Coroners Act, 1996

[Section 26(1)]

Western  ***Australia***

RECORD OF INVESTIGATION OF DEATH

Ref No: 02/14

I, Evelyn Felicia VICKER, Deputy State Coroner, having investigated the death of ***Haley DIAMOND*** *with an inquest held at the* ***Kununurra Courthouse, Ivanhoe Road, Kununurra*** *&* ***Perth Coroners Court, CLC Building, 501 Hay Street, Perth,*** *on* ***4 & 10-11 February 2014*** *respectively, find the identity of the deceased child was* ***Haley Sonya Ann DIAMOND*** *and that death occurred on* ***19 June 2009*** *at* ***Royal Darwin Hospital*** *as the result of* ***Acute Cerebral Hypoxia arising out of Suffocation due to the Inhalation of Toxic Vapour*** *in the following circumstances:*

Counsel Appearing:

Ms K Ellson assisted the Deputy State Coroner
Mr P Gazia assisted by Ms N Dwyer instructed by ALSWA appeared on behalf of Mr Kevin Diamond
Ms R Young assisted by Ms J O'Meara instructed by the State Solicitors Office appeared on behalf of the Department for Child Protection and Family Support (the Department)

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INTRODUCTION

On Tuesday 16 June 2009 the deceased child, Haley Sonya Ann Diamond[1] (Haley), inhaled the fumes of a spray deodorant can which had been sprayed onto a T-Shirt. Haley appeared to be affected by the fumes in that she ran up some stairs and asked if her friend had "seen that?". She then fell over and hit her head on the staircase wall. Her friend tried to help her and called out for assistance.

Haley was taken to Kununurra Hospital (KH), stabilised and, in the early hours of 17 June 2009, transferred to the Royal Darwin Hospital (RDH) by Royal Flying Doctor Service (RFDS). On 18 June 2009 brain function tests indicated Haley was no longer able to function as an individual. Following repeat testing she was finally declared deceased on 19 June 2009.

Haley was 14 years of age.

BACKGROUND

Haley was born in Kununurra on 14 October 1994. She was the eldest of three girls (Diamond girls) born to Jessica Barney and Kevin Diamond. Both parents had children from other relationships which are older half-sisters to the Diamond girls.

The first contact the Department for Community Services,

[1] Enquiries made with the Registry of Births, Deaths and Marriages confirms the deceased child's name as Haley Sonya Ann Diamond. Email communication 31.3.14.

now represented by the Department for Child Protection and Family Support (DCPFS) – (the Department) had with the Diamond girls was before the younger girls, Yasmin and Carmen, were born. The contact related to Haley when she was four months old and her father, Kevin Diamond, reporting to the Department he was concerned about her mother's drinking. When the Department checked with the East Kimberley Aboriginal Medical Service that service stated Haley was well and there was no reason for concern. Mr Diamond then took Haley, whilst she was still breast feeding, to Wyndham and the Department assisted in the return of Haley to her mother with help from the police, the Aboriginal Legal Service (ALS) and a local women's refuge.

After advice Kevin Diamond said he would pursue family court orders with respect to custody of Haley due to her mother's drinking. The Department case file concerning Haley was closed in March of 1995.

The next contact the Department had with Haley occurred after the births of Yasmin and Carmen, and related to requests for assistance from the Diamond girls' mother, Jessica Barney, with food and other services.

There was intermittent contact between the Department and the family at times when Jessica Barney was in custody and alternative care arrangements were needed for the girls. Generally, in the early 2000s, this was provided by their maternal grandmother, Joyce Barney (Chunnary), assisted

by the Department to make application for appropriate Centrelink payments.

It was not until early 2007 the Department again became aware of concerns with respect to the appropriate care of the Diamond girls. Their kinship grandmother, Mingli Wanjurri – Nungala (Ms Wanjurri) contacted the Department's Kununurra Office and advised she did not consider the Diamond girls to be safe because they were residing at "The Ranch" with their maternal grandmother, Ms Chunnary. Ms Wanjurri did not feel that was a suitable environment for the girls of which Haley, at 12 years of age, was the oldest. Ms Wanjurri requested the Department investigate her concerns and she advised she would be prepared to look after the girls in Perth if her concerns were substantiated and there was no alternative. Ms Wanjurri did not consider Mr Diamond to be a capable person to care for the girls, due to his working out of the state.

As a result of Ms Wanjurri's contact there were a number of visits to Ms Barney's home at The Ranch. The option of sending the children to Perth was initially considered to be viable, however, ultimately it was agreed their aunty, Jacqueline Barney, who had also expressed concerns about the girls, was prepared to look after them in Kununurra. As a result the children did not go to Perth and Ms Wanjurri was advised arrangements had been made for the girls to stay in Kununurra with their aunty, Jacqueline Barney. Ms Wanjurri was content with this situation.

The Department considered the children were not in need of care and protection because the family, as a collective, were behaving in a protective manner of the children, who appeared to be going to school, were appropriately cared for and capable of self-advocacy.

Shortly thereafter the Department discovered Haley was back with her grandmother, Ms Chunnary, because she was having difficulty with her younger sisters and her aunty Jacqueline. Due to concerns expressed about Haley being with Ms Chunnary, Department officers visited Haley and were satisfied she appeared to be happier staying with her grandmother, due to her fighting with her aunty.

During the remainder of 2007 there was considerable discussion between the Department and Haley's various relatives over appropriate living arrangements for Haley, while her sisters were being cared for by aunty Jacqueline. It was always agreed aunty Jacqueline was an appropriate carer for the children. It was Haley's difficulty in behaving appropriately which saw her spend time with her grandmother, Ms Chunnary, as her preference.

During this period contact between the Department and the Diamond girls focused on supporting the family in their preferences for the Diamond girls' care.

2008[2]

Concerns more specifically related to Haley appeared to arise in 2008. The first documented concern was on 21 January 2008 when the Kununurra police advised the Department there were groups of youths wandering Kununurra at night indulging in risk taking behavior. Haley was noted to be one of these children.

On 13 February 2008 Kevin Diamond expressed concern for the Diamond girls and their older half-sister, Marissa. He advised the Department he believed the children were living in an environment where there was a lot of intoxication and he wanted to care for the children in Darwin, with the assistance of his daughter, another older half-sister to the three Diamond girls. Mr Diamond was again advised that consideration of full time custody of the children was a Family Court issue.

While various specific concerns were raised with respect to the safety of the older half-sister (not Mr Diamond's daughter) and the younger Diamond girls, the concerns were not expressed to be current other than Marissa's difficulties with her mother and grandmother.

On 21 February 2008 Ms Wanjurri contacted the Department with concern the two older girls were wanting to stay away from their mother because they did not feel safe.

[2] Ex 1, Vol 1, Tab 19

Ms Wanjurri had been contacted by her son to see if she would care for the girls in Perth. She again indicated she would be prepared to care for them if no alternative could be found. She asked if the Department could investigate the concerns to do with a lack of safety due to intoxication.

By March 2008 both the police and their aunty Jacqueline were concerned about the children and the fact they did not wish to be at home with their mother. The police reported their concerns to the Department. On 21 March 2008 Crisis Care was contacted by an off duty departmental case worker who had seen Haley out at night. Haley had complained to the case worker about her mother's behavior and the case worker asked Crisis Care to follow up the children's safety.

Crisis Care contacted the police and the police advised Crisis Care they had already taken the children home to their mother at The Ranch that night. It was the view of the police officers Jessie Barney was not intoxicated, and the children were safe at home.

The police were asked to re-investigate the situation that night. They returned to Jessie Barney's residence at The Ranch and found her asleep and not intoxicated. Consequently, it was assessed the children had provided false information, and that they were not at immediate risk of harm from their mother, who appeared to be capable of caring for them appropriately.

The matter was referred to the Department the following morning to ensure the children had returned home and to discuss with Haley her allegations about her mother attacking her with a blunt knife.

A couple of nights later the police again contacted the Department and advised they had found Haley and another girl walking around the streets of Kununurra at night. Haley had again reported to police it was not safe to go home because when her mother was drunk she threatened her with a knife. As a result the police had taken the girls to the home of a different responsible adult.

The Department responded by meeting with Jessie Barney at the Kununurra office. While Ms Barney was in the office attempts were made to call Ms Wanjurri in Perth to see if she was prepared to have the children stay with her.

On 14 April 2008 there was an organised family meeting which included a telephone link with Ms Wanjurri in Perth and Mr Diamond in Darwin. It was agreed the Diamond girls would travel to Perth to live with Ms Wanjurri. All family members were in agreement and the Department considered this to be a family decision, not a departmental decision, although the Department was prepared to assist with some costs.

Ms Wanjurri was recovering from an operation and did not

believe it appropriate she care for the children while still relatively unwell. She advised that once she had recovered there would be an occasion for her to travel to Kununurra, and she thought it more appropriate she collect the Diamond girls whilst she was in Kununurra, and travel with them back to Perth.

As a result of this arrangement the girls were booked on the same flight as Ms Wanjurri to travel to Perth from Kununurra on 9 August 2008. Accommodation was to be provided to the family to ensure the Diamond girls were available to fly to Perth at that time. Ms Barney was advised that would be the arrangement.

Ms Barney was concerned about her youngest daughter, Carmen, travelling to Perth, however, the Department in facilitating the family agreement determined it was more appropriate the three girls fly to Perth together.[3]

On 7 August 2008 the Department discussed with Ms Wanjurri the possibility of obtaining financial support via Centrelink for her care of the children. The Department also advised Ms Wanjurri the Kununurra office would contact the Cannington office to advise them of the Diamond girls relocation to Perth and the Department's involvement in facilitating family arrangements. Ms Wanjurri was provided with the telephone number for the Cannington office, being the appropriate office to her

[3] Exhibit 1, Volume 1, Tab 19, Para 113

place of residence, in case she should need additional support from the Department. The Department also advised Centrelink Ms Wanjurri was now the full time carer for the three Diamond girls.

The Kununurra office closed its file for the Diamond girls on 20 August 2008. It was felt Ms Wanjurri was able to provide a safe and protective environment for the three Diamond girls and this was a protective situation for the children agreed to by the entire family. Care and protection orders for the girls were not considered.

It is apparent the girls attended school once in Perth and Haley was enrolled in the Kent Street Senior High School in Victoria Park.

RETURN TO KUNUNURRA

In late October 2008 Ms Wanjurri contacted the Department's Cannington office asking for some assistance with services for the Diamond girls. Ms Wanjurri was finding the three girls difficult to cope with and was not getting assistance from the Department in dealing with Abstudy or their schools.

An appointment was arranged for 13 November 2008 for Ms Wanjurri to discuss the situation with the Department, however, it appears that meeting did not take place and there is no indication the Department provided Ms Wanjurri with any assistance.

On 15 December 2008 Ms Wanjurri arrived at the Cannington office with the three Diamond girls, their packed bags and the information the family had intended the girls return to Kununurra that day but they had missed their flight. Ms Wanjurri was unable to care for them any longer. She felt she had not received any assistance with them, which was not what she believed would happen, and she felt unable to cope with the arrangement any further.

The Department commenced what they term "negotiated placement arrangements" (NPA) for the girls until they could make arrangements, in the absence of Ms Wanjurri's ability to assist. Having explained her situation clearly Ms Wanjurri left the girls at the Cannington office.

The evidence of Ms Kathleen Hellyer, Senior Child Protection Worker, then at the Cannington office indicated she was supervising the team which became involved with the children that day. Ms Hellyer described all three girls as polite, beautifully dressed, confident and as being extremely "lovely" children. They did not appear to be neglected or in need of care and protection and as a consequence the Department felt its role consisted of facilitating the family arrangements for the appropriate care of the children.[4] For an NPA to have effect it is necessary one of the children's parents agree to the arrangement.

[4] t 11.2.14 p233

Contact was made with the Kununurra office for them to provide some input into the appropriate residence for the children until they could be returned to Kununurra. Ms Barney was bought into the Kununurra office and spoke to the children on the telephone. Ms Barney agreed to the girls being cared for overnight by Ms Wanjurri's daughter and then being returned to Ms Wanjurri until the children returned to Kununurra.[5]

The Department's Kununurra office was profoundly under resourced, as was the Cannington office in Perth. Ms Emma White, Regional Director for the Department, advised in 2008/2009 the Kununurra office was 23 full-time employees (FTEs) under resourced.[6]

There was a new team leader at Kununurra, Ben Whitehouse, and he provided some input to Ms Hellyer in Cannington over an appropriate placement for the children if they should return to Kununurra. He advised there were no available places in hostels in Kununurra and Halls Creek. The children had not previously been appropriately cared for by their mother, Jessie Barney, and maternal grandmother, Ms Chunnary, and when in Kununurra in early 2008 the children had been roaming the streets at night without a responsible adult to make them safe. They had been reluctant to return home because they

[5] t 10.2.14 p122
[6] t 11.2.14 p242

did not feel safe at The Ranch.[7]

Mr Whitehouse did not know the children were to be returned to Kununurra, and asked a case worker to assist Cannington with their tasks. In his view it was a departmental matter being assessed by the Cannington office with specific input from Kununurra office as requested.

Despite this the Cannington office understood, from what they believed to be a reputable source, the children's maternal grandmother, Ms Chunnary, was an appropriate adult to take care of the children on their return to Kununurra. They believed someone from the Kununurra office had informed them the coordinator of the crisis accommodation center in Kununurra was regarded by the Kununurra office as being a suitable person to determine the safety of a placement for the children.

Mr Whitehouse advised the inquest he did not believe information with respect to the appropriateness of the coordinator of the crisis accommodation centre to assess the safe placement for the girls had come from a departmental Case Worker. In his view the Crisis Care Accommodation Centre was not an accredited facility and he did not believe the coordinator was in a position to either care for the children or recommend an appropriate placement. He understood the children were not in care and the whole

[7] t 10.2.14 p169, p171/172

situation would require careful assessment.[8]

Apparently, the coordinator of the Crisis Care Accommodation had visited Ms Chunnary herself and indicated to the Cannington office her view the Diamond girls would be safe there. As a result of that input the Cannington office rescheduled the return flights for the Diamond girls to Kununurra for 18 December 2008. Pending that flight they were to remain with their Aunty, Ms Wanjurri's daughter, and Ms Wanjurri, in Perth.

The Diamond girls were taken by Ms Hellyer to their aunty, Ms McGlade, on the evening of 15 December 2008. Ms McGlade also advised Ms Hellyer she did not believe the children would be safe with their mother or their maternal grandmother in Kununurra. Ms Hellyer believed she conveyed this information to Mr Whitehouse in Kununurra by email. Mr Whitehouse had already advised Cannington that in the days prior to the children returning attempts would be made to arrange a family meeting in Kununurra to ensure safe placement of the girls on their return. This had been allocated to a care and protection worker, Ms Suzanne Parker to arrange.

The Diamond girls returned to their kinship grandmother, Ms Wanjurri, on the 16th and Cannington were advised to liaise with the Kununurra case worker, Ms Parker, with respect to the return of the children and family

[8] t 10.2.14 p173

arrangements.

Ms Wanjurri was to take the girls to the airport on 18 December 2008 by which time it was envisaged there would have been facilitated family arrangements in place for the children on their return to Kununurra.

Ms Parker advised the inquest that at all times she considered the Department was only facilitating a NPA which existed until the return of the children to Kununurra. It was a task she was doing to assist the Cannington office. She did not consider the Diamond girls to be a Kununurra matter.[9] Ms Parker did attempt to contact relatives in Kununurra but case workers were unable to make contact with enough family members to arrange an appropriate family meeting prior to 18 December 2008.

As far as Cannington was concerned the children were dealt with according to the NPA, in that they were placed with Ms McGlade and Ms Wanjurri for the three day period until they boarded the flight to return to Kununurra. It was their understanding this was a family arrangement they were facilitating.[10]

It does not appear there ever was a facilitated family meeting in Kununurra with respect to the placement of the girls on their return to Kununurra. The fact Mr Kevin Diamond had said he would have the girls failing all other

[9] t 10.2.14 p128
[10] t 10.2.14 p190

arrangements does not seem to have been discussed. Presumably on the understanding there were safe family arrangements in place for the children in Kununurra.[11]

The Cannington case notes reflect there was departmental assistance in collecting the girls from the Kununurra airport and taking them home on 18 December 2008.

History suggests the girls spent their time between family members in Kununurra with the understanding being the two younger girls were considered to be placed with their aunty, Jacqueline Barney, where they were safe and appropriately cared for.

Haley was often located with her mother or her grandmother, but on occasions was known to be with her aunty. It would seem Haley was realistically placed with her mother and grandmother as her preference. There was no assessment as to whether this was safe or appropriate because the Department did not view themselves as being responsible for the children while in Kununurra.

The Kununurra office did not consider it had an open file with respect to the girls. Rather, the file belonged in Cannington, who would direct Kununurra with specific tasks to the Department's open file for assistance with the Diamond girls. [12]

[11] t 10.2.14 p191
[12] t 10.2.14 p128

2009

Sergeant Gentili advised the inquest that in early 2009 Haley was a member of a group of known risk taking youths who wandered the streets of Kununurra at night due to a lack of safety in their living arrangements. The children would involve themselves in risk taking, largely anti-social, behavior because they felt they had nowhere to go. They would travel in a group and eventually settle wherever they felt safe on that particular occasion, usually somewhere at The Ranch. The police concern in early 2009 was mostly with underage drinking.

On 19 March 2009 Haley was admitted to KH for intoxication. She had been found in White Gum Park and was discharged into Jessie Barney's care the following day. She was referred to the Social Support Unit of the Ord Valley Aboriginal Health Service (OVAHS). Jessie Barney had advised the hospital she was unable to control Haley.

It does not appear the Department was notified of this incident other than the police advising that, as part of their liaison with welfare groups within Kununurra, it was known Haley was a member of this group of displaced youths.

The court heard evidence from Rebecca Fisher, a Youth Worker with OVAHS at that time. Ms Fisher advised OVAHS was contacted by Dr Tolbert from the KH and asked to assist with input with Haley.

Ms Fisher has a BA major in Psychology and worked for OVAHS in the capacity of a Youth Worker in the Social Support Unit which provided services to do with alcohol and drug support and counselling. She worked with Aboriginal children by running school holiday programs and providing educational sessions for children on risky behaviors involving alcohol, drugs, tobacco and the dangers associated with foetal alcohol syndrome.[13]

Referrals from the hospital to OVAHS Social Support Unit were not automatically reported to the Department depending on individual circumstances, and the ability for OVAHS to provide services the Department did not. Ms Fisher advised she received referrals from families, the hospital and North West Mental Health Services.

Ms Fisher's clients were predominately under 18 years of age and she considered over a third of her clients to be between the ages of 12 and 16. Ms Fisher indicated a lot of her work involved "bridging girls" (returning them to mainstream education) due to there being more facilities available for boys. However, she also provided counselling services to boys depending on their needs. Ms Fisher's work also involved assisting families to apply for Centrelink assistance on behalf of children for study, and assisting families to apply for special educational services for their children.

[13] t 04.02.14 p50

Ms Fisher advised it was not her role to promote boarding school for children, however, should parents wish their children to go to boarding school she would assist them with Centrelink and Abstudy applications for children to meet the requirements for those referrals. It was a matter of the family wishing for that to occur, and her assisting them with the paperwork.[14]

Ms Fisher had never been asked by Haley's family to assist with a boarding school application although Haley did want to go to boarding school. Ms Fisher did not believe Haley would have qualified for assistance with a boarding school referral in that she doubted Haley's school attendance was suitable at the time she knew her. She stated Haley was an intelligent, bright, vocal and engaging child who would have the ability, but did not yet have the commitment, to achieve appropriately. She believed Haley had potential which had not yet been realised.[15]

She advised Haley was referred to her with another girl with whom she was already acquainted. Ms Fisher's aim was to engage with her clients and generally assist them back to main stream education by encouraging them to attend, and remain, at bridging classes in preparation for mainstream schooling.

Once Ms Fisher had made contact with Haley and started talking to her and visiting her she was able to get Haley

[14] t 4.2.14 p67
[15] t 4.2.14 p58

back to school quite quickly and, it seems, Haley attended quite regularly, at least three days a week and often more. Ms Fisher collected the girls from home in the mornings and took them to school.

Ms Fisher advised Haley was very easy to get to know, she was a beautiful girl and was very communicative. She was not shy and Ms Fisher felt that she had become very close to Haley in the short time she knew her.

Ms Fisher hoped Haley would be able to return to the main stream school because she had the intelligence to do so although, due to her previous truancy, she had not been achieving. If the girls attended school all week they would be rewarded with a special outing and Ms Fisher would sometimes take the OVAHS bus and take the children to Ivanhoe Crossing to swim or fish and play music they enjoyed whilst travelling. They had picnics and OVAHS would fund Ms Fisher to provide lunches to the children she was rewarding. Ms Fisher did not believe Haley was undertaking any more risky behavior than the youths with whom she associated, rather they were all doing the same things. This was generally misbehaving by throwing rocks at the police, engaging in antisocial behavior, and generally avoiding returning to their homes.

