Coroners Act 1996
[Section 26(1)]

Western ***Australia***

RECORD OF INVESTIGATION INTO DEATH

Ref: 30/17

I, Sarah Helen Linton, Coroner, having investigated the death of ***HLS*** *with an inquest held at the* ***Broome Courthouse, 8 Hamersley Street, Broome*** *on* ***7 – 10 August 2017*** *find that the identity of the deceased person was* ***HLS*** *and that death occurred between* ***13 and 14 March 2013*** *at* ***La Djadarr Bay, Dampier Peninsula****, in circumstances* ***consistent with immersion in a young man with traumatic amputation of the left foot and multiple soft tissue injuries****.*

Counsel Appearing:

Mr T Bishop assisting the Coroner.
Mr P Gazia (Aboriginal Legal Service) appearing on behalf of the family.
Mr E Fearis (State Solicitor's Office) appearing on behalf of the Department of Communities and the Department of Education.

SUPPRESSION ORDERS

There are two suppressions order made in respect to this matter. The deceased's name and the deceased's friend who is referred to throughout the finding as WIC.

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INTRODUCTION

1. On the morning of 13 March 2013 HLS, a 15 year old Aboriginal boy with an intellectual disability, was seen walking through mud flats away from La Djadarr Bay Community. HLS had been living in that community with carers. The area is remote and has many dangers so his carers were very concerned for his safety. They immediately reported him missing to the agency managing his care, who then notified the police.

2. A large search operation was commenced that continued throughout that day and into the following day. The body of HLS was eventually located late in the morning of 14 March 2013 in thick mangrove near the La Djadarr Bay Community. It was apparent his left foot had been amputated and a large saltwater crocodile was seen several metres away, suggesting that the deceased had possibly been the victim of a crocodile attack.

3. Shortly after his birth HLS had been diagnosed with severe Fetal Alcohol Syndrome, which is caused by exposure to alcohol while in the womb. HLS had complex care needs due to his condition that were beyond the capabilities of his birth mother. When he was only four months old HLS was taken into the care of his aunty but after many years of trying to care for him his needs eventually became too great and he was placed into the care of the Chief Executive Officer of the Department for Child Protection and Family Support (DCP) on 2 March 2011, just prior to his 14th birthday.[1] HLS remained in DCP's care until his death.

4. As HLS was in DCP's care when he died, a coronial inquest is mandatory and I must comment on his care, treatment and supervision prior to his death.[2]

5. I held an inquest in Broome from 7 to 10 August 2017. There was an emphasis in the inquest on HLS' diagnosis of Fetal Alcohol Syndrome and what flowed as a consequence of that diagnosis in terms of his care needs. Two experts in the area of diagnosis, treatment and care of children with FAS gave evidence at the inquest to help shed some light on HLS' care needs so that I could consider whether those needs were met by DCP and the other agencies involved.[3]

6. I also heard more detailed evidence about FASD generally, and what steps are being taken to improve diagnosis and care for children, like HLS, born with FASD in the Kimberley.

7. After the inquest information was sought from Catholic Education WA[4] and written submissions were then provided on behalf of the Department of Communities[5] and the WA Country Health Service.[6] Life Without Barriers was also given an opportunity to make submissions, if they wished to do so.

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[1] As it was then known. Since 1 July 2017 the Department is no longer referred to as the Department for Child Protection and Family Support but now forms part of the Department of Communities.

[2] Pursuant to sections 3 and 22(1)(a) *Coroners Act* the death is deemed to be a 'death in care'.

[3] Exhibit 2, Tab 1B, Report of Dr Boulton 16.1.2009.

[4] Letter to Counsel Assisting from Dr Debra Sayce dated 18.12.2017.

[5] Department of Communities' Closing Submissions dated 7.3.2018.

HOW DID HAVING FAS AFFECT HLS' CARE NEEDS?

8. Any time a pregnant woman drinks alcohol, it can influence and damage whatever is developing in the baby at the time because alcohol is toxic to a developing foetus.[7] There is a spectrum of effects that alcohol can have on an unborn baby and various disorders that can result. These have traditionally been captured under the umbrella term of Fetal Alcohol Spectrum Disorder (FASD). In 2016 Australian clinicians and researchers arrived at new diagnostic terminology for FASD that now means it can be used as a diagnostic term.[8]

9. At the most severe end of the spectrum, the child might have noticeable outward physical changes at birth, such as abnormally small head size (microcephaly) and changes to facial features. They may also experience growth problems and central nervous system problems. In addition, they can suffer severe neurocognitive impairment, which may cause significant challenges with learning, memory, attention span, concentration, vision and hearing. When the effects of prenatal alcohol exposure are most severe and associated with marked clinical features, it is known as Fetal Alcohol Syndrome, a syndrome which was first defined in 1973.[9]

10. At the other end of the spectrum there may be no obvious physical signs that a child has FASD but there may be underlying brain damage caused by prenatal alcohol exposure that may still lead to various levels of behavioural, cognitive, social and neurodevelopmental problems.[10] There can be some commonality of these features with better known conditions such as attention deficit hyperactivity disorders and autism spectrum disorder, and a child may have more than one disorder.[11] A diagnosis in cases such as these, where there are no obvious physical signs, is recommended to be done by a multidisciplinary team: for example a paediatrician together with other professionals such as a special language therapist, a psychiatrist or psychologist, a neuropsychologist, and an occupational therapist.[12]

11. The brain damage caused by alcohol exposure in the womb is incurable.[13] Nevertheless, early diagnosis of children and young people with FASD (preferably before the age of 6) is important as interventions by a network of professional and social support at an early stage can produce significant improvements to the quality of life of a child or young person living with FASD.[14] The diagnosis helps to inform the nature and extent of the therapy and support the young person requires.[15]

12. HLS was born on 25 March 1997 in Derby. He showed subtle physical features suggestive of Fetal Alcohol Syndrome, such as microcephaly and

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[6] WACHS' Submissions dated 22.3.2018.
[7] Exhibit 3, p. 10.
[8] T 301.
[9] Exhibit 2, Tab 1A; Exhibit 3, p. 10; Exhibit 5.2.
[10] Exhibit 2, Tab 1A; Exhibit 5.3, p. 2.
[11] Exhibit 12, Tab 1A.
[12] T 179, 303.
[13] Exhibit 5.3, p. 2.
[14] T 304 – 305; Exhibit 3, p. 11.
[15] T 303 - 304.

skeletal defect, and was diagnosed at a relatively early stage.[16] HLS' biological mother was unable to care for him and he was taken in by his aunt, who cared for him as his foster mother, from approximately 4 months of age. As a child he was reviewed regularly by paediatricians and other applied health practitioners. DCP also had involvement, and responded to requests for financial assistance, family support and child concern reports, but HLS remained in his extended family's care.[17]

13. As time went on HLS showed stunted growth levels and developmental problems. He was challenged at school emotionally and scholastically and as a result, he had been disruptive and was not achieving.[18] It was suggested in July 2004 that he have a formal educational assessment of his abilities as it was suspected he had Attention Deficit Hyperactivity Disorder in association with his FAS. He was eventually started on dexamphetamine but this was stopped after a short trial period due to some negative side-effects and concerns by his foster mother and some medical practitioners as to the appropriateness of the medication in his case.

14. Instead, there was a focus on behavioural modification techniques.[19] HLS' schooling was problematic as he found school an unrewarding environment. As he showed an interest in music, music classes were explored as an incentive for keeping him in school.[20]

15. At this early age there were already concerns that HLS was exhibiting behavioural problems, which was often attributed to HLS being used by older boys to do things such as stealing cigarettes and alcohol. By the age of 10 he was not only using alcohol and cigarettes on occasion, but also appeared to have consumed cannabis on at least one occasion. HLS' new paediatrician, Senior Regional Paediatrician Dr John Boulton, knew from past experience that children with FAS can face serious issues with substances as they become older, so his focus was on containment and trying to help HLS' carer prevent HLS from getting into serious problems in the future.[21]

16. In September 2007 HLS was psychiatrically reviewed after grave concerns were expressed for his physical, mental and emotional well-being. It was noted by the psychiatrist that HLS had a genetic loading for psychiatric illness due to a "huge family history of alcoholism and mental illness."[22] He had recently experienced a number of social stressors in his home life and was still seriously struggling academically, to the point it was concluded that it would be close to impossible for HLS to follow regular education in class or gain much from it. It was recommended that HLS have a full-time aide at school and further testing and assessments should be done by various medical and allied health professionals.[23]

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[16] Exhibit 2, Tab 1B, Report of Dr Henderson, 23.9.1998; Exhibit 2, Tab 2.4.

[17] Exhibit 2, Tab 2, p. 2.

[18] Exhibit 2, Tab 1B, Reports of Dr Erlich, 22.7.2004.

[19] Exhibit 2, Tab 1B, Report of Dr Erlich 8.10.2004 and Report of Dr Gubbay 17.5.2005, 21.6.2005 and Report of Dr Parry 7.6.2006.

[20] Exhibit 2, Tab 1B, Report of Dr Kay 21.11.2006.

[21] Exhibit 2, Tab 1B, Report of Dr Boulton, 13.5.2007.

[22] Exhibit 2, Tab 1B, Report of Dr Memmert, 13.9.2007.

[23] Exhibit 2, Tab 1B, Report of Dr Memmert, 13.9.2007.

17. In 2008 HLS began to show an escalation in his behavioural issues, including violent behaviour for the first time. He disclosed sexual abuse by an older boy, which was investigated by police. During that year a series of comprehensive neuro-psychiatric-cognitive tests were performed at Princess Margaret Hospital. The tests confirmed that HLS had intellectual development delay as a consequence of Fetal Alcohol Syndrome. His global low functioning was "extremely low" on most scales tested and his personal safety was at "significant risk" on a social vulnerability rating instrument.[24]

18. The outcome of the testing was that he became eligible for funding of services by the Disability Services Commission and DCP allocated funds for additional support from a relative to provide personal support and help focus on what HLS was good at, which was playing guitar and drum. In January 2009 he was noted to be playing in the school band, which was a highly positive outcome.[25]

19. In 2010 HLS is recorded to have begun sniffing accelerants/aerosol and abusing alcohol. At this time he was showing signs of increasing violence towards family members and concern was expressed that as he got older and stronger he would become uncontrollable. HLS was referred to DCP by police as he was engaging in antisocial behaviour and not attending school. It was made clear to HLS at that time that he had two diverging paths open to him: one which involved stopping alcohol and sniffing and channelling his anger and aggression into positive things, or the alternative, which would place his life in danger and probably lead to him having to leave his foster family, who could no longer cope and were fearful of finding him dead from the effects of sniffing.[26] Nevertheless, he appeared unable to stop sniffing, which sadly I am told is a common consequence of FAS.

20. HLS' family went so far as to put up flyers around the Beagle Bay community requesting that they be contacted if anyone became aware of HLS sniffing or if they had concerns for his wellbeing. On many occasions he was brought to the Beagle Bay clinic due to the effects of his sniffing. He also increasingly came to the attention of police during this time.[27]

21. HLS was admitted to Broome Hospital on 10 June 2010 due to concerns he was psychotic and required an involuntary psychiatric admission. He was only 13 years old at this time. HLS was assessed by a Consultant Psychiatrist during the admission, who concluded that HLS was at chronic risk of harm to himself, and possibly others, in the context of his substance abuse problems. However, he did not have a psychiatric disorder that required admission or treatment. It was recommended that HLS needed an environment with structure and adequate supervision so that he could not access substances. Some services in the Northern Territory were suggested as a possibility.[28]

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[24] Exhibit 2, Tab 2, pp. 2 – 3.
[25] Exhibit 2, Tab 1B, Report of Dr Boulton, 16.1.2009; Exhibit 2, Tab 2.3.
[26] Exhibit 2, Tab 1B, Email chain 28.5.2010 - 9.6.2010; Exhibit 2, Tab 2, p. 3.
[27] Exhibit 2, Tab 2, p. 3.
[28] Exhibit 2, Tab 1B, Report of Dr Bala, 11.6.2010.

22. Subsequently, DCP assisted HLS to engage in Illpuria Rehabilitation Program, which is a Northern Territory drug and substance abuse program specifically designed to provide support to chronic solvent abusers. He engaged with the program from August 2010 to February 2011. He returned to Beagle Bay on 14 February 2011 and by 23 February 2011 he had relapsed and commenced sniffing again on a regular basis.[29]

23. On 24 February 2011 HLS was medically evacuated from Beagle Bay to Broome Hospital due to a near fatal episode of solvent abuse. The following day HLS' aunty/foster mother advised the Department she was unable to continue to care for HLS.[30] His foster mother feared for HLS' safety and believed that being in the care of the Department would improve his life expectancy. Therefore, although they loved him deeply and still wanted to play a significant role in his life, HLS' family requested DCP become involved.[31]

24. It is important to note that prior to this occurring, DCP had arranged five Strong Families' meetings with HLS' birth mother, foster mother and extended family, as well as other relevant parties, to try to provide support for HLS to remain within his family and prevent him coming into care. Sadly, despite the best efforts of everyone involved, a solution could not be found that kept HLS safe while remaining in his own community. This was despite the fact that HLS' foster mother had provided a loving, nurturing home environment and all of the local community had engaged with her to try and stop him sniffing, including taking steps to lock up any volatile substances in their possession. At the end of the day, these steps had failed to solve the problem of HLS' solvent abuse.

25. Ultimately, HLS was taken into the Department's provisional care on 3 March 2011. A final order was then granted on 17 March 2011 for him to remain in care until he attained 18 years. HLS' family consented to the order being made.[32]

HOW WERE HLS' NEEDS INITIALLY MET BY THE DEPARTMENT?

26. HLS was considered by the Department to be an extremely vulnerable child and his placement required specialist carers.[33] It was acknowledged that he required a high level of supervision due to his absconding behaviours and solvent abuse. Special Purpose Subsidy funding was approved and he was placed through the Disability Services Commission with carers who worked for the organisation known as Life Without Barriers.

27. Life Without Barriers is a secular, not-for-profit organisation providing care and support services across urban, rural and remote locations in Australia and New Zealand.[34] A Disability Placement and Support Program Service

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[29] Exhibit 2, Tab 2, p. 3.
[30] Exhibit 1, Tab 17 [15].
[31] Exhibit 1, Tab 17.
[32] Exhibit 1, Tab 17; Exhibit 2, Tab 2.5A.
[33] Exhibit 2, Tab 2, p. 3.
[34] Exhibit 1, Tab 6, p. 10.

Agreement was commenced between the Department and Life Without Barriers on 4 April 2011.[35]

28. The agreement required Life Without Barriers to provide a placement and respite options where there was limited access to substances and ideally encourage abstinence from solvents, develop a safety/risk management response and behavioural goals. They were also required to encourage school attendance and provide HLS with an opportunity to engage in educational pursuits, facilitate contact with his family and encourage and develop strategies to assist HLS to develop his musical talents. In recognition of the complexity of the case, HLS was allocated a Life Without Barriers case manager whose sole responsibility was to manage HLS' case.[36]

29. After a brief temporary placement in Broome, during which HLS absconded almost daily and returned to solvent misuse,[37] HLS's first permanent placement was at a community known as 'The Plantation', which was near his community of Beagle Bay. The advantage of the placement's location was that he remained within his country and had opportunities to have regular contact with family, in particular his aunt/foster mother who had always been the most significant person in his life. He received 24 hour intensive support from a primary specialist carer and support worker.[38]

30. The placement at the Plantation was viewed by DCP as an extremely positive outcome for HLS, as it was the first time in the West Kimberley that DCP had been given such an option for a child presenting with the high care needs of HLS. Previously, HLS would have had to leave his community to go to Perth in order to provide him with the wraparound services he required. The thought of HLS having to leave his community had horrified DCP staff, so the option of the Plantation, where he could stay connected to his family and his culture, was viewed by DCP as "heaven-sent."[39]

31. Initially HLS was reported to be thriving at the Plantation and his family indicated that they had seen positive changes in him. His placement seemed to have successfully minimised his absconding behaviour and access to solvents. He was given a general medical examination on 18 March 2011 and was described as being in generally good health. He was being medicated with an antipsychotic medication, Risperidone, at this time, which was intended to continue. While he was not sniffing solvents there were no concerns for his health.[40]

32. HLS' educational needs were met on the Plantation by a carer who had previously taught HLS at Beagle Bay School and other educational support was provided via the internet and weekly phone calls from a volunteer. He was found to performing at a basic Year 1 level although based on his age he would ordinarily have been in Year 8.[41]

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[35] Exhibit 2, Tab 2, p. 3 and Tab 2.1.
[36] Exhibit 2, Tab 2, p. 3.
[37] Exhibit 1, Tab 17.
[38] Exhibit 2, Tab 2, p. 4.
[39] T 227.
[40] Exhibit 2, Tab 2.5A, p. 5.
[41] Exhibit 2, Tab 2.6B.

33. Music and playing instruments was central to HLS' life at this time and arrangements were made for his carers to take HLS to Broome at least once a week to learn some music and play the drums.[42]

34. He was also given regular access to cultural learning, both at the Plantation and from relevant organisations in Broome. Planned contact visits with his family were also arranged to continue his kinship ties on his mother's side.[43]

35. Everything about the placement appeared to be positive and images from that time show HLS happily engaging in activities such as guitar playing, spear making, didgeridoo making and camping on the land.[44] Up to this stage there is no criticism of the Department's care, treatment and supervision of HLS.

36. Unfortunately, the placement broke down in April 2012 when HLS absconded while on a visit to Broome with his carers. He stayed with family and sniffed solvents over several days. HLS was returned to the Plantation on 14 April 2012 but he then absconded again a few days later, this time to Beagle Bay. HLS refused to return to the Plantation as he claimed he was "bored"[45] there and preferred to live with his family in Broome.[46] Although attempts were made to convince HLS to return to the Plantation, ultimately it was decided on 19 April 2012 that another placement had to be found.[47]

37. One option for a new placement was to send HLS to Perth, but as previously mentioned it was greatly preferred to keep him up in the Kimberley, where he could stay connected to his family and his culture.[48] Relatives of HLS heard that he might be sent to Perth and they became involved in helping to find an alternative placement in the region, which ended up being at La Djadarr Bay on the Dampier Peninsula. Like the Plantation, DCP staff described this option as "heaven-sent"[49] given the alternative was moving HLS to Perth.

PLACEMENT WITH CARERS AT LA DJADARR BAY

38. On 24 April 2012 HLS was placed at a small community at La Djadarr Bay on the Dampier Peninsula. La Djadarr Bay is 60 kilometres from Beagle Bay Community, significantly further than the Plantation.[50] The isolation was considered a positive, as it would keep HLS away from the temptations of solvent abuse in town.[51]

39. HLS' carers were initially Lawrence (Laurie) and Penelope (Penny) Cox. Mr Cox is a traditional owner of the land and was distantly related to HLS

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[42] Exhibit 2, Tab 2.5A.
[43] Exhibit 2, Tab 2.5A, pp. 6, 8, 10.
[44] Exhibit 2, Tab 2.2.
[45] Exhibit 2, Tab 5, p. 38.
[46] Exhibit 2, Tab 2, p. 4.
[47] Exhibit 1, Tab 17; Exhibit 2, Tab 5, pp. 40 – 41, 48.
[48] Exhibit 2, Tab 5, p. 41.
[49] T 227.
[50] Exhibit 2, Tab 2, p. 4.
[51] Exhibit 2, Tab 21.

through his foster mother. Mr and Mrs Cox had been approached by Life Without Barriers to start looking after children at La Djadarr Bay and HLS was one of the first children they took in after they were told by relatives he would otherwise be sent to Perth, so they volunteered to take him.[52]

40. Mr Grant Roberts, the Program Manager for Life Without Barriers in Broome for much of the time HLS was engaged with that service, explained that it was felt that the area was semi-secure, easily supervised, and with facilities available in reasonably close proximity, all of which made it suitable for young people who needed to be placed in a safe community setting. Life Without Barriers reportedly invested about $50,000 into the La Djadarr property to update buildings and equipment to make sure it was well equipped for that purpose.[53]

41. The placement was considered to be 'on country' for HLS and gave him opportunities to develop his cultural understanding and independent living and social skills.[54] According to his family, HLS also loved the fact that he was near the sea.[55]

42. Mr Cox was hoping that by taking HLS in he could help to guide him, as he understood that he was "a pretty smart kid" who needed help as he had a bad habit of sniffing petrol and glue. Mr Cox hoped that he could teach HLS practical skills and keep him safe.[56]

43. On 10 May 2012, a short time after HLS had moved to La Djadarr Bay, he ran away while on an outing to Beagle Bay. He immediately began sniffing solvents again, and his aunty/former foster mother told Departmental staff that HLS needed to go back to La Djadarr Bay. HLS was taken back to La Djadarr Bay by Laurie Cox on 11 May 2012.[57]

44. Other than that initial incident, Mr Cox recalled that things initially went well with HLS. He taught him basic car mechanics, welding and grinding and also household maintenance.[58] Mrs Cox described HLS as a gentle boy who was cooperative and seemed to settle in to the community.[59]

45. HLS was visited by staff from the Kimberley Mental Health and Drugs Services and they reported he had not been sniffing and appeared happy and settled.[60]

46. HLS went missing again on 24 October 2012 and turned up in Broome. It was suspected he was again affected by solvents.[61] He was located a number of times by police, Life Without Barriers staff, DCP staff and family members, but he refused to return to La Djadarr Bay and repeatedly absconded. He

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[52] Exhibit 1, Tab 12.
[53] T 109.
[54] Exhibit 2, Tab 6.
[55] Exhibit 1, Tab 11.
[56] T 65 – 66.
[57] Exhibit 2, Tab 5, pp. 43 – 44.
[58] Exhibit 1, Tab 12.
[59] Exhibit 1, Tab 13.
[60] Exhibit 1, Tab 17 [56] – [57].
[61] Exhibit 2, Tab 5, p. 51.

was abusing solvents and choosing to stay in unsafe situations during this time.[62]

47. A critical incident was reported to police on 29 October 2012 regarding HLS alleging producing a knife and demanding sex from a woman. Subsequently, Laurie Cox advised that he did not wish to care for HLS as he had grandchildren living with him and was concerned there might be safety issues if HLS remained in his care. While the police investigation continued HLS moved into the care of his grandmother in Broome. Police eventually advised the Department that there was no evidence that an offence had been committed by HLS.

48. On 3 November 2012 he returned to La Djadarr Bay but with a plan by Life Without Barriers to transfer his care to another person, David Ishiguchi, who lived in a different house on the property.[63] Mr Ishiguchi was also related to HLS through his foster mother and had known HLS since he was born.[64]

49. From around that time Mr Ishiguchi cared for HLS but Mr and Mrs Cox would assist if Mr Ishiguchi was unavailable.[65]

50. A visit by Life Without Barriers staff to La Djadarr Bay on 9 January 2013 found HLS in good spirits and he indicated he enjoyed living with Mr Ishiguchi. HLS said he and Mr Ishiguchi had been spending a lot of time fishing and hunting together.[66] Mr Ishiguchi described HLS as “a good kid”[67] who generally did what he was asked.

51. Also at La Djadarr Bay at this time was another 15 year old youth, WIC, who had also been diagnosed with FASD and was in the Department’s care.[68] WIC had recently arrived at the community and was being cared for by Laurie and Penny Cox, although it seems he also lived with Mr Ishiguchi.[69] The two boys had known each other for a few years, having met while HLS was in the treatment programme in Alice Springs, and they were also distantly related.[70]

52. They appeared to generally get on well, although there were reports that WIC would sometimes boss HLS around.[71] Mrs Cox was also concerned that HLS’ behaviour changed in a negative way under the influence of WIC.[72] Mr Cox described there being “something wrong between them”[73] as they were “up and down together.”[74] Mr Cox thought it might relate to something that happened in Alice Springs but HLS would not discuss it with him.

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[62] Exhibit 1, Tab 17; Exhibit 2, Tab 5, pp. 52 – 53.
[63] Exhibit 2, Tab 2, p. 4 and Tab 5, pp. 57 – 58..
[64] Exhibit 1, Tab 15.
[65] Exhibit 1, Tab 12.
[66] Exhibit 2, Tab 9.
[67] Exhibit 1, Tab 15 [18].
[68] Exhibit 1, Tab 6, p. 10.
[69] T 59.
[70] Exhibit 1, Tab 11.
[71] T 56 – 57; Exhibit 1, Tab 9 and Tab 12 and Tab 13.
[72] Exhibit 1, Tab 13.
[73] T 67.
[74] T 67.

53. HLS also had contact with peers who had come to La Djadarr Bay for Youth Bail Options Camps overnight and on weekends as well as some younger children, who were the grandchildren of Laurie and Penny Cox. The Cox's grandchildren were living at La Djadarr during the school holidays and HLS reportedly enjoyed watching out for them.[75]

54. Another visit was made by Life Without Barriers staff on 31 January 2013. Mr Ishiguchi and Laurie Cox indicated at the time that the kids were going 'stir crazy' as they couldn't leave the community due to the weather. They spoke to WIC and HLS individually and HLS did not raise any issues or concerns. Later attempts to visit again were unsuccessful due to the weather making the roads impassable.[76]

55. On 22 February 2013 a Life Without Barriers staff member reported to the Department that on HLS' last visit to Broome he had a medical check-up at the Broome Hospital Emergency Department with a doctor who had been involved with HLS' medical care for some years. No discharge summary was provided but the staff member confirmed that the doctor reported HLS was in excellent physical conditions and urine analysis at the time indicated no misuse of substances.[77]

56. On 23 February 2013 HLS and WIC absconded from La Djadarr Bay after stealing Mr Ishiguchi's car. Mr Cox later asked HLS why they did so, and HLS said it was because WIC wanted to go to town.[78] At the time they drove to Broome there was a yellow alert on Broome and the Dampier Peninsula and the road was closed, so their decision to make the journey was particularly dangerous, putting to one side they were juveniles driving a stolen car.[79] This underscores the lack of consequential thinking of both boys.

57. They drove the car until it broke down about 40 kilometres out of Broome. Police were made aware of the situation and both boys were located and found accommodation in Broome by Life Without Barriers with staff to care for them. After a meeting of the stakeholders it was decided that both boys should be returned to La Djadarr Bay but due to road and weather conditions the boys could not be returned to La Djadarr Bay immediately. While he remained in Broome HLS absconded and was self-selecting placements in the Broome area.[80]

58. HLS' aunty/foster mother was spoken to by a DCP Team Leader and she advised she had told family members that HLS could not stay in Broome and needed to go back to his placement.[81]

59. Mr Cox drove to Broome and tried to speak to HLS but when HLS saw Mr Cox he ran away. Mr Cox believed it was because HLS was scared about getting in trouble for stealing the car.[82]

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[75] Exhibit 2, Tab 9.
[76] Exhibit 1, Tab 18.
[77] Exhibit 2, p. 5.
[78] T 75.
[79] T 234.
[80] Exhibit 1, Tab 21.
[81] Exhibit 2, Tab 5, p. 67.

60. HLS was spoken to by his DCP Team Leader on 26 February 2013 and he indicated he did not want to go back to La Djadarr Bay. He asserted there was an incident with David Ishiguchi and WIC involving a gun although HLS admitted he did not see it occur and was only told about it by WIC. It was assessed that HLS' main motivation for not wanting to return to La Djadarr Bay was because he would not have easy access to solvents and did not want to have to follow the rules and boundaries put in place at the community.[83]

61. HLS was picked up on 5 March 2013 and returned with Life Without Barriers staff to the Beagle Bay area. HLS was high from sniffing when he was first collected by Life Without Barriers staff.[84] WIC had not been relocated at this stage and HLS indicated that he didn't want to return to La Djaddar Bay without WIC. It was agreed by Life Without Barriers staff that it would be better for them to return to La Djadarr Bay together.[85]

62. Therefore, HLS went with a Life Without Barriers carer, Lynton Smith, to the Embulgun Aboriginal Community for the next week. This was to allow WIC to be located, to relieve some stress on HLS in the meantime, and also due to weather conditions that made it difficult to travel to La Djadarr Bay.[86]

63. Lynton Smith had known HLS since his birth and was very close to him. Embulgun is Mr Smith's family property and his father, William Smith, is the elder at the community. HLS was excited to be going with Lynton Smith to Embulgun and on the way he asked if he could perhaps stay there rather than going back to La Djadarr Bay. Mr Smith had only started working at Life Without Barriers two weeks before, so he wasn't sure of the protocol, but he was open to the idea.[87] While at Embulgun HLS spent time crabbing and fishing and he seemed to be enjoying spending time 'with the boys'.[88]

64. WIC was located on 12 March 2013 by Life Without Barriers staff and he was driven that day to the Beagle Bay area. He reportedly made it very clear to the Life Without Barriers staff that he didn't want to return to La Djadarr Bay but arrangements were made for him to be returned anyway.[89]

65. In the meantime, Lynton Smith had been notified and told to bring HLS to Beagle Bay so the two boys could be returned to La Djadarr Bay together. Mr Smith recalled HLS seemed calm and happy when told of the plan to go back to La Djadarr Bay, although he had also indicated he wanted to stay at Embulgun. Mr Smith reassured him that he would organise for HLS to come back to Embulgun for weekends. He then drove HLS to a spot near Beagle Bay where they were due to meet up with WIC. While waiting, Mr Smith and HLS went hunting for goanna.[90]

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[82] T 76 – 77.
[83] Exhibit 1, Tab 17.
[84] T 31, 33.
[85] T 118 – 119.
[86] T 118 – 119, 132; Exhibit 1, Tab 21; Exhibit 2, Tab 9.
[87] T 20.
[88] Exhibit 1 Tab 16.
[89] T 35.
[90] T 20 – 21; Exhibit 1, Tab 16.

66. Eventually the car containing WIC arrived and Mr Smith and HLS returned to the meeting point. HLS initially was cooperative and got into the other car with WIC, but then WIC started saying that they were going to get a 'flogging' when they got back to La Djadarr Bay and HLS became concerned. He got out of the car and walked away, saying he didn't want to return to La Djadarr Bay. To allay his concerns, Mr Smith offered to go with him. In the end, HLS drove back to La Djadarr Bay with WIC, Lynton Smith and Lynton Smith's brother and two other Life Without Barriers workers, Mark Patching and Jack Lane.[91]

67. Both HLS and WIC continued to express some reluctance during the car journey about returning to the placement as they were concerned about the consequences of stealing the car. Mr Hutchings and Mr Lane thought WIC was deliberately creating anxiety for HLS about the possible consequences during the journey, suggesting unrealistic outcomes for what they might face. The boys were reassured that their carers were not angry with them, although they could expect to do some extra chores to make up for the damage done to the car.[92]

68. Once back at La Djadarr Bay, Mark Patching from Life Without Barriers, sat talking with the two boys in the car for half an hour and again reassured them. Mr Smith had a conversation with David Ishiguchi, who owned the stolen car, to explain HLS and WIC's anxiety and to assess how he felt about the situation. Mr Ishiguchi indicated he was not angry but did expect them to do some work to compensate for the damage done, which he also conveyed to HLS and WIC.[93]

69. Lynton Smith, Mark Patching and Jack Lane stayed at La Djadarr Bay for about two hours in total, resettling HLS and WIC and ensuring they were calm, before they left. Jack Lane describes the boys as having a 'tantrum' at one stage but eventually they seemed to calm down.

70. Mr Patching said during that time they rang their line supervisors to see how they should proceed given the boys' resistance to remaining but they were instructed that both boys had to remain as there was nowhere appropriate for them in Broome.[94]

71. Eventually the three men got ready to leave. The Life Without Barriers staff told HLS and WIC they would return for a visit later in the week.[95] Mr Smith also told HLS he would come back on the weekend to take him to Embulgun.[96]

72. HLS shook their hands and seemed settled and content before they left but WIC was still upset and as they drove away Mr Lane and Mr Patching saw WIC kick their car.[97]

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[91] T 21 - 22; Exhibit 1, Tab 16 and Tab 19.
[92] Exhibit 2, Tab 9.
[93] Exhibit 2, Tab 12.
[94] T 97.
[95] Exhibit 2, Tab 9.
[96] Exhibit 1, Tab 16.
[97] Exhibit 1, Tab 19 and Tab 20.

73. Mr Patching said that the three Life Without Barriers staff weren't very happy with their direct orders to leave the boys there but had no option but to comply with them. It was not so much that they felt either boy was in any threat of immediate harm but Mr Patching indicated he did feel it was a bit remote for the boys to be placed there.[98] Nevertheless, Mr Patching accepted that there were a lot of temptations in Broome that might have led the boys to go down the wrong path, so it was a difficult situation.[99]

74. Mr Smith was asked at the inquest whether he believed it was a good decision to leave HLS there, given how well he knew him, and he agreed that he thought it was a good decision. Mr Smith explained that he thought the people at La Djadarr Bay were good people who would look after HLS properly and there were plenty of things for HLS to do out there to keep him busy.[100] Jack Lane held a similar view, noting that the boys had their own space in a nice house and good carers; what he described as the "whole package."[101]

75. The main concern about leaving the boys there expressed by Mr Lane was the concern about WIC's influence of HLS. Mr Lane gave evidence that he had a discussion with Mr Smith and Mr Patching on the drive home about WIC being a bad influence on HLS and they were concerned WIC might encourage HLS to do something stupid. They agreed to raise their concerns with their Life Without Barriers superiors, which they did on their return.[102]

76. Mr Roberts, who was their line supervisor, acknowledged that these concerns were raised with him, and that he was aware that WIC was prone to exaggeration and did have some influence over HLS, which meant it could be an upsetting factor for HLS.[103] Nevertheless, there were no major concerns about the boys being left together. Instead, Mr Roberts' recollection was that the support workers were more interested in moving both boys together to Embulgen, because its location was less remote than La Djadarr Bay.[104]

77. However, as earlier explained, the isolation of La Djadarr Bay was considered to be a positive by senior staff at DCP and Life Without Barriers in that it was more likely to keep HLS safe from physical harm as he could not abscond to Broome and relapse into solvent abuse.[105] The people at Embulgen were also not approved as permanent carers by DCP.[106] For those reasons, there was no serious plan to move HLS to Embulgen at that stage.

78. Back at La Djadarr Bay, WIC recalled that HLS was "fine and appeared happy"[107] at lunchtime although WIC could tell that HLS was a bit upset about staying at La Djadarr Bay again.[108]

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[98] T 97.

[9999] T 100.

[100] T 24.

[101] T 44.

[102] T 38, 99.

[103] T 115 - 116

[104] T 116.

[105] T 117.

[106] T 119.

[107] Exhibit 1, Tab 11 [19].

[108] Exhibit 1, Tab 11 [19].

79. That afternoon HLS and WIC walked to the beach at low tide. It seems while at the beach the two boys had a conversation about walking to Derby. It's not clear from the evidence who instigated the conversation, although the general tenor of the evidence indicated the idea most likely initially came from WIC.

80. It is approximately 80 km across the bay from La Djadarr Bay to Derby and crossing the bay is physically impossible on foot.[109] WIC claims he pointed this out to HLS and told him that there were crocodiles and he did not want to go to Derby,[110] although in a conversation after HLS' death he told Mr Patching they had agreed to go on Tuesday afternoon but then they decided it was too dark.[111] The two boys then returned to the house.

81. HLS went to bed early that night. The next morning, HLS woke early and woke up WIC just as it was getting light. He told WIC that he was going to Derby and asked WIC if he wanted to go. WIC responded that he didn't want to go as he was too sleepy. HLS then shook his hand and left, while WIC went back to sleep.[112]

82. HLS did his normal rounds at 6.00 am and went and sat with Mr and Mrs Cox. Mrs Cox asked if he was ready for work and he said that he was. She asked him where WIC was, and HLS told her he was still sleeping. Mrs Cox told HLS he could wait until WIC was up so that he could have some help doing the chores. Mrs Cox thought that HLS appeared to be happy and behaving like his normal self at this time.[113]

83. HLS returned to the other house and had breakfast with Mr Ishiguchi at about 8.30 am. Mr Ishiguchi thought HLS seemed to be in good spirits and behaving like his normal self. He did not give any indication to Mr Ishiguchi that he didn't want to be there.[114] HLS then said he was going for a walk and Mr Ishiguchi told him that he had chores to do before he went for a walk. Mr Ishiguchi went to move the sprinkler and then saw HLS walking towards the channel. He followed HLS but by the time he reached the channel HLS had already crossed it. Mr Ishiguchi called out to HLS but he did not respond and Mr Ishiguchi thought that HLS might not have heard him due to the direction of the wind.[115]

84. Mr Ishiguchi returned home and told Mrs Cox and then returned to the last place he had seen HLS with Mrs Cox, but they could not see any sign of HLS. The tide was very low at the time HLS started walking, but Mrs Cox and Mr Ishiguchi knew that there was a big king tide (up to 10 metres)[116] due to come in later that morning and that there were crocodiles seen regularly in the area. They were both very concerned for HLS' safety. Mrs

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[109] Exhibit 1, Tab 6, p. 15.
[110] Exhibit 1, Tab 11.
[111] Exhibit 1, Tab 20.
[112] Exhibit 1, Tab 6, p. 11 and Tab 11.
[113] T 59 - 60; Exhibit 1, Tab 13.
[114] T 153.
[115] Exhibit 1, Tab 6, p. 11.
[116] T 7.

Cox notified her husband, who was at work, and Life Without Barriers staff and the police were notified.[117]

85. Mrs Cox believed HLS was aware of the dangers in the area so she was very surprised that HLS had crossed the channel. He had been told about crocodiles being in the area and none of the children, including HLS, were allowed to go to the beach without an adult present unless it was low tide.[118] He had never crossed the channel before and she "didn't think he would do something like that."[119] Mr Cox also expressed surprise.[120]

THE SEARCH FOR HLS

86. Police officers at Dampier Peninsula Police Station were contacted by Life Without Barriers at 10.35 am on 13 March 2013 and told that Laurie Cox had reported that HLS had gone missing. They called Laurie Cox, who confirmed his concerns for HLS given his age and intellectual disability and the hostile environment, including the high tidal movement and the presence of large crocodiles in the area. It was also noted that the weather was very hot and HLS was not believed to have taken any food or fresh water with him.[121]

87. Given the serious concerns for his safety, a search for HLS was commenced immediately. The Acting officer in Charge at Dampier Police Station, Brevet Sergeant Raper, is qualified in both Land and Marine Search Rescue Control and he took on the role as the Incident Controller for the search.[122] Sergeant Raper later described the search as the most difficult search he has ever completed given the remoteness of the area, which made access difficult and hindered communication.[123]

88. Other police officers were called in to the station and given various roles to perform in the search. Sergeant Raper also requested assistance from the Beagle Bay Nyul Nyul Rangers and Bardi Rangers, who could provide a boat to help with the search, and the Broome Fire and Emergency Services Agency staff. The Police Airwing Unit provided a helicopter.

89. It takes approximately one and a half hours to travel by 4WD from the Dampier Police Station to La Djadarr Bay.[124] The first police officers arrived at the scene at 1.53 pm and the helicopter was already conducting a sweep search of the coastline by that time. Some footprints leading into the mangroves were found by the helicopter at 3.11 pm and rangers attempted to search the relevant location but did not find any sign of HLS. The search was eventually stopped for the night as light faded, with a plan to recommence the following day at first light with more volunteers and police officers to assist.

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[117] Exhibit 1, Tab 13 and Tab 15.
[118] T 54, 59.
[119] T 60.
[120] T 78.
[121] T 7; Exhibit 1, Tab 23.
[122] Exhibit 1, Tab 6 and Tab 23.
[123] T 13.
[124] Exhibit 1, Tab 23.

90. The search recommenced around 5.00 am on Thursday, 14 March 2013. At 9.00 am more footprints were found by the helicopter leading into the mangroves. At 11.16 am a survivability expert provided an opinion that, given HLS' impaired logic and reasoning skills, he may not have been able to work out he needed to get to higher ground so there was a high risk he might already have died. Sadly this proved to be correct as HLS's body was found not long after, at 11.40 am. He was within the designated search area in thick mangrove approximately 5 km from La Djadarr Bay Community.[125]

91. The searchers had followed the footprints that had been seen by the helicopter from the air. The footprints had given the impression HLS had been wandering in circles and it was thought that due to his mental impairment, dehydration and environmental conditions HLS had been unable to get out of the mangroves.[126]

92. The searchers initially found a t-shirt and shorts belonging to HLS and then they found the naked body of HLS a short distance away. His left arm was wrapped around a fork in a tree and his right arm was stretched out. His feet were about 40 cm above the ground and it was immediately clear that he had suffered a traumatic amputation of his left foot and part of his left leg.[127]

93. While approaching the deceased one of the searchers saw a large salt water crocodile a short distance away and the helicopter pilots confirmed they had seen at least 9 large crocodiles in the broader area during the search.[128]

HOW DID THE DEATH OCCUR?

94. On 19 March 2013 a post-mortem examination was performed by two forensic pathologists, Dr White and Dr Hewison. It was apparent that there was traumatic amputation of the left foot and multiple other soft tissue injuries to the limbs, head and torso. There was no evidence of significant natural disease. Further investigations were then undertaken, but some of the analysis was hampered by extensive decomposition changes. At the conclusion of all investigations Dr White and Dr Hewison formed the opinion the cause of death was consistent with immersion in a young man with traumatic amputation of the left foot and multiple soft tissue injuries.[129]

95. Dr Adam Britton, a zoologist who specialises in crocodile-related biology and management, was asked to assist in determining whether the injuries sustained by HLS were consistent with a crocodile attack. After examining the injuries, and taking into account the known circumstances of where HLS was found, Dr Britton concluded that overall the injuries were consistent with having been caused by a crocodile attack. Dr Britton indicated it is impossible to determine conclusively whether the injuries were the cause of

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[125] Exhibit 1, Tab 6 and Tab 23.
[126] Exhibit 1, Tab 6, p. 15.
[127] Exhibit 1, Tab 6 and Tab 23.
[128] Exhibit 1, Tab 6 and Tab 22.
[129] Exhibit 1, Tab 3.

HLS' death or whether they were inflicted post-mortem, although he felt the most likely explanation was that the crocodile attack caused the death.[130]

96. Dr Rory McAuley, a scientist who is an expert on sharks and has been involved in reviewing shark bite incidents, also examined the injuries sustained by HLS and concluded that a shark or sharks were responsible for some of the injuries to HLS' lower limbs but, significantly, not the amputation of his left foot.[131]

97. Taking into account all of the expert opinions outlined above, I am satisfied on the evidence before me that HLS died as a result of traumatic injuries he sustained during a crocodile attack, with the complication that he was immersed in water.

98. The evidence indicates that HLS walked out into crocodile infested waters although he had been told by his carers of the dangers.[132] This raises the question of what his intention was when he did so. In an ordinary 15 year old, one might think such behaviour could indicate suicidal intent, but in HLS' case this seemed very unlikely.

99. There were suggestions by witnesses that WIC may have influenced HLS to take the unusual step of going out alone into such a dangerous area, as he was generally considered to be risk averse (other than his sniffing habit).[133] However, WIC did not admit to anyone that he did so, and he was not able to give evidence at the inquest, so it is really just speculation.[134]

100. An expert in FASD in children, Dr Raewyn Mutch, was asked about how HLS' diagnosis of FASD may have affected his ability to estimate or calculate risk, noting he was prone to impulsivity and lack of consequential thinking. Dr Mutch emphasised that HLS was still a child in terms of his developmental age, in many ways like a seven year old. She expressed the opinion it is extremely unlikely that he could have comprehended the immense risk it was to his life to walk out that day. Instead, Dr Mutch believes HLS would have been thinking about all the possibilities that would come once he got to the other side.[135]

101. In the end, I am satisfied that there is no evidence that HLS had any intention to take his life. I am also satisfied that he had a general understanding of the dangers, but given his young developmental age, he was incapable of properly weighing up the risks.

102. I find that the death occurred by way of misadventure.

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[130] Exhibit 1, Tab 30.
[131] Exhibit 1, Tab 29.
[132] T 71.
[133] T 70, 78.
[134] T 70.
[135] T 197.

WAS THE PLACEMENT AT LA DJADARR BAY APPROPRIATE?

103. Under s 25(3) of the *Coroners Act 1996*, where a death investigated by a coroner is of a person held in care, the coroner must comment on the quality of the supervision, treatment and care of the person while in that care. As HLS was in the care of DCP at the time of his death, my obligation under s 25(3) is triggered.

104. From the outset, I acknowledge the complexity of the issues that impacted upon HLS' care, including:

- HLS' severe learning disabilities due to his FAS;
- the high level of support and supervision HLS required to keep him from accessing solvents, which necessitated a remote placement out of town;
- the need for such a placement to still be 'in country' for HLS, if at all possible;
- the environmental factors that impacted on travel and transportation in the area; and
- difficulties in maintaining consistent case management due to problems with staff retention in the Kimberley.[136]

105. Further, I note there were no obvious concerns with HLS' care while he was at the Plantation. The concerns arise once he was placed at La Djadarr Bay and, therefore, this placement is the focus of my comments.

106. Dr Raewyn Mutch, is a paediatrician with considerable expertise in the diagnosis and treatment of FASD. The basis of her expertise is set out in more detail later in this finding. Dr Mutch was engaged to review the materials describing the supervision, treatment and care of HLS while he was in the care of DCP and provide an expert opinion to assist me in undertaking my statutory obligation under s 25(3). I have taken Dr Mutch's expert opinion into account in reaching my conclusions about the quality of the supervision, treatment and care of HLS.

107. For the sake of simplicity, I have set out first Dr Mutch's opinion, based upon the materials she was provided, and then I break my comments down under specific categories that arise from the various issues raised.

Expert Opinion of Dr Raewyn Mutch

108. Dr Mutch noted in her report that HLS' life was "replete with events which commonly assault young people when they have not been afforded a diagnosis of FASD," despite the fact that HLS had been diagnosed with FASD from a very early age.[137] In Dr Mutch's opinion, HLS was "consistently managed in a way which indicated that the implications of that diagnosis were not understood by the educational, health, child protection and judicial

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[136] Exhibit 2, Tab 4, pp. 5 – 6.
[137] Exhibit 2, Tab 1A, p. 2.

services he encountered."[138] Dr Mutch referred to HLS' innate vulnerability arising from his FASD and associated impaired cognitive function, which in the context of various negative experiences he had encountered throughout his life, had the effect of exposing him to complex trauma.[139]

109. Much of this complex trauma occurred before HLS came into the care of the Department, so it cannot translate into an adverse comment against DCP. However, it was the legacy of that trauma that DCP had to face in dealing with HLS' increasingly complex care needs.

110. Looking to his last year, which is the focus of my comments here, Dr Mutch observed that even at this time, when "he essentially had 24 hour care (a recommended approach to someone with a FASD) the nature of that care appears to have not understood his evident cognitive impairment."[140] Overall, Dr Mutch concluded that the evidence suggested that the nature of HLS' FASD was not well understood.[141]

111. Dr Mutch spoke of the need for HLS' carers to have received training to understand that HLS had the brain of a child in the body of a teenager. Depending upon how he processed information, he also may have needed different techniques to be implemented to help him understand things.

112. As an example, Dr Mutch spoke of training in the difficulties HLS would have experienced around memory and learning, with the need to use receptive language and expressive language, or different communication techniques, to help him understand things. Dr Mutch gave examples of visual cues if his relative strength was visual, that would depict in pictures all the things he might need to do in a day, such as getting dressed and showering, etc. Or where the person has a degree of memory impairment, using very simple instructions, with words frequently replicated by all the carers, with the repetition reinforcing the message. Such methods enable success for a person with learning difficulties.

113. Dr Mutch emphasised that HLS' carers could not expect to be successful if they weren't equipped to understand the complexity of his needs, and from her reading of the materials she was not satisfied this had occurred. Those comments are borne out by the evidence of HLS' carers at La Djadarr Bay, which I refer to in detail below. It is clear that Mr and Mrs Cox and Mr Ishiguchi were given little to no training in FASD and the complexities of HLS' needs arising from his cognitive impairment and other effects of FASD.

114. Dr Mutch was asked her opinion of what would occur if HLS' carers were not given such training, as was the case here, and she responded that "you would be setting them up for failure"[142] as they would be left reaching into their own experiences of how to manage a difficult personality rather than the skills required to deal with a child with FASD. That does seem to have been what occurred based on the evidence of the three carers, who indicated

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[138] Exhibit 2, Tab 1A, pp. 2 – 3.
[139] Exhibit 2, Tab 1A, p. 3.
[140] Exhibit 2, Tab 1A, p. 3.
[141] Exhibit 2, Tab 1A, p. 3.
[142] T 190 - 191.

they drew on their own knowledge and life experience as a rule to manage HLS' behaviour.

115. Dr Mutch was also critical of the decision to place HLS in such an isolated community, rather than looking at options within his own community, amongst family and friends. Dr Mutch emphasised HLS' developmental age, estimated as below 10 years old, which meant his psychosocial needs were more those of a child than a teenager, and for him to feel safe it should have been a priority to keep him with family.[143] Dr Mutch emphasised that she based this opinion on her years of experience as a paediatrician, knowing what is normal for a child's development and what makes them healthy and happy, rather than simply projecting her own views in that regard.[144]

116. As for education, Dr Mutch suggested that once HLS had been assessed at PMH there should have been an individualised education plan prepared around which they could scaffold rehabilitation teaching methods. This should have been in place by the time HLS came into DCP care, although it does not appear to have been done.[145] Dr Mutch referred to methods of harnessing his clear talent and love for music to help him acquire knowledge and for behaviour management.[146]

117. Dr Mutch acknowledged in her evidence that there is a lot of work done now by DCP upskilling their staff around knowledge of FASD and specific detailed response to FASD, and there are options now to refer children who are diagnosed to specialists in the private and public sector. In that respect, Dr Mutch acknowledged that the knowledge and action around FASD now is very different to what was available when HLS was growing up.

118. In that regard, it is important to note that many of Dr Mutch's concerns related to HLS' early years, which predated his coming into DCP care. Dr Mutch gave evidence at the inquest that she approved of DCP's Care Plan dated 4 April 2011, that had been developed with Life Without Barriers not long after he came into DCP care. She described it as a "very good document" and she liked the thought that had gone into it. In Dr Mutch's words, "it just came a bit late"[147] but that cannot be a criticism of the Department given he had only recently come into their care.

119. Dr Mutch also acknowledged that, in terms of what occurred once HLS was in DCP's care, they were faced with a difficult problem with his solvent abuse. Dr Mutch understood why, in those circumstances, DCP opted to place him in a remote location, to limit his access to harmful substances. However, Dr Mutch expressed the view that this environment had its negative aspects for a young man like HLS, which have been set out above.[148]

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[143] T 187 - 188.
[144] T 209 – 210.
[145] T 191.
[146] T 191.
[147] T 215.
[148] T 217 – 218.

Supervision and Physical Safety

120. HLS was diagnosed with FASD at a very young age, so DCP was well aware of his diagnosis when he came into care. HLS also had a known addiction to solvents, in particular aerosols and petrol, HLS had been involved in a number of near fatal incidents involving solvent abuse before he came into care, which was the primary reason why his family were no longer able to care for him.

121. Sadly, HLS' solvent abuse was most likely related to his FASD. Dr Mutch explained that the prenatal exposure to alcohol lays down chemical receptors in the brain that respond to volatile substances. She described HLS being "pre-set for failure" in that regard, which was compounded by his lack of executive function and consequential thinking. Further his lived trauma also increased his risk of taking substances.[149]

122. Irrespective of the cause, the need to limit HLS' access to solvents and inhalants was considered the highest priority by DCP. Unless he could be kept physically safe, the other aspects of his care became largely irrelevant. Accordingly, a main consideration in the placement at La Djadarr Bay was that the placement kept him in a physical environment far away from Beagle Bay and Broome, given 24 hour supervision was effectively impossible.[150]

123. On the two occasions when HLS absconded from La Djadarr Bay and made his way to Broome, he immediately became involved in inappropriate use of solvents and his physical and emotional health quickly deteriorated, to the point that he required medical treatment.[151] Efforts to keep him safe in that environment were futile, and the same problem had been experience by his family in Beagle Bay before he went into care.

124. HLS' DCP team leader, Ms Kathryn Dowling, acknowledged that there was tension in the isolation of La Djadarr Bay, as it had the benefit of keeping HLS safe from solvents but also resulted in him being socially isolated. HLS had reportedly described the placement as "lonely and boring."[152] He was a teenage boy, with the same desire to spend time with his peers as any other teenage boy and it is understandable that his preference was to be in town rather than in a remote and quiet location like La Djadarr Bay.

125. Nevertheless, the priority of DCP was keeping him alive and safe, so the benefit of the isolation was considered to firmly outweigh the negative aspect.[153]

126. Still, it was acknowledged by DCP that it was important from a social perspective that HLS had adults around him to supervise him, as he was deemed to be very vulnerable.[154] The carers at La Djadarr Bay were believed to fulfil that description, having a family connection to HLS who could

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[149] T 198.
[150] T 114, 225, 228.
[151] T 118.
[152] Exhibit 2, Tab 2 p. 6.
[153] T 229 – 231.
[154] T 228.

connect him with his culture and for whom all the feedback was that they "were wonderful people."[155]

127. While he was staying at La Djaddar Bay HLS generally appeared to be in good physical health and he was encouraged to engage in regular exercise by his carers.[156] A safety plan had been prepared for his carers if he started sniffing solvents, which included advice on who to notify and what to do to keep him safe until he sobered up.[157] They were also vigilant about trying to limit his access to solvents.[158]

128. After HLS absconded in Broome the first time, he had to be taken to hospital on 28 February 2013 as he was found highly intoxicated on inhalants. He later absconded from the hospital.[159] This reinforces how his physical health was compromised by his sniffing, and supports the benefits of keeping him in a remote location.

Education

129. There was evidence during the inquest about HLS' schooling, prior to coming into care, and witnesses commented on some of the apparent limitations on what was provided in that regard. It was emphasised that HLS was educated in the Catholic school system, rather than the public school system, which meant that some of the supports described for managing children with FASD in government schools may or may not have been available to HLS.

130. To clarify this issue, after the inquest counsel assisting sought some information from Catholic Education WA. A letter was later provided by Dr Debra Sayce, the Acting Executive Director, in response.

131. Dr Sayce advised that there were systems in place for HLS to engage with his education at Sacred Heart School Beagle Bay and he was provided with an Individual Education Program and an individual education aide.[160]

132. Later, after HLS was taken into care, a Life Without Barriers Disability Support Worker was engaged to support HLS with his school program inside and outside of school. A meeting was held on 25 January 2012 to discuss how this would operate. In attendance were the Program Manager for Life Without Barriers and various representatives from DCP and Catholic Education WA. The plan was for HLS to be provided with a full school program, with the support of Life Without Barriers, including on and off campus activities.[161]

133. The service agreement stipulated that HLS was to attend Beagle Bay school three times per week and for two days of work experience near the school at a mechanical workshop and in an agricultural area.[162] However, while at La

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[155] T 230.
[156] Exhibit 2, Tab 6.
[157] Exhibit 2, Tab 7.
[158] T 63.
[159] Exhibit 1, Tab 17; Exhibit 2, Tab 8.
[160] Letter from Dr Sayce to Counsel Assisting, 18.12.2017.
[161] Letter from Dr Sayce to Counsel Assisting, 18.12.2017.
[162] Exhibit 2, Tab 2, p. 6.

Djadarr Bay HLS was not attending school regularly and Dr Sayce noted in her letter that the school recorded HLS' attendance throughout 2012 as low.[163]

134. A number of reasons were given for HLS' low attendance at school throughout that year. The primary reason was because there were concerns HLS was able to abscond and access solvents if he went to school in Beagle Bay.[164] There was an incident early on when HLS absconded from school and was gone for the whole afternoon. He was found the next day with his foster mother, and it was apparent he had been using solvents and had to be taken to the Beagle Bay Clinic for assessment. After this incident it was decided that the risk was too high for HLS to attend school without close supervision.[165]

135. It was hoped that this problem could be resolved by Life Without Barriers arranging for a person to attend school with HLS to provide 'one on one' support and to ensure that he did not wander away and access solvents. However, the person who was to perform this task, Mr and Mrs Cox's son-in-law, had not yet completed the required 'training to perform that role.[166] There were also a lot of difficulties with access, as during the rainy season the area could become inaccessible by road due to flooding and cyclones, and there were also issues with the reliability of the carers' cars.[167]

136. From his own experience with HLS, Mr Cox expressed the view that school would never be a place for HLS because he wouldn't sit still in one place and wasn't interested in school subjects. He observed that HLS loved being outside and playing his drums and guitar and working with Mr Cox, all of which he thought were better options for HLS in the circumstances.[168]

137. From the perspective of DCP staff, they were conscious that HLS should be educated but also were aware that he had absconded from Beagle Bay Primary School in the past in order to sniff solvents, so they were willing to try to find other education options.[169] Ms Dowling gave evidence that in the next phase of planning by DCP there would have been some focus on doing more educationally with HLS, although at every stage the priority remained keeping him alive. Hence educational opportunities played a secondary role in the choice of his placement.[170]

138. Efforts were made by the Department of Education and Sacred Heart Beagle Bay School to work with the Life Without Barriers carers to come up with an education service that could suit HLS' needs. Other options to attending school in Beagle Bay were discussed, including online learning and 'one to one' tutoring in La Djadarr Bay. Online learning was deemed unsuitable and while tutoring was considered, it was considered that it would not keep HLS

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[163] Letter from Dr Sayce to Counsel Assisting, 18.12.2017.
[164] T 244 – 245; Exhibit 2, Tab 2, p. 5.
[165] T 258.
[166] T 129.
[167] T 54 – 55; Exhibit 2, Tab 2, p. 5.
[168] T 69 – 70, 150.
[169] T 232.
[170] T 231 - 232.

positively engaged beyond the two to three days that could be offered.[171] His behaviour was only manageable when he was engaged in activities that prevented him from being bored.

139. In the absence of formal education there appears to have been an emphasis in both placements on cultural activities, recreational activities and opportunities to develop independent living skills. [172]

140. HLS had been asked during a visit by a Life Without Barriers Care Coordinator in January 2013 what he would like to do that year in terms of education. HLS had indicated he would rather do work experience or a TAFE course than go back to school and listed a number of particular interests, all of which involved him going to Broome.[173]

141. There were issues with engaging HLS in work experience as it was recognised that work in a mechanics workshop or agricultural work would expose him to solvents.[174] He did, however, apparently attend a 'hands on' welding course.[175] While at La Djadarr Bay HLS also did practical work with Laurie Cox, learning how to change tyres and make things with metalwork, such as small tomahawks and spears, which he showed some aptitude for and pride in.[176]

142. His musical ability was also nurtured with provision of a guitar and electric drums, and there was evidence at the inquest that HLS had even begun teaching Mrs Cox's grandchildren how to play the guitar,[177] which was a lovely opportunity to let his skills shine.

143. Nevertheless, the reality was that, at the age of 15 years, HLS could not read or write or do basic maths.

144. Mr Gregory Robson, Regional Executive Director for the Kimberley for the Department of Education, described a far better awareness of FASD in the Kimberley region today than in the past, which has allowