing, three such meetings have been convened.[1150]

716. Mr Chapman explained that the forum is a 'highly authorised environment… where we have… all of the levers possible available to us that we can activate… to find alignments between systems, to find where we… might have to think creatively or activate funding to make something happen.'[1151] This can involve attendance and contribution of external medical experts. [1152] Mr Chapman confirmed that XY's case 'would have been… absolutely in scope for that sort of response.'[1153] As to acquiring insight into whether a particular child's case involves the kinds of features warranting this kind of intervention, Mr Chapman described how 'mechanisms like the High-Risk Youth Panel, and also our client incident management system, CIMS, is also mechanisms (*sic*) that we use to review and to give us windows into these sorts of triggers.'[1154]

717. Mr Chapman also confirmed that subcontracted service providers can initiate a meeting of the Multi-Agency Senior Governance network.[1155]

Loddon Area's Local Site Executive Committee

718. Additionally, Mr Chapman gave evidence about the cross-government Local Site Executive Committee. The initiative 'operates at a senior level to bring together key government agencies and… sector colleagues… to look at the system issues… in that

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[1148] Statement of AW, CB 2034-2035 [28]-[29]. The DFFH noted by way of clarification that the Multi-Agency Senior Governance Network is a Loddon Area initiative, and is available in respect of all children within the Department's care, not only those in residential care: DFFH Responsive Submissions (fn 688) 31 [66].
[1149] T 476:4-8.
[1150] T 476:1-18. See also T 475:20 – 479:9.
[1151] T 476:19-24.
[1152] T 477:8.
[1153] T 476:16-18.
[1154] T 480:13-17.
[1155] T 481:4-15.

area.' [1156] The Loddon Area's Local Site Executive Committee also comprises representation from BDAC, Njernda, Anglicare and MacKillop Family Services. [1157] Mr Chapman indicated that the purpose of the Committee is not to consider individual cases, but to 'look at the systems issues to find better alignments and better opportunities for streamlining and for… better outcomes for people.'[1158]

Care Hub model

719. The Care Hub model was also examined in the context of case planning and management. Ms Corin explained that the model is being piloted in Loddon Area, and involves a 'multi-disciplinary, multi-agency team' providing 'early assessment, planning and wrap-around supports to children and young people who are first time entrants into care.'.[1159] Agencies involved include Anglicare (as the lead agency), Bendigo Community Health Services, the Salvation Army, YSAS, Berry Street, BDAC and Njernda, [1160] The 'primary objectives' of the model include family reunification, reducing time spent in care, and promoting placement stability.[1161] Ms Corin gave evidence that 53 of the 163 clients who had utilised the Care Hub to date were Aboriginal children, 16 of whom had returned home by the time their case with the program closed.[1162]

Wungurilwil Gapgapduir

720. Ms Corin also gave evidence that Child Protection have implemented a number of structural improvements to its approach to case management in respect of Aboriginal children. Ms Corin described *Wungurilwil Gapgapduir*: a tripartite agreement between the 'Aboriginal community, Government and the child and family services sector to commit to better outcomes for Aboriginal children and young people and increase Aboriginal self-determination… to ensure that all Aboriginal children and young people

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[1156] T 487:19-22.
[1157] T 488:1-2.
[1158] T 488:7-15.
[1159] T 492:7-14.
[1160] T 492:25-493:7.
[1161] T 492:15-24.
[1162] T 501:22-25.

are safe, resilient and can thrive in culturally rich and strong Aboriginal families and communities'.[1163]

721. Ms Corin noted that a new strategic action plan was developed to implement the objectives of the program for the period of 2021-2024, with associated funding.[1164] Ms Corin's stated that the realisation of *Wungurilwil Gapgapduir* to date has seen 'the expansion of… children authorised to Aboriginal agencies [pursuant to the Aboriginal Children in Aboriginal Care program under section 18 of the *CYFA*]… as well as… the progression of Community Protecting Boorais'.[1165] Ms Corin observed that 'there is significant variation across the state in terms of readiness of ACCOs'. [1166] She also referred to early intervention and support initiatives including the 'rapid response and diversion programs' funded through the Department, and to 'trialling the AFLDM process at an earlier point'.[1167] Ms Corin's reflection was that if those initiatives had been available to XY, many would have been 'of assistance', particularly cultural connectedness through an ACCO.[1168]

Community Protecting Boorais

722. Ms Corin also detailed a pilot program known as Community Protecting Boorais, which facilitates Aboriginal-led investigation of Aboriginal children and young people reported to Child Protection. The pilot, which was enabled by the passing of the Children and Health Legislation Amendment (Statement of Recognition, Aboriginal Self-determination and Other Matters) Bill 2023 (Vic), which modified section 18 of the *CYFA* to allow ACCOs to support Aboriginal children and families as soon as a report to children protection is made. In the 2023-24 State Budget, the Victorian Government invested $13.7 million to expand the pilot of the Community Protecting Boorais for up to 348 children by 2026-27.[1169] Ms Corin noted that the pilot commenced in October 2023, 'so it is too early to tell… the outcomes that we will see from that.'[1170] However,

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[1163] Statement of Simone Corin (4 November 2022), Appendix A, CB 2050-2051 [3]; see also *Wungurilwil Gapgapduir* (fn 641).
[1164] T 502:12-21.
[1165] T 502:22-28. See also [737] of these Findings.
[1166] T 503:14-15.
[1167] T 503:20-30.
[1168] T 504:3-7.
[1169] Exhibit E - Table of changes in relation to Child Protection policy and legislation (fn 644) 2, item (B) and 5, item (F).
[1170] T 504:15-24.

as Ms Corin observed, 'that's a significant… piece that has been undertaken and led by the ACCOs and really brings Aboriginal ways of working, and a relational approach to working with the children and families.'[1171] According to Ms Corin,[1172] the expanded authorisation of ACCOs under section 18 could have significantly improved the approach taken in XY's case because it enables 'engagement at the earliest point… post-notification of… a Child Protection report [following intake].'[1173]

Family Preservation and Reunification Response

723. Finally, Ms Corin described the development of the Family Preservation and Reunification Response, which commenced in respect of Aboriginal families in August 2021, with delivery provided by ACCOs. The program consists of a 'range of… modules', which seek to 'restore fractured and fragmented relationships, healing… from trauma', with a 'relational approach to practice' as a 'a key element.'[1174] The program deploys 'dedicated child protection navigators' who identify children likely at risk of entering out-of-home care, and then work alongside family services and child protection to mitigate that risk (to achieve the goal of preservation).[1175] The navigators also work towards reunifying families with children already in out-of-home care.[1176] The program is structured with a 'lead practitioner who then works with the family and brings that together.'[1177] Ms Corin observed that the program has been evaluated and, since its inception, has seen 14% fewer Aboriginal children in care.[1178]

Recommendation to support ongoing improvement of case management and case planning practices[1179]

724. While I was attempting to draw together the prevention opportunities relating to Child Protection's case management practices, the interested parties were afforded an

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[1171] T 504:15-24.
[1172] Note, the transcript indicates that this evidence was given by Ms Argiropoulos, but that is an error.
[1173] T 505:18-22, noting that the transcript erroneously indicates that this evidence was given by Ms Argiropoulos.
[1174] T 505:25 - 506:16-17.
[1175] T 506:17-23.
[1176] T 506:6.
[1177] T 506:23-25.
[1178] T 506:26 – 507:1.
[1179] See Scope of Investigation at [2] and Scope of Inquest at [2].

opportunity to consider recommendations proposed by my Counsel Assisting in closing submissions.[1180] These included the following:

> **Recommendation [X]**: Noting Yoorrook's recommendation that the Victorian Government 'transfer decision making power, authority, control and resources to First Peoples, giving full effect to self-determination in the Victorian child protection system', [1181] in our submission, your Honour should consider making a recommendation that DFFH significantly upscale the capability, competence and support of all persons working within the child protection system to ensure that they are able to:
>
> a) comply with sections 10, 11, 12, 13 and 14 of the *Children, Youth and Families Act 2005*;
>
> b) adopt a relational approach to child protection work which prioritises the practitioner's ability to relate to the child and their families over compliance-driven measures; and
>
> c) engage in effective case management and case planning, including long-term planning and transition planning.
>
> In particular for this purpose, DFFH should:
>
> d) review and revise all relevant policies, procedures, guidelines and like documents;
>
> e) review and revise all relevant training courses and programs; and
>
> f) ensure, to the greatest extent possible, that it has appropriate staffing levels and is able to retain experienced child protection practitioners.

725. Significantly, this recommendation was supported by XY's Mother and BDAC.[1182]

726. The DFFH submitted that the proposed recommendation was broad in scope and ambiguous in its guidance. They submitted that:

[1180] Counsel Assisting Closing Submissions (fn 1063) [92].
[1181] Yoorrook Report 26, Recommendation 1.
[1182] XY's Mother Final Submissions (fn 660) [35]; BDAC Closing Submissions (fn 729) [1]-[2].

a. by virtue of the Department’s executive mandate, it is already responsible for ensuring the competence and capability of its staff to comply with statutory obligations, adopt a best-practice relational approach, and engage in effective case management;

b. the training programs described in evidence and submissions were indicative of the extensive resources and supports already delivered to Child Protection staff; and

c. implementation of the recommendation would be unnecessarily repetitive.[1183]

727. Finally, the Department submitted that this recommendation is excessively goal-oriented and somewhat idealistic, in that it overlooks the myriad obstacles to recruiting and retaining experienced Child Protection Practitioners, many of which are beyond the control of the Department. The DFFH also noted that it has already developed internal strategies to improve recruitment and retention outcomes within Child Protection.

728. The Department’s work shows a considered commitment to improving Child Protection case management of Aboriginal children, and that is to be commended. However, many of the improvements described above and in evidence were so new at the time of the hearing and closing submissions that they cannot yet be said to have had the impact that I accept the Department earnestly desires. For that reason, I have decided to make the recommendations in the form supported by XY’s Mother and BDAC, and thereby require the Department to respond to them through the formal response process, by which time they will have had an additional opportunity to track sufficient data to be able to report on their success or otherwise in implementing my recommendations.

Recommendation 16

729. *Noting the Yoorrook Justice Commission’s recommendation that the Victorian Government ‘transfer decision making power, authority, control and resources to First Peoples, giving full effect to self-determination in the Victorian child protection system’,*

[1183] DFFH Responsive Submissions (fn 688) [82].

I recommend that DFFH significantly upscale the capability, competence and support of all persons working within the child protection system to ensure that they are able to:

a. comply with sections 10, 11, 12, 13 and 14 of the Children, Youth and Families Act 2005;

b. adopt a relational approach to child protection work which prioritises the practitioner's ability to relate to the child and their families over compliance-driven measures; and

c. engage in effective case management and case planning, including long-term planning and transition planning.

In particular for this purpose, DFFH should:

d. review and revise all relevant policies, procedures, guidelines and like documents;

e. review and revise all relevant training courses and programs; and

f. ensure, to the greatest extent possible, that it has appropriate staffing levels and is able to retain experienced child protection practitioners.

XY's Voice[1184]

730. The Aboriginal Independent Expert Panel expressed the opinion that DFFH did not adequately involve XY in decision-making about her circumstances.[1185]

731. As I have set out in the *Charter* section of this Finding, XY had an internationally and domestically recognised right to voice priorities and preferences for her care,[1186] and she did so.

732. The DFFH, as a public authority, had obligations under section 38 of the *Charter*. First, recall that the Department had a substantive obligation not to act in a way that is incompatible with a human right, unless it could demonstrate that it was reasonable and

[1184] See Scope of Investigation at [2(f)] and Scope of Inquest at [2(e)].
[1185] T 133:24 – 137:15.
[1186] See *Charter* s 17; *ICCPR* article 24(1); *CRC* article 3.

justifiable to do so. Second, the Department had a procedural obligation to properly consider XY's human rights, which involved hearing her voice and properly considering her views under s 17(2). Without these obligations, her *Charter* right would be empty. I will focus on two examples: her letter of complaint to the Department, and the Children's Court sibling access orders.

733. Perhaps the starkest example of XY's lack of voice was her letter to the Department dated 17 December 2020, and their response to it.[1187] XY was 16 years old at the time of writing this letter. In it, she capably communicated her preferences about her accommodation placement, connection with and support from her Aboriginal community, and for actual decision-making collaboration with Child Protection. In a voice that ought be '…given due weight in accordance with [her] age and maturity', [1188] XY herself articulates that her *Charter* rights, including consideration of her best interests, were being engaged in relation to the Departments actions and decision-making. As she put it:[1189]

[1187] MR 6665-6666; FNID (fn 116) [258].
[1188] *CRC* article 12; see also *Human Rights Committee General Comment 20*, [3].
[1189] MR 6665-6666.

Dear child protection, solomen st, Bdac 17/12/20

I would like to be treated as a mature minor. I am writting this letter out of frustration as I do not feel I am being validated, supported or cared for properly by your services. I would like this letter to be ~~viewed~~ viewed as feedback on my behalf.

I identify as a proud Wamba Wemba women and would like the accociated support that a young Aborinal femeale shoul be provided with further care. This is a human right.

I would like support with connecting with my aboriginal heritage, elders and community, I would like the aboriginal community to support me. My family connections with Bdac which has impacted my access to service which has resulted of disconnection to my people and community.

(regarding solomen st)

I would like another chance please. I feel I am being punished for acting on my feelings. I feel restricted by some of the rules, like having to get police checks everytime I stay overnight somewhere and being restricted to a certai amount of days or hours which i'm aware is not fully in your control but I would like to be treated like I'm independent as for from my understanding that's what we're workir towards? I would be 100% open to making a new saftey plan to try and reduce my risks and so I have a say in what supports me best.

(Regarding child protection.)

I don't feel supported by you, I don't feel you have my best Interest at heart. Of all your options with housing Solomen street was the most supportive, and place of least risk, you removed me from there which has only created more unnecessary stress on me and has taken a huge toll on my mental health, I just very much feel like you are providing unclear directions. I Would like to be treated as a mature minor, I believe I have capacity regarding my accommodation and life style choices.

Regards,

XY

734. The DFFH's response to XY's letter was summarised in an internal complaints report.[1190] It is apparent from that document that rather than listening to XY's voice and using her letter as an opportunity to develop a collaborative approach with her,[1191] the DFFH responded to XY's letter by reminding her of the importance of attending their care team meeting (so she could presumably repeat the views she had just offered in her articulate letter) and reminding her of Child Protection practices and procedures in regard to decision-making. The 'Actions Taken' section of the internal report concluded 'No system or organisational changes or action', without any further explication being offered by the author.[1192] This evidence suggests that the Department failed to take XY's views into account and thereby limited her right, because it was not in her best interests to not have her views taken into account.

735. The AIEP considered that the DFFH's approach was 'highly inadequate' because it shifted the responsibility back onto XY, suggesting that if she didn't feel supported, she had to take actions to change her behaviour. Instead, DFFH should have validated XY's concerns, which were her subjective truth, and talked to XY about how she would like to take things forward and how she would like DFFH to respond.[1193] A concerted effort

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[1190] PR 5489-5492; T 134.
[1191] Ibid.
[1192] PR 5489-5492; FNID (fn 116) [258]-[259].
[1193] T 134:12-23; Statement of BJ Newton, CB 3098 [95]; Statement of Jacynta Krakouer CB 3731 [87(c)].

could then be made to consider whether her voice could be actioned. A response like this to her voice could have represented a reasonable and demonstrably justified attempt to protect and promote her rights, even if the Department did not actually end up doing what she wanted them to do. Instead, they shifted the responsibility back to XY and told her to change her behaviour. This suggests that the limits imposed on XY's rights by the Department were not demonstrably justifiable.

736. In his oral evidence, Mr Chapman clarified that the report recording Child Protection's response to XY's letter was 'internal documentation.'[1194] XY was not provided with the document, rather, the matters listed were discussed with her through dialogue.[1195] I accept that, but this added context for the document means it is at least a candid internal encapsulation of the Department's managerial style.

737. In relation to the topics actually raised in XY's letter, there are no documented attempts to action her wishes, nor any recorded explanations offered to her about why that was not possible for some reason. This suggests that the public authority failed to engage with XY's voice as required by the best interests principle within the right, which in turn limited XY's right to a voice. For instance, accommodation placement decisions fall squarely under the substantive obligation to not act or decide matters in a way that is incompatible with her rights. If the Department could not properly listen to her, and 'being heard' is part of the content of the right, then the right has been engaged and limited. There was no evident reasonable or demonstrably justifiable reason for this limitation. The absence of such reasonable and demonstrable justification can be interpreted as a substantive breach of her right to be heard – and indeed a procedural breach too.[1196]

738. The Department acknowledged in its closing submissions that more could have been done to respond to XY's complaint.[1197]

739. The DFFH also accepted the AIEP's criticisms that XY's voice was not sufficiently heard,[1198] and acknowledged that '[t]he service system struggled to listen to XY and

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[1194] T 609:29-610:5.
[1195] T609:30-610:5.
[1196] *Certain Children (No.2)* at [490]-[500].
[1197] [162].
[1198] Statement of Kirstie-Lee Lomas, CB 3599-3600 [36]-[37]; T 601:29 – 603:133, T 609:27-29.

accept her reality of her experiences and subsequent frustrations' in relation to some of the placement decisions made.[1199] This further supports procedural, if not substantive, unlawfulness under section 38(1) of the Charter.

740. There is a similar lack of engagement with XY's voice insofar as the DFFH failed to action the Children's Court Family Reunification Order (FRO) [1200] and Interim Accommodation Orders, where those orders provided for XY to have contact with her siblings.[1201] These orders reflect the Children's Court's independent distillation of what was in the child's best interest at that time.

741. The Children's Court Decision Sheet[1202] records that the 'DHHS will consider whether the FRO is viable or not' and the Department did not appeal any of the orders.