Ms Fisher would teach her clients about risky behavior and ways of not placing themselves in a risky place by walking the streets at night, functioning in society appropriately,

going to school and learning about the risks of alcohol and drugs. She indicated Haley was very strong willed and quite capable of making up her own mind about what she wanted to do. She did not think there was anything wrong with Haley, other than being strong willed and wishing to have a good time, like many teenagers. Ms Fisher felt Haley had the most potential out of the group with which she worked. Because she collected Haley from home to go to school before the others in the group she had the opportunity for one on one discussion with her.

With respect to any discussion about boarding school Ms Fisher felt Haley was not happy with her home life but it was not in any specific way Ms Fisher could identify. She reported Haley's home as being a difficult place to live. It was like most of the homes in The Ranch.

Haley never complained to Ms Fisher of having any issues with her mother, other than the common issue in The Ranch of the adults drinking. Ms Fisher had never heard Haley complain of being abused by her mother and she said to all appearances Haley was well cared for and not neglected. She was always well dressed and well-mannered. Ms Fisher acknowledged the children as a group moved around a lot, and slept in packs, to avoid difficulties with intoxicated adults. The children would travel together and sleep wherever they felt safe. Ms Fisher believed it to be likely the home in which Haley was staying had an issue with alcohol. She did not recall Haley talking about her

father although she understood he was in Darwin.

Ms Fisher taught the girls about the risks of being intoxicated themselves and of being around intoxicated adults.

Specifically with respect to volatile substances, Ms Fisher indicated she had not been aware of a particular concern with the children in Kununurra with sniffing prior to early 2009. She was aware it was a problem in some of the more outlying communities with the inhalation of different toxic fumes but there had not been so much involvement in Kununurra.

This view was supported by Sgt Gentili who indicated prior to the involvement of the police in Haley's death he had not been aware the children in Kununurra were engaging specifically in "sniffing". As a result of Haley's death police became aware there had been "sniffing" involving some children in Kununurra for a period of months.

On 15 April 2009 Ms Hellyer, then acting team leader at Cannington, telephoned Ms Parker, then team leader in Kununurra, and requested Kununurra case officers conduct a home visit to follow up on the current circumstances at the Diamond girls. Cannington wanted to finalise their assessment, which had started with their involvement with the Diamond girls on 15 December 2008, but needed to ensure there were no ongoing concerns with respect to the

children's wellbeing.

Ms Parker responded to the request on 21 May 2009 by advising Ms Hellyer, by email, she had allocated two case workers to conduct a home visit at the children's place of residence to ensure their care and protective needs were being met.[16]

The two case workers had conducted a home visit but had been unable to speak with anyone in the family because they were out shopping. It was intended there would be another visit. The understanding of the Department's Cannington office was that the children would be with Ms Chunnary. In reality the two younger girls were usually with aunty Jacqueline, and Haley spent time at both her mother/grandmother's home due to difficulties with aunty Jacqueline.

On 25 May 2009 Kevin Diamond contacted the Kununurra office and reported complaints from Haley with respect to her mother's behavior. This was communicated to Cannington as the case manager for the children, and on 29 May 2008 Ms Hellyer again contacted Ms Parker and asked that she investigate these new matters due to the Kununurra office's proximity to The Ranch.

It was suggested the case be opened in Kununurra as these were new concerns. In addition, Kevin Diamond had

[16] Ex 1, Vol 1, Tab 19, Para 148, Att EW53

advised the children were being mostly cared for by aunty Jacqueline because their mother was usually intoxicated. Mr Diamond asked the children be sent to boarding school, preferably in Darwin so he would have access to their care.

On that date the two case workers previously assigned returned to The Ranch and to the home of Jessie Barney. There they met an OVAHS youth worker, presumably Ms Fisher, who advised Ms Barney was located nearby. The two case workers did not believe it appropriate they intervene on discussions between the OVAHS youth worker and the Diamond girls and went to find Ms Barney. Although the case officers located Ms Barney the circumstances were not conducive to a discussion about the allegations concerning the girls, however, Ms Barney was given an outline of their concerns and she provided permission for the case workers to talk to the girls. She agreed she drank, but stated she did not hit her children.

A meeting was arranged for 5 June 2009, at the Department's Kununurra office, but was not attended by either Ms Barney or the children. There is no indication The Ranch was re-visited or contact made for another meeting prior to the events of Haley's death.

On 4 June 2009 Ms Fisher participated in a volatile substance use (VSU) training session. She became aware of some of the warning signs a child was using volatile substances or "sniffing". In evidence, Ms Fisher explained

she had noticed the strong smell of deodorant on some of the girls in the group she drove to and from school.[17] She had believed it was just their grooming habits. After the VSU training session Ms Fisher realised it was probably symptomatic of the girls sniffing deodorant.

Ms Fisher used her opportunities with her group of girls to talk with them about sniffing. Ms Fisher did not note any of the children to appear physically affected by sniffing and was only alerted by the strong smell of deodorant. While at first denying they had been sniffing the children eventually advised Ms Fisher that some of them had been sniffing and to some extent "dobbed" on one another. It was as a result of dobbing Ms Fisher understood Haley had tried sniffing deodorant. The girls told her they learnt it from one of the local outlying communities.

Part of Ms Fisher's training had emphasised the issue of volatile substance abuse should not be dealt with in a group session due to a tendency for children to be susceptible to suggestion and copycat new and relatively inexpensive substance abuse. Consequently, she would broach the subject of sniffing individually with the girls she believed at risk.

On the three or four times Ms Fisher had discussed the issue with Haley in a one on one situation she would tell Haley that it was bad for a person, "it can kill you" and "it

[17] t 4.2.14 p63

stops oxygen to the brain".[18] Ms Fisher says Haley told her she had stopped sniffing. Ms Fisher never noticed any change in Haley's appearance and demeanor and she believed that to be true. Ms Fisher never did the full VSU counselling session with Haley because she thought she was a leader of the pack, not involved with sniffing and therefore not in need of that type of counselling. Ms Fisher did conduct full counselling sessions with other children she believed were more heavily involved with sniffing.

Ms Fisher had conducted a full education session with a couple of Haley's friends and had explained to them the details of the effect of sniffing in terms one would expect the girls to understand. She also couched her warnings in terms of their cultural heritage with advice like "stops oxygen to the brain", "your stories will be lost", "your memories will be lost", and "it can kill you". Ms Fisher stated she could see they were very shocked by her information and said they would not continue.

The last contact Ms Fisher had with Haley was on 16 June 2009 when she took Haley to the bank to complete a key card application. Haley had been to school on that day and in conversations Haley confirmed she had stopped sniffing. Ms Fisher stated she only brought the matter up with Haley to reinforce with her the dangers involved with sniffing. Ms Fisher considered others in her group of clients more vulnerable to volatile substances abuse than Haley

[18] t 4.2.14 p63

and, following Haley's death, was also concerned about one of the younger Diamond siblings.

