IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 3163

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the Coroners Act 2008

Findings of:	Sarah Gebert, Coroner
Deceased:	Master S[1]
Date of birth:	[redacted] 2000
Date of death:	3 July 2017
Cause of death:	*Unascertained in the setting of volatile substance abuse*
Place of death:	Bert Williams Hostel at 21 Normanby Avenue, Thornbury, Victoria
Other Matters:	*Chroming, volatile substances, child protection*

[1] This finding has been de-identified by order of Coroner Sarah Gebert to replace the names of the deceased, his family members and select individuals with pseudonyms to protect their identity and redact identifying information

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INTRODUCTION

1. Master S[2], born [redacted] 2000, was 17 years old at the time of his passing. He was a proud young Yorta Yorta man with siblings [redacted], [redacted], [redacted], [redacted], [redacted], [redacted] and [redacted].[3] Master S was the son of [redacted] and [redacted].

2. During Master S's early life, he was exposed to significant episodes of family violence and experienced instability as well as developmental, behavioural and mental health issues, which are recognised impacts suffered by children who have experienced family violence.[4]

3. Master S was placed on a Family Preservation Order which was due to expire on 10 October 2017. He had been the subject of 12 reports to Child Protection between 2004 and 2016. Seven of these reports proceeded to investigation and three investigations resulted in protective intervention. The first protective order was made on 31 January 2008 when Master S was 7 years old.

4. Master S was a client of Youth Justice at the time of his passing and his recent criminal history included theft of a motor vehicle, stalking and intentionally causing damage. On 27 June 2017, Master S was placed on a Children's Court Youth Diversion order at the Melbourne Children's Court for a period of 2 months.

5. On 3 July 2017, Master S was found unresponsive in his room at the Bert Williams Hostel in Thornbury where he had been living since 30 May 2017.

THE CORONIAL INVESTIGATION

6. Master S's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

7. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding

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[2] Referred to as 'Master S' unless more formality is required.

[3] [redacted] and [redacted] were both stillborn.

[4] Documented references to family violence from 2004 to 2014 include Master S being yelled at, physically assaulted and being present whilst his mother was physically assaulted:

- *the children had made disclosures about* [their stepfather] *physically assaulting them;*
- *Master S was experiencing trauma responses in relation to the family violence he had been witness to throughout his childhood;*
- *Master S had made disclosures that he had been physically assaulted by his stepfather.*

circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

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

9. Victoria Police assigned Senior Constable Russell Cameron (**SC Cameron**) to be the Coroner's Investigator for the investigation into Master S's passing. SC Cameron conducted inquiries on my behalf,[5] including taking statements from witnesses and submitting a coronial brief of evidence. The brief includes statements from Master S's mother, workers from the Bert Williams Hostel, a resident of the Bert Williams Hostel,[6] the Chief Executive Officer (**CEO**) of the Victorian Aboriginal Health Service (**VAHS**), Master S's general practitioner (**GP**), the forensic pathologist who examined him and investigating officers, as well as other relevant documentation.[7]

10. Statements were also provided to the Court by Dr Eamonn McCarthy, Principal Practitioner for Child Protection services in the North Melbourne Area[8] and Rebecca Falkingham, Secretary, Department of Justice and Community Safety.[9]

11. In addition, the Court obtained Master S's medical records from the Northern Hospital and his files from the Children's Court Family Division, Youth Justice and Child Protection.

12. Given the circumstances surrounding Master S's passing, I also asked the Coroner's Prevention Unit (**CPU**)[10] to consider the potential dangers of chroming, and to advise on possible prevention recommendations to reduce the risk of future deaths.

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[5] The carriage of the investigation was transferred from Deputy State Coroner English (as she then was).
[6] The police were unable to obtain statements from other residents.
[7] I also reviewed the medical records of Master S's younger brother who had an unexplained collapse on 8 November 2018 which required an overnight admission.
[8] Dated 12 June 2020.
[9] Dated 12 August 2021.
[10] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

13. This finding draws on the totality of the coronial investigation into Master S's passing. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[11]

BACKGROUND

Master S's Physical Health

14. Master S was generally in good health. His mother said that in 2004 he was diagnosed with Attention Deficit Hyperactivity Disorder (**ADHD**)[12] and was prescribed Dexamphetamine. Master S's mother said,

> *He took it through his primary school years and then when he got to secondary school and was in year 9, he told me he didn't want to take it anymore because it made him lose his appetite. He told me he felt like a zombie. It wasn't really a plan - we had a conversation about it and he stopped taking it.* '[13]

15. Master S usually attended at VAHS for his medical needs. Paediatrician, Dr P[14] noted that Master S had a history of *learning difficulties, sleep difficulties, behavioural issues and ADHD.* He first saw Master S on 7 August 2014, when he was 14 years old. He was living at a refuge at the time (having escaped *family based violence*) and was not enrolled at school. Master S was prescribed Concerta for ADHD in 2014 but had ceased taking the medication in December 2016 and it had not been re-prescribed. Master S last attended at VAHS on 4 December 2016. Dr P said,

> *He attended with his VACCA (Victorian Aboriginal Child Care Agency) worker.* [Master S] *informed me that he had been expelled from Bundoora Secondary College, disengaged from The Island School in Coburg, but planned to attend the Pavilion School in 2016. He had ceased taking his medication as he felt it was not working. I did not re-prescribe. It was clear to me at the time he had issues with anger management and school attendance.*

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[11] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[12] Master S was diagnosed with ADHD by the Plenty Valley Community Health Centre psychologists and was commenced on dexamphetamine.

[13] Statement dated 21 May 2018.

[14] Medical Report dated 4 December 2017.

16. Several further appointments were scheduled but Master S did not attend. His medical records document that he was referred to the VAHS Koori Kids in May 2017 by a Youth Justice Worker and was booked to see the Paediatric Registrar within the Koori Kids program on 23 May 2017, but there was no record of him attending.

Master S's Education

17. Master S attended various schools up until December 2016.

18. Master S's mother said,

> *that he tried different schools but didn't last long and at least* [once] *he was bullied. He never said he didn't like school –he just struggled with the other children because of his ADHD he would say something and they would say something back and it would start. Particularly if someone said something about his family. He never got into physical fights, it was more verbal.*
>
> *At school he would only socialise with people at school because we were in the refuge. He never went over to people houses.*

19. When Master S was attending Preston North East Primary, he undertook an intellectual assessment on 22 November 2006 to determine whether there were any cognitive reasons for his slow literacy development and behaviour, besides difficulty concentrating. The teachers reported that Master S was a very outgoing and responsive child, however he had difficulty following teacher instructions and consequences. Overall, he performed within borderline range and a number of recommendations were made to assist his learning in the classroom and at home.

20. On behalf of Child Protection, Dr McCarthy noted the following,

> [Master S] *articulated on many occasions that he enjoyed attending school and described it as a safe place. When at school he was well engaged and supported although he struggled academically and socially. His education was very disrupted due to his mother's transience and frequently needing to relocate to refuges due to ongoing family violence perpetrated by stepfather* [redacted].
>
> ....

[Master S] *was attending school regularly and assessed as below average academically. The school advised that* [Master S] *responded well to clear instructions and structure and he was receiving extra supports to strengthen his academic and social skills.*[15]

[Master S] *spoke positively about his school and his Counsellor raised concerns for* [Master S's] *longstanding experience of abuse, trauma and instability.*[16]

....

On 24 July 2014 child protection received the tenth report raising concerns that [Master S] *was not enrolled or attending school and* [Master S's mother] *struggled to meet his needs. Child protection made enquires and could not locate* [Master S's mother] *and* [Master S], *and the case was closed.*[17]

.....

On 21 July 2015 Bundoora Secondary College reported [Master S] *and his friend slept at the school over night and was found by a cleaner at 7am.* [Master S] *was observed to be dishevelled and had paint on his hands as a result of graffitiing another students home and school property.* [Master S] *advised the school he did not want to return home as his mother hits him with a broom. The Welfare Coordinator advised child protection of her engagement with* [Master S] *and described him as a vulnerable and angry young person with significant behavioural challenges. She stated* [Master S] *is behind in literacy and numeracy and enjoys attending school. The Principal advised* [Master S] *would be suspended for graffiti, vandalising and destroying school property, stealing and other disruptive and challenging behaviours that placed other students at risk.*

...

On 5 August 2015 Bundoora Secondary College advised [Master S] *and* [Master S's mother] *that due to* [Master S's] *behaviours and concerns by teachers and students about their safety he could not return. The school reported* [Master S] *required another school that had the expertise and resources to support him.* [Master S] *was disappointed and advised he wanted to attend school.* [18]

[15] Master S at 8 years old.
[16] Master S at 12 years old.
[17] Master S at 14 years old.
[18] Master S at 15 years old, eleventh Child Protection Report.

21. It was noted in August 2015 that the Victorian Aboriginal Child Care Agency (**VACCA**) remained involved with the family supporting Master S's mother with her parenting skills, locating another school for Master S and connecting him to his culture.

22. Master S had also attended The Pavilion School in Preston but told a Youth Justice Worker in May 2017 that he stopped attending due to *wanting to bash* some other young people who attended at the school.

Master S's Exposure to Family Violence

23. Master S was exposed to and the subject of family violence throughout his childhood.[19] His mother said that in 2005 the family experienced family violence noting that her partner (who was the father of three of her children) was on heroin, *pills* and consuming alcohol at the time. Master S was a witness to his mother being physically abused and tried to intervene (*don't beat my Mum*). Master S's mum said,

I'd just say something and I'd cop a punch in the face or be dragged and jumped on. He knocked my teeth out at one stage. He would beat me in front of the kids. I don't even know what I said that would cause that. I would always think if I didn't say that then he wouldn't beat me – I look back and think how the relationship was and I was a mum doing all the right things – I'm not a drug user. I used to leave him and go into refuge but then go back. He wasn't always violent – he would change the nappies and then clean the house – he would beat me when I wasn't pregnant – my life was constantly hectic, trying to compromise with him, trying to reason with him, finding needles around the house. It was like I was in the wrong because if I mentioned it I would cop a beating or he would emotionally abuse me – put me down, call me names, saying how poorly I was doing with the kids. The kids would hear it as well – he wasn't discreet about anything, he wouldn't care but when we were out and about he was a different person, so nice to everyone he would bend over backwards for them.

[19] Master S was the subject of various orders under the Family Violence Protection Act 2008, which included, an Interim Order on 14 April 2009, at the Heidelberg Magistrates' Court (Respondent: his step father) which was struck out on 18 May 2009; a Final Order on 22 November 2010 for 12 months, at the Mildura Magistrates' Court (Respondent: his step father); a Final Order on 8 December 2011 for 12 months, at the Heidelberg Magistrates' Court (Respondent: his step father); an Interim Order on 29 April 2016, at the Heidelberg Magistrates' Court (Respondent: his step father); an Interim Order on 9 May 2016, at the Heidelberg Magistrates' Court (Respondent: his step father), Master S was the only AFM; and a Final Order on 8 December 2016 for 12 months, at the Heidelberg Magistrates' Court (Respondent: his step father).