742. XY had expressed her desire to see her siblings on numerous occasions,[1203] including in her heartfelt letter of August 2019 to her mother, pleading,

> …For so long you wouldn't let me see the kids, why?... [1204]

743. While XY's willingness to engage with either of her parents fluctuated, she was steadfast in expressing her desire to have contact with her siblings.[1205] The AIEP explained that for a young Aboriginal person in XY's position, contact with siblings would be protective from a mental health perspective and culturally safe from a First Nations perspective.[1206] So, it was objectively in the best interests of XY to have contact with her siblings. She repeatedly and actively expressed this wish, which was well within the scope of her *Charter* right to have decisions made in her best interests, and her right to participate in the process by which decision affecting her were made.

744. Yet my review of the substantial volume of Protection Records in this matter, with the assistance of the interested parties, has not been able to identify an earnest attempt at enabling sibling access, nor an articulated rationale for why that was not possible at

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[1199] Statement of Kirstie-Lee Lomas, CB 3599.
[1200] PR 5550.
[1201] See PR 5560, 5565, 5572, 5603, 5732, 5743, 5749, 5755.
[1202] PR 5753.
[1203] See PR 1667, 2195, 2572, 3247, 3858, 3263, 3265; MR 1144.
[1204] PR 3192.
[1205] See PR 3860, 3858, 3263,3265; MR 1144.
[1206] See T 80:28 – 81:7; Statement of BJ Newton, CB 3086 [55]

certain times, nor what alternative legitimate statutory objective the DFFH was pursuing by this inaction.

745. This failure speaks to the DFFH's substantive obligation to act compatibly with XY's rights and its procedural obligation to give 'proper consideration' to XY's voice. While Child Protection actively considered whether to pass this letter on to XY's Mother, and documented that they believed it would be too detrimental to her mental health to do so,[1207] there is no record of Child Protection nonetheless considering, nor attempting to facilitate, XY's court ordered sibling access through other safer avenues, such as by utilising extended family, the Aboriginal community or even discrete DFFH supervision networks or mechanisms. These avenues could potentially have circumvented the obstacles to sibling access that the dangers of exposure to her stepfather and XY's Mother's periodic unwillingness to cooperate represented.

746. The Children's Court order was reflective of XY's best interests, which means that her s 17(2) rights were engaged. The failure of DFFH to execute the order limited her rights. Whether the limitation was reasonable and demonstrably justified in part turns on minimal impairment of her rights. The failure to consider alternative pathways or strategies to implement the court orders means that there were potentially less restrictive means reasonably available to Child Protection, which may have provided justification for the limitation on the rights.[1208] Instead, there was no reasonable and demonstrable justification for their inaction on this front. It was unlawful in a substantive sense for the Department not to attempt to comply with the sibling access court order (which by definition was in XY's best interest) without demonstrating that it was reasonable and justifiable under section 7(2) to act in this way. Accordingly, the Department acted in a way that was incompatible with XY's right, and thus acted unlawfully under section 38(1).

747. Moreover, there is no evidence that proper consideration was given to pursuing the sibling access order or, if it was, that consideration was not documented. The only matter that was documented was the countervailing interest of XY's Mother (particularly her mental health), which was considered, but the Court ordered articulation of XY's best interests and XY's own voice were not. This goes to the procedural element of the section

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[1207] PR 3191.
[1208] *Certain Children (No 2) at* [473] – [475].

38 obligations. In short, it was unlawful in a substantive sense not to comply with the sibling access court order, and procedurally unlawful to not have documented proper consideration of the issue. Both represent a breach of XY's human right to be heard in relation to decisions that affect her.

748. This lack of effective engagement and response by the Department to her specific sibling contact wishes across the years in which the DFFH stood *in loco parentis*, contributed to XY's incremental disillusionment with the Child Protection system, which, in the absence of any substitute support network, was obviously contrary to her own best interests as a vulnerable young person.

749. Mr Chapman conceded in both his statement and his oral evidence that the Department 'should have made better efforts to …maintain sibling contact…' [1209] Ms Lomas also conceded that XY's '…voice and experiences were not always heard or validated' within a system under significant strain.[1210]

750. As an aside, I note that in *Certain Children (No 2)*, Dixon J held that asserting strain on public resources 'fell well short in demonstrating that resources were inadequate for the provision of less restrictive means.'[1211] Despite that strain, it is glaring that a government department did not more energetically pursue compliance with a court order or, at the very least, document in some detail why that outcome was not possible in this particular case at certain particular times, especially where it was contrary to the expressed wishes of the child whose best interests they were obliged to keep foremost in mind.

751. To sum up, these two failures by the DFFH to actively consider XY's views about her own best interests constitute an unjustified and disproportionate limitation of XY's *Charter* right to the protection of her best interests as a child,[1212] and thereby constitute unlawfulness under section 38(1) because the Department acted in a way that was incompatible with her right. There was no demonstrable justification here because the attempts, or failures, to action her voice were not documented. Nor are any reasonable rationales for not pursuing sibling access recorded. They are disproportionate because

[1209] CB 3633; T 519.24.
[1210] CB 3624 at [49], 3597 at [26].
[1211] *Certain Children (No 2)* (fn 66) [473].
[1212] *Charter*, ss 7(2) and 17(2).

without access to, or hope of obtaining, the quality of life XY had herself articulated, far greater resources were continually expended as she lurched from crisis to crisis, without a long-term solution in sight.

752. I accept the AIEP's characterization of this conduct as a pattern of resignation[1213] and passivity[1214] on behalf of those obliged and resourced to act in XY's best interests. For instance, it is a notable contrast to the later sibling access issue that when hearing XY's voice required no action from the Department, such as early on following XY's removal from home, when XY expressed she was not ready to have contact with her family, Child Protection accepted this stance at face value and did not arrange contact. [1215] Such resignation and passivity are hallmarks of procedural unlawfulness, where a public authority has a procedural obligation to give proper consideration to human rights when making a decision. They are also suggestive of substantive unlawfulness. When XY's own views about her best interests ought to have been listened to and given due weight in accordance with her age and maturity under section 17(2) of the *Charter*, and additionally required positive action on the part of the Department, she instead received resignation and passivity in breach of her rights in a manner that was not reasonable or demonstrably justified.

753. In plain English, while no single individual was solely responsible, I conclude that the cumulative effect of the DFFH's lack of action in pursuit of, and lack of documented consideration of XY's voiced care goals, unjustifiably breached her human right to such protection from her legal guardian as was in her best interests whilst she was still a child. In the language of the *Charter*, the Department acted in a way that was incompatible with XY's human right, and when making decisions the Department failed to give proper consideration to XY's human right.

754. Having gained perspective by considering many cases, rather than just the life of a single Aboriginal child, the Yoorrook Justice Commission envisaged an independent advocacy solution to children's lack of voice inside the child protection system. At Recommendation 7 of their report, the Commission said:

[1213] Statement of BJ Newton, CB 3088-3089 [67], [69], [71], [93]-[97].
[1214] Ibid CB 3098-3099 [97], [100]; Statement of Jacynta Krakouer, CB 3730-3731 [83]-[85].
[1215] Statement of BJ Newton, CB 3098 [97]; T 86:25 – 86:8; PR 3968.

The Victorian Government must amend the *Commission for Children and Young People Act 2012* (Vic) to:

a) specifically establish the role of the Commissioner for Aboriginal Children and Young People in the same way that the Principal Commissioner for Children and Young People's role is provided for in the legislation

b) provide the Commissioner for Aboriginal Children and Young People with the same statutory functions and powers as the Principal Commissioner insofar as these powers relate to Aboriginal children and young people in Victoria

c) expressly provide the Commissioner for Aboriginal Children and Young People the function to receive and determine individual complaints from or relating to First Peoples children and young people concerning their treatment in child protection, including out of home care, and

d) give the Commissioner for Aboriginal Children and Young People and the Principal Commissioner rights of intervention in legal proceedings relating to a child or young person's rights under the Charter to be exercised at their discretion.

These roles and powers must be appropriately resourced.[1216]

755. This inquest proceeded concurrently with Yoorrook's proceedings, so I did not have the opportunity to consider expert opinions or submissions on the form of this recommendation. However, I have reproduced it here as it would self-evidently provide a mechanism for independent scrutiny in cases where children do not believe their voices are being heard, which would in turn improve transparency and accountability in favour of vulnerable children.