Ms Fisher was visibly distressed while giving evidence over the loss of Haley's life. She ceased working as a youth worker very shortly after the incident.[19]

AFTER SCHOOL 16 JUNE 2009

The inquest heard evidence from Lauren Winton (Lauren), about events after school on Tuesday 16 June 2009. Lauren is two years younger than Haley. Lauren described Haley as a lively member of the group and how they used to meet together after school. She enjoyed doing things with Haley.

Although Lauren had not been to school that day she knew Haley had and met with her after school at about 4:30pm. They decided they would go to the Coles supermarket and steal some spray deodorant so they could "sniff".[20] They were part of a larger group of children. Sharna Thompson (Sharna) also gave evidence about her contact with Haley that afternoon, although her evidence was neither she or Haley had been at school that day but rather had been walking around town.[21] I accept Sharna had not been at school that day but accept Lauren Winton's and Rebecca Fisher's evidence Haley was at school earlier on that

[19] t 4.2.14 p61
[20] t 4.2.14 p38
[21] t 4.2.14 p10

Tuesday.

The fact the group went to the Kununurra Coles supermarket on Konkerberry Drive is confirmed by CCTV footage. It records the two girls in the supermarket picking up cans of deodorant and spraying themselves. At about 5:12pm Lauren can be seen picking up a can of Lynx and leaving immediately. Lauren advised the inquest she placed the deodorant down her pants and the girls then went to the stairs of the art gallery opposite the butcher shop on Konkerberry Drive and inhaled the deodorant after spraying it onto Haley's shirt.[22]

Lauren described how the girls would inhale the deodorant through their mouths, rather than their noses, and that she had been shown how to do this on an occasion earlier in the year by another girl when in a group of children, not including Haley. The group had been "sniffing" for a period of months only and had not been "sniffing" prior to Haley's return to Kununurra.

Lauren said she "sniffed" the deodorant and then Haley "sniffed". Lauren described Haley as sniffing three times and then suddenly running up the stairs and saying "did you see that?". Haley then fell over and banged her head on the wall alongside the stairwell. She looked as though she was trying to vomit and having a seizure. Lauren rolled Haley onto her side and tried to get her to wake up. In

[22] t 4.2.14 p11

evidence Lauren described how she poured coke onto Haley's head in an attempt to revive her, however was unsuccessful and called out to her friends for help.[23]

It was then other children in the group came over and Sharna says, on understanding what had happened, some of them ran to the Chicken Treat and asked that they call the police.[24]

Police were conducting patrols in the area and the group of children flagged the police down and directed them to the stairwell where Haley was collapsed. The police went up the stairs onto the landing and found Lauren crying while trying to assist Haley.

The police described the landing and stairs as being constructed from concrete, with the landing being about 1.2m wide surrounded by a brick wall on the north and a metal rail on the south. The landing was approximately 15 feet from the ground.

The police removed Lauren from the landing to give them the opportunity to attempt to revive Haley. There was no sign of life from Haley and St John Ambulance (SJA) was requested to attend priority one, while the attending police commenced cardiopulmonary resuscitation (CPR).[25]

[23] t 4.2.14 p36
[24] t 4.2.14 p12
[25] t 4.2.14 p17

Kununurra SJA received the request for attendance at 5:28pm and attended at the scene just off Konkerberry Drive. They attended to Haley and she was conveyed via ambulance to KH with CPR being continued by police and SJA officers.

Later investigation of the ground below the top landing disclosed a t-shirt and the underarm deodorant can.

Haley was transferred to KH in full cardiac arrest with a Glasgow Coma Scale (GCS) of three. Her resuscitation continued in hospital. Haley was in asystole when she arrived at the hospital but a rhythm and output were restored around 6pm. An endotracheal tube and femoral line were inserted, adrenaline and normal saline fluid replacement was given. Her pupils were reactive at 6:45pm however they remained pinpoint and she did not regain consciousness.

Haley's pathology results from KH indicated a low hemoglobin level, low platelets and an elevated white cell count. The urine drug screen was negative for alcohol, opiates, amphetamines, benzodiazepines and cannabis, while her liver function test showed marginally raised alkaline phosphatase and raised ALT. Her bicarbonate levels were very low with a raised creatinine. Haley's chest x-ray showed extensive air space shadowing in the mid and upper zones of her lungs in keeping with progressive aspiration and her ECG showed ST depression.

ROYAL DARWIN HOSPITAL (RDH)

After stabilisation Haley was transferred to the RDH by the RFDS in the early hours of 17 June 2009. Handover at RDH occurred at 1:17am.

At the time of Haley's arrival in the RDH in the early hours of 17 June 2009 she was noted to have fixed dilated pupils, and remained on sedation. Her mother, Jessie Barney, was noted to be next of kin and her father's name, Kevin Diamond, was not recorded.

Ms Barney was present at RDH by 18 June 2009.

Testing for brain function was done following the ANZICS guidelines. These require tests to be done by two separate clinicians at separate times. It is only then a determination can be made that a patient is "brain dead".

Haley's first brain function testing was done on 18 June 2009 by Dr Paul Goldrick (SCICM, Supervisor of Training at RDH). His results indicated Haley was brain dead.

On that date Dr Winter, Intensive Care Consultant, RDH, spoke with Haley's mother, Ms Barney, and explained to Ms Barney the fact Haley would not survive as a result of the testing to date. Ms Barney asked RDH wait until the arrival of Ms Chunnary (Haley's grandmother) from Kununurra, along with some other family members, so the family was in

a position to say goodbye to Haley.

Dr Winter also spoke with Haley's father, Kevin Diamond, on the same date. Dr Winter does not recall how she became aware of Mr Diamond due to the fact he was not listed as one of Haley's next of kin, however, she was informed that he was Haley's father and she had a conversation with him. Mr Diamond made it clear he did not wish to have anything to do with Haley's mother. It was Dr Winter's understanding from speaking with Mr Diamond she had communicated the fact Haley would not survive. Mr Diamond stated he would come back the following day but he did not wish to come into contact with the maternal side of Haley's family.

Dr Winter undertook the second set of brain function tests on 19 June 2009. It is the second set that confirms the death.[26] Dr Winter advised the family on 19 June 2009 at approximately 1:20pm of the fact Haley was considered to be dead.

There were a number of family members present at that time. Dr Winter was aware of Haley's mother and grandmother, but there were also a number of other relatives. Dr Winter explained to the group Haley was dead and spent time explaining the purposes of the testing. Dr Winter raised organ donation with the family but Ms Chunnary rejected that outright.

[26] t 10.2.14 p25

Dr Winter also covered with the family the decision as to when to remove any supporting machinery was one for the hospital, not the family. The support machinery involved assisted breathing by way of endotracheal tube and ventilation. Due to the fact Haley was no longer considered to be alive, it was a matter for the hospital as to when the machinery would be removed, however, Dr Winter explained they would work with the family with respect to that decision. The RDH does not intentionally remove life assistance at a time when family members are still gathering to say goodbye. Dr Winter was aware Haley's father was not at this meeting but due to her previous conversation understood he did not wish to be present with the rest of the family.

