IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2018 002344

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge John Cain, State Coroner
Deceased:	Lachlan John Howe
Date of birth:	31 March 2005
Date of death:	18 May 2018
Cause of death:	1(a) Hanging
Place of death:	Royal Children's Hospital, 50 Flemington Road, Parkville, VIC 3052
Keywords:	Aboriginal; Suicide; Family violence

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

Amended pursuant to section 76A of the *Coroners Act 2008 (Vic)* on 25 January 2024 by order of the State Coroner, Judge Cain. Paragraph 35 on page 7 was amended and redacted to comply with statutory obligations.

INTRODUCTION

1. On 18 May 2018, Lachlan John Howe was 13 years old when he passed away upon arrival at the Royal Children's Hospital in Parkville, Victoria. At the time of his death, Lachlan was living with his mother, Chantal Howe, and was the youngest of five children born to parents, Ms Howe and Damien Howe. Lachlan's older siblings include Courtney Howe, Madeline Howe, Chelsea Howe and Joshua Howe[1].

2. Lachlan enjoyed a good relationship with his siblings growing up in Violet Town. When Lachlan was ten years old, the family moved to Benalla.

3. Lachlan's parents separated in early 2015 and Ms Howe took Lachlan and two of his sisters to live with their maternal grandmother. Following the separation, Lachlan and his siblings initially remained with Ms Howe, although Lachlan then moved to live with his father from time to time. The available evidence from services and family indicate that Lachlan was adversely affected by the separation and began exhibiting challenging behaviour at school and at home during this time.

THE CORONIAL INVESTIGATION

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

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

6. 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.

[1] Joshua passed away shortly after birth due to a brain haemorrhage.

7. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Lachlan's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

8. This finding draws on the totality of the coronial investigation into the death of Lachlan John Howe including evidence contained in the coronial brief. 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.[2]

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

Circumstances in which the death occurred

9. In the months leading up to the fatal incident, Lachlan was exhibiting significant concerning behaviours at school.

10. On 1 March 2018, Lachlan reportedly drew an image of an individual suiciding. During discussion with his school wellbeing officer, Lachlan advised that he had felt unheard during a recent family trip to Queensland. Lachlan was assessed as having '*no timeframe or plan to act on thoughts*'[3] of suicide. Concerns were communicated to Ms Howe and it was agreed that Lachlan would be referred to North Eastern Child and Adolescent Mental Health Service (**NECAMHS**), there is conflicting records in the available evidence as to whether this referral was made or not.[4]

11. Following notification of the school's concern for Lachlan's mental health, Lachlan's paediatrician met with him but '*felt Lachlan was unchanged in his manner'*[5] and '*denied being suicidal, and refused to accept any help*.'[6]

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[2] 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.
[3] Benalla College, Records of Lachlan Howe – Student Wellbeing Notes, 789.
[4] Ibid.
[5] Statement of Dr N Perera, 3.
[6] Ibid.

12. On 18 April 2018, another student's parent contacted Lachlan's school advising that Lachlan had expressed suicidal ideation in an online chat with his friends.[7] Ms Howe was notified of this incident and the school spoke with Lachlan and his paediatrician the following day. In an email to the paediatrician, the school expressed urgency in seeking support for Lachlan and a limited knowledge of how best to manage the situation.[8] In discussions with Lachlan he advised school counsellor that he had felt '*depressed and had felt suicidal after comments from his dad'*.[9] He noted that he did not wish to see a psychologist or speak with his family about his difficulties.

13. On 24 April 2018, the school wellbeing officer called kids helpline whilst Lachlan was present '*so that he would be familiar with this support'*.[10] On the same day a referral was sent by Lachlan's paediatrician to NECAMHS, noting Lachlan's suicidal ideation.[11] A formal referral was requested[12] which was not sent until 2 May 2018.[13]

14. NECAMHS attempted to contact Ms Howe on 9 and 11 May 2018 without success and Lachlan was not engaged with this service prior to his death.

15. On 15 May 2018, Lachlan was observed by family to be upset. Reports from one of Lachlan's older sisters, Chelsea, indicated that the previous weekend Mr Howe had '*told Lachlan that he didn't want to see him and to go away'*. Phone records indicate that on the same day Mr Howe sent abusive text messages to Lachlan and made derogatory references to Ms Howe.[14]

16. On 17 May 2018, an altercation occurred at school and Lachlan was reportedly told to '*go kill himself*', it is reported that this abuse continued up until the time of his death.[15]

17. On 18 May 2018, a school teacher found a note from Lachlan stating that he was '*having thoughts to suicide'*.[16] Following this discovery, the school attempted to contact Ms Howe without success. The school also placed a call to NECAMHS and advised that they would contact Ms Howe again.[17] During this conversation the school wellbeing counsellor advised

[7] Benalla College, Records of Lachlan Howe – Student Wellbeing Notes, 786.
[8] Benalla College, Records of Lachlan Howe, 783.
[9] Benalla College, Records of Lachlan Howe – Student Wellbeing Notes, 786.
[10] Ibid, 785.
[11] Statement of Dr N Perera, 3.
[12] Statement of Dr N Perera, 4.
[13] Coronial Brief, Letter from Dr N Perera to NECAMHS, 557.
[14] Coronial Brief, Exhibit 8 – Test messages between Damien Howe and Lachlan Howe
[15] Coronial Brief, Damien Howe statement, 42
[16] Letter from Benalla College dated 1 July 2019, 9
[17] Ibid.

NECAMHS that Lachlan had previously attempted suicide but noted that they were unsure whether Lachlan was at increased risk. Notes obtained from NECAMHS state that the school wellbeing counsellor had reported to the service '*that Lachlan was not expressing intent to act on suicidal thoughts*.'[18]

18. After leaving school on 18 May 2018, Lachlan returned home to his mother's house. On this day, the family were preparing for Courtney and Chelsea to participate in the debutante ball.