756. DFFH witnesses assisted me with evidence of several initiatives directed to improving participation by young people like XY in care decisions. Mr Chapman described the Care Teams Improvement Project, a Loddon initiative that seeks to 'systematise how we actually hear… their voices' and 'construct care teams in a much more child-friendly

[1216] Yoorrook Report 29, recommendation 7.

way.'[1217] Mr Chapman also gave evidence about 'My Views', a state-wide initiative designed to improve Child Protection's engagement with children and young people's perspectives. My Views is a booklet which has been designed in collaboration with children, and which represents a 'resource to help practitioners have the conversation with children to hear what are the issues that are… current for them' and facilitates a 'guided conversation'. [1218] Ms Corin referred to the DFFH's Placement Planning Refresh,[1219] which examines how the Department's guidelines 'consider the needs and the views of young people' in matching them to placements.[1220] Aspects of the SAFER children framework are also directed towards amplifying the voices of children who have contact with Child Protection.[1221]

757. Despite having introduced these initiatives, the Department submitted that the recommendation that follows overlooks the 'foundation educational training with which Child Protection Practitioners enter the profession'.[1222] Yet in XY's case, that training sometimes achieved the opposite result, so in my view, a review would be timely.

Recommendation 17

758. *That DFFH review and revise its relevant training courses and programs with a focus on improving Child Protection Practitioners' skills in engaging with children and young people, so as to hear, acknowledge, understand and give weight to a child's experience and expressed views in their subsequent decisions and actions.*

759. I note that both XY's Mother and BDAC expressed support for this recommendation.[1223]

[1217] T 610:15-25.
[1218] T 611:20-28.
[1219] Exhibit E - Table of changes in relation to Child Protection policy and legislation (fn 644) 10, item (K).
[1220] T 613:16-18.
[1221] Exhibit H – SAFER guide (fn 776) 7, 35, 70.
[1222] DFFH Responsive Submissions (fn 688) [164].
[1223] XY's Mother Final Submissions (fn 660) [7]-[8]; BDAC Closing Submissions (fn 729) [1]-[2].

CONCLUSION

760. At its best, a coronial inquest can provide a space where the voice of the dead can guide, and even help, the living.[1224]

761. XY's passing has shown us the importance of that voice being heard, pointing us towards the protective features of self-determination, cultural connection and loving homes as a wellspring, not just for vulnerable children, but for all of us.

762. I commend XY's Mother and the other interested parties for embracing the prevention focus I brought to what was otherwise an undeniably sad and unfortunately not unique set of circumstances.

763. Finally, I wish to express my condolences to XY's family and their communities for their loss.

RECOMMENDATIONS

764. Pursuant to section 72(2) of the Act, I make a number of recommendations connected with XY's passing which appear in Appendix E.

[1224] *Mortui vivis praecipiant* means 'Let the dead teach the living'.

ORDERS

765. Pursuant to section 73(1) of the Act, I order that this finding be published on the internet.

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

XY's Mother, Senior Next of Kin

XY's Father, Senior Next of Kin

Peta McCammon, Secretary of the Department of Families, Fairness and Housing

Professor Euan Wallace, Secretary of the Department of Health

Chief Commissioner of Police, c/- MinterEllison

Anglicare Victoria, c/- Hall & Wilcox

Bendigo Health, c/- HWL Ebsworth Lawyers

Bendigo & District Aboriginal Co-operative, c/- HQ Law

Australian Community Support Organisation, c/-K & L Gates

Dr Thileepan Naren, c/- Avant Law

Dr BJ Newton, Expert Witness

Dr Jacynta Krakouer, Expert Witness

Professor Patricia Dudgeon AM, Expert Witness

Associate Professor Robert Parker, Expert Witness

Liana Buchanan, Principal Commissioner for Children and Young People

Meena Singh, Commissioner for Aboriginal Children and Young People

Hugh de Kretser, Yoorrook Justice Commission

Lee Forace, Social Services Secretary, Community and Public Sector Union

Adjunct Professor Muriel Bamblett, Victorian Aboriginal Child Care Agency

Aboriginal Justice Caucus

Victorian Aboriginal Community Controlled Health Organisation

Coroner's Investigator, Leading Senior Constable Wendy Turner

Signature:

SIMON McGREGOR
Coroner

19 June 2024

APPENDIX A – PROCEEDING SUPPRESSION ORDER (21 SEPTEMBER 2022)

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2021 3810

PROCEEDING SUPPRESSION ORDER AND PSEUDONYM ORDER

Form 42 Rule 66(1)

Section 18(2) of the ***Open Courts Act 2013***

Section 55(2)(e) of the ***Coroners Act 2008***

I, Simon McGregor, Coroner, make the following **ORDER** in respect of the investigation into the passing of:

Details of deceased:

Surname:	Y
Given names:	X
Date of Birth:	31/03/2004

1. BACKGROUND

1. The inquest into the passing of XY (**XY**) will be held on dates yet to be confirmed.

2. This proceeding is an investigation into the passing of a 17-year-old Aboriginal young person from Bendigo. In July 2021, she left her Anglicare residential unit, where she lived in care, and was reported missing. She was later located deceased.

3. On 18 August 2021, I made an interim order pursuant to s 20 of the *Open Courts Act 2013* (the **Open Courts Act**) prohibiting the identification of, or information that would tend to lead to the identification of, XY (the deceased) and/or any other child referred to in these proceedings (the **interim order**). The interim order was to remain in effect until a substantive application under s 18 of the Open Courts Act could be heard or until it was revoked.

4. The Open Courts Act governs the making of suppression orders by Victorian courts and tribunals. A coroner may make a proceeding suppression order in the case of an investigation or inquest into a death, if the coroner reasonably believes that an order is necessary because

disclosure would be likely to prejudice the fair trial of a person or be contrary to the public interest.[1] In determining whether to make a suppression order, the court is to have regard to the principle of open justice and the free communication and disclosure of information. The court is only to make a suppression order if satisfied that the specific circumstances of a case make it necessary to override or displace this principle.[2]

2. SUPPRESSION ORDER APPLICATION

5. On 20 August 2021, the Secretary of the Department of Families, Fairness and Housing (**the Secretary**) made an application for a proceeding suppression order pursuant to s 18(2) of the Open Courts Act (the **Application**). It was submitted that the identity of XY should be suppressed to ensure that there is no inadvertent breach of s 534 of the *Children Youth and Families Act 2005* (the **CYF Act**). The Secretary submitted that the suppression order be made on a final basis for a period of 5 years (the maximum allowable duration of a suppression order under the Open Courts Act).[3]

6. Section 534(1) of the CYF Act 'Restriction on Publication' provides that:

> (1) A person must not publish or cause to be published—
>
> (a) except with the permission of the President or of a magistrate under subsection (1A), a report of a proceeding in the Court or of a proceeding in any other court *arising out of a proceeding* in the Court that contains any particulars likely to lead to the identification of—
>
> (i) the particular venue of the Children's Court, other than the Koori Court (Criminal Division) or the Neighbourhood Justice Division, in which the proceeding was heard; or
>
> (ii) *a child or other party to the proceeding; or*
>
> *(iii) a witness in the proceeding;* or
>
> (b) except with the permission of the President or of a magistrate under subsection (1A), a picture as being or including a picture of a child or other party to, or a witness in, a proceeding referred to in paragraph (a); or
>
> (c) except with the permission of the President or of a magistrate under subsection (1A), or of the Secretary under subsection (3), *any matter that contains any particulars likely to lead to the identification of a child as being the subject of an order made by the Court.*
>
> Penalty:
>
> (a) In the case of a body corporate—500 penalty units;
>
> (b) In any other case—100 penalty units or imprisonment for 2 years [emphasis added].

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1 Open Courts Act, s 18(2).
2 Open Courts Act, s 4.
3 Open Courts Act, s 12(3).

7. Section 534(4) identifies particulars deemed likely to lead to the identification of a person as stipulated as follows:

> (a) the name of the person;
> (b) the names of—
> > (i) any relative of the person; or
> > (ii) any other person having the care of the person; or
> > (iii) in addition to subparagraphs (i) and (ii), in the case of an Aboriginal person, a member of the Aboriginal community of the person;
>
> (c) the name or address of any place of residence of the person, or the locality in which the residence is situated;
> (d) the name or address of any place of education, training or employment attended by the person, or the locality in which the place is situated.

8. On 20 September 2021, XY's Mother (**XY's Mother**), the mother and senior next of kin of XY, filed submissions in response to the Application. Broadly, XY's Mother seeks pseudonym orders in respect of XY and certain family members, and the making of a final, limited suppression order prohibiting the disclosure by publication or otherwise of the names of those family members. XY's Mother opposed a suppression order in the broad terms sought by the Secretary.

9. On 21 June 2022, the Secretary filed further submissions,[4] seeking the expansion of a final suppression order to include the identities of persons associated with other child protection proceedings and submitting that the use of pseudonyms in open court is not necessary and would place a burden on witnesses. The Secretary supports an order for a schedule of pseudonyms where the publication of information that might identify a protected person is necessary.[5]

3. SUBMISSIONS BY INTERESTED PARTIES

The Secretary

10. The Secretary has submitted that:

[4] Submissions on Behalf of the Secretary of the Department of Families, Fairness and Housing (DFFH) on Suppression and Pseudonym Orders dated 21 June 2022.
[5] Ibid [21].

i. There are important public policy reasons in suppressing the identity of XY and members of her family named in child protection proceedings.[6]

ii. It is necessary to expand the terms of the proposed final suppression order to include other particulars capable of identifying XY's siblings as subjects of other child protection proceedings.[7]

iii. Consideration should be given to extension of the suppression order to prohibit identification of XY's friend, ZA, on the basis that it is necessary to prevent disclosure of her identity as the subject of child protection proceedings.[8]

iv. The use of the terms 'Minggayin' and 'Kuyinggurrin', previously nominated by XY's Mother, risks identifying XY as Wemba Wemba and thus risks identifying her.

v. It is not necessary to order the use of pseudonyms in open court as proposed in XY's Mother's submissions. The use of multiple pseudonyms as per Annexure A of the Submission on behalf of XY's Mother is not necessary and use of pseudonyms in court will *inter alia*, place a significant burden on witnesses. DFFH supports an order for a schedule of pseudonyms provided that the pseudonyms are not capable of being used to identify XY or her family, adopting the approach taken by Coroner Peterson in a recent ruling considering the application of s 534 CYF Act *Inquest in the death of JZA (Ruling 1),* 20 October 2021 (**the *JZA* Inquest**).

vi. The prohibition on publication of protected names pursuant to s 534 CYF Act or a suppression order negates the need to use pseudonyms in open court.[9]

vii. It is submitted that it is possible a coronial proceeding is a proceeding 'arising out of Children's Court proceedings' given that XY was subject to child protection involvement.[10] The Secretary submits that 'by order of the Children's Court, XY was brought within the definition of 'a person placed in custody or care' in s 3(1) of the *Coroners Act 2008* (**the Coroners Act**). Therefore, it was XY's status immediately

6 Ibid [12].
7 Ibid [13] and {20] paragraph a.
8 Ibid [14] and {20] paragraph b.
9 Submissions on Behalf of the Secretary of the Department of Families, Fairness and Housing (**DFFH**) on Suppression and Pseudonym Orders dated 21 June 2022 [15] – [17].
10 Submissions on Behalf of the Secretary of the Department of Families, Fairness and Housing (**DFFH**) on Suppression and Pseudonym Orders dated September 2021 [16]; Submissions in Reply on Behalf of the Secretary to the DFFH dated September 2021 [8].

before her passing as a person placed in care which makes the holding of an inquest into her passing mandatory under s 52(2)(b) of the Coroner's Act 2008.[11]

viii. Parliament has clearly intended that there not be publication of the identity of children in relation to child protection proceedings and that XY had been the subject of child protection involvement.[12]

ix. Material and reports before the Children's Court should also not be published.[13]

x. Publication of the identity of XY could inadvertently breach s 534 of the CYF Act.[14]

xi. The suppression order, as expressed in the interim order, appropriately balances the public interest in maintaining open courts against the public interest in ensuring no inadvertent breach of the CYF Act and the importance of protecting sensitive information relating to children.[15]

XY's Mother

11. In summary, XY's Mother's position is as follows:[16]

i. The Court should make an order, pursuant to s 55(2)(e) of the Coroners Act for the names of XY and certain of her family members, to be referred to in information published by the Court, and in open court, by way of pseudonyms.[17]

ii. That order having been made, the Court should make a final suppression order, pursuant to s 55(2)(e) of the Coroners Act and s 18(2)(b) of the Open Courts Act, prohibiting the disclosure by publication or otherwise of the names of XY and certain of her family members, in connection with the Inquest.[18]

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11 Ibid.
12 Ibid [17].
13 Ibid [17].
14 Ibid [28].
15 Ibid [30].
16 Submissions on Behalf of the XY's Mother about the Application for a Final Proceeding Suppression Order, 20 September 2021 [50].
17 Ibid [4].
18 Ibid.

iii. The Court should not make a final suppression order in the broad terms set out in the Application, at least not before the coronial brief is disseminated and XY's Mother is provided with an opportunity to consider her position in relation to the order. In the alternative, to preserve XY's Mother's rights, any final proceedings suppression order in these broad terms should be made to expire at the date of the next directions hearing.[19]

As to s 534 *Children Youth and Families Act 2005*

iv. XY's Mother submits that 's 534 does not apply in relation to XY's identity in the current Coronial proceeding'[20] as 'XY does not meet the definition of a 'child' under s 534. XY was 17 years old when she passed away, and as she is deceased, is not a person in respect of whom a child protection order "continues in force"'.[21]

4. ANALYSIS AND DETERMINATION OF THE APPLICATION

Preliminary issue: s 534 of the CYF Act

12. On its face, s 8(1A) of the Open Courts Act expressly precludes the court from making a suppression order where such information is already prohibited by the operation of other legislative provisions, including s 534 of the CYF Act. A preliminary issue therefore arises about the applicability of s 534 of the CYF Act to the Inquest.

13. In relation to the question as to whether XY was a child for the purposes of s 534 534(1)(a)(ii), the relevant definition of 'child' in section 3(b) of the CYF Act refers to a 'a person who is under the age of 17 years or, if a protection order, a child protection order within the meaning of Schedule 1 or an interim order within the meaning of that Schedule continues in force in respect of him or her, a person who is under the age of 18 years'.

14. XY was subject to a Care by Secretary Order at the time of her passing, which is a protection order under s 275 (1)(d) of the CYF Act and a child protection order within the meaning of Schedule 1. She is a 'child' prior to her passing for the purposes of s 534.

15. Section 534 applies only if the protection order 'continues in force' in respect of a person under the age of 18. I agree with the submission on behalf of XY's Mother that the protection order does not 'continue in force' as XY is deceased, however, in my view the protection

[19] Ibid.
[20] Submissions on Behalf of the XY's Mother about the Application for a Final Proceedings Suppression Order undated [50] - [54].
[21] Ibid [52].

afforded by s 534 is intended to apply to a child who was under 18 years of age and subject to a protection order, or other order specified under s 534 provided the protection order was in force at a time when they were under 18 years age.[22] The fact that XY has passed away does not preclude the protection being afforded to her.

16. It is also necessary to determine whether this Inquest is a proceeding 'of another court *arising out* of Children's Court proceedings'. The application by the Secretary has cited the ruling by Coroner Peterson in the *Inquest in the death of JZA*[23] and urged this Court to follow that decision. Significantly, JZA did not consider whether or not the proceedings arise 'out of the Children's Court proceeding'.

17. It is my view that this Inquest is not a proceeding 'arising out of Children's Court proceedings'. The plain and ordinary meaning of the term 'arise' is to begin to occur or to come into being.[24] Whilst it was contended by the Secretary that XY was brought within the definition of 'a person placed in custody or care' in s 3(1) of the Coroners Act, rendering the holding of an inquest into her passing mandatory under s 52(2)(b) of the Coroners Act, this coronial proceeding in fact arose out of a preliminary step, being the mandatory reporting of XY's unexpected passing under the Coroners Act. The machinery of the Coroners Act then acted upon the existence of the care order, and meant that an Inquest would subsequently be a mandatory part of the proceeding. The point of distinction from the Secretary's submissions being that this proceeding would have existed whether there was a care order or not, so this proceeding does not 'arise' from the said care order, albeit that the existence of the order has subsequently materially altered the shape of the proceeding. Accordingly, I am not persuaded that s 534 of the CYF Act applies in the present circumstances. Therefore consideration is to be given to the appropriateness of a pseudonym order under the Coroners Act and/or suppression orders under the Open Courts Act.

i. Pseudonym order

18. It has been submitted on behalf of XY's Mother that '[s]ince XY's death, XY's Mother has been subjected to harassment and threats over social media. She is concerned that this harassment may be directed towards her children if she and her other children are identified by their names in the proceedings. This harassment could prevent XY's Mother from being able to fully

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22 *GHJ v Secretary to the Department of Justice and Community Safety* [2019] VSC 89, cited in the Submissions in Reply on Behalf of the Secretary to DFFH dated September 2021 [7] in which it was submitted that 'despite the fact that the Plaintiff was not a "child" the court considered the considerable weight and policy of the CYP Act'.

23 *Inquest in the death of JZA (Ruling 1),* 20 October 2021.

participate in the Inquest as XY's mother and senior next of kin'.[25] Pseudonym orders have been sought as being necessary as '[t]hey will protect XY's identity and dignity. And they will reduce the potential for XY's Mother, her partner, and her children to face harassment and stigmatisation from being identified in the proceedings.'[26]

19. Section 55(1)(a) of the Coroners Act empowers me to give directions that I believe to be 'necessary for the purposes of an inquest'. Section 55(1)(e) enables me to make 'any other directions and do anything else the coroner believes necessary'.

20. I consider section 55(2)(e) of the Coroners Act 2008 to be the appropriate legal basis upon which I can make a pseudonym order in the context of an Inquest, noting further that, pursuant to section 7(d)(i) of the Open Courts Act 2013, nothing in that Act limits or otherwise affects the making of an order or decision by a court or tribunal that conceals the identity of a person by restricting the way the person is referred to in open court.

21. I am persuaded that pseudonym orders in the terms sought by XY's Mother are necessary to secure the proper administration of justice in the proceeding for the reasons stated on behalf of XY's Mother, including to ensure her capacity to actively participate in the inquest. However, to avoid issues associated with pseudonyms derived from Language from XY's cultural group, including the fact that these words may be identifying and that appropriate permissions are required for their use, I will order the use of generic pseudonyms as contained in the attached Schedule.

ii. Suppression order

22. I am also empowered under ss 17 and 18(2) of the Open Courts Act to make proceeding suppression orders that are 'necessary' because disclosure by publication or otherwise of the information protected by the interim suppression order would be 'contrary to the public interest'. Section 4(2) of the Open Courts Act provides that '[a] court or tribunal is only to make a suppression order if satisfied that the specific circumstances of a case make it necessary to override or displace the principle of open justice and the free communication and disclosure of information'.

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[24] Merriam-Webster Dictionary.

[25] Submissions on Behalf of the XY's Mother about the Application for a Final Proceedings Suppression Order dated 20 September 2021 [9].

[26] Ibid [10].

23. The assessment of whether disclosure by publication or otherwise of information would be 'contrary to the public interest' under s 18(2) of the Open Courts Act necessarily involves the balancing of multiple, competing objectives. Section 18(2)(b) of the Open Courts Act imposes an onus on the applicant for a suppression order 'to persuade the court that the order is necessary – not merely reasonable or desirable'.[27]

24. The Court must be satisfied that the suppression order is 'necessary because disclosure would … be contrary to the public interest' under s 18(2) 'on the basis of evidence, or sufficient credible information that is satisfactory to the court': s 14(1).

25. As to 'necessity', I am cognisant that this requirement under section 18(2) Open Courts Act 2013 must be established independently of the requirement for a pseudonym order under section 55(2)(e) Coroners Act 2008; namely, that I may only make a suppression order in exceptional cases of true necessity, which, if there exists a pseudonym order effectively 'doing the same work' as a suppression order under the Open Courts Act 2013, may impact on the 'necessity' of such further order.

26. Notwithstanding, I am persuaded that a suppression order is necessary to give full effect to the pseudonym orders I am making, in circumstances where those who are subject to this order or following the Inquest proceedings may be users of social media as well as those operating within traditional media outlets, which necessitates, in my view, an additional layer of protection.

27. This also triggers the option of penalties under section 23 of the Open Courts Act 2013 for any breach of suppression order, which may be more easily enforced and better understood by members of the public and social media users than the law of contempt (which is the only avenue to me to remedy any breach of a pseudonym order, as per section 103 of the Coroners Act 2008).

28. In addition, in the circumstances, I accept that the absence of a suppression order is likely to compromise XY's Mother's capacity and willingness to participate in these proceedings and risks the prospect that she would face harassment and intimidation. I therefore consider that disclosure of the identities of XY, XY's Mother and their family members would be contrary to the public interest.

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27 *Chaarani v DPP (Cth)* [2018] VSCA 299 [41].

5. CONCLUSION AND DETERMINATION

29. I have considered the:
    a. application of DFFH;
    b. submissions received on behalf of DFFH and XY's Mother;
    c. affidavit of XY's Mother;
    d. affidavits of Tracy Beaton, Chief Practitioner and Executive Director Office of Professional Practice, DFFH; and
    e. relevant provisions of the Coroners Act, CYF Act and Open Courts Act.

30. Both XY's Mother and the Secretary have submitted that XY's name and the names of her family members should not be published. The Secretary further submits that it is appropriate to suppress information that would tend to lead to the identification of XY and her family members.

31. I acknowledge the concerns raised by the Secretary as to the risk of inadvertent breach of the CYF Act. As I have outlined, I do not consider that s 534 of the CYF Act applies in relation to XY's identity in the current coronial proceedings because the Inquest does not arise out of the Children's Court proceedings. Nevertheless, to protect against any inadvertent breach of s 534 of the CYF Act where applicable, and to address the concerns raised on behalf of XY's Mother in relation to protection of the identity of XY and her family members including XY's siblings, I direct that:

i. a notice be placed on the door of the court alerting attendees that any particulars likely to lead to the identification of the deceased (including images) are prohibited and those particulars include, but are not limited to:
    a. XY's name;
    b. the names of XY's family members; and
    c. the names of any other children.

ii. a notice be provided by electronic means to those attending the inquest remotely.

32. I will revoke the interim order and make a pseudonym order prohibiting the publication of the names of XY and her family members, including those listed in the Schedule, in connection with the Inquest, as well as the names of any other children.

33. I will also make a suppression order to prohibit publication of information that would identify or tend to identify XY and her family members, including those listed in the Schedule, in connection with the Inquest, as well as the names of any other children.

34. I am satisfied in respect of the concerns raised on behalf of XY's Mother, pursuant to s 18(2) of the Open Courts Act as I reasonably believe that the order is necessary because publication would be contrary to public interest.

6. ORDER

1. The interim order dated 16 August 2021 is hereby revoked and replaced by this order.

2. Pursuant to s 55(2)(e) of the *Coroners Act 2008* and s 18(2)(b) of *the Open Courts Act 2013*, publication of the name, image and any information that would identify, or tend to identify:

   i. XY;

   ii. XY' family members; and/or

   iii. Any children (as of the time of XY's passing or currently) is

   prohibited.

3. The prohibition on publication in paragraph 2 applies in Victoria and elsewhere in Australia.

4. Where the name of any person or category of person in paragraph 2 of this order is published, a pseudonym must be applied as per the attached Schedule.

5. The ground relied upon in making this order is section 18(2)(b) of the Open Courts Act.

6. For the purpose of this order, "publication" has the meaning attributed to it by section 3 of the Open Courts Act, that is to say, it means the dissemination or provision of access to the public or a section of the public by any means, including by -

   (a) publication in a book, newspaper or other written publication; or

   (b) broadcast by radio or television; or

   (c) public exhibition; or

   (d) broadcast or electronic communication.

7. This order will not expire until 5 years from today's date, in light of the young age of many of XY's family members.

8. A redacted version of this order removing reference to the identities of the persons set out in paragraph 2 of this order be published on the Coroners Court website.

9. A notice be placed on the door of the court, and provided by electronic means to those attending the inquest remotely, alerting attendees that any particulars likely to lead to the identification of the deceased (including images) are prohibited, and those particulars include, but are not limited to:

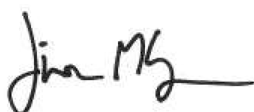
   a) XY's name;

   b) the names of XY's family members; and

   c) the names of any other children.

10. The pseudonyms apply only to publication as defined in this order. The pseudonyms are **not** required to be used in the coronial brief, materials tendered at Inquest, or in the courtroom by legal representatives or witnesses.

Signature:



SIMON MCGREGOR
CORONER
Date 21 September 2022

NOTE: *Under section 23 of the* ***Open Courts Act 2013*** *a person must not engage in conduct that constitutes a contravention of an interim order. The maximum penalty for an individual is 5 years imprisonment or 600 penalty units or both, and 3000 penalty units for a body corporate.*

SCHEDULE OF PSEUDONYMS

Name	Relationship to XY	Pseudonym
XY	-	XY
XY's Mother	Mother	XY's Mother
XY's Grandmother	Grandmother	XY's Grandmother
Brother 1	Brother	Brother 1
Brother 2	Brother	Brother 2
Brother 3	Brother	Brother 3
Sister 1	Sister	Sister 1
Sister 2	Sister	Sister 2
XY's Stepfather	Stepfather	XY's Stepfather
ZA	Friend	ZA

*** This is not an exhaustive list of individuals covered by this ruling and suppression order. Please use a suitable pseudonym or reference to individuals not specifically named above but still covered by the current order.**

APPENDIX B – PROCEEDING SUPPRESSION ORDER (19 OCTOBER 2023)

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2021 003810

PROCEEDING SUPPRESSION ORDER

Form 42 Rule 66(1)

Section 18(2) of the ***Open Courts Act 2013***

Section 55(2)(e) of the ***Coroners Act 2008***

I, Simon McGregor, Coroner, make the following **ORDER** in respect of the investigation into the passing of:

Details of deceased:

Surname:	Y
Given names:	X
Date of Birth:	31 March 2004

BACKGROUND

1. An Inquest into the passing of XY is listed to commence on 23 October 2023.

2. Three Notices of Application for Suppression Order have been filed pursuant to section 10 of the *Open Courts Act 2013* (Vic), as follows:

   a) Michael Oerlemans of Anglicare Victoria ("**AV**") filed a Notice of Application for Suppression Order dated 17 January 2023. This is supported by the Affidavits of Michael Oerlemans affirmed 16 January 2023 and Marianne Watson affirmed 13 October 2023.

   b) Dallas Widdicombe of Bendigo and District Aboriginal Cooperative ("**BDAC**") filed a Notice of Application for Suppression Order dated 16 March 2023. This is supported by the Affidavit of Dallas Widdicombe affirmed 16 March 2023.

   c) Nathan Chapman of Department of Families, Fairness & Housing ("**DFFH**") filed a Notice of Application for Suppression Order dated 11 September 2023. Leave was granted to file an amended application dated 12 October 2023. This is supported by the Affidavit of Nathan Chapman affirmed 11 September 2023.