Dr Winter can recall social workers attempting to contact Mr Diamond but that being unsuccessful.[27]

At about 2:30pm Haley's mother and grandmother indicated they had completed their goodbyes and that it was now appropriate the machines be turned off, if that was the hospital's decision. This was stated to the bedside nurse who checked with Dr Winter. Dr Winter removed Haley's endotracheal tube. Her heart stopped at 2:30pm on 19 June 2009. Everyone was aware this was a Coroner's case.

Dr Winter now understands Mr Diamond approached the

[27] t 10.2.14 p96 p99

hospital shortly after life support was removed and was aware Haley had died. Mr Diamond subsequently expressed some distress to the Coroner's office the hospital had removed Haley from the ventilator prior to his personally being in a position to say goodbye, along with some of Haley's older half siblings.

RDH maintains the view the removal of machinery is their decision, however, had they understood Mr Diamond expected to say goodbye to Haley whilst still attached to the machinery that could have been accommodated, and would have been accommodated had they been able to reach him at the time enquiries were made.

POST MORTEM EXAMINATION

Haley's post mortem examination was carried out on 26 June 2009 by Dr T Sinton at RDH.

Dr Sinton found severe and extensive acute hypoxic brain damage, focal bronchopneumonia in the lungs, fluid accumulation in both chest cavities and in the abdominal cavity, which he found to be consistent with heart failure.[28]

There was no evidence of any recent bony trauma. Dr Sinton was satisfied Haley died as a result of acute brain damage following the inhalation of toxic vapour, the effects of which were later compounded by the acute bronchopneumonia she suffered post collapse.

[28] Ex 1, Vol 1, Tab 7

In evidence Dr Sinton stated he was very experienced in assessing the effects of the inhalation of toxic vapour at post mortem.[29] He had been involved in between 70 and 80 cases of fuel or vapour inhalation related to death and it was his experience the common causes of death which ultimately killed individuals who had been involved with the inhalation of toxic fumes were overwhelmingly brain damage or bronchopneumonia, or both. In Dr Sinton's view Haley's death was a classic example of the inhalation of toxic vapours.

Dr Sinton had been under the impression Haley had a confirmed diagnosis of epileptic seizures in the past and advised the changes in Haley's brain were also consistent with those from an epileptic seizure, but he was of the view the history supported her death as being related to the inhalation of toxic fumes rather than a seizure. When it was explained that Haley did not have a diagnosis of epilepsy, but rather had been understood to have suffered a seizure as a result of, possibly a spider bite, when very small rather than suffering an epileptic seizure, Dr Sinton was even more adamant Haley's death was a direct result of inhaling toxic vapour immediately before she collapsed.[30]

Dr Sinton was asked whether toxicology had been done in Haley's case and he said he did not order toxicology because Haley had been in hospital for a number of days. RDH did

[29] t 11.2.14 p 206
[30] t 11.2.14 p 208

not have access to Haley's KH admission bloods for the purposes of toxicology at the time of collapse, rather than following three days of medical treatment. Dr Sinton could see what Haley had been prescribed in RDH from her medical notes, and he did not require toxicology in the absence of the KH admission bloods. He was quite satisfied, given all the findings both ante and post mortem, Haley had died as a result of brain damage following suffocation which in turn was consequent on inhaling noxious fumes. It was also his view the brain damage had been compounded by her acute bronchopneumonia following her collapse and necessary subsequent hospitalisation.

"So again the brain is damaged, it's acutely damaged by the inhalation of these fumes and then she suffered what is potentially life threatening in its own right in terms of bronchopneumonia. This is a pattern, a combination, which is not to be wished".[31]

The deodorant can which had been located at the scene of Haley's collapse was a can of Lynx men's deodorant and the fumes comprising Lynx deodorant contained 60% ethanol and 40% hydrocarbon propellant composed of 13-30% butane and 10-30% isobutane and 5% propane. Hydrocarbon inhalation can cause central nervous system (CNS) depression, coma and seizure. Butane can cause a toxic injury as it acts as an asphyxiant. The inhalation of deodorant fumes acts in two ways in that some of the fumes

[31] t 11.2.14 p 205

are toxic, in and of themselves, and others cause displacement of oxygen. The combination can cause severe hypoxia.

In summary, Haley died of acute brain damage following inhalation of toxic vapour, the effects of that damage compounded by acute pneumonia following on from her collapse and necessary intubation.

THE INVOLVEMENT OF THE DEPARTMENT IN HALEY'S LIFE

Essentially the position of the Department at the time was that they were involved in Haley's life to the extent they assisted the family from time to time on request, but Haley was never considered to be in such a vulnerable position that she was required to be placed in the protection of the Department. From the perspective of the Department Haley's care appeared to be adequate, or at least not as troubling as that of many of the other children with whom they were involved. The Diamond girls were rarely viewed as being critically in need of protection and on the one occasion there had been a check-up by the police, directly as a result of a complaint by Haley, the police had not been able to substantiate Haley's information when they attended at her mother's home.

Following Haley's death the Department has unreservedly accepted the history of the Department's involvement as a whole with the three Diamond girls was not optimal. By

way of explanation, and not excuse, there were serious staffing difficulties in both the Cannington and Kununurra offices in 2008/2009. This resulted in cases not considered critical being qued. The care of the Diamond girls was always seen as appropriately managed by the family, with some assistance provided by the Department when specifically requested. It is apparent from the experience of Ms Wanjurri assistance was not always provided even when it was requested,[32] although the ability of the Department to be proactive where arrangements made were not followed was compromised by the chronic staff shortages and need to que even serious cases.[33]

The Department accepts in hindsight there were opportunities where more involvement with the Diamond girls would have been appropriate. However, the situation at the time was it just didn't happen. Realistically, the Department was having difficulty dealing with children statutorily under its care at that time.

People who had day to day contact with Haley, such as Rebecca Fisher, did not consider Haley to appear to be neglected or unable to advocate for herself.

I accept entirely the evidence of the police Haley was one of a group of children which were risk taking because there were no responsible adults in their environment from time to time. There was no suggestion Haley's mother or

[32] t 11.2.14 p 290
[33] t 11.2.14 p 303

grandmother were not able to care for the girls when not intoxicated. The evidence is the two younger girls, accommodated mainly with aunty Jacqueline are still appropriately cared for and benefiting from living in that environment.

THE INVOLVEMENT OF OVAHS IN HALEY'S LIFE

I have formed the view from the evidence that while Haley was not receiving assistance from the Department, she was receiving appropriate assistance from OVAHS by way of the input of Ms Fisher. It is doubtful on the evidence of the state of the Kununurra DCP office in 2008/2009 the Department would have been able to do as much for Haley as OVAHS was in a position to do following the referral from the KH to the Social Support Unit of OVAHS.[34]

It is unlikely Haley would ever have been considered in need of care and protection to the extent the Department became her guardian while she had a supportive family. I appreciate there was conflict over the extent of protectiveness of the different parts of her family but a dispute over custody between her parents was not a matter for the Department. It would have been preferable the Department be in a position to be proactive in family support in this case, but it wasn't.

In its absence, in this case, Haley was receiving support and care to assist her education and develop life skills. The

[34] t 11.2.14 p 269

incident which caused her death occurred at a time when most teenagers Haley's age would have been out of both home and school and capable of the acts leading to her death regardless of their home situation had they been so inclined. Haley knew the dangers involved through Ms Fisher.

DECISION TO REMOVE LIFE SUPPORT ON 19 JUNE 2009[35]

Mr Kevin Diamond made a complaint to the Department of Health and Family Services in Northern Territory with respect to his concern Haley's life support had been removed before he and her other sisters had an opportunity to say goodbye to Haley. The complaint was investigated by the Northern Territory Health and Community Services Complaints Commission and arising out of that complaint some recommendations were established. These essentially required those dealing with family members during times of great stress surrounding the treatment of a critically ill patient should ensure they maintain comprehensive records of their dealings with members of the public, including comprehensively documenting conversations in person, or by phone, with patients and any of their next of kin.

Some emphasis was to be put into considering circumstances where parents of a minor are divided, as was the case with Haley and should record the actions and information provided by staff to both parents/guardians

[35] Ex 1, Vol 2, Tab 22

and adequately note the responses by both parties.

It was recommended that when a critically ill aboriginal patient is admitted to hospital the social worker and/or Aboriginal Liaison Officer be contacted and provided with the details of the parents/guardians and any referral is noted in the medical records.

When entering the name of persons next of kin in the medical records the source of the information be verified with both parents and it be noted who provided the verifying information.

RDH is in the Northern Territory (NT) and falls under the jurisdiction of the coroner for NT. With respect to Haley's death there is nothing further I would wish to add. There is no doubt Dr Winter was concerned and caring as to the circumstances surrounding Haley's death and it is unfortunate she and Mr Diamond misunderstood their conversation about separate goodbyes for the maternal and paternal sides of Haley's family.

CONCLUSION AS TO THE DEATH OF HALEY

I am satisfied Haley was a 14 year old aboriginal girl who had spent the majority of her life in Kununurra. Much of it at the community referred to as The Ranch.

She was the oldest of three sisters and by all accounts was a bright, lively, intelligent and, probably most to the point,

spirited young woman.

There is no doubt her father, Mr Kevin Diamond, and her mother Ms Jessie Barney, loved her and wished the best for her. The difficulty is with the appropriate care of Haley, aside from the love for Haley. Mr Diamond was concerned Ms Barney was not in a position to care properly for Haley and her sisters no matter how much she loved her. It was as a result of this difficulty there were disputes over the appropriate residence of the girls when they were growing up due to the tension between a loving environment and a caring and responsible environment.

It seems to have been generally accepted by all sides of the family Haley's aunty, Jacqueline Barney, was an appropriate adult, in that she was both responsible and caring, to have care of the three girls. Unfortunately due to Haley's somewhat spirited nature she found the restrictions imposed by living in a caring environment difficult. She made life difficult for her aunty and her sisters. Consequently Haley preferred to spend time at her mother and maternal grandmother's residence, rather than with her aunty Jacqueline.

Due to family concerns about appropriate care for the girls they were cared for by Ms Wanjurri in Perth from September to December 2008. This must have been extremely stressful for Ms Wanjurri. The girls were in a new environment with plenty of options for difficult behavior without constant

supervision.

This was not as facilitated by the Department as it could have been, and Ms Wanjurri found herself exhausted by care of the three girls who had become accustomed to the relative freedom of their lifestyle on the Ranch, albeit in different homes. It is clear from the evidence the girls wished to return home to Kununurra.[36]

The Department saw their input as solely facilitating a family decision to return the girls to Kununurra. The Cannington office followed the recommendation of the coordinator of the refuge in Kununurra rather than being fully cognizant of the concerns expressed by Mr Ben Whitehouse at the Kununurra office of the Department.

On the girls being returned to Kununurra on 18 December 2008 the two younger girls resided predominately with their Aunty Jacqueline, while Haley sometimes stayed at the home of her mother/grandmother, although Lauren's evidence was Haley usually slept at her aunty's home.[37] Due to the concerns which had always been ongoing with her mother's tendency toward intoxication Haley joined a group of youths who effectively looked out for one another and attempted to care for themselves by travelling in packs and moving from place to place.

This inevitably led to risk taking behavior without the

[36] t 4.2.14 p47,48
[37] t 4.2.14 p 47

parameters of responsible adults. It was also probably seen by the children as exciting.[38]

One of the concerns with the risk taking behavior is the youths involved were unlikely to appreciate how risky their behavior was in view of the fact most of the adults in their lives were exhibiting similar behaviors. It is difficult to convince youth their behaviors may be more risky for them, than it is for the adults allegedly caring for them.

In those circumstances it is not surprising Haley was taken to KH in March 2009 in a severely intoxicated state. It was a state to which she had considerable exposure. It is for this reason it would have been desirable for the Department to have been in a position to have appropriate input to Haley's care on her return to Kununurra. But to what level, in the absence of a care and protection order, is a difficult proposition.

Following her stay at KH and her release back into the care of her mother the next day, KH made a referral for Haley to OVAHS and her case was assigned to Ms Rebecca Fisher.

I am satisfied OVAHS, through the role of Ms Fisher, was an appropriate referral for Haley. On the evidence Ms Fisher was in a position to provide more input with Haley than had Haley had an active case worker with the Department.

[38] t 4.2.14 p48

I am of the view a family at The Ranch in 2009[39]would have been more responsive to input from an organisation such as OVAHS than input from the Department in Kununurra.

It is unlikely Haley's presentation would have fostered a Care and Protection Order in view of the fact she generally appeared well dressed, well presented and happy. In those circumstances it is unlikely she would have received the sort of support from the Department she received from Ms Fisher.

Ms Fisher collected Haley in the mornings to take her to school, encouraged her to remain at school and hopefully eventually move from bridging education into mainstream schooling. Ms Fisher collected the children after her work day, returned them home, assisted them with social life skills and generally spoke to them in terms they could understand about matters which may be troubling them.

I accept Ms Fisher had not done the full volatile substance workshop with Haley, however, she did talk to Haley about sniffing and Haley denied she was still involved. I do not think that is so unusual for a 14 year old girl who enjoys a particular adult's company and wishes to remain on good terms with that adult.

It was clear from Lauren's evidence, although Lauren denied

[39] t 11.2.14 p273

she had received input from Ms Fisher, she understood the dangers of sniffing. She used the same terminology in court when asked about the dangers as Ms Fisher stated she described to the girls as being the dangers of sniffing.[40]

The fact Haley sniffed on 16 June 2009 sometime between 5:12pm and 5:30pm just off Konkerberry Drive in the center of Kununurra satisfies me this was behavior Haley would have indulged in if that was her inclination, regardless of her place of residence or safety at that time.[41] It was teenage risk taking behavior and had a very tragic outcome.

I am satisfied on the whole of the evidence Haley died as a direct result of the voluntary inhalation of the fumes from the deodorant she inhaled in Kununurra on 16 June 2009.

The damage to her at that stage caused a collapse and her resulting down time resulted in an hypoxic injury to her brain. She was not left unattended. The youths with her obtained help for her as quickly as they were able and it was provided, firstly, by the attendance of the police and appropriate CPR, followed shortly by the input of the St John Ambulance paramedics.

Unfortunately she had extensive damage and by the time she was appropriately stabilised her time without adequate oxygen was such that appropriate perfusion could not repair the brain damage suffered. That was exacerbated by the

[40] t 4.2.14 p41
[41] t 4.2.14 p42,46,48

development of bronchopneumonia which further depressed her ability to respire affectively.

Haley was transferred to RDH as the nearest and most appropriate hospital. There is no doubt RDH has extensive experience with the treatment of youths suffering hypoxic brain injury as the result of noxious substance inhalation. Brain testing within the appropriate guidelines was undertaken and confirmed Haley was no longer Haley. The maternal side of Haley's family had the opportunity to say goodbye to her before life support was discontinued. There was a miscommunication and life support was removed before Mr Diamond had time to attend Haley with her half-sisters. It was not intentional but arose out of a misunderstanding between hospital liaison and Mr Diamond. It is tragic that occurred.

Haley died on 19 June 2009 in RDH.

I find death arose by way of Misadventure.

CHANGES TO THE DEPARTMENT'S PROGRAMS SINCE THE DEATH OF HALEY[42]

Ms Emma White, Executive Director, Country Services, on behalf of the Department, gave evidence at the inquest of programs which were available at the time of Haley's death, and those which have been developed since that time. These may have seen an improved outcome for the scenario

[42] Ex 1,Vol 1,Tab 19

which led to Haley's death.

That is speculative in that it is unclear to me the implementation of these programs would necessarily have dissuaded Haley from her involvement with her actions between 5-5:30pm on Konkerberry Drive on 16 June 2009.

I accept the additional programs now in place may have minimised the risks of that occurring. Most significantly I note Lauren Winton indicated that sniffing had only been prevalent in Kununurra for a matter of months prior to Haley's death, and was very rare after Haley's death due to the impact her death had on those sniffing. They now understood the reality of the dangers of sniffing noxious substances, as oppose to the theory.[43]

There is no doubt the initiatives now being followed by the Department should improve the ability to engage with communities generally for a more positive outcome for children. It is impossible for the Department to act alone. The communities must engage with the initiatives if the children are to be appropriately cared for, and most importantly educated to care for themselves and their future.

Probably one of the most beneficial changes since 2009 has been the evidence staffing in the Department generally has improved. Individual offices, such as Cannington and

[43] t 4.2.14 p45

Kununurra, are now more stable in their continuity of staff than was apparent in 2008/2009. The Kununurra office was relatively new in that the Kimberley had previously been run as one region. The Kununurra office was the new center for the East Kimberley, as opposed to being part of the Kimberley region.[44]

There are a number of programs which may have benefited the Diamond girls, and there have been a number of 'revisions of strategies' that existed, which would hopefully make those programs more accessible to communities in 2014 than was the case in 2008/2009.

In 2009 the new Kununurra office was operating with one team leader instead of two, and had one Senior Field Officer instead of five. At around the same time the Cannington office was understaffed to the extent that 64 of their 98 cases on hand were unallocated. Many of these cases were potentially serious.

In 2014 the Department practice requires an assessment to be made of a family where there have been multiple contacts with the Department over a short period of time, as there had been with the Diamond girls in 2008/2009. This assessment involves accessing all previous departmental records and engaging with the family directly. It is accepted that this had not been done in the case of the Diamond girls.

[44] t 11.2.14 p242 & Ex 4–Data Comparison for Kununurra and East Kimberley DCP offices 2014 & 2008

It is now the practice that where an assessment has not been done the reason for it not being completed must be recorded and approved by the designated Senior Officer before attempts to complete the assessment are ceased. In the environment of 2014 it would be the case the Kununurra office did not close its involvement with the girls in 2008 when they were relocated to Perth, and the girls would have been provided with a co-worker from the Cannington office to assist with their transition in both directions.

In 2009 the Department developed and implemented an Aboriginal Services Framework to ensure greater responsiveness and effectiveness in its service provision to aboriginal children and their families. This was reviewed in 2012 and provided for a number of aboriginal specific initiatives to support districts in their response to vulnerable aboriginal children and their families specifically to their locality. The aim is for the Department to be more focused on child support in the family rather than family support.

Aboriginal Practice Leaders are now intended to support culturally appropriate practices in the districts, remote community child protection workers in remote aboriginal communities co-located with police, and a Strong Families program, which existed in 2009, but has been strongly developed since, designed to bring agencies together to

provide services for families with complex problems who require multiagency support.

Also in 2009, as a result of legislative changes, a Parent Support program was introduced in the Kimberley and a Responsible Parenting program has been developed since that time. Teams operate from Broome, Derby, Fitzroy Crossing, Kununurra and Halls Creek. The program has been designed to be culturally appropriate for aboriginal families. Where excessive use of alcohol in a home is impacting on the safety and wellbeing of children, child protection workers can consider applying to the Director of Liquor Licensing to have the premises declared "liquor restricted". In 2014 there are 27 restricted premises in Kununurra.[45]

Also developed since 2009 is Operation SHARP (safety at home with a responsible person). A service instigating inter agency discussions with other services and community members about youth on the street, in particular the need for all services and the community to be proactive about trying to ensure young people are with responsible adults.

The Community Response to our Children (CROC) program set up at the end of 2009, into early 2010 is a departmental involvement with a number of services as to ways to engage with different sections of the community. Specifically, at The Ranch, there were barbeques and opportunities to have

[45] Ex 1, Vol 1, Tab 19

community discussion which was intended to lead to more focus on specific children for whom concern had been expressed as a result of the broader SHARP program. Ms White described SHARP as the feeder to CROC.[46] The services in an area become aware of young people on the street as a community concern. Over time that focused on the individuals comprising the groups on the streets, and tailoring care to the individuals needs with respect to the family concern that saw them become part of the group.

In addition there have been specific strategies put in place with respect to East Kimberley substance abuse which arose out of earlier strategies for responding to petrol sniffing and general substance misuse.[47]

There is currently in place a Commonwealth driven East Kimberley Volatile Substance Use Strategic Plan 2013–2014[48] which funds the East Kimberley Volatile Substance Working Group which is responsible for over-seeing development, implementation, ongoing monitoring and evaluation of the various strategies.

I accept the problems faced by the communities in the regions such as Kununurra are daunting. It will only be by the combined efforts of dedicated agencies and the communities any of the strategies being trialed will become successful. Outside agencies cannot succeed without input

[46] t 11.2.14 p263
[47] Ex 2 & 3
[48] Ex 2

from the communities and understanding there is a great willingness to try and find solutions on all sides. It is not a one way street.

E F Vicker

Deputy State Coroner

31 March 2014