19. During the evening, Lachlan was left at home alone whilst his mother and sisters attended practice for the ball. Whilst at home, Lachlan entered an online chat discussion with two school friends, AA and BB, who he was having disagreements with about events that had occurred earlier that day and the day prior. Lachlan was simultaneously speaking with AA privately and queried '*why he didn't want to be his friend anymore'*.

20. At approximately 4.45pm, during the online discussion, Lachlan disclosed his intentions to suicide however AA was not active in the chat at this time.

21. At approximately 5.03pm, AA returned home and discovered the last messages from Lachlan on his iPad and attempted to ring Lachlan without success. AA notified his father who was aware of Ms Howe's location and was able to get in contact with Ms Howe to alert her to the situation.

22. Ms Howe returned home to find Lachlan hanging inside the rear shed and contacted emergency services. AA's father and Lachlan's grandfather arrived shortly after Ms Howe returned home and assisted with attempts to resuscitate Lachlan.

23. Ambulance paramedics arrived at approximately 5.33pm and were able to stabilise Lachlan in an induced coma with life support and transported him to Benalla Airport where he was flown to the Royal Children's Hospital.[19] However due to several cardiac arrests enroute to the hospital, Lachlan was pronounced deceased by hospital medical staff upon arrival.

[18] Records provided to the Court from NECAMHS – Case Notes 3, 6
[19] Coronial Brief, Statement of Ambulance paramedic dated 19 October 2018, 88

Identity of the deceased

24. On 18 May 2018, Lachlan John Howe, born 31 March 2005, was visually identified by his uncle, Cal Hutchins.

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

Medical cause of death

26. Forensic Pathologist Dr Joanna Glengarry from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 21 May 2018 and provided a written report of her findings dated 3 June 2018

27. The external examination revealed the following:

    a) The external examination showed features consistent with hanging; and

    b) Post mortem CT scans revealed no evidence of skull fracture or intracranial haemorrhage. The neck structures were intact and increased lung markings were noted.

28. Toxicological analysis of post-mortem samples identified the presence of midazolam and atropine. All substances identified were not at concentration levels that impacted on the cause of death and were administered as part of resuscitation attempts by attending Ambulance paramedics on 18 May 2018.

29. Dr Glengarry provided an opinion that the medical cause of death was 1 (a) Hanging.

FURTHER INVESTIGATIONS AND CORONER'S PREVENTION UNIT REVIEW

30. For the purposes of the *Family Violence Protection Act 2008*, the relationship between Lachlan and his father was one that fell within the definition of '*family member*[20] under that Act. Moreover, Mr Howe's actions in communicating emotional abuse in the lead up to the fatal incident constitutes '*family violence'*.[21]

[20] Family Violence Protection Act 2008, section 8(1)(a)
[21] Family Violence Protection Act 2008, section 9

31. In light of Lachlan's death occurring under circumstances of proximate family violence, I requested that the Coroners' Prevention Unit (**CPU**)[22] examine the circumstances of Lachlan's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[23]

History of family violence and Child Protection involvement with Lachlan and his family

32. The Department of Families, Fairness and Housing - Child Protection (**Child Protection**) is specifically targeted to those children and young people at risk of harm or where families are unable or unwilling to protect them. The main functions of Child Protection are to investigate matters where it is alleged that a child is at risk of harm; refer children and families to services that assist in providing the ongoing safety and wellbeing of children and take matters before the Children's Court if the child's safety cannot be ensured within the family.

33. Child Protection were involved with Lachlan's family on fifteen occasions following reports of family violence, welfare concerns and abuse. In most of these incidents, Child Protection closed their involvement with the family following little or no investigation of the allegations.

34. The most substantial involvement with the family occurred in April 2015, following allegations of that Madeline, Lachlan and Chelsea were at significant risk of harm. At this time, Madeline was presenting as at high risk of self-harm. Investigations indicated that Lachlan was placed into the care of his father and that Madeline had felt a heightened level of responsibility for his safety in Mr Howe's care. It was alleged that Mr Howe was extremely violent to Ms Howe, Chelsea, Madeline and Courtney in the past, had choked all four of them and that Madeline was afraid to return to Mr Howes address in fears that he would '*hit her'*.[24]

35. [redacted].

[22] The Coroners Prevention Unit is a specialist service for Coroners established to strengthen their prevention role and provide them with professional assistance on issues pertaining to public health and safety

[23] The VSRFVD provides assistance to Victorian Coroners to examine the circumstances in which family violence deaths occur. In addition the VSRFVD collects and analyses information on family violence-related deaths. Together this information assists with the identification of systemic prevention-focused recommendations aimed at reducing the incidence of family violence in the Victorian Community

[24] Department of Health and Human Services, Case Record of Lachlan Howe, 165

36. During Child Protection's involvement, they identified that Mr Howe '*could be contributing to some disrespect by Lachlan towards his mother and sisters'* and noted that Mr Howe showed '*no insight or accountability for the trauma his children have been exposed to'*.[25] Child Protection closed their involvement with the family on 30 November 2015 following the assessment that both Mr and Ms Howe and the children had formal and informal support networks, that would reduce ongoing conflict and that neither child had expressed feeling unsafe in either parents care.

37. Child Protection were involved with the family on six occasions following this engagement. Most of these matters were closed without any significant investigation or concern. Given the magnitude of Child Protection's involvement and the historical nature of many of these notifications, the coronial investigation has focused on the most recent Child Protection engagement, occurring 14 months prior to Lachlan's death.

38. On 9 March 2017, Child Protection received a report advising that unnecessary welfare checks had been conducted on Ms Howe at the request of Mr Howe. This report detailed concerns that Mr Howe '*continues to try to control the older children'*.[26] This report noted that Mr Howe had a history of perpetrating family violence towards Ms Howe and that Madeline's mental health was declining as a result of recent contact with her father. The notification also documented that Ms Howe was feeling '*stressed because the father is causing trouble'*.[27]

39. Following this report, Child Protection referred the family to ChildFIRST[28] and closed the matter, with practitioners noting that '*it is acknowledged that Lachlan's behavioural issues and lack of routine in schooling and Chelsea's lack of engagement with school may impact upon their well-being and development. Furthermore, the concerns raised for Mother's stress suggest that she may not be coping with the current stress of Father reportedly being controlling.*'[29] Child Protection concluded that it was hoped that the referral to ChildFIRST would reduce 'the likelihood of significant risk to their wellbeing'[30] in the future.

[25] Ibid, 298
[26] Ibid, 70
[27] Ibid, 71
[28] Child FIRST (Child and family information, referral and support teams) are an entry point into family services.
[29] Department of Health and Human Services, Case Record of Lachlan Howe, 64
[30] Ibid, 64-65

Mental health treatment provided to Lachlan in the lead up to the fatal incident

40. Lachlan was referred to NECAMHS on three occasions.[31] These referrals pertained to Lachlan's suicidality and behavioural issues.

41. The most recent referral to NECAMHS was sent on 2 May 2018, noting '*suicide attempts and threats'* and noting that this behaviour related to Lachlan's engagement with his father, advising that '*there were many angry phone messages and texts from his father'*.[32]

42. This referral was actioned on 9 and 11 May 2018, when NECAMHS unsuccessfully attempted to contact Ms Howe.

43. On 18 May 2018, NECAMHS were contacted by the Benalla College School Wellbeing Officer following the suicidal imagery and text on Lachlan's school work. Case notes from this discussion indicate that NECAMHS were informed that Lachlan was '*not expressing intent to act on suicidal thoughts*'.[33] NECAMHS advised that they had previously attempted to contact Ms Howe but had been unsuccessful.

44. In addition to the referral to NECAMHS, Lachlan was referred to a paediatrician, Dr Niroshini Perera, on 15 June 2016 and remain regularly engaged with her until 1 December 2016. Lachlan met with Dr Perera on one occasion in 2017 and twice in 2018, with his final appointment being on 17 April 2018.[34]

45. During his involvement with Dr Perera, Lachlan was examined for Attention Deficit and Hyperactivity Disorder (**ADHD**) and treated for behavioural issues. On several occasions throughout her treatment of Lachlan, Dr Perera observed that Mr Howe was abusive towards Lachlan and that this abuse was having detrimental effects on Lachlan's mental health.

46. On 22 August 2016, Dr Perera sent a letter to Lachlan's treating GP, stating that she was aware that '*Lachlan's father can be quite* aggressive'[35] and noting that these behaviours were now presenting in Lachlan.

[31] NECAMHS, Case Records of Lachlan Howe
[32] Ibid
[33] Ibid
[34] Coronial Brief, Letter from Dr Perera, 440
[35] Ibid.

47. On 10 October 2016, Dr Perera sent another letter to Lachlan's GP advising that Lachlan's '*language is so harsh and I am sure part of it stems from the childhood trauma he had with an aggressive father'*.[36] At the time of these observations, Lachlan was engaged with a psychologist based at the school.

48. By April 2018, Lachlan was not engaged with any supports except for Dr Perera. In a letter to Lachlan's doctor on 27 April 2018, Dr Perera noted that Lachlan had been observed by Benalla College staff as being '*quite depressed and talking about hanging himself'*.[37]

49. Dr Perera further noted that '*he has ongoing issues with his relationship with his father and I can see that Lachlan is both angry and hurt about this*' and that '*he mentioned that there had been some abusive phone calls and texts*'.[38] Dr Perera advised that Lachlan had '*posted about [sic] desire to kill self. The school understands that this is often in response to his difficult relationship with his father'* but noted that Lachlan had consistently '*refused to respond to any counselling or accept any assistance'* and '*steadfastly refused any help'*.[39] Dr Perera concluded by noting that Lachlan had informed her that he was in a '*good place'* and denied any '*wish to harm himself'.*[40]

Proximate educational services provided to Lachlan

50. Lachlan was an enrolled student with Benalla P-12 College (Benalla College) at the time of the fatal incident. The available evidence raises concerns in relation to Benalla College's responses to Lachlan's mental health and experience of family violence.

51. Following the end of Child Protection's involvement with the family on 24 March 2017, Benalla College were notified on six separate occasions that Lachlan had disclosed suicidal ideation.[41] These disclosures often occurred at school and were directly disclosed to staff or indirectly communicated through drawings and schoolwork.[42]

52. Following each of these disclosures, the school responded by meeting with Lachlan, speaking with Ms Howe and communicating with NECAMHS or Lachlan's paediatrician. Whilst the

[36] Ibid, 493
[37] Ibid, 567
[38] Ibid
[39] Ibid
[40] Ibid
[41] Benalla College, Records of Lachlan Howe, 780, 775, 789, 786, 784
[42] Ibid

school staff appeared to attempt to proactively manage Lachlan's suicidality it is evident in the records provided to the Court that staff were inadequately resourced to achieve this task.

53. Ms Louise McCloskey, the Student Welfare Officer at Benalla College, was responsible for providing students with an array of support relating to social and wellbeing issues.[43] Ms McCloskey worked with Lachlan from 2017 until his passing.[44] In her statement to the Court, Ms McCloskey reiterated the steps taken to support Lachlan and his family in accessing mental health support.[45]

54. From the information provided to the Court, Lachlan was referred to North East Child and Adolescent Mental Health Services (**NECAMHS**) on 11 May 2017 by Benalla College,[46] however NECAMHS have no record of this referral.

55. On 23 May 2017, Ms McCloskey discussed referring Lachlan to NECAMHS after he disclosed suicidal ideation to her.[47] On this occasion, Ms McCloskey advised that NECAMHS was an appropriate support for Lachlan and that she would '*call [Ms Howe] to see what her thoughts are.*'[48]

56. On 26 May 2017, Ms McCloskey contacted NECAMHS for a case consultation[49] and was advised that Ms Howe could contact the service for an appointment.[50] No further details regarding this conversation are known and Lachlan does not appear to have been referred to NECAMHS on this occasion.

57. On 6 June 2017, Ms McCloskey contacted Ms Howe and was informed that Lachlan had visited his GP and had been referred to a paediatrician and child psychiatrist.[51] However, from the notes available to the Court, it does not appear that Lachlan was engaged with a child psychiatrist prior to his death.

58. On 1 March 2018, Ms McCloskey was notified that Lachlan had sketched depictions of suicide on a note at school and indicated that this would soon be him.[52] Following discussions with

[43] Benalla P-12 College, Statement of Louise McCloskey, 1.
[44] Ibid.
[45] Benalla P-12 College, Statement of Ms McCloskey.
[46] Benalla P-12 College, Records of Lachlan Howe, 198.
[47] Benalla P-12 College, Records of Lachlan Howe, 100.
[48] Ibid.
[49] Ibid, 105.
[50] Ibid, 105.
[51] Ibid, 105.
[52] Benalla P-12 College, Records of Lachlan Howe, 108.

Lachlan, Ms McCloskey spoke with Ms Howe and encouraged her to contact Lachlan's GP to seek a Mental Health Care Plan for Lachlan to see a psychologist.[53]

59. On 2 March 2018, Ms McCloskey spoke with Lachlan again who reported that he was '*ok'*.[54] On the same day, Ms McCloskey made contact with Ms Howe '*about NECAMHS'*,[55] however it is unclear what the outcome of this conversation was and there is no evidence to suggest that Lachlan was referred to NECAMHS on this occasion.

60. On 29 March 2018, Ms McCloskey contacted Lachlan's paediatrician advising that Lachlan had expressed '*suicidal thoughts at school'*[56] and '*refuses to attend an appointment'*[57] with his GP for a Mental Health Care Plan. Ms McCloskey requested that the paediatrician discuss '*these concerns'*[58] at their next appointment and noted that Lachlan had previously received support from NECAMHS.

61. Following further disclosures of suicidal ideation, Ms McCloskey contacted Lachlan's paediatrician on 19 April 2018 and advised that Lachlan '*continues to express feeling suicidal to his class mates both in person and online'*.[59] Ms McCloskey further advised that Lachlan '*really needs some support to deal with his emotions in a more healthy way'*[60] and it was agreed that Lachlan's paediatrician would contact Ms Howe.

62. On 27 April 2018, Ms McCloskey contacted NECAMHS again to '*check on [the] referral'*[61] however, it is unclear what the outcome of this consultation was and NECAMHS do not appear to have been in receipt of a referral at this time.[62]

63. By 2 May 2018, Lachlan was still not engaged with NECAMHS and Lachlan's paediatrician made a formal referral to the service following permission from Ms Howe.[63]

64. On the day of Lachlan's passing, Ms McCloskey contacted the service again after Lachlan made further disclosures of suicidal ideation. NECAMHS advised the school that they had

[53] Benalla P-12 College, Records of Lachlan Howe, 108.
[54] Benalla P-12 College, Records of Lachlan Howe, 108
[55] Benalla P-12 College, Records of Lachlan Howe, 108
[56] Ibid, 109.
[57] Ibid, 109.
[58] Ibid, 109.
[59] Benalla P-12 College, Records of Lachlan Howe, 111.
[60] Ibid.
[61] Benalla P-12 College, Records of Lachlan Howe, 112.
[62] Ibid.
[63] Dr Niroshini Perera, Statement of Dr N Perera, 4; Coronial Brief, Letter from Dr N Perera to NECAMHS, 557.

attempted to contact Ms Howe several times without success and requested that Ms McCloskey encourage Ms Howe to contact their service.[64]

65. At the time of his passing, Lachlan was not engaged with any support outside of his paediatrician who had informed Benalla College that Lachlan refused to speak to them about his mental health concerns.[65] In meetings with school staff, Lachlan stated that he would not discuss his mental health with his family, would not seek support and would not attend appointments with a psychologist.[66] In addition to this, Ms Howe, for reasons unknown to the Court, was not engaging with NECAMHS or being proactive in sourcing psychological support for Lachlan.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

66. On the available evidence, there were several significant factors affecting Lachlan on and proximate to 18 May 2018. The following commentary is focused on the services that had contact with Lachlan in the lead up to the fatal incident and who were responsible for providing support to Lachlan and his family. The comments are made to identify improvements to public health, safety and the administration of justice that are connected but not causal to the death being investigated.

67. While I have made comments below that appear appropriate to me as they arise from the coronial investigation into Lachlan's death, the available evidence does not support a finding that there is any causal connection between the circumstances highlighted in the comments and Lachlan's death.

Child Protection contact with Lachlan and his family in the lead up to the fatal incident

68. The last notification received by Child Protection was on 9 March 2017. Whilst I acknowledge that this was some 14 months prior to the fatal incident, I have concerns with Child Protection's management of this notification and the impact it may have had on supports provided to Lachlan and his family in the lead up to the fatal incident.

[64] North Eastern Child and Adolescent Mental Health Service, Case Records of Lachlan Howe – Case Notes 3.
[65] Coronial Brief, Letter from Dr N Perera to NECAMHS, 557.
[66] Benalla College, Records of Lachlan Howe, 780, 775, 789, 786, 784.

69. The 9 March 2017 notification was the fifteenth report received by Child Protection in relation to this family, with five of these reports specifically relating to Lachlan, four of which had been received between January 2016 and March 2017.

70. These reports largely related to concerns of family violence perpetrated by Mr Howe towards Ms Howe and their children and detailed physical abuse experienced by the children in Mr Howe's care. Concerns for Madeline and Lachlan's mental health were also key features of several of these reports and ultimately led to the children being taken from Mr Howe's care in 2015 and Mr Howe being identified as responsible for inflicting harm on Lachlan and his siblings.

71. Despite these previous concerns, Child Protection did not appear to undertake any further investigations into the allegations made to their service on 9 March 2017. According to the Child Protection Manual, intake workers are required to '*gather relevant assessment information from other professional sources including information holders or service agencies where possible'* upon receipt of a notification.[67] Advice to intake workers, in place at the time of this report, suggested that practitioners contact '*agencies, services and professionals who may be involved with the family where necessary to verify, corroborate or gather further information regarding the concerns identified in the report'*.[68] It is only with the analysis of this information that workers are equipped to determine the risk posed to the children and to determine the level of intervention required.

72. The available evidence suggests that this investigation was not undertaken by Child Protection intake workers at the time of the notification made in relation to Lachlan and his siblings. At the time of closure, Child Protection were unaware as to how much involvement Mr Howe had with the children, what supports were available to the family and whether there had been any additional incidents of family violence since the investigation in 2015. Without this information, staff were inadequately resourced to be able to determine the level of welfare or wellbeing needs experienced by the family. I find this particularly concerning given the history of Child Protection's involvement with this family.

[67] Department of Health and Human Services, 'Receiving, registering and classifying a report' (2019) < https://www.cpmanual.vic.gov.au/policies-and-procedures/phases/intake/receiving-registering-and-classifying-report

[68] Department of Health and Human Services, 'Intake phase- advice', (2016) <https://www.cpmanual.vic.gov.au/advice-and- protocols/advice/intake/intake-phase>

73. The available evidence suggests that Child Protection also appear to have placed too much responsibility on Ms Howe to support her children and neglected to consider her experience as a family violence victim which may have diminished her capacity.

74. Research suggests that a parent's capacity to negotiate parenting and child arrangements with an abusive parent can be compromised by their placement as a victim.[69] Low self-esteem, limited social network and diminished financial resources that victims are often subjected to as a result of family violence, can work to reduce the capacity of these women to navigate parenting arrangements following separation. Research also notes that women who have left a violent relationship often feel powerless when negotiating child caring arrangements and '*felt they had been pressured into unfair agreements'* regarding such arrangements.[70] Women leaving abusive relationships also report making decisions regarding parenting arrangements based on fear of the perpetrator[81] or as a result of manipulation or disempowerment.

75. Child Protection recorded observations that Ms Howe was '*not coping with the current stress of father reportedly being controlling'*,[71] thus demonstrating that her capacity may have been limited and that further support was required. Best practice in the circumstances of this case, may have been for these factors to be discussed with the family prior to the referral being closed so that additional support could have been explored.

76. The available evidence also suggests that Child Protection practitioners do not appear to have considered cumulative harm in their assessment of this contact. The Best Interests Case Practice Model, in place at the time of this report and currently in place to guide Child Protection practice, indicates that Child Protection workers must '*critically reflect on indicators of cumulative harm in the case history'*[72] and re-examine historical reports each time a new report is made. The Best Interests Practice Model notes that these steps are necessary to '*assess whether a number of low-level risk factors combined are placing the child at risk of significant cumulative harm'*.[73] The importance of doing this is especially highlighted at the intake phase, when critical decisions regarding the response to a notification are made. Despite this direction, Child Protection appear to have given little consideration to

[69] Australian Institute of Family Studies, 'The effect of family violence on post-separation parenting arrangements' (2011) <https://aifs.gov.au/publications/family-matters/issue-86/effect-family-violence-post-separation-parenting-arrangements>.
[70] Ibid.
[71] Department of Health and Human Services, Case Record of Lachlan Howe, 71
[72] Department of Human Services, 'Cumulative harm- best interests case practice model specialise practice resource', (2012), 24
[73] Ibid.

the cumulative harm that was reported to their service in previous notifications. Had this been considered, it is possible that the need for further Child Protection involvement may have been identified.

77. The records provided to the Court by Child Protection indicate that throughout their engagement with the family, Lachlan and his siblings were misidentified by Child Protection as not being of Aboriginal or Torres Strait Islander descent.[74] This is despite Lachlan's school records and school wellbeing profile recording his Aboriginality.[75]

78. The Child Protection Manual notes strict considerations and procedures that Child Protection practitioners are required to abide by when a child of Aboriginal descent comes into contact with their service. These requirements have been developed in efforts to support self-determination and empowerment within the Aboriginal and Torres Strait Islander communities and to move away from colonial child protective practices that led to the Stolen Generation. In the circumstances of this case, no culturally sensitive services were offered to Lachlan and his siblings.

79. Since the fatal incident, Child Protection have undertaken significant work to improve their practices, policies and training in response to the Royal Commission into Family Violence (**RCFV**).[76] This includes the implementation of a new family violence risk assessment framework aligned with the Multi-Agency Risk Assessment and Management Framework (**MARAM**). The development of new family violence risk assessment tools resulted in the introduction of the SAFER framework which commenced on 20 November 2021.

80. Training from Recommendation 29 of the RCFV, Titling our Practice and MARAM, along with SAFER, has promoted a shift in Child Protection's understanding of family violence, including increasing awareness about what constitutes family violence, the impact on victim survivors and how to respond more effectively, by partnering with victim survivors and seeking perpetrator accountability.[77]

81. From March 2020, Child Protection have also committed to consolidating management into a single state-wide management structure to enable better matching of practitioner resources to

[74] Department of Health and Human Services, Child Protection Records of Lachlan Howe, 404
[75] DET school file records for Lachlan Howe – 61, 82
[76] Royal Commission into Family Violence Final Report May 2016
[77] Statement of Dr Sharon Gilroy (Principal Practitioner DFFH CP) dated 18 September 2023, 10-11

demand, and to maximise opportunities to improve consistency of practice and responsiveness. There has also been a further increased investment in Practice Leaders and Senior Child Practitioners to support practitioners with risk assessments, decision making and professional capability building.[78]

Mental health treatment provided to Lachlan by Dr Perera

82. As noted earlier, at the time of his passing, Lachlan was not engaged with any support outside of his paediatrician, Dr Perera. Dr Perera's management of Lachlan during her treatment of him raises some concerns.

83. Despite noting Mr Howe's abuse towards Lachlan, Dr Perera does not appear to have taken any significant action to address this with Lachlan and his family. Instead, Dr Perera, like Lachlan's school, focused on treating Lachlan and seeking mental health support for him, without consideration for the effects of Mr Howe's behaviour on Lachlan.

84. In light of the challenges engaging Lachlan in support, it may have been appropriate for Dr Perera to consider consulting with Child Protection or ChildFIRST to identify how best to manage Lachlan's escalating suicidality and the corresponding relationship difficulties with his father.

85. The Australian Health Practitioner Regulation Authority (**AHPRA**) works with the fifteen national medical practice boards of Australia to regulate Australia's registered health practitioners. One of these boards is the Medical Board of Australia which regulates the training and performance of medical professionals including paediatricians.

86. In review of the Medical Board of Australia website, there does not appear to be any guidelines, training or practice manuals pertaining to child abuse, child welfare concerns or support avenues for children and families in need. Medical practitioners, especially paediatricians, are uniquely positioned to identify and respond to risk in adults and children given their frequent engagement with patients.

87. I note that the Royal Australian College of Physicians (**RACP**) is the accreditation body for training programs leading to eligibility for specialist registration as a paediatrician in Australia. The RACP website has dedicated resources including:

[78] Ibid.

a. Guidance on the role of paediatricians in providing mental health services to children and young people;[79] and

b. Royal Australian College of Physicians guidance on Child Protection – Protecting Children is Everybody's Business.[80]

88. It is vital that practitioners keep up to date with the resources necessary to identify child welfare concerns and to respond appropriately to these concerns by making referrals to specialist supports for vulnerable children and families.

Review of the educational services provided to Lachlan and his family in the lead up to the fatal incident

89. The ongoing nature of Lachlan's mental health concerns and the limited support he was receiving from mental health services suggests that additional intervention may have been needed to address Lachlan's wellbeing. By May 2018, Lachlan was not engaged with any support outside of his paediatrician who continually informed Benalla College that Lachlan refused to speak to them about his mental health concerns.[81]

90. In meetings with Lachlan, he informed school staff that he would not discuss his mental health with his family, seek support or attend appointments with a psychologist. Given the escalation in Lachlan's suicidal ideation and behavioural issues and the decline in his willingness to engage with support services around this time, it may have been appropriate for the school to consider referring the matter to Child Protection for additional support.

91. Staff employed in public schools are mandated reporters of child sexual and physical abuse and are also required to report alleged or suspected child abuse.[82] Staff are also expected to monitor the broader wellbeing and welfare of their students. The Department of Education stipulates that that staff should contact Child Protection if they '*hold wellbeing concerns for a child'*[83] including concerns that '*have a serious impact on a child's safety, stability or*

[79] Available online at: https://www.racp.edu.au/docs/default-source/advocacy-library/racp---the-role-of-paediatricians-in-the-provision-of-mental-health-services-to-children-and-young-people.pdf
[80] Available online at: https://www.racp.edu.au/docs/default-source/advocacy-library/pol-protecting-children-is-every-bodys-business.pdf
[81] NECAMHS, Statement of K Black, 1
[82] Department of Education, *Protecting Children – Reporting and Other Obligations*, <https://www2.education.vic.gov.au/pal/protecting- children/policy
[83] Department of Education, *Responding to other concerns about the wellbeing of a child,* <https://www.education.vic.gov.au/school/teachers/health/childprotection/Pages/responding.aspx

development'[84] or that '*are persistent and entrenched and likely to have a serious impact on a child's safety, stability or development'*.[85] If a staff member does not feel that this threshold is met, the Department of Education stipulates that a referral must be made to ChildFIRST or the Orange Door which are community services that provide support to families and can monitor and escalate matters requiring Child Protection involvement.[86]

92. The available evidence suggests that Benalla College did not appreciate the impacts of Mr Howe's behaviour on Lachlan's mental health, and thus failed to act on these concerns. Benalla College had previously been made aware of Mr Howe's behaviour towards Lachlan and the resulting effects of this behaviour on Lachlan.

93. Prior to Lachlan's passing, these issues appear to have escalated and on 19 April 2018, the school wellbeing officer met with Lachlan after they were informed that he had disclosed suicidal ideation. During this meeting, Lachlan disclosed that he was '*depressed and felt suicidal after comments from his dad'*.[94] No further information was noted in relation to these comments. This comment from Lachlan is one of significant concern and indicates the impact that Mr Howe's behaviour had on Lachlan's wellbeing.

94. Despite this disclosure, the school do not appear to have queried Lachlan's relationship with his father any further or to have considered notifying Child Protection of these concerns. Instead, Lachlan's suicidality appears to have been treated as a personal pathology, whilst contributing factors such as his father's violence, remained unaddressed.

95. Benalla College was invited to provide further statements and materials to address concerns about Lachlan's welfare and support provided to him. Benalla College submitted several statements to the Court regarding their contact with Lachlan and the training provided to staff members in responding to child welfare concerns.

96. Whilst I commend Ms McCloskey's (Student Welfare Officer at Benalla College) efforts to support Lachlan and his family during this period, I am concerned that the school did not consider taking additional steps to address Lachlan's suicidality. Despite the school's efforts

[84] Ibid
[85] Ibid
[86] Ibid

to refer Lachlan to NECAMHS it appears that the organisation did not have an active referral for Lachlan until 2 May 2018.

97. The available evidence suggests that it may have been appropriate for the school to consider making a notification to Child Protection given Lachlan's escalating suicidal ideation and his unwillingness to engage with support services. Due to the statutory powers of Child Protection, it is possible that their involvement may have helped to facilitate mental health support for Lachlan prior to his passing. In noting this however, the Court appreciates that Child Protection's involvement may not have been useful in this instance and may have created further distress for Lachlan and his family. This is especially true in the context of Lachlan's Aboriginality and the current and historical traumas associated with Child Protection's involvement with Aboriginal families.

98. The coronial investigation raises concerns regarding the school's inadequate response to Lachlan's reported experiences of family violence or explore this in any capacity during their engagement with Lachlan.

99. In statements provided to the Court and in the evidence contained within the coronial brief, it was acknowledged that Lachlan's challenging behaviour at school often followed a negative interaction with his father.[87] Lachlan had also made disclosures of suicidal ideation following comments from his father[88] and the school were aware of previous incidents of family violence perpetrated by Mr Howe towards Ms Howe and their children.[89] Despite this, Lachlan was not provided with support in relation to his experience of family violence and his mental health concerns instead appear to have been treated in isolation of this trauma.

100. Since Lachlan's passing, Benalla College provided a statement outlining the policies, training and resources provided to staff to assist them in the identification, assessment and management of child welfare concerns. Whilst Benalla College provided limited insight into the resources provided to staff in responding to family violence among students, the College noted that they operate in compliance with the training requirements outlined by the Department of Education and Training (**DET**).[90]

[87] Benalla P-12 College, Statement of M Cairns, 2; Benalla P-12 College, Statement of T Clark, 9.
[88] Coronial Brief, Exhibits, 622.
[89] Benalla P-12 College, Records of Lachlan Howe, 9-16.
[90] Benalla P-12 College, Second Statement of T Clark.

101. To support the mental health of students attending the school, Benalla College have also recently funded a private psychologist to attend the campus on a weekly basis for the purposes of providing students with one-to-one support.[91] Benalla College now also participate in the Doctors in Schools Program, which allows students to access medical appointments at school for a range of purposes including to obtain a mental health care plan for subsidised mental health support.[92]

102. As of 2021, staff at Benalla College are also able to access the *Question. Persuade. Refer* training, which '*is designed to help staff to identify warning signs that someone may be suicidal and gives them the confidence to talk with that person about suicidal thoughts'*.[93]

103. In addition to the reforms outlined by Benalla College, the Victorian Government has recently announced a range of reforms to the mental health supports available to children and young people in Victoria. Recently, the Victorian Government invested in the development of a Mental Health Toolkit. This Toolkit seeks to provide schools and school communities, health and wellbeing workforces and mental health practitioners with expert guidance and resources on mental health. This toolkit draws from existing DET resources, guidance and programs and leverages expert external advice on promoting and supporting mental health in schools[94].

104. In Term 3, 2019, the Victorian Government also announced the mental health practitioner initiative. This initiative aims to employ mental health practitioners in secondary schools across the State, with all eligible government schools expected to have an appointment by the end of 2021. In doing so, the Victorian Government has recognised schools as an integral part of a student's network and as being well placed to influence positive mental health and wellbeing among young people.

105. Under this initiative, a mental health practitioner includes:

- Registered Nurses with a specialisation in mental health
- Occupational Therapists
- Psychologists
- Social Workers

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[91] Ibid.
[92] Ibid.
[93] Ibid.
[94] Mental health toolkit (education.vic.gov.au) <www.education.vic.gov.au/school/teachers/health/mentalhealth/Pages/mentalhealthtoolkit.aspxa>,accessed 11 November 2021.

106. Nurses, Occupational Therapists and Psychologists must hold full Australian Health Practitioners Regulation Agency (**AHPRA**) registration. Social workers must be eligible for membership with the Australian Association of Social Workers. The practitioners are located in the school settings and provide additional resources to support the schools existing well-being team. They are expected to:

- contribute to whole-school approaches to mental health prevention and promotion
- provide direct counselling support to students and other early intervention services
- coordinate supports for students with more complex needs.

107. Mental health practitioners are also expected to provide short term intervention for students with mild to moderate mental health needs and liaise with the relevant internal and external services where a student's needs require more intensive support.[95] It would be reasonable to expect that where a student is referred to the school mental health practitioner, they will conduct an appropriate assessment of mental state and associated risk factors and escalate to more intensive care where required, such as where a student may have active suicidal/violent ideation with plans to act upon them. Benalla College have noted their support for this initiative, advising that the employment of mental health practitioners in secondary schools will assist their staff to access '*more tailored advice and support…in managing child welfare concerns*.'[96]

108. In March 2021, the Royal Commission into Victoria's Mental Health System also handed down its final report, outlining 65 recommendations which were all accepted for implementation by the Victorian Government. I note that Recommendation 17: supporting social an emotional wellbeing in schools, states that the Victorian Government should:

Fund evidence-informed initiatives, including anti-stigma and anti-bullying programs, to assist schools in supporting students' mental health and wellbeing. Develop a digital platform that contains a validated list of these initiatives. Develop a fund, modelled on School

[95] Mental health practitioners in secondary schools (education.vic.gov.au), <www.education.vic.gov.au/school/teachers/health/mentalhealth/Pages/mental-health-practitioners-secondary.aspx, accessed 11 November 2021.
[96] Benalla P-12 College, Statement of T Clark, 2.