24. Master S's mother said that throughout the time she lived with this partner, he would treat Master S *very badly*. She said,

He would emotionally abuse him - put him down, call him names. He has assaulted him - he's put him in hospital. [redacted] *punched* [Master S] *to the head when he was still living in Reservoir and he got taken to Northern Hospital after* [his girlfriend] *called the ambulance. Apparently* [Master S] *didn't stay to see the Doctor because he was worried about* [his girlfriend] *being at the address.* [redacted] *would get angry at* [Master S] *- abuse him. Throughout the time I lived with* [redacted] *- he did hit* [Master S]. *I would always tell* [redacted] *that he had to leave* [Master S] *alone - no matter what* [Master S] *had done he was always constantly on his back.*

……..

I was always protective of [Master S] *and would always tell* [redacted] *he was not his dad. I was always* [Master S's] *mum and dad.*

25. On behalf of Child Protection, Dr McCarthy noted the following in relation to the third child protection report on 7 August 2007, when Master S was 7 years old,

Child protection conducted an investigation and [his stepfather] acknowledged hitting [Master S] *with his hand to his head multiples times as he felt frustrated after he was advised that* [Master S] *had taken a knife from the after-school care kitchen and destroyed toys.* [Master S] *did not sustain injuries and he disclosed that [his stepfather] regularly called him derogatory names, that his mother and [his stepfather] continued to argue and at times he did not feel safe at home.* [Master S] *identified school as a safe place.* [Master S's mother] *was distressed by [his stepfather's] actions against* [Master S] *and she told [his stepfather] to leave the home until he sought support and address his issues.* [Master S's mother] *was engaged with VACCA who was providing family support, counselling and advocacy for the family to secure suitable long-term accommodation.*

26. Other observations of Dr McCarthy relating to Master S's experience of family violence included the following,

The Paediatrician recommended counselling for [Master S] *due to concerns of cumulative harm.*[20]

[Master S] *expressed to his Counsellor being fearful of* [his stepfather] *and that he did not want to have further contact with him.* [Master S] *was overly concerned about his mother's welfare and did all he could to support her including caring for* [his sister].[21]

VACCA raised concerns about [Master S's mother's] *transience and instability this caused for* [Master S] *who kept moving schools and homes.*[22]

27. Respite notes of March 2013 also recorded,

[Master S] *last stayed with the writer in October 2012…Since his last stay* [Master S] *has regressed at a frightening rate…The writer has grave concerns for* [Master S's] *emotional wellbeing – he is displaying behaviours that are consistent with significant exposure to trauma, violence and lack of familial attachment – cumulative harm.*

28. Master S and his family moved around numerous times during his childhood, including staying at a number of refuges (motels, hostels, emergency accommodation) to escape family violence. Master S spent his 14th birthday at Elizabeth Hoffman House. The family also moved to regional Victoria on a number of occasions and Master S was placed in respite care with VACCA carers at his mother's request.

29. Police records also document that Master S witnessed a number of family violence incidents against his mother including on 6 December 2008, 21 November 2010, 6 December 2011, 24 January 2013 and 31 January 2017.

30. Master S was also the respondent in an interim order under the *Family Violence Protection Act 2008* granted on 28 December 2016 at the Sunshine Children's Court in relation to his ex-girlfriend, which was withdrawn on 22 March 2017.

31. The evidence also suggests that in the last 12 months of Master S's life his mother entered a new relationship with a male who had an extensive criminal history and Master S told his mother that he did not like her new partner and this appeared to increase his absconding behaviours.

[20] Master S was 8 years old.
[21] Master S was 12 years old, seventh Child Protection report.
[22] Master S was 14 years old, ninth Child Protection report.

Significant Events Prior to final Family Preservation Order

25 April 2016

32. On 25 April 2016, Master S attended the Northern Hospital Emergency Department (**ED**) where, according to hospital records, he reported he had an alcoholic drink and a disagreement about his girlfriend not talking to him. He made threats of suicide to his friends and his stepfather which made his stepfather angry. Master S said that he felt frustrated and angry so he punched a whiteboard in the lounge room. Master S's stepfather yelled at him and then hit him on his right temple with a closed fist after which he delivered a further four to five hits with a closed fist to the right side of head. Master S followed his stepfather and said he would kill himself. His stepfather reportedly said to Master S *that I'll turn my head and you do it*. Master S said he wanted to be with his sister who was stillborn and had died a year before Master S was born. Master S left the house and wandered in front of cars (Master S said they happened to be on the road) and subsequently called Ambulance Victoria (**AV**) and police from a shopping centre. He told hospital staff that he had no plans for self-harm and wanted to go home.

33. Child Protection were contacted by hospital staff and advised that they had spoken to his mother who was going to attend the hospital. Master S told hospital staff that he did not want to see his mother and later left the hospital prior to discharge. As it was determined that he had no acute risks, he was not required to be compelled to return for further assessment. Child Protection were advised and told the hospital that they would follow up with Master S and would call police and attempt to find appropriate/safe accommodation for him.

34. Victoria Police issued a Safety Notice prohibiting his stepfather from committing violence against Master S.

9 July 2016

35. On 9 July 2016, Master S was taken to the Northern Hospital where it was documented, *16 yo Male BIBP – Not s351, Brought in mainly for medical clearance. 5-6 calls to '000'. On being located in middle of the road ….Screaming for his mother & trying to stop cars to take him to his mother – who was in PARCS currently. Brought in to ED. Police found him on the kerb at 22.15hrs. At 00.07 hrs his BAC 0.126%.*

36. Master S disclosed that he was punched five times by his stepfather two months prior, and his stepfather was abusive when he was younger. He was fully assessed and it was documented that he did not display any sign of psychosis and denied an intention to self-harm.

37. Child Protection were contacted at approximately 2.22am, prior to his final assessment and the hospital were advised that he was the subject of a 'Safe Custody Warrant' to his aunty who lived in Ballarat. Child Protection were later advised of the outcome of the assessment and advised that Master S had been placed in temporary accommodation over the weekend.

<u>26 August 2016</u>

38. On 26 August 2016, as part of a missing person's report, Master S left his stepfather's house stating that he would never see him again. He later contacted a female friend and stated that he had a gun and was going to shoot himself.

Family Preservation Order - Child Protection

39. Master S was placed on a Family Preservation Order for a period of 12 months on 11 October 2016 at the Broadmeadows Children's Court.

40. On 5 January 2017, Child Protection received a report[23] that Master S was in the city and had consumed 25 Panadol tablets and expressed suicidal thoughts, stating that his stillborn siblings were calling him and that he needed to be with them. He also expressed his desire to *hang himself* which he later denied. Workers spoke to him the following day (after a warrant was granted due to concerns around his mental health), at which time Master S denied suicidal ideation but advised that he did not care if he lived, died or got locked up. A plan

[23] *On 5/1/2017, Child Protection received a report that* [Master S] *had absconded from his mother's care and taken her phone with him into the city. The report outlined that* [Master S] *had made contact with a family member, and told them he had taken '25 pills', and was having suicidal ideations. It was reported that* [Master S] *expressed his two deceased sisters had been 'calling him', and that he had been hearing voices over a period of time, and needed to be with them.*
[Master S] *accepted a phone call form Child Protection at approximately 3.45pm, confirming he had ingested 25 Panadol tablets around 15 minutes prior to the phone call. He advised he was in the city at Southern Cross station, however would be soon catching a train. He agreed to make his way to his step father .....house.* [Master S] *agreed for Child Protection to meet him there, and speak again at 4.15pm.*
Phone calls were made to [Master S] *at 4.15pm and 4.30PM by Child Protection, however were not answered.*
[Master S] *contacted Child Protection at 4.36 PM advising he was no longer making his way to* [his step father's] *home. He expressed he is very stressed, and refused to advise of his location. He stated 'I should go to the Police and hand myself in, so they can put me on location. He stated 'I should go to the Police and hand myself in, so they can put me on suicide watch'.* [Master S] *refused to meet with Child Protection at any locations, and advised he was going to his girlfriend's house to 'hang himself', before ending the phone call.*

was made for him to stay with his aunty and he agreed to attend a GP and receive a mental health plan.

41. It was documented that there were significant concerns around Master S's mental health, as he had expressed suicidal ideation and he appeared to be experiencing a deterioration in his mental health and had expressed threats to harm himself in the past. It was further noted that there had been grief and loss in the family, with the birth of a stillborn sibling in late 2016.[24]

42. On 9 January 2017, Child Protection was granted a warrant [section 341(2) of the *Children Youth and Family Act 2005* (**CYFA**)] that allowed Master S 's Family Preservation Order to be breached due to his mother not complying with the directions of the order or demonstrating a capacity to care and respond to Master S 's needs. According to Child Protection, Master S was spending large periods of time away from his mother, significant concerns were held for his safety and wellbeing and (Master S's mother) was not proactive in maintaining engagement with supports and prioritising Master S's needs for stability and support.

43. Master S was located on 13 January 2017 with a group of young people and after police attended the Essendon train station they executed the warrant. An urgent outreach visit was conducted by After Hours Child Protection Emergency Service (**AHCPES**) at the Moonee Ponds Police station. Master S agreed to remain at his mother's home for the weekend. An application to breach the Family Preservation Order was issued and a Bail Justice Hearing convened. Given that Master S and his mother both agreed that he return home, an Interim Accommodation Order (**IAO**) was issued placing Master S back in his mother's care until it could be heard at the Broadmeadows Children's Court on 16 January 2017.

44. Master S was observed during the assessment to be emotionally and mentally stable and presented as articulate. Master S noted that he had grown up being exposed to family violence and coupled with his ADHD, he recognised that he could easily lose his temper following arguments with his mother. He also expressed a desire to have the freedom to visit friends without being reported missing. Master S expressed his desire to be able to get a job and become independent. The following was recommended:

[24] On 4 November 2016, Master S's stepfather reported that the children were distressed the previous night because apparently during a contact visit with their mother, who had miscarried, had taken them to the hospital to see the foetus and they were distressed as the baby didn't have any eyes.

- Master S be linked to a psychologist/counsellor to develop coping mechanisms and prevent suicide ideation.

- Master S and his mother be linked to support services to assist in communication and improve parent-adolescent relationship.

- Regular safe respite options be identified for Master S to reduce parent-child conflict and future placement breakdowns.

- Master S be linked to a day programme to support his desire to seek employment and work towards independent living.

45. On 16 January 2017 the breach application of the Family Preservation Order was listed in the Children's Court but (Master S's mother) did not attend. The Magistrate issued a warrant (s 598 of the CYFA) and adjourned the matter *sine die*. Child Protection advised (Master S's mother) of the court outcome and requested she make a missing person's report in relation to Master S. Child Protection later filed that report.

46. It was documented on 30 January 2017, that Child Protection were to consult with the Principal Practitioner in relation to placing Master S on the High Risk Youth Schedule.

47. Also on this day, Master S was noted by Child Protection who attended his home to have presented as very pale in the face. He was yelling and swearing, stating *fuck the police* and *fuck DHS*. He was sighted to have what appeared to be a number of self-inflicted cuts on his forearm. There was a concern that he may be affected by methamphetamine due to the extreme anger and pacing behaviours.

48. On 1 February 2017 police advised Child Protection that they attended Master S's home and spoke with Master S and noted no concerns. Police later called AHCPES once they became aware that Master S was subject to a missing person's report and a section 598 warrant. AHCPES advised police the warrant was for Master S to reside with his mother and therefore no action was required.

49. On 2 February 2017 Master S's mother advised Child Protection that she had not taken Master S to Court as she was in a car accident. She stated that she did not believe Master S was using *Ice* but acknowledged concerns regarding self-harm. Child Protection raised concerns with (Master S's mother) about Master S's deterioration.

50. On 7 February 2017 Child Protection conducted an unannounced home visit to (Master S's mother's) home but nobody answered the door. Child Protection said that they made multiple efforts to contact (Master S's mother) but she did not respond. Master S's number indicated it was disconnected.

51. During an unannounced home visit conducted by Child Protection on 24 February 2017, Master S presented as quite angry during conversation. He was angry that his siblings were spending half their time with their father (his stepfather) as he said that they were being exposed to drug use and he feared for their safety. He threatened that if Child Protection did not do anything about it, he would. He also said that he did not care if he lived or died and that he was not going to live past his next birthday. He also said that he felt unsafe in the community.

52. On 2 March 2017, Child Protection spoke to The Pavilion School and encouraged them to reach out to Master S. The school agreed to attend the next care team meeting to plan for engagement with Master S.

53. A subsequent case plan dated 21 March 2017 documented that Master S was enrolled at The Pavilion School, but he did not attend and that he had education supports available through VACCA. There were no concerns in relation to Master S's development noted. His protective concerns included absconding behaviours and engaging in criminal activities.

54. On 20 April 2017, Master S's mother sought refuge from Master S's stepfather, and was placed in a hotel with Master S and his brother with the assistance of Safe Steps.

55. On 5 May 2017, Child Protection was advised that Master S had been arrested due to an outstanding warrant and police were seeking to have Master S remanded as he had missed three criminal court hearings.

56. On 23 May 2017, Child Protection attended (Master S's mother's) home and Master S was present. Master S was yelling *Fuck DHS, DHS dogs*. Child Protection were later advised that Master S had a new worker from Dardi Munwurro (Aboriginal Youth Support Service) who suggested a program that may be suitable for him.

57. Child Protection were advised that Master S was on bail and that he was not adhering regularly to the curfew condition of 8.30pm despite police undertaking compliance checks.

Master S's contact with the police and the justice system

58. Master S had only had minimal contact with police regarding a small number of criminal matters, aside from being the subject of missing persons reports as well as family violence involvements.

59. A warrant for his arrest was issued on 5 April 2017 at Heidelberg Children's Court in relation to fail to appear on bail regarding a charge of theft of a motor vehicle said to have occurred on 3 December 2016. A warrant for his arrest was issued on 28 April 2017 at Melbourne Children's Court in relation to fail to appear on bail regarding a charge of stalking (intent to cause mental harm), which was said to have occurred on 27 December 2016.

60. Other outstanding charges by way of summons included deposit litter, smoke in a non-smoking area and spit on a train.

Master S and the Youth Justice System

61. At the Heidelberg Children's Court on 5 May 2017, Master S was remanded in custody to the Melbourne Children's Court on 8 May 2017. He was incarcerated at the Parkville Youth Justice Precinct.[25] This was Master S's first time in custody. Records document that he appeared *overwhelmed* and *anxious* at the time of being remanded.

62. On 8 May 2017, Master S was granted bail with conditions and the case was listed for 27 June 2017.

63. On 10 May 2017, [redacted], Senior Practice Cultural Advisor, placed referrals to Dardi Munwurro Journey's Program and VAHS Koori Kids Counselling Service. On the same day, Mr L from Dardi Munwurro confirmed with Youth Justice that the referral had been accepted. In addition, [redacted], VAHS Koori Kids Mental Health Clinician, confirmed that she would make contact with Mr R (who was employed by VAHS but worked with Master S through Dardi Munwurro) to arrange a meeting with Master S and advised that she would arrange for a paediatric review.

64. The referral to Dardi Munwurro noted under areas of interest,

[25] Parkville Youth Justice Precinct comprises two youth justice centres and is located in the inner northern Melbourne suburb of Parkville, approximately five kilometres from the central business district.

To be explored however this young person is at risk of entering the criminal justice system and requires urgent attention to be connected with positive mentors and peers and needs to strengthen his identity and connection with community. He has an interest in being connected with footy and also wants to participate in cultural programs/camps.[26]

65. Ms J, Children's Court Youth Diversion Coordinator, Youth Justice, was asked to assess Master S's suitability for the Children's Court Youth Diversion Program for his return date on 27 June 2017. In consultation with Dardi Munwurro it was agreed that the assessment meeting would take place at Bert Williams Hostel on 19 June 2017.

66. During the meeting, Ms J observed that Master S had difficulty retaining and remembering information; that he moved from sadness to anger to calm and back throughout the assessment; that he thought he was already on a diversion plan and that he was confused about the charges; that he made references to killing himself approximately four different times (when asked about these feelings he was *dismissive and avoidant and emphatically* stated that he did not want to talk to anyone about it or participate in counselling); that his time in custody wasn't that bad and that everybody gets locked and that he expected to spend a lot of time in prison. It was noted that it was difficult to find activities that he was willing to participate in; and he expressed inappropriate paranoia and paranoid beliefs for example with respect to police looking for him. There was discussion of a possible mechanical traineeship and re-engaging at The Pavilion School.

67. Ms J was concerned that he had an intellectual disability and about his expressions of suicidal thinking, mental health, criminalised thinking and disengagement with education.

68. She made a referral to Koori Kids regarding Master S's mental health (depression, suicidal ideation, paranoia, anxiety, anger) and possible cognitive delays on 19 June 2017 (with an email to Koori Kids requesting referral be prioritised).

69. On 22 June 2017, the referral was discussed with Mr B, Koori Early School Leavers Worker, Bert Williams Aboriginal Youth Services (**BWAYS**) including Master S's remarks of killing himself. Mr B agreed to follow up the referral and that BWAYS would also do their best to get Master S to court on 27 June 2017.

70. On 27 June 2017, Master S was placed on a Children's Court Youth Diversion order at the Melbourne Children's Court for a period of 2 months. Master S was assisted by BWAYS

[26] Initial Contact (Expression of interest) form Journeys Program.

and it was noted that the diversion plan was discussed with Master S and he presented well and also engaged well in discussions.

Connection to Master S's culture

71. Master S and his family were supported by a number of Aboriginal organisations including VACCA which were involved to help Master S connect with his culture. White Lion, Bunji Bunji program was offering mentoring to Master S and engagement with community activities and sports.

72. It was noted that Master S did not attend a Koori camp through VACCA he enrolled in during May 2015, as [Master S] *expressed that he was too concerned to leave* [his mother] *at this time to go away on the camp.*

73. On 11 October 2016, Child Protection noted that [Master S] *is quite disconnected from his Aboriginal culture, and does not appear to have any role models in his life at the current time.*

Connection with Master S's father

74. Master S was keen to see his biological father. His mother said Master S reconnected with his father on Facebook and was promised things which did not eventuate. She said that this upset Master S,

when [Master S] *got drunk he would express his feelings. I would hear him in the shower crying his eyes out and he would get angry. It would break my heart to hear him saying 'what is wrong with me, why would people do this to me?' and 'when I contact him he's never available*.

75. Dr McCarthy noted on behalf of Child Protection the following when Master S was 9 years old,

On 31 August 2009 [Master S's father] *contacted child protection and requested contact with* [Master S]. [Master S's father] *attended a Children's Court hearing and was able to have supervised contact. On 1 September 2009* [Master S's mother] *attended with* [Master S] *to see his father and this was supervised by child protection.* [Master S] *called* [Master S's father] *"daddy" and* [Master S's father *advised* [Master S] *of his half-brother and of extended family members who wanted to meet him. Child protection requested further meetings with* [Master S's father] *and his family to conduct assessments to plan for further*

contacts with [Master S]. [Master S's father] *did not make himself available and did not have further contact with* [Master S].

Male Role Models

76. There were several references suggesting a need for Master S to have a male role model in his life. Master S's mother said,

I wanted a mentor - a male role model - for [Master S]. *He had no good male role models - all of my family males had been to jail. I wanted a proper way to show him there is a proper way for men to be.* [Master S] *was happy about this*.

Moving into the Bert Williams Aboriginal Youth Services – BWAYS

77. Mr R started to work with Master S on 24 May 2017. Master S told him at their first meeting that he wanted support to move into a youth hostel *as his mother's house was becoming over crowded.*[27]

78. Around 25 May 2017,[28] Mr M, Hostel Co-ordinator for BWAYS, said he received a call from Mr R asking if they had a bed for Master S *due to lack of room* at his home.[29]

79. A meeting was arranged between Master S, his mum and Mr L. He said that Master S identified at that first meeting that he would like support to move into a youth hostel as his mother's house was becoming overcrowded. He said a referral was made to the hostel for Master S which his mother agreed with.

80. Master S's mother said,

[Mr R] *was* [Master S's] *worker from VACCA. He came into the picture while I was at the West Heidelberg house. He was the one helping him with court matters, opening a bank account, trying to get him back to school at Pavilion. He was the one that told me about the hostel.*

81. She said that Master S had a good relationship with Mr R and said,

[27] Statement dated 2 August 2018.
[28] Master S had been a client of BWAYS since 25 May 2017 by referral from Dardi Munwurro according to CEO, VACSAL.
[29] Statement dated 20 November 2017.

When [Master S] *came back to live with me, he was telling me his brothers were annoying him and he wanted to move to America. When* [Mr R] *came over, he must have been telling* [Mr R] *about it as well.* [Master S's] *siblings were coming into his room –* [redacted] *and* [Master S] *did share room but it was hard. There was only so much they could do with each other.* [Mr R] *and I spoke about it - that he could live at the hostel.* [Mr R] *told me that I could still see him - it wasn't restricted or anything. That's what happened.*

82. On 30 May 2017, Master S moved into the Bert Williams Hostel (**the Hostel**). The Hostel provided up to three months accommodation to males between the ages of 16 to 24 years. There were up to five young males housed at any one time and each had their own bedroom. The room doors were fitted with locks to protect the resident's property. Only staff had keys and as such, staff were required to open the doors of the residents for them to gain access. Residents of the Hostel were woken at 7.30am every morning and had to be out of bed by 8.00am on weekdays (and 9.30am on weekends). They were required to clean their rooms before they left and were not allowed to be in the house if there was no staff member present.

83. Master S occupied the Wurundjeri room by himself and brought his clothes, TV and PlayStation. The Hostel provided his bedding and dinner, and Master S did not have to pay for any of the amenities or meals.

84. Master S's mother said that she was uneasy about the move but she knew he needed his own space. She said,

I was so uneasy about it because [Master S] *has never really lived away from me – I'm Mother hen but I also knew he needed his own space.*

85. According to Mr W,[30] a worker at the Hostel, Master S was a *really top kid. He was never in trouble while he was at the hostel.* He said, *I remember seeing* [Master S] *on Friday before he died. His family had visited and he had been mucking around with his brothers and sisters.*

86. Master S's mum would visit him at the Hostel to bring food and would come with his younger brothers and sisters.

[30] Statement dated 6 December 2017.

87. According to Mr M, [Master S] *was a pretty happy young guy. He was full of beans, a larrikin, a bit of a joker. We really had no problems with his behaviour, and the only drug use I was aware of was on his referral that he had recreational use of marijuana (Yandi).*

88. A fellow resident described Master S as *pretty healthy and he was always happy and smiling* although he thought that Master S was really young to be living in a place like the Hostel.

89. Another resident said that he had an argument with Master S after he discovered he had taken his *choof* following which he didn't talk to him. About two weeks later, he said he snapped at Master S and *shook him around a bit.*[31] He said that Master S *smoked choof and chromed Rexona cans* and that while he was still talking to him he tried to warn him against chroming and *what it would do to him, but he didn't listen.*

90. Master S's mother remembers a doctor's appointment for Master S before he moved into the Hostel and that he had told his mother he was coughing up blood. He also told her that he was getting headaches. She said that an appointment was made for the doctor but he did not go.

Master S's Substance Use

91. Master S's mother said that he started smoking marijuana and chroming when he was about 14 or 15 years of age. She never saw any signs of it in his room and thought he must have done it when he was out with friends. She said, *I sort of had an idea but it wasn't until he told me that I knew for sure. It wasn't an everyday habit*. She said that while he was in the Hostel, Master S asked her not to buy any Rexona cans for him as he was chroming them.

92. His mother said that he was fit and healthy and would catch public transport everywhere. *He was really fit and healthy for his age - he was full of life and he had plans. He liked playing PlayStation and listening to music.*

93. Master S turned 17 on 21 June 2017 (six days prior to being placed on the Youth Children's Court Youth Diversion Order).

94. Youth Worker, [redacted], said that he had known Master S for almost two months and *worked with him due to his youth justice issues and found him to be a good kid who did not have any behavioural issues during his time at the Hostel*. He said that,

[31] Statement dated 2 July 2018.

In the week before [Master S's] *death, I believe it to be on the Thursday or Friday, I had run into him out the back of the Hostel when I was having a cigarette. He showed me some items that I believed he had stolen, a set of headphones and a can of Rexona. I now realise that he was potentially "chroming" with the aerosol can.*[32]

95. Mr R said that he last spoke to Master S by phone on Thursday 29 June 2017 to schedule a catch up for lunch on Monday 3 July 2017. He said, [Master S] *sounded happy on the phone when I spoke to him and he informed me that he was looking forward to going back to school.*

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

Circumstances in which the death occurred

96. At approximately 11.30am Saturday 1 July 2017, Mr W, who had worked the overnight Friday shift at the Hostel, said that Master S told him that he was going away for the weekend. He said,

I was on sleep over shift on Friday night and I saw [Master S] *in the morning on Saturday 1st of July at about 11.30am. He told me that he was going out for the weekend. I was expecting him to come back on Monday. This was not unusual as he would sometimes stay away for the weekend like that.*

97. Residential Worker, Mr I commenced his shift at 12.00pm on 1 July 2017 and last saw Master S around 4.00pm that day when Master S told him he was going out. Mr I did not see Master S leave, but also did not see anyone come or go from Master S's room after this stage. The Case Note documented (written following Master S's passing),

Discussion with [Mr I], [Master S] *states that he did not see the client leave the hostel on the 1st of July and did not check the room the following morning as he believed client did not return to hostel.*

98. At the changeover of the shift the following day, Sunday 2 July 2017, the Case Note documented (written following Master S's passing),

[32] Statement dated 5 July 2021.

Handover occurred at 12noon between residential workers [Mr I] *and* [Mr W]*,* [Mr I] *states in his case notes that it was a verbal handover and informed* [Mr W] *that all residents except for* [Master S] *were home the previous night.* [Mr I] *stated* [Master S] *did not return on the night of the 1st of July.* [Mr W] *reports in his incident declaration that the verbal handover from the previous shift informed him that* [Master S] *had left for the weekend.*

99. On Monday 3 July 2017, Mr W finished his shift at about 9.00am. He said,

[redacted] *was still there but he was downstairs as they are not allowed upstairs with out supervision. I checked the rooms that I knew boys had slept in over night but didn't check* [Master S's] *room as I thought he was still away. All the rooms were locked as usual.*

100. According to Hostel Manager Mr D,[33] on this day he was on his way to work when he *received a call from* [Mr M]*, my co-ordinator, who informed me that he was running late but had spoken to* [Mr W]*, our night worker, and had been told that all the boys currently at the house had left for the day.*

101. Mr M arrived at work at about 10.00am. Standard practice dictated that the overnight worker carry out a hand over with the morning staff. If the morning staff were late then the residents would be locked out of the hostel to allow the worker to finish his shift.

102. At about 11.45am, he was preparing to leave the Hostel for attendance at a NAIDOC flag raising ceremony. He said, *After securing the office, the back door and night workers room I began checking the clients room as per procedure when locking up to ensure that no clients are left in the hostel by themselves.*

103. Upon opening the Wurundjeri room, he discovered Master S and first thought he was asleep but soon called emergency services when he discovered that this was not the case.

104. He immediately inquired why Master S was in the house without supervision and was advised by Mr W that he had not seen Master S all weekend. Mr W said, *I feel really bad that I hadn't checked his room.*

105. Mr D said that on arrival he also asked, *why* [Master S] *was there when I had been told he wasn't. In fact I remember that was the first question I asked. I was told by the workers that* [Master S] *had told them on Saturday that he was going away for the weekend and wouldn't*

[33] Statement dated 20 November 2017.

be back to Monday. This was not unusual as he often went to stay away at mum's for the weekend.

106. The Case Note documented,

Residential shift worker [Mr W] *reports checking one room prior to leaving the hostel and locking up. Coordinator did not start work until 10.00am which had previously been arranged with BWAYS manager. Coordinator reports on arrival to hostel there was a resident inside unsupervised. At approximately 11.45am Coordinator is leaving hostel and checks the rooms and finds the deceased*.

Police Investigation

107. SC Cameron and Constable Vahid Kamali arrived at 12.09pm and commenced an examination of the scene. Master S was located fully clothed and laying across his bed.

108. SC Cameron observed that the lock had been broken and repaired previously and was advised that *it was common over the years for clients to break into each other's rooms.* Mr M *confirmed that the room was locked when he opened it that morning and discovered the deceased.*[34]

109. At the scene a small radio on the right side of the bed was plugged in and operating at a low volume.

110. Detective Senior Constable (**DSC**) Timothy Kohler and DSC Andrew Webb from the Darebin Criminal Investigation Unit (**CIU**) arrived at the scene at approximately 12.21pm. They arranged for members of the Darebin Crime Desk to attend and photograph the scene.

111. Paramedics arrived and made a declaration in relation to Master S's life at 12.35pm on 3 July 2017.[35]

112. DSC Kohler[36] observed that,

On the floor in the narrow area of the bed and the left side of the room I found several cans of Rexona brand deodorant cans. I noticed on the three cans the plastic spray top had been

[34] Statement dated 21 November 2017.
[35] Ambulance Victoria Verification of Death Form.
[36] Statement dated 27 October 2017.

removed and the contents had been frosted on the top which made me think the cans had been chromed.

113. He said that a further four Rexona brand deodorant cans, all with the plastic spray tops removed and their contents frosted on the top, were located in the wardrobe. The Court was advised by police however that no photographs were taken of the deodorant cans.

114. DSC Kohler observed that[37] each of the cans of deodorant had been used in their entirety as each can was empty. The tops of the cans normally have a plastic circular device which can be moved right or left to lock the can, preventing it from being sprayed when the very top is depressed. The circular top had been removed on all deodorant cans on the floor and on the four cans later found in the wardrobe. *By removing the plastic top it exposed a long nozzle type of cylinder which can still be depressed to expose the deodorant spray. I remember thinking that the exposed nozzle would be ideal for sticking up a nose which came to mind because of the hardened frosted deodorant which had built up around the nozzle.* He said that after finding the other four cans in the wardrobe he considered that the cause of Master S's death may have related to chroming.

115. A fellow resident stated that at about 4.00 pm on Friday 30 June 2017, a worker told him that Master S went out. The resident said however that he later heard music playing in Master S's room. He said that he knew that Master S sometimes snuck back into his room so he could *chrome without being disturbed* and figured that was what he had done but did not tell the worker. He said that Master S played the song 'My Time Part 2' by Alex Jones. He said he played it really loudly on repeat not just on Friday but all weekend. He said he banged on the door and asked him to turn it down at some point but he didn't.

116. DSC Kohler and DSC Webb attended with Master S's mum to deliver the death message. DSC Kohler said,

Information at the time from [Master S's mother] *suggested that* [Master S] *had complained about not feeling well, that he was chroming and at times coughing up blood. ...He was not using drugs apart from the occasional use of Cannabis. He was chroming however she believed it was nothing serious and not something that could hurt him and he was improving his life.*

[37] Statement dated 4 April 2018.

117. Following their investigation, police found no evidence of any suspicious circumstances or an intention to self-harm.

IDENTITY OF THE DECEASED

118. On 4 July 2017, Master S's mother visually identified her son, Master S born [redacted] 2000.

119. Identity is not in dispute and requires no further investigation.

MEDICAL CAUSE OF DEATH

120. Forensic Pathologist Dr Victoria Francis from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 6 July 2017 and provided a written report of her findings dated 1 November 2017.

121. Dr Francis provided an opinion that the medical cause of death was *Unascertained.*

122. Dr Francis said,

The materials available to me at the time of compiling this report include the Victoria Police Report of Death Form 83, medical records from the Victorian Aboriginal Health Service and post mortem CT.

Post mortem examination revealed no evidence of injury or significant natural disease.

Toxicological analysis of blood showed no alcohol, common drugs or poisons. There was evidence of cannabis use.

Synthetic cannabinoids, synthetic cathinones and volatile compounds were not detected and volatile compounds were not identified in the lung fluid. This does not preclude the use of these substances as not all of these substances may be detected in post mortem samples.

No glucose was detected in the vitreous humour. Glucose levels normally decrease in the post mortem period.

Post mortem biochemistry showed no significant electrolyte abnormality within the limits of interpreting post-mortem samples. C-reactive protein was within normal limits. C-reactive protein is a molecule that increases in the blood stream in response to inflammation, particularly infections.

Tryptase was not elevated. Tryptase is a molecule that increases in the blood in the setting of anaphylaxis or allergy.

In my opinion, the cause of death was unascertained.

A possible mechanism of death is the sudden onset of a cardiac arrhythmia, characterised by a sudden disruption to the conducting system of the heart. The risk of developing disease that may cause an arrhythmia increases in age, and are usually associated with a genetic abnormality when they occur in younger individuals. Cardiac arrhythmias may be triggered by obvious more pathological processes such as coronary atherosclerosis, hypertension, or cardiomyopathies. Sometimes, cardiac arrhythmias may occur in people with anatomically normal hearts. In these cases, there may be problems with the heart's ion channels. It is strongly recommended that family members be referred for medical counselling regarding their risk, and a referral for family counselling has been initiated.

Another possible mechanism of death is the use of a drug that was not identifiable in the post mortem specimens.

It is noted that [Master S] *had a history of 'chroming' and multiple deodorant tins were found in his room. 'Chroming' is a form of inhalant substance abuse that may cause 'sudden sniffing death' through cardiac arrhythmia, damage to the throat or larynx or due to dangerous behaviour whilst intoxicated. Butane and propane are the major hydrocarbons found in aerosol sprays such as deodorants.*

Inhalation of these substances may cause effects such as euphoria, narcosis, cardiac arrhythmia, fluctuations in blood pressure and temporary memory loss. These substances were not detected in the post mortem samples.

123. Following consideration of all the evidence collected in this matter I sought further advice from VIFM regarding the possible role of 'chroming' in the cause of death.

124. In Dr Francis' absence, Dr Linda Iles, Head of Forensic Pathology at the VIFM advised that in the setting of volatile substance abuse (**VSA**), propane and butane can be detected in post mortem toxicological samples. However, as indicated in Dr Francis' report, their absence does not preclude VSA.

125. Dr Iles said she would be reluctant to change the cause of death from *unascertained* to complications of VSA as there are possible causes of death not identifiable at autopsy which

may be of familial significance. It was noted that a younger sibling of Master S presented to hospital with unconscious collapse and associated bradycardia.[38]

126. Dr Iles advised that an alternate cause of death under the circumstances could be given as "unascertained in the setting of volatile substance abuse". She noted that if Master S did have an underlying genetic cardiac channelopathy, VSA would be particularly hazardous.

127. I accept the advice of Drs Iles and Francis.

FURTHER INVESTIGATIONS

Limitations of the coronial investigation

128. The Act permits a coroner to investigate matters which are sufficiently proximate and relevant to the death under investigation. As already noted, despite a full autopsy being conducted with associated tests, the cause of death remains 'unascertained' although the setting will be recorded as *volatile substance abuse*. There is also no evidence of intentional self-harm in this case and no evidence of suspicious circumstances.

Master S's involvement with Child Protection

129. As Master S was on a Family Preservation Order at the time of his passing, Child Protection were asked to provide a statement to assist with the investigation, which was subsequently provided by Dr Eamonn McCarthy, Principal Practitioner for Child Protection Services in the North Melbourne Area[39].

130. It was noted that the purpose of a Family Preservation Order and the role and obligation of Child Protection under such an order is:

> *Support and assistance should be provided to the family while the child's safety within the family is monitored. It is required that the department undertake or coordinate focussed, goal-oriented work with children and families for the duration of the family preservation order, with a view to empowering the family to sustain their capacity to protect their child and promote the child's development without the need for court-ordered intervention.*

[38] See footnote 6.
[39] Dated 12 June 2020.

131. Following a review of Master S's records, I noted that information available or known to Child Protection at the time of the Family Preservation Order appeared to include suspected drug use; a deterioration of Master S's mental health including suicidal ideation and attempts of self-harm; a lack of school attendance; involvement with police; criminal charges, Master S's first time on remand, his placement on a Diversion Plan; continuing unstable living conditions and his cultural needs. With these matters in mind, I asked Child Protection whether they complied with applicable and best practice processes and procedures, including any requirements under the Family Preservation Order. I also specifically asked whether there should have been a cumulative harm review and an Aboriginal Family Led Decision Making Conference.

132. In response, Dr McCarthy stated that the Master S's records contained *minimal notes that demonstrate compliance with policy and practice advice* in response to the matters raised and he set out a number of the *deficits* in the management of his case.

133. With respect to case planning and services, it was noted that while there were a number of Aboriginal services involved with Master S and his family throughout his life, much of the work undertaken appeared to occur in silo. An Aboriginal Family Led Decision Making meeting was attempted on two occasions (but not successfully completed), although links were made for Master S with his maternal aunt and maternal grandmother.

134. Dr McCarthy stated,

> *Regular case planning or care team meetings for* [Master S] *should have occurred to enable regular information sharing, coordination of services and planning for* [Master S's] *needs. Given his age he should have been supported to participate in meetings and be involved in planning and decision making about his life. Moreover, the majority of Aboriginal services involved with* [Master S] *appear to have been primarily focussed on supporting his mother in terms of her parenting and did not focus directly on* [Master S].

135. With respect to Master S's suspected drug use, it was noted that despite clear indications that Master S was using substances, there were no referrals to drug and alcohol specific services initiated by Child Protection.

136. In response to the documented deterioration of Master S's mental health, including suicidal ideation and attempts of self-harm, it was noted that a comprehensive mental health assessment of Master S was not undertaken, despite a number of efforts made for this to have occurred.

137. Master S appears to have been diagnosed at an early age with an intellectual disability by a neurological psychologist, however it is unclear if he had any disability support or any aides at school. Dr McCarthy said it was also unclear if Master S received an educational needs assessment at school in order to identify appropriate supports. He said there was insufficient information to indicate that Child Protection made significant effort to re-engage Master S in school.

138. It was further noted that Master S's file indicated Child Protection first became aware of Master S's criminal matters when, having taken custody of him pursuant to a Child Protection warrant, police informed Child Protection they would be seeking remand as Master S had failed to appear in court on three occasions.

139. Dr McCarthy said that the Child Protection files do not contain notes to suggest further exploration of Master S's offences or missed court dates, nor that contact was made with Youth Justice to inquire after their involvement. Further,

There is minimal information or demonstration of joint work and information sharing between child protection and youth justice.

140. Dr McCarthy noted that on many occasions Master S's whereabouts were unknown, and apart from support he received from his maternal aunt, he did not appear to have a close and trusting relationship with other family members that he could rely on or reside with. Family that were able were usually caring for his younger siblings when his mother and stepfather could not.

141. It was noted that more efforts to connect with the paternal family should have been made as these may have been helpful for Master S in terms of his identity, self-esteem, connection to family and a consistent placement.

142. Dr McCarthy stated that it was clear from his file that throughout Master S's life he lacked stability and connection to a parental figure, and he experienced cumulative harm as a result of numerous factors.

143. Dr McCarthy also highlighted that many changes had been made in child protection practice since Master S's passing.

144. A review of Master S 's case also resulted in the North Division reviewing the placement of children subject to Child Protection orders within hostels. It was noted that while it was

readily acknowledged that the various hostels provided a supportive and much needed service to people in need, it was recognised that the level of staffing and client supervision was not comparable to that typically required and provided for Child Protection clients within the out-of-home care system. Moreover, it was deemed to be in the best interests of Child Protection clients to be placed with service providers that are approved under the Children Youth and Families (**CYF**) accreditation process. This was to ensure that they are subject to the level of safety and protection stemming from the various monitoring and oversight systems therein.

145. Dr McCarthy also stated that while the option of allocating siblings to different Child Protection practitioners had always been available, up until Master S's passing it had typically been implemented in cases where the siblings' placements or overall case plans were vastly different. However, upon review of Master S's case, it was identified that family cases in which the needs and circumstances of a high-risk child are at risk of being overlooked, by virtue of the overall complexity or unique child needs, require consideration for dual allocation. He said that due to the importance of ensuring case plans are complimentary and that families are not overwhelmed by the number of professionals involved, this strategy is still reserved for a small number of cases. However, at the time of making his statement it continued to be successfully utilised for a number of the most at-risk cases.

146. Dr McCarthy noted the ongoing commitment to supporting Aboriginal children within the Child Protection system and that there had been a number of changes to policy and practice. He stated,

Aboriginal Children in Aboriginal Care aims to promote Aboriginal children's cultural identity and promote their connection to family, community and culture. Connection to culture, community and Country is fundamental to supporting the safety and identity of Aboriginal children. The department has a tripartite agreement between the department, Community Service Organisations (CSOs) and Aboriginal Community Controlled Organisations (ACCOs) to gradually transition the case management of 100 percent of Aboriginal children subject to protection orders in care to ACCOs by 2021.

In addition, section 18 of the Children, Youth and Families Act 2005, allows the Secretary to authorise the Principal Officer of an Aboriginal Community Controlled Organisation to take on specified roles and functions usually undertaken by the Secretary. Currently two ACCOS have received full authorisation and a further two are funded to prepare for authorisation.

Under the Aboriginal Children in Aboriginal Care program, authorised ACCOs will have the opportunity to actively work with the child's family, community and other professionals to develop and implement the child's case plan and achieve their permanency objective in a way that is culturally safe and in the best interests of the child.

Youth Justice Operations - Department of Justice and Community Safety

147. As already noted, there appeared to be a lack of collaboration between Child Protection and Youth Justice in relation to Master S's first engagement with the youth justice system. In this context, I sought information about how collaboration can assist with the criminal justice process and the development of diversion plans.

148. The Secretary of the Department of Justice and Community Safety, Rebecca Falkingham advised that engagement between Youth Justice coordinators and Child Protection is important as it supports children to receive a comprehensive and informed diversion assessment and plan that is tailored to their individual needs and backgrounds. She noted that Child Protection can provide important information about a child's family history which the child, family and carer might not feel comfortable disclosing, and assist in managing wellbeing risks. A diversion plan that is responsive to the individual child is likely to engender their engagement with supports and services which, in turn, enables better diversionary outcomes for the child.

149. In relation to Master S's case, she noted that at the time of his diversion assessment, Master S indicated to his Youth Justice coordinator that he had no current Child Protection involvement. The Youth Justice coordinator tried to call Master S's mother but was unable to establish contact at the time of assessment. However, it was noted that there appeared to be no record of Master S's responses being directly verified with Child Protection.

150. The Secretary advised that since that time, significant system and process improvements have been embedded and clear guidance has been put in place for Youth Justice coordinators. And that these measures are helping greater engagement between Youth Justice and Child Protection and more effective and integrated services for children common to both systems. The improvements include:

- New practices requiring coordinators to confirm a child or young person's involvement with Child Protection. If unable to establish contact, they may seek an adjournment to obtain this information.

- New practices also requiring that, where a child is a client of Child Protection, the coordinator must ensure that Child Protection is provided with details of their involvement with Youth Justice, including copies of the diversion plan.

- Specific Child Protection contact details now being provided to the Children's Court Youth Diversion (**CCYD**) service so CCYD coordinators can obtain direct and timely information on a young person's Child Protection status.

- Updates to Client Relationship Information System (**CRIS**) functionality such that Child Protection cases no longer default to restricted access, enabling greater accessibility to relevant Child Protection information.

- Greater emphasis being placed on CCYD coordinators developing local relationships with Child Protection so that CCYD staff are aware of any Child Protection involvement with its diversion clients.

- CCYD coordinators also have access to the CRIS, the information and case management system used by Child Protection and Youth Justice and can view common client information when appropriate.

Bert Williams Hostel – Internal Review

151. Linda Bamblett, CEO of the Victorian Aboriginal Community Services Associated Ltd (**VACSAL**), provided a comprehensive statement to the Court which included their internal incident review. BWAYS is a VACSAL's program which works to reduce over-representation of young Aboriginal people within the youth justice system and homeless service system.

152. One of BWAYS services is the Bert Williams Hostel which is a Youth Hostel Crisis/Homeless Short-Term Accommodation. In addition to accommodation and meals, the Hostel provides case management, training in independent living and life skills, assistance in pursuing educational and vocational outcomes, assistance to secure medium-term accommodation and reconnection with family and community.

153. The residents (**clients**) are free to leave the Hostel at any time, including overnight. Part of their philosophy is to provide guidance and support to empower the clients to make their own choices. Ms Bamblett said,

We respect our clients' rights to make their own decisions and do not force them into any particular action. …While clients are expected to abide by BWAYS rules, we aim to teach independent life skills and clients are encouraged to engage with their families and the broader community.

154. The clients are required to abide by the BWAYS rules at all times and this includes a prohibition against using drugs (including alcohol), other than those prescribed by a doctor, or being at the Hostel while under the influence of drugs and alcohol.

155. It was noted that it was common for clients to go out, especially on the weekends, and to choose to stay out overnight. Staff sleep from approximately 11.00pm to 7.00am unless woken by clients, and clients may leave the premises at any time including during the night.

156. Clients are also not to be present in the Hostel unless there is a member of staff present and this was the BWAYS policy at the time Master S passed away.

157. Ms Bamblett noted that although there should always be staff present to support and assist clients, staff are not able to monitor the activities of each client at all times.

158. An internal audit of the case was conducted and relevant to the coronial investigation the following was noted with respect to its findings and subsequent changes:

- Master S was last seen by Mr I around 4.00pm Saturday 1 July when Master S told Mr I he was going out. Mr I did not see Master S leave, but also did not see anyone come or go from Master S's room after this stage. Mr I assumed that Master S had not returned since no one could enter the room without Mr I unlocking the door, and this had not been requested. When Mr W arrived to take on the next residential shift at midday on Sunday, Mr I told Mr W that Master S was out from the Hostel for the weekend. Mr W did not see Master S return and had not been asked to unlock Master S's bedroom.

- Workers must record which client stays overnight and provide support to those present, but they are not required to check rooms as a matter of procedure in the evening. Nor were bedrooms entered in the morning as a matter of procedure. Subsequently, records for the Daily Case Notes (which workers fill out every shift) have changed so that workers must record in writing whether bedrooms have been checked each day and evening.

- Some BWAYS procedures were not fully complied with on the weekend of Master S's passing. BWAYS procedure stipulates that the Hostel must be checked if it is left unattended by staff, to ensure that no resident is left alone. This would comprise a knock on each bedroom door, followed by unlocking the door and visually inspecting each room. It was noted that the Hostel was left unattended on Monday 3 July between 9.00am and 10.00am, where there was a gap between staff due to a medical appointment. The worker on this occasion checked the common areas and one of the bedrooms, but made an incomplete check of the remaining rooms, calling out to see if residents remained rather than unlocking each room. The review found that this meant that there was a missed opportunity to discover Master S's passing earlier (but earlier checking would not have prevented this from occurring).

- BWAYS policy required both a verbal and written changeover of shift, and the review found that written case notes were not completed contemporaneously which was required by procedure. Changes made now include a requirement for two staff members to sign the case notes, additional information is sought (for example, room checks) with an extra half an hour ('crossover') between shift for record keeping and a discussion of client needs.

- A new IT case management system was introduced to increase cohesiveness within the organisation and facilitate record keeping and information sharing between staff.

- The review found a lack of communication between programs and recommended staff speaking with clients be obliged to report any disclosure of risk taking behaviours to staff in other programs. The review found two instances where information was not disclosed to Hostel staff. The first where a staff member of the BWAYS Early School Leaver program stated that Master S had confided in him that he and his brother had used aerosol cans for chroming in the past. This was not reported to Hostel staff. The second instance was where a staff member of the BWAYS Youth Justice program stated that another resident had confided in him that he had once seen Master S chroming. The worker thought that a Hostel worker was aware of this incident, however it appears the matter was in fact not reported to Hostel staff.

- Ms Bamblett said that she did believe that the staff members discussed the dangers of chroming with the clients involved. However, pursuant to their policies a written report should have been made regarding the disclosures and this was not done at the time. It was noted that if this had occurred, this information would have been

accessible to all BWAYS staff. It was noted that whilst disclosures of client's information is generally prohibited, disclosures should be made, according to their policies, where the client or another person may be at risk. Further training regarding the obligations of staff was also instituted as a result.

- Ms Bamblett said that this situation would have given additional opportunity to discuss the dangers of chroming with Master S.

- It was noted that the objects in this case *were not obviously dangerous but were seemingly innocuous items being deodorant and paper. In addition, BWAYS staff do not have the authority to search or seize clients' possessions.*

159. It is evident that the internal review conducted was thorough, frank and identified areas for improvement which have now been addressed. I also agree with the review's findings that whilst there was a missed opportunity to discover Master S's passing earlier on the morning of 3 July 2017, this would not have changed the outcome.

Dangers of Chroming, Volatile Substance Abuse

160. The CPU were asked to consider the potential dangers of chroming and advise on whether there might be any recommendations to reduce the risk of deaths occurring in future. I have set out a summary of the review undertaken by the CPU.

Terminology – Chroming

161. 'Chroming' was originally a slang term but is now recognised in government policy and academic literature. Chroming belongs to the broader category of inhalant misuse or volatile substance misuse (the two terms are interchangeable), which is "deliberate inhalation of a volatile substance to achieve a change in mental state".[40]

162. Chroming was named originally for the practice of spraying chrome-based paint into a plastic bag and inhaling the volatile hydrocarbons that became trapped in the bag. Volatile hydrocarbons are present as thinners in many paints (for example, toluene) and are also used as spray can propellants (for example, butane, propane, and hydrofluorocarbons). Over time, the term has come to take on a more general meaning of concentrating and inhaling volatile

[40] Drugs and Crime Prevention Committee, Parliament of Victoria, *Inquiry into the Inhalation of Volatile Substances: Final Report*, September 2002, p.6.

hydrocarbons from any aerosol: hair spray, deodorant, baking spray, shaving cream and so on.

Harms and deaths

163. Most volatile substances (including the aromatic hydrocarbons that predominate in chroming) are central nervous system (**CNS**) depressants with psychoactive properties. They are generally used for their euphoric, relaxant and hallucinogenic effects. Onset of effect is almost immediate (the substance enters the bloodstream directly from the lungs on inhalation) and with most substances is very short-lived, such that it is possible to go from being "bombed out of your mind" to completely sober within an hour.[41] People who regularly use volatile substances can develop dependence and experience withdrawal when not using them.

164. Undesired effects (side-effects) include respiratory irritation, memory loss, tremors, seizures, paranoia and hallucination. The precise effects a user will experience are unpredictable from instance to instance.

165. Volatile substances' CNS depressant effects, alone or in combination with other drugs, can include respiratory depression, unconsciousness and in extreme cases death. People who inhale volatile substances can also, in very rare circumstances, die from a condition known as 'sudden sniffing death', the exact mechanism of which is not known (hypotheses include cardiac arrhythmia and sensitisation of the myocardium). The most prevalent indirect cause of death associated with volatile substance use is asphyxia. This can occur when, for example, a person inhales the volatile substance from a plastic bag and loses consciousness with the bag pressed to his or her mouth. Another type of asphyxia observed in several deaths is choking on vomit and being unable to clear airways because of profound CNS depression and torpor.[42]

Considerations for Prevention

166. When considering how to prevent harms associated with volatile substance misuse, it is crucial to account for the nature of the volatile substance being targeted. The term 'volatile

[41] Drugs and Crime Prevention Committee, Parliament of Victoria, *Inquiry into the Inhalation of Volatile Substances: Final Report*, September 2002, p.24.

[42] Field-Smith ME et al, *Trends in Death Associated With Abuse of Volatile Substances, 1971-2007*, London: St George's University of London, July 2009, p.15; D'Abbs P et al, *Volatile Substance Misuse: A Review of Interventions*, Canberra: Commonwealth Department of Health and Ageing, 2008, p.21; Guo TJ, "A rare but serious case of toluene-induced sudden sniffing death", *Journal of Acute Medicine*, 5(4), December 2015, pp.109-111.

substance misuse' implies that all such substances are the same or similar, when in fact hundreds of different volatile substances can be inhaled to achieve a variety of intoxicating and psychoactive effects.[43]

167. The CPU noted that the available evidence indicates that proximate to Master S's passing he was likely concentrating and inhaling a volatile substance from a Rexona branded deodorant can and that Rexona cans were a preferred chroming source for him. The following prevention considerations focus particularly on Rexona and other deodorants in chroming.

Volatile substance misuse is prevalent in young people in Australia

168. While the CPU was unable to find any information specifically on who uses deodorant cans in chroming, the available evidence indicates volatile substance misuse is overwhelmingly the domain of young people. A 2008 review found that in Australia, peak prevalence of volatile substance misuse is among young secondary school children (aged 12-14 years), and this drops rapidly with age. A more recent overview from the Australian Drug Foundation described a similar pattern, with a substantial proportion of younger students having used inhalants at least once, but most students "growing out of it" by age 15. A 2017 survey found that 18% of Australian secondary students had deliberately sniffed inhalants at least once in their lifetime, which was far higher than prevalence of use reported for most other drugs.[44] Finally, the 2019 National Drug Strategy Household Survey results included a report that lifetime use and recent use of inhalants among respondents had increased between 2016 and 2019, though the results did not include a breakdown by age or by type of inhalant.[45]

[43] D'Abbs P et al, *Volatile Substance Misuse: A Review of Interventions*, Canberra: Commonwealth Department of Health and Ageing, 2008, p.7; Drugs and Crime Prevention Committee, Parliament of Victoria, *Inquiry into the Inhalation of Volatile Substances: Final Report*, September 2002, pp.14-15.

[44] D'Abbs P et al, *Volatile Substance Misuse: A Review of Interventions*, Canberra: Commonwealth Department of Health and Ageing, 2008, pp.9-10; Australian Drug Foundation, "Inhalants and young people", 16 March 2021, <https://adf.org.au/insights/inhalants-young-people/>, accessed 4 March 2022; Guerin G and White V, *ASSAD 2017 Statistics & Trends: Australian Secondary Students' Use of Tobacco, Alcohol, Over-the-counter Drugs, and Illicit Substances*, second edition, Melbourne: Cancer Council, 2020, p.31.

[45] Australian Institute of Health and Welfare, *National Drug Strategy Household Survey 2019*, Canberra: AIHW, 2020, p.42.

Chroming of deodorant spray has been happening for a long time

169. The October 2002 Final Report of the Victorian Parliamentary Inquiry into the Inhalation of Volatile Substances, included material demonstrating that deodorant chroming has occurred in Victoria since at least the 1980s.[46]

Rexona deodorant is specifically targeted in chroming

170. Use of Rexona spray cans specifically (rather than deodorant cans generally) in chroming appears to be a well-established phenomenon in Australia. While there are no academic or government policy papers addressing this topic, news media outlets over the last decade have repeatedly identified Rexona as the primary product used in deodorant chroming; the term "rexing" is used in some media coverage to describe the practice.[47]

Victorian deaths from deodorant chroming share some commonalities

171. The CPU sought to establish the prevalence and nature of deaths involving deodorant chroming in Victoria over the past decade.

172. In addition to Master S, four Victorian deaths were identified having occurred in a setting of deodorant chroming between 2012 and the present. Like Master S, three of the deceased persons were males aged under 18 years; and in two cases there was evidence of Rexona chroming.

Chroming and the law

173. Volatile substance misuse is not illegal in Victoria. However, under section 57 of the *Drugs Poisons and Controlled Substances Act 1981* volatile substances[48] are included within the category of 'deleterious substances'; and section 58 of the same Act says,

[46] Drugs and Crime Prevention Committee, Parliament of Victoria, *Inquiry into the Inhalation of Volatile Substances: Final Report*, September 2002, pp.93-94.

[47] See for example Rohweder S, "Rexona talks about changing sniffable chemical in deodorant", *NT News*, 10 June 2014; Jordan B, "Teens risk death 'huffing' cans of deodorant", *Daily Telegraph*, 9 February 2016; Powell R and Feeney K, "Rexona maker Unilever acknowledges five deaths linked to misuse of product", *ABC News*, 27 September 2019; Tolj B, "Mum's warning after Rexona deodorant leaves teen with brain damage", *Yahoo! News*, 11 August 2021.

[48] Volatile substances are defined in section 57 of the Act to include "plastic solvent, adhesive cement, cleaning agent, glue, dope, nail polish remover, lighter fluid, gasoline, or any other volatile product derived from petroleum, paint thinner, lacquer thinner, aerosol propellant or anaesthetic gas".

58. Sale of deleterious substances

(1) as otherwise expressly provided in this Act or the regulations, a person shall not sell a deleterious substance to another person if the first-mentioned person knows or reasonably ought to have known or has reasonable cause to believe that the other person intends—

(a) to use the substance by drinking, inhaling, administering or otherwise introducing it into his body; or

(b) sell or supply the substance to a third person for use by that third person in a manner mentioned in paragraph (a).

174. The provision suggests that if a retailer believes that a person is purchasing a deodorant can for the purpose of chroming, they are required to refuse the sale.

Some information is available about the dangers of chroming

175. Information is available to the public about chroming, awareness of the dangers of chroming, and the like. For example:

- The Better Health Channel has produced information to inform the public about inhalants.[49]
- The Alcohol and Drug Foundation has produced public education information.[50]
- The Victorian Department of Health has produced guidance and resources for retailers on the responsible sale of solvents, explaining the health risks of solvent abuse, how to manage the sale of solvents, and how to go about refusing a sale.[51]

176. Additionally, as already indicated, stories about young people chroming (including use of deodorant cans) recur in the media.

[49] Better Health Channel, "Inhalants", reviewed 15 October 2018, <https://www.betterhealth.vic.gov.au/health/healthyliving/inhalants>, accessed 8 March 2022.
[50] Alcohol and Drug Foundation, "Inhalants", revised 10 November 2021, <https://adf.org.au/drug-facts/inhalants/>, accessed 8 March 2022.
[51] See Victorian Department of Health, "Responsible sale of solvents", 9 September 2015, <https://www.health.vic.gov.au/aod-treatment-services/responsible-sale-of-solvents>, accessed 5 March 2022.

Specific strategies for addressing deodorant chroming

177. The CPU noted that interventions to address harms associated with substance use fall into three main categories: supply reduction (stopping people from accessing the substance), demand reduction (stopping people from wanting to use the substance) and harm reduction (reducing the negative impact of the substance use when it occurs).

Supply Reduction

178. Deodorant aerosol cans are legal to sell in Victoria and are legal to chrome. Supply reduction countermeasures are in practice therefore difficult to implement.

179. One possible supply reduction strategy might be to restrict sale of aerosol deodorants to people over a certain age (for example adults). This strategy has already been deployed with spray paint in Victoria, though the purpose was to reduce graffiti rather than reduce chroming.[52] It is not known whether age-based restrictions on deodorant sales might actually work to reduce chroming and inhalant use, or might simply shift it to the hundreds of other products containing volatile substances that can be inhaled.

180. A related supply reduction strategy is for retailers to make aerosol deodorants less easily available in stores, so they can more readily meet their obligations under the Sale of Deleterious Substances section in the *Drugs Poisons and Controlled Substances Act 1981* (Vic). There are media reports that retailers in certain areas have locked up aerosol products including deodorants or put them behind counters, to stop children from stealing or buying them to chrome.[53] Again, the efficacy of this strategy is not clear, nor is the likelihood of substituting other inhalants.

181. A third strategy is to modify the product itself, for example, by replacing the propellent with something that does not produce a psychoactive effect, or modifying the can design so the propellent cannot be extracted from the can easily. According to a 2014 news report, Unilever (the company who produces Rexona products) was investigating how to achieve this:

[52] See the *Graffiti Prevention Act 2007* (Vic), which created offences for selling aerosol paint to people aged under 18 years, and for possession of aerosol paint by people aged under 18 years.

[53] See Vincent P, "Coles and Woolworths are forced to lock up their aerosols as children as young as seven openly snuff fumes to get high in this Outback town", *Daily Mail*, 13 May 2021; Fitzgerald R, "Major supermarkets lock up aerosol deodorants to combat 'chroming' in NT", *ABC News*, 22 July 2021.

Rexona have actually contacted us about changing the propellant in their deodorant, just like the Opal fuel strategy, to make it non-sniffable," [health spokesperson] said. "Dulux did the same thing and now we don't see people wandering the streets, getting high from sniffing paint. We are hoping it will be possible to change the chemical make-up of the deodorant to make it a low-toxicity. If we stop people sniffing deodorant it will be a clear win because they can't sniff paint or petrol anymore, which means they won't have anything to sniff.[54]

182. However, a more recent news article suggested that little progress has been made towards product modification:

[…] despite Unilever spending 900 million euros ($1.4 billion) last financial year on research and development, […] the company was yet to find a way to change the recipe. "The action will come. This has been a problem for a number of years and over the last few years … and the one thing we can take out of this is that we haven't been able to find a silver bullet. We've made changes to the can, including putting warning labels on the pack, specifically calling out solvent misuse. As well as we've redesigned the can so that you can't even isolate the gas that these kids are using to get high by itself."[55]

183. The CPU noted that even if Unilever succeeded, the question of substitution (swapping Rexona for another deodorant brand, or shifting to inhalation of another volatile substance) is still unresolved.

Demand Reduction

184. Demand reduction interventions primarily focus on two strategies: education and awareness (to discourage people from trying the substance) and drug treatment (to support recovery from substance use and reduce the likelihood of relapse).

185. Education strategies aimed at increasing awareness of the risks and dangers of volatile substance use were explored in detail in the 2002 final report of the Parliamentary Inquiry. The CPU noted that the conclusions reached are likely still valid today:

- Providing general education on volatile substance misuse to young people (who are by far the most likely to use inhalants) is risky, because it essentially is also alerting them

[54] Rohweder S, "Rexona talks about changing sniffable chemical in deodorant", *NT News*, 10 June 2014.
[55] Powell R and Feeney K, "Rexona maker Unilever acknowledges five deaths linked to misuse of product", *ABC News*, 27 September 2019.

to the fact that common household products can be inhaled for their psychoactive effects, and might encourage experimentation as a result.[56]

- Providing targeted education to certain groups who are in a position to intervene in volatile substance use might be more effective: for example parents, social workers, teachers, police, ambulance paramedics, and retailers.[57]

186. Further to the second dot point, the CPU noted that among the drug education teaching materials on the Victorian Department of Education and Training website there is a publication titled *Volatile Substances: A Resource for Schools*. This was last updated in 2000.[58]

Harm Reduction

187. Harm reduction interventions proceed from the understanding that people will use substances regardless of their legal or other status; and that therefore we need to consider what measures we can introduce to reduce the potential for harm when people use substances.

188. Education in managing risks of volatile substance use is a very reasonable strategy when applied to deodorant chroming, because there are clear safety precautions including:

- Avoid enclosed spaces where oxygen supply can become limited.
- Don't use volatile inhalants in an environment where there are physical hazards, such as near a busy road or on a balcony or so on.
- Have somebody present who is not intoxicated, so they can seek help if needed.
- Recognise the signs of overdose and profound central nervous system depression, and know what to do in response.[59]

[56] Drugs and Crime Prevention Committee, Parliament of Victoria, *Inquiry into the Inhalation of Volatile Substances: Final Report*, September 2002, pp.306-309.
[57] Drugs and Crime Prevention Committee, Parliament of Victoria, *Inquiry into the Inhalation of Volatile Substances: Final Report*, September 2002, pp.310-342.
[58] Bellhouse R, Johnston G, Fuller A, Guthrie C, *Volatile Solvents: A Resource for Schools*, Department of Education and Training, December 2000.
[59] D'Abbs P et al, *Volatile Substance Misuse: A Review of Interventions*, Canberra: Commonwealth Department of Health and Ageing, 2008, p.xix.

189. However, to be effective these harm reduction messages need to be targeted to users of volatile substances without also being disseminated to non-users - particularly children - who might regard them as an 'instruction manual' for how to chrome.

Relevance to Master S's passing

190. Master S is one of five young people in Victoria during the past decade whose passing occurred in a setting of spray deodorant chroming. As noted above, four of the five deceased persons (including Master S) were males aged under 18 years, and in three deaths Rexona was the deodorant brand being chromed.

191. This profile is consistent with the available evidence on who uses volatile substances in Australia: drug surveys have found that use peaks in those aged 12-14 years and drops off sharply thereafter.

192. Having considered the circumstances of Master S's passing in the context of the available information on deodorant chroming and volatile substance misuse more generally, I identified two potential prevention opportunities.

193. Firstly, it was apparent that those people supporting him in the period proximate to his passing were not aware that he had been chroming deodorant, even though other residents of the Hostel were aware. If however staff were alert to this possibility, they could have put in place appropriate measures to support him, such as referral for volatile substance misuse-specific treatment or education in chroming risks. This was also highlighted as a prevention opportunity by Ms Bamblett as part of the Hostel's review.

194. The benefits of developing training programs and resources for people who work with those at risk of volatile substance abuse was explored in a 2011 Queensland Commission for Children and Young People and Child Guardian report, which recommended inter alia that:

> *Child Safety Services develop a 'practice resource' that is readily available for frontline officers regarding the delivery of services to children in care who are chroming.*[60]

195. I note that the Victorian Department of Health has a booklet titled *About Inhalant Abuse: For Health and Community Workers* on its website, which is undated and does not include any reference to resources produced after 2002.

[60] Queensland Commission for Children and Young People and Child Guardian, *The Chroming Report: A Government Framework for Children in Care*, 10 November 2011, p.64.

196. Secondly, it is apparent that there haven't been any new substantial efforts to understand volatile substance misuse and how it might be evolving in Victoria for at least a decade to assist public health bodies to help determine whether anything new needs to be done.

FINDINGS AND CONCLUSIONS

197. Pursuant to section 67(1) of the Act I make the following findings:

(a) the identity of the Deceased was Master S, a Yorta Yorta young man, born [redacted] 2000;

(b) his passing occurred on or around 3 July 2017 at the Bert Williams Hostel at 21 Normanby Avenue, Thornbury, Victoria from a cause *Unascertained in the setting of volatile substance abuse*; and

(c) his death occurred in the circumstances described above.

198. Whilst the cause of Master S's passing remains unascertained, the evidence suggests that he was chroming using Rexona brand deodorant proximate to his passing and had been engaging in this kind of activity for a number of years. It is also likely that he (and his mother) did not appreciate the risks involved, despite him receiving some limited warnings.

199. There is no evidence that Master S intended self-harm or that there were suspicious circumstances surrounding his passing.

200. Master S was exposed to and the subject of family violence, including physical, verbal and emotional, throughout his young life. It is clear that he experienced the effects of this exposure to the extent that cumulative harm had been identified, and his ability to participate in normal childhood activities such as school (which he loved), engaging with other students and cultural activities, was impacted.