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3. Oral submissions were made on behalf of each applicant at the Directions Hearing held on 16 October 2023.

4. Each application was opposed by XY's mother and Senior Next of Kin, XY's Mother. I have regard to the Affidavit of XY's Mother sworn 20 September 2021, written submissions received 20 September 2021, written submissions received 1 August 2022 and written submissions dated 15 October 2023.

5. Sections 17 and 18(2) of the *Open Courts Act 2013* empower the making of a proceeding suppression order. The ground(s) relied on in making this order are that it is reasonably believed, based upon sufficient credible information, that these orders are necessary because disclosure by publication or otherwise would be contrary to the public interest.

6. This order does not affect the operation of section 534 of the *Children, Youth and Families Act 2005* (Vic) and section 166 of the *Family Violence Protection Act 2008* (Vic) as they apply to these proceedings.

ORDER

1. Pursuant to section 55(2)(e) of the *Coroners Act 2008* and section 18(2)(b) of the *Open Courts Act 2013*, publication of the name, image and any information that would identify, or tend to identify:

   a. Frontline staff of AV and BDAC who were involved in XY's care and/or have given or will give evidence in this proceeding; and,

   b. DFFH Child Protection practitioners who were involved in XY's care and have made statements or had statements made on their behalf in this proceeding,

   is prohibited.

2. The prohibition on publication made under Order 1 applies throughout Australia.

3. A Schedule of Pseudonyms that can be used for publication is annexed to this Order. The pseudonyms are not required to be used in the coronial brief, materials tendered at Inquest, or in the court room.

4. For the purpose of this order, "publication" has the meaning attributed to it by section 3 of the *Open Courts Act 2013*, that is to say, it means the dissemination or provision of access to the public or a section of the public by any means, including by - (a) publication in a book, newspaper or other written publication; or (b) broadcast by radio or television; or (c) public exhibition; or (d) broadcast or electronic communication.

5. This order will expire on 18 October 2028.

Signature:

SIMON MCGREGOR
CORONER
Date: 19 October 2023

NOTE: *Under section 23 of the* ***Open Courts Act 2013****, a person must not engage in conduct that constitutes a contravention of a proceeding suppression order or an interim order that is in force if that person—*
(a) knows that the proceeding suppression order or interim order is in force; or
(b) is reckless as to whether a proceeding suppression order or an interim order is in force.
Individual Penalty: maximum 5 years imprisonment or 600 penalty units or both. Body Corporate: 3000 penalty units.

SCHEDULE OF PSEUDONYMS

Name	Relationship	Pseudonym
AA	AV	AA
AB	AV	AB
AC	AV	AC
AD	AV	AD
AE	AV	AE
AF	AV	AF
AG	AV	AG
AH	AV	AH
AI	AV	AI
AJ	AV	AJ
AK	AV	AK
AL	BDAC	AL
AM	BDAC	AM
AN	DFFH	AN
AO	DFFH	AO
AP	DFFH	AP
AQ	DFFH	AQ
AR	DFFH	AR
AS	DFFH	AS
AT	DFFH	AT
AU	DFFH	AU
AW	DFFH	AW
AX	DFFH	AX
AY	DFFH	AY
AZ	DFFH	AZ
BA	DFFH	BA
BB	DFFH	BB
BC	DFFH	BC
BD	DFFH	BD
BE	DFFH	BE

APPENDIX C - SCOPE OF INVESTIGATION

IN THE CORONERS
COURT OF VICTORIA
AT MELBOURNE

Court Reference: COR 2021 3810

INVESTIGATION INTO THE PASSING OF XY

SCOPE OF INVESTIGATION AS AT 12 OCTOBER 2022

1. The factors contributing to XY's poor mental health at the time of her passing including:

    a. clinical diagnoses;

    b. stressors contributing to self-harm and suicidal ideation;

    c. impacts of COVID-19 lockdowns;

    d. absence of cultural connection;

    e. familial/kinship isolation; and

    f. sexual abuse reported by XY.

2. The adequacy of care, treatment and services provided to XY including ,where applicable, their oversight by the Department of Families Fairness and Housing (DFFH), between 2017 and her passing, concerning:

    a. the effectiveness of XY's case planning and case management including provision of an appropriate level of supervision and monitoring;

    b. the level of appropriate risk assessment and risk-management;

    c. the effectiveness of XY's care and transition planning including support offered to XY in relation to being moved out of care before she turned 18;

    d. the extent to which XY's mental health treatment needs were addressed and treated;

    e. the extent to which XY's drug and alcohol use was addressed and treated;

    f. the extent to which XY was involved in decision-making including decision-making relating to:

   i. placements with whom she wished to live;
   ii. engagement in drug and alcohol treatment; and
   iii. rules applicable to XY when she was absent from her residential placement.

g. the level of support provided to XY's out-of-home carers;

h. the impacts of placement instability on XY's mental health;

i. the adequacy of XY's supports addressing her:

   i. mental health;

   ii. trauma history; and

   iii. cultural needs; and

j. the adequacy of information-sharing, care planning and communication between Child Protection and the other services involved in XY's care.

3. The adequacy of care offered and provided to XY by Bendigo and District Aboriginal Co- operative (BDAC) as an authorised agency under section 18 of the *Children Youth and Families Act 2005* (Vic).

4. The adequacy of care offered and provided to XY by the Aboriginal Child Specialist Advice and Support Service (ACSASS)

5. The adequacy of counselling and care offered and provided to XY during her schooling from the commencement of the 2017 school year.

6. The adequacy of counselling and support provided through Victoria Police to XY following her disclosures of sexual abuse, including by CASA and SOCIT.

7. The extent to which XY's care, treatment, and Cultural Plan was culturally competent and culturally safe.

8. Whether culturally grounded suicide prevention strategies were considered and/or available for XY.

9. The circumstances of XY's attempted suicides and self-harm episodes from January 2021 onwards, and the adequacy of the response from:

   a. health care providers;

   b. mental health care services;

   c. Child Protection;

d. Anglicare Victoria; and

e. Victoria Police.

10. The circumstances of XY's admission to and discharge from the Youth Prevention and Recovery Care (YPARC) facility on 16 July 2021.

11. The response of Anglicare Victoria staff when XY went missing from Maison Residential Care House on 18 July 2021.

12. The response of Victoria Police in conducting a search for XY on 18 July 2021.

APPENDIX D – SCOPE OF INQUEST

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Ref: COR 2021 003810

INQUEST INTO THE PASSING OF XY

SCOPE OF INQUEST AS AT 8 SEPTEMBER 2023

1. The extent to which Child Protection were responsive to opportunities to engage with and provide support to XY and her family.

2. The adequacy of the care and services provided to XY by Child Protection and other services under its auspices between 2017 and her passing, including:
    a. the effectiveness of case planning and case management;
    b. the adequacy of supervision and monitoring;
    c. the adequacy of risk assessments and risk management plans;
    d. the extent to which XY's drug and alcohol use was addressed and treated;
    e. the extent to which XY was involved in decision-making, including in relation to her care, treatment, and residential placements;
    f. the impacts of placement instability on XY's mental health and social and emotional wellbeing;
    g. the level of support provided to XY's carers;
    h. the adequacy of XY's supports addressing her:
        i. mental health;
        ii. social and emotional wellbeing;
        iii. trauma history; and
        iv. cultural needs;
    i. the adequacy of information-sharing, communication and coordination between Child Protection and the other services involved in XY's care.

3. The adequacy of care and case management provided to XY by Bendigo and District Aboriginal Co-operative.

4. The adequacy of care provided to XY by the Aboriginal Child Specialist Advice and

Support Service (ACSASS).

5. The adequacy of Victoria Police's response to XY following her disclosures of sexual abuse to SOCIT.

6. The extent to which XY's care, treatment and cultural plan was culturally competent and culturally safe.

7. Whether culturally grounded suicide prevention strategies were considered and/or available for XY.

8. The adequacy of the response to XY's attempted suicides and self-harm episodes from January 2021 from:

    a. Child Protection; and

    b. Anglicare Victoria.

APPENDIX E – RECOMMENDATIONS

Recommendation 1

a. 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 ACCO, pending the transfer of decision-making power, authority, control and resources to First Peoples communities as recommended by Yoorrook.

b. That DFFH, in collaboration with ACCOs including BDAC, ensure that ACCOs are adequately funded and resourced to have the capability and resources to accept section 18 authorisations, including in cases involving Aboriginal and Torres Strait Islander children and young people with complex needs.