Readiness Funding for kindergartens, to support schools, with priority given to those in rural and regional areas, to select the most appropriate suite of initiatives for them.[97]

109. When implemented, it is expected that this recommendation will further improve Victorian students' mental health and well-being.

110. Also following recommendations from the Royal Commission into Family Violence (**RCFV**), Victorian Schools along with the Doctors in Schools Program and the Enhancing Mental health Support in Schools Program are also now prescribed under the Victorian Government's Multi-Agency Risk Assessment and Management Framework (**MARAM**).[98]

111. The MARAM provides a range of resources and tools designed to assist in the identification, assessment and management of family violence and '*seeks to build a shared understanding of and consistent response to family violence across Victoria's service system, which includes schools'*.[99]

112. At present, the DET is '*finalising how the MARAM is implemented in schools and will update relevant Department policies and guidance to align with the MARAM when this process is complete*.'[100] It is hoped that with these reforms across mental health and family violence, and the additional training and resources being made available to schools will help to build staff competencies in responding mental health and family violence experienced by young people.

Child experiences of family violence and the impact on their development and wellbeing

113. Lachlan and his siblings were alleged to have witnessed incidents of violence perpetrated by Mr Howe towards Ms Howe as noted above. There has been significant research into the impacts of childhood exposure to family violence. RCFV report outlined the serious short- and long-term effects that family violence can have on the health and wellbeing of children

[97] Royal Commission into Victoria's Mental Health System - Download report (rcvmhs.vic.gov.au), <Royal Commission into Victoria's Mental Health System - Download report (rcvmhs.vic.gov.au)>, accessed 11 November 2021.
[98] Department of Education and Training, *Family Violence Support*, <https://www2.education.vic.gov.au/pal/family-violence-support/policy>.
[99] Ibid.
[100] Ibid.

and young people, noting that the effects may be '*acute and chronic, immediate and accumulative, direct and indirect, seen and unseen'*.[101]

114. 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'*[102] and are more likely to suffer '*learning difficulties, trauma symptoms and behavioural problems'*.[103]

115. 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.[104] 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.

116. In addition to being indirectly exposed to family violence, Lachlan and his siblings also appear to have been direct victims of emotional and physical abuse. In a statement to police, Lachlan's eldest sibling advised that Mr Howe was '*always verbal'* towards the children and would '*belittle'* and make the children '*feel worthless'*.[105]

117. Mr Howe also reportedly used material objects to manipulate Lachlan's behaviour, by promising gifts or threatening to take items from Lachlan if he did not stay at his father's house.[106]

118. Text messages sent from Mr Howe to Lachlan in the week prior to the fatal incident, also provide confirmation of this abusive behaviour.[107]

119. The behaviour perpetrated by Mr Howe towards Lachlan appears to have caused significant distress to Lachlan. Several statements indicate that Lachlan's behaviour was observably

[101] North and West Regional Children's Resource Program, '*Through a Child's Eyes: Children's Experiences of Family Violence and Homelessness'* (2013) 4.
[102] The Royal Commission into Family Violence, *Children and young people's experience of family violence,* 107.
[103] Ibid.
[104] 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>.
[105] Coronial Brief, Statement of C Howe, 74
[106] Coronial Brief, Statement of YRO P Allen, 155; Exhibit 8 - Text Messages from Damien Howe to Lachlan Howe
[107] Coronial Brief, Exhibit 8 - Text Messages from Damien Howe to Lachlan Howe

worse after staying at his father's and that he would sometimes become upset when on the phone with Mr Howe.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Lachlan John Howe, born 31 March 2005;

    b) the death occurred on 18 May 2018 at the Royal Children's Hospital, 50 Flemington Road, Parkville, VIC 3052, from 1(a) Hanging; and

    c) the death occurred in the circumstances described above.

121. A finding of suicide can impact upon the memory of a loved one and can reverberate throughout a family for generations. Such a finding should only be made on compelling evidence, not indirect inferences or speculation.

122. It is often difficult to determine what may have precipitated a decision to end one's own life. There are sometimes issues known only to the deceased person and sometimes events in the person's life suggest a reason.

123. The available evidence suggests that Lachlan was significantly affected by the family violence that resulted in his parents' separation and the impact of his parent's separation on himself and his family.

124. I find that Lachlan did intend to do the acts leading to hanging but I am unable to determine whether he was able to comprehend that it was a final act.

125. I convey my sincere condolences to Lachlan's family for their loss.

126. Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Ms Chantal Howe, Senior Next of Kin

Mr Damian Howe, Senior Next of Kin

Barrie Woollacott, Solicitor, Slater and Gordon Lawyers

Ms Melissa Ozer, Solicitor, Department of Education

Mrs Jenny Ellix, Albury Wodonga Health North East & Border Mental Health Service

Ms Madhavi Ligam, Solicitor, Avant Law

Dr Neil Coventry, Chief Psychiatrist, Office of the Chief Psychiatrist

Leading Senior Constable Sarah Halnon, Coroner's Investigator

Signature:

Judge John Cain
STATE CORONER
Date: 26 January 2024

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.