201. Master S was on a family protection order at the time of his passing first coming to the attention of Child Protection when he was 7 years old. Child Protection provided advice to this Court that Master S's records contain minimal notes to demonstrate compliance with policy and practice advice and deficits were identified in the management of his case.

202. Master S's response to family violence was always to protect his mother and siblings, even from when he was a little boy. Reviewing the evidence around these matters was deeply distressing. His protective focus extended to when he was older, including his concern that

his siblings were being exposed to drug use by their father, expressing to Child Protection that if they didn't do anything he would.

203. Master S spent his first nights in custody on 5 May 2017 and was later placed on a Children's Court Youth Diversion order on 27 June 2017. It was apparent that there was no communication between Child Protection and Youth Justice around this process and changes have been made to prevent this from occurring in future.

204. Master S was expressing suicidal thoughts in 2016, early 2017 and as late as 19 June 2017. He said on a number of occasions that he wanted to be with his siblings who had passed and that he would not live past his 17th birthday. Despite this, he did not undergo a mental health assessment, although it appears that an appointment may have been scheduled for this to occur.

205. Learning difficulties were identified in Master S's early years, and the possibility of an intellectual disability was identified. Other records suggest a young man who would engage well, was articulate and had clear insight into his own issues. This was particularly evident during the AHCPES assessment in January 2017, where Master S was noted to be emotionally and mentally stable as well as articulate. He was able to relate that he had been exposed to family violence and, coupled with his ADHD, recognised that he could easily lose his temper following arguments with his mother. He also expressed a desire to have the freedom to visit friends without being reported missing and, be able to get a job and become independent. The recommendations made at that time (see paragraph 44) appear to respond directly to some of the needs Master S articulated as being important to him, although there was no information to suggest that these recommendations were fully implemented.

206. Master S's mother expressed that at the time of his passing, Master S's life was improving and that he was full of life and had plans. He had no outstanding criminal matters, was proud that he had not received a conviction and had his own space to live with the freedoms this brought. It is apparent that he received significant assistance through Dardi Munwurro, BWAYS and other Koori support workers, who came into his life in the months before his passing and helped him navigate his court proceedings and other life challenges.

207. It has taken some time to investigate the passing of this extraordinary young man, who was proud of his culture, always protective of his family and, despite the numerous disadvantages he faced, and the deficiencies acknowledged by those authorities tasked with his protection, had found some space for himself and made plans for his future.

208. I convey my sincere condolences to Master S's family and community for their loss and acknowledge the tragic circumstances in which Master S's passing occurred.

COMMENTS

209. Pursuant to section 67(3) of the Act I make the following comments connected with Master S's passing:

Impacts of Family Violence

210. There has been significant research into the impacts of childhood exposure to family violence. The Royal Commission into Family Violence (**RCFV**) outlined the serious short and long term effects that family violence can have on the health and wellbeing of children and young people, noting that the effects may be *acute and chronic, immediate and accumulative, direct and indirect, seen and unseen*.[61]

211. In their report, the RCFV advised that children exposed directly or indirectly to violence *can suffer from a variety of physical, emotional and mental health effects including depression, anxiety, low self-esteem, impaired cognitive functioning and mood problems*[62] and are more likely to suffer *learning difficulties, trauma symptoms and behavioural problems*.[63]

212. Research has indicated that even when a child is not directly exposed or witness to violence, they can still experience significant impacts on their health and wellbeing and exhibit behavioural, mental health and social problems.[64] Young people exposed either indirectly or directly to family violence were also found to experience similar consequences, with correlations found between exposure to family violence and unemployment, mental health issues and homelessness in adolescents and adulthood.

Youth Justice

213. The Commission for Children and Young People, *Our youth, our way* report considered the views of all Aboriginal children and young people in contact with Youth Justice from October 2018 to March 2019 and noted the following, relevant to Master S's case,

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[61] North and West Regional Children's Resource Program, 'Through a Child's Eyes: Children's Experiences of Family Violence and Homelessness' (2013) 4.
[62] The Royal Commission into Family Violence, *Children and young people's experience of family violence,* 107.
[63] Ibid.
[64] Family Court, *Exposure to family violence and its effect on children,* <http://www.familycourt.gov.au/wps/wcm/connect/fcoaweb/reports-and-publications/publications/family+violence/exposure-to-family-violence-and-its-effect-on-children>.

Many Aboriginal families are affected by trauma and grief. The Taskforce case file review indicated that 78% of Aboriginal children and young people in the cohort had a history of trauma and abuse, and 66% had experienced family violence as a victim/survivor or a witness. Every child and young person who was the subject of a Taskforce case planning session had experienced trauma. Aboriginal families and communities are strong and resilient. However, many Aboriginal families also experience disadvantage in various forms, including poverty, housing instability, family violence and mental illness.

The importance of connection to culture

214. The importance of connection to culture was highlighted in the *Our youth, our way* report which noted that *connection to culture is a powerful protective factor for Aboriginal children and young people.*

215. The Commission for Children and Young People and Victorian Equal Opportunity & Human Rights Commission, *Aboriginal cultural rights in youth justice centres,* June 2018 also noted,

Maintaining a positive spiritual, physical and emotional connection to country, culture and community is inherent in many Aboriginal beliefs about mental, social and emotional wellbeing.[65] *Research on Indigenous young people worldwide has long identified cultural affiliation as an important factor in supporting resilience and wellbeing.*[66] *A strong cultural identity has been found to 'promote resilience, enhance self-esteem, engender pro-social coping styles and has served as a protective mechanism against mental health symptoms'.*[67]

[65] See, Royal Commission above n 16, 180; Stephen R. Zubrick et al, 'Social Determinants of Social and Emotional Wellbeing' in Nola Purdie, Pat Dudgeon and Roz Walker (eds), Working Together: Aboriginal and Torres Strait Islander Mental Health and Well-Being Principles and Practices (Department of Health and Ageing, 2010); See also, Social Health Reference Group for National Aboriginal and Torres Strait Islander Health Council and National Mental Health Working Group, Social and Emotional Well Being Framework: A National Strategic Framework for Aboriginal and Torres Strait islander Peoples' Mental Health and Social and Emotional Well Being 2004–2009 (2004).

[66] Lisa Wexler, 'The Importance of Identity, History, and Culture in the Wellbeing of Indigenous Youth' (2009) 2:2 Journal of the History of Childhood and Youth 267, 267.

[67] Stephane M Shephard et al, 'The Impact of Indigenous Cultural identity and Cultural Engagement on Violent Offending' (2017) 18(50) BMC Public Health 1.

Culturally Appropriate Pilot Programs in Victoria – Child Protection

216. The following Victorian pilot programs which seek to establish culturally appropriate initiatives around child protection should be highlighted in the context of this investigation.

Broadmeadows Magistrate Court pilot program

217. The Marram-Ngala Ganbu (which means "we are one" in the Woiwurrung language) pilot was launched at the Broadmeadows Magistrates' Court in August 2016, and was established as an innovative response to the over-representation of Aboriginal children and families in the child protection system in Victoria.

218. The pilot program aims to improve outcomes for Koori children and families involved in child protection proceedings. It seeks to provide a more effective, culturally appropriate and just response for Koori families through a culturally appropriate court process, that enables greater participation by family members and culturally-informed decision-making.

219. Since opening, the program has supported close to 400 Koori families through the court process. Available information suggests that the evaluation identified sufficient evidence that Marram-Ngala Ganbu is achieving its intended short to medium-term outcomes, and there are early indicators that it is on track to deliver the desired long-term outcomes.

Aboriginal led Child Protection – BDAC pilot program

220. *Aboriginal Children in Aboriginal Care* is a relatively new program for Aboriginal children and young people subject to a Children's Court protection order. Pursuant to section 18 of the *Children, Youth and Families Act 2005,* the Secretary of the Department of Families, Fairness and Housing is able to authorise the principal officer of an Aboriginal agency to undertake specified functions and powers in relation to a Children's Court protection order for an Aboriginal child or young person. The term principal officer refers to the CEO of an Aboriginal Community Controlled Organisation (**ACCO**).

221. The Victorian Government is working alongside ACCOs and Community Service Organisations (**CSOs**) to support Aboriginal self-determination. Aboriginal Children in Aboriginal Care recognises the needs of Aboriginal children are best met by Aboriginal community services that are culturally attuned. ACCOs are also best placed to reconnect Aboriginal children and families to culture where there has been a disconnection. Aboriginal Children in Aboriginal Care aims to promote Aboriginal children's cultural

identity and promote their connection to family, community and culture. Connection to culture, community and Country is fundamental to supporting the safety and identity of Aboriginal children.

222. A 12-month rural Aboriginal Children in Aboriginal Care 'as if' pilot commenced in July 2016 at the Bendigo and District Aboriginal Cooperative (**BDAC**). The pilot involves a small number of Aboriginal children on protection orders who are living both at home and in out-of-home care. A number of family reunifications and return to Country for Aboriginal children have taken place to date.

223. The 'as if' pilots have taken place to ensure that implementation of Aboriginal Children in Aboriginal Care is as effective as possible, and that all system and organisational issues are addressed before authorisations occur.

Chroming and volatile substance misuse

224. In the past, volatile substance misuse has been a prominent public health issue in Victoria, with the Parliament of Victoria's Drugs and Crime Prevention Committee Inquiry into the Inhalation of Volatile Substances (which delivered its final report in September 2002) marking a particular high point for engagement with the issues. I note, however, that there does not appear to have been much if any new activity in recent years.

225. The Department of Health's booklet *About Inhalant Abuse: For Health and Community Workers* illustrates this point well; its list of resources and references doesn't contain anything more recent than 2002.

226. Similarly, the Victorian Department of Education and Training publication titled *Volatile Substances: A Resource for Schools* has not been updated since 2000. In this investigation the CPU was required to rely more on recent mass media articles about 'rexing' and deodorant chroming, than on academic and government research.

RECOMMENDATIONS

227. Pursuant to section 72(2) of the Act I make the following recommendations connected with Master S's passing:

1. *That the Department of Health review and update the contents of its booklet titled About Inhalant Abuse: For Health and Community Workers in light of what is now known about volatile substance misuse and related harms, to ensure that youth workers and others who work with young people at risk of volatile substance misuse have access to the best and most contemporaneous advice to support this vulnerable group. The booklet should be re-launched when the update is complete.*

2. *That the Department of Health undertake a review of what is known about volatile substance misuse, how it has evolved as a public health issue in Victoria over the past 15 years, and what strategies have worked both here and internationally to reduce associated harms. The review would ideally include engagement with manufacturers of products that are strongly implicated in volatile substance misuse, to gain a better understanding of how product re-design might contribute to harm reduction in this area. Upon completing the review, the Department of Health should consider what resources it might produce for relevant audiences (for example educators, parents, police) who might be in a position to identify and address volatile substance misuse among young people in our community.*

PUBLICATION

228. Pursuant to section 73(1) of the Act, I order that this Finding (in a redacted format) be published on the internet.

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

Master S's mother, senior next of kin

Master S's father, senior next of kin

Victorian Aboriginal Community Services Associated Ltd

Commission for Children and Young People

Department of Justice and Community Safety

Department of Families, Fairness and Housing

Department of Health

Senior Constable Russell Cameron, Victoria Police, Coroner's Investigator

Signature:

_____

SARAH GEBERT

CORONER

Date: 28 July 2022