Recommendation 2

That DFFH, Anglicare and other organisations providing services to Aboriginal and Torres Strait Islander children and young persons in out-of-home care (other than ACCOs) review their current policies and practices and implement any changes that are needed to enhance their capacity to provide culturally connected care, including by:

a. implementing aspects of culture (that can easily be accessed by non-Aboriginal people) such as displaying the Aboriginal and Torres Strait Islander flags, displaying Indigenous artwork, engaging with Aboriginal music and TV, learning about Aboriginal food/holidays/language etc;

b. recognising the deeper levels of culture that are not accessible by non-Aboriginal people and being guided by Aboriginal and Torres Strait Islander people about these – by taking on board advice from ACCOs, Aboriginal practitioners within your organisation and building relationships with the wider Aboriginal community;

c. employing Aboriginal cultural mentors and having them available to both staff and young people in their care (particularly in residential care);

d. developing a close relationship with, and being led by the child or young person about their own levels of cultural connection and how they would like to further connect to culture, and providing those opportunities;

e. having a presence at, and taking children and young people to, public events such as NAIDOC week and National Aboriginal and Torres Strait Islander Children's day; and

f. providing opportunities for Aboriginal children and young people to connect with community online (for example, via Facebook).

Recommendation 3

That ACSASS be sufficiently funded by the Victorian Government to:

a. enable full compliance with sections 10, 11 and 18 of the CYFA, so that all decision makers at all critical points in time have full and frank access to Aboriginal specialist advice; and

b. ensure all service providers who have contact with Aboriginal children have free and reliable access to Aboriginal specialist advice, so that no Aboriginal child is placed in a position where they do not have cultural supports around them.

Recommendation 4

That DFFH engage with its stakeholders to review their existing training programs so as to ensure that:

a. all frontline and executive staff employed by agencies that provide child protection, case management and/or residential care services under DFFH's auspices, including but not limited to Anglicare, provide their staff with regular, mandatory cultural awareness and antiracism training covering issues including:

   i. the history of colonisation and in particular the impact of 'protection' and assimilation policies;

   ii. the continuing systemic racism and paternalism inherent in child protection work today that must be identified, acknowledged and resisted;

   iii. the value of First Peoples family and child rearing practice;

   iv. upholding human rights including Aboriginal cultural rights; and

   v. the strength of First Peoples families and culture and culturally appropriate practices; and

b. such training includes mandatory refresher training; and

c. such training is designed and delivered by a First Peoples business or consultant on a paid basis.

Recommendation 5

That DFFH:

a. review and revise all relevant policies, procedures, guidelines and like documents; and

b. review and revise all relevant training courses and programs

to improve its workforce's understanding of the importance of cultural plans and improve the quality, timeliness, implementation and monitoring of cultural plans for Aboriginal and Torres Strait Islander children in out-of-home care. In particular, DFFH should ensure that cultural plans:

c. are individually tailored;

d. involve the child or young person and their family in their creation and review;

e. are updated regularly (at a minimum, annually or when placement or other significant circumstances change);

f. provide a plan to (re)establish or maintain cultural connections, such as contact arrangements with family members, plans for Return to Country with Elders and family members from the same mob group as the child or young person;

g. include SMART goals with clearly defined accountabilities, either as part of the cultural plan or an actions table supporting the child or young person's case plan; and

h. include a legible genogram.

Recommendation 6

That the DFFH, in consultation with the Attorney General, explore the viability and utility of granting the Children's Court supervisory powers over Aboriginal young people's cultural plans.

Recommendation 7

That DFFH:

a. in consultation with the Department of Health and Bendigo Health, develop and implement more focused Social and Emotional Wellbeing approaches to the treatment of Aboriginal and Torres Strait Islander young people requiring mental health diagnosis and treatment, and do so in consultation with Aboriginal Community-Controlled Organisations such as BDAC, and that appropriate and ongoing training be provided to clinical and Child Protection staff to support these approaches;

b. in consultation with the Department of Health and Bendigo Health, develop and implement systems for the cultural support of Aboriginal and Torres Strait Islander young people admitted to hospital for acute and other mental health episodes, to ensure that Aboriginal health liaison officers are actively made available to the young person at the time of admission and that that cultural connection is available beyond crisis admissions;

c. in consultation with the Department of Health and Bendigo Health, take appropriate steps to ensure that its practice of offering contact with an Aboriginal Health Liaison Officer upon admission is effected on each occasion that a young Aboriginal or Torres Strait Islander person is admitted with mental health issues.

d. develop and implement systems to ensure that young Aboriginal and Torres Strait Islander people with acute and/or chronic mental health conditions are provided prompt and ongoing mental health assessment and treatment, and ensure that this is done in ongoing consultation with appropriate Aboriginal input, such as ACCOs like BDAC, and take all steps open to ensure these ACCOs are appropriately funded to enable that work to occur.

Recommendation 8

That Victoria Police:

a. make every effort to increase the number and availability of Aboriginal and Torres Strait Islander people it employs;

b. make every effort to employ Aboriginal and Torres Strait Islander people in SOCITs;

c. increase the number and availability of Aboriginal liaison staff in its dealings with young Aboriginal sexual assault complainants;

d. as a matter of policy, when dealing with female Aboriginal sexual assault complainants, make available a female police officer to conduct VAREs and lead contact with the complainant, unless the complainant requests otherwise or it is not practicable;

e. improve its cultural awareness training as it relates to dealing with female Aboriginal sexual assault victims, including by incorporating reference to 'cultural humility' as described by Dr Krakouer.

Recommendation 9

That:

a. DFFH, in consultation with the Department of Health, clarify respective roles, fund and ensure facilitation of early, intensive and culturally appropriate mental health intervention for young Aboriginal people in its care presenting with complex mental health problems and allegations of sexual assaults.

b. DFFH continue to fund and develop Aboriginal sexual assault healing services delivered by ACCOs.

c. DFFH implement practices for appropriately urgent action and follow up with the Department of Health, and/or its service providers, to ensure young Aboriginal people in its care presenting with allegations of sexual assault are receiving culturally appropriate mental health intervention.

d. DFFH develop and implement processes for appropriate support for out-of-home carers who are dealing with young people suffering the mental health effects of sexual assault.

e. Bendigo Health consider developing and implementing integrated Aboriginal and Torres Strait Islander worker and lived experience workers within the Bendigo health system itself.

Recommendation 10

That the Department of Health, DFFH and Bendigo Health coordinate culturally appropriate drug and alcohol support for young Aboriginal and Torres Strait Islander people who present with drug/alcohol misuse, including by adequately funding and liaising with appropriate ACCOs such as BDAC and/or suitable family/community supports.

Recommendation 11

That DFFH:

a. in association with its ACCO partners, the Department of Health and Bendigo Health, urgently consider how existing mental health services and new mental health service options could be developed to provide care that is accessible to and culturally appropriate for Aboriginal and Torres Strait Islander young people with complex mental health needs;

b. offer funded mental health first aid training for all out-of-home carers, or, at minimum, for out-of-home carers caring for children and young people with mental health concerns, and make such training available in accessible locations in regional Victoria.

Recommendation 12

That:

a. DFFH develop measures to improve coordination between stakeholders in the development and implementation of safety plans, with a particular cultural emphasis where safety plans concern Aboriginal and Torres Strait Islander young people; and

b. DFFH and service providers ensure that any 'line of sight monitoring' policies mandate consideration by carers of compelling surrounding circumstances, such as patterns of escalation in suicidality risk, risk of exposure to identified triggers of a self-harm event, and the young person's recent behaviour and affect.

Recommendation 13

That DFFH ensure that kinship carers:

a. have access to training, support, and services that are appropriate to their circumstances;

b. are aware of and receive assistance accessing financial supports; and

c. are aware of the existence of the Care Support Help desk and how to access it.

Recommendation 14

That:

a. the KEYS or like model of residential care services continue to be rolled out in regional Victoria and that such services for young Aboriginal and Torres Strait Islander people be developed in consultation with ACCOs such as BDAC;

b. ACCOs be prioritised as the preferred organisation to deliver residential care in the tender process for allocating funding, with quality of care and best practice outcomes given a higher priority than economic rationalisation in the tender process.

Recommendation 15

That DFFH extend AFLDM referral powers to organisations providing contracted case management services to DFFH and to ACCOs exercising delegated powers pursuant to section 18 of the CYFA.

Recommendation 16

Noting the Yoorrook Justice Commission's recommendation that the Victorian Government 'transfer decision making power, authority, control and resources to First Peoples, giving full effect to self-determination in the Victorian child protection system', I recommend that DFFH significantly upscale the capability, competence and support of all persons working within the child protection system to ensure that they are able to:

a. comply with sections 10, 11, 12, 13 and 14 of the Children, Youth and Families Act 2005;

b. adopt a relational approach to child protection work which prioritises the practitioner's ability to relate to the child and their families over compliance-driven measures; and

c. engage in effective case management and case planning, including long-term planning and transition planning.

In particular for this purpose, DFFH should:

d. review and revise all relevant policies, procedures, guidelines and like documents;

e. review and revise all relevant training courses and programs; and

f. ensure, to the greatest extent possible, that it has appropriate staffing levels and is able to retain experienced child protection practitioners.

Recommendation 17

That DFFH review and revise its relevant training courses and programs with a focus on improving Child Protection Practitioners' skills in engaging with children and young people, so as to hear, acknowledge, understand and give weight to a child's experience and expressed views in their subsequent decisions and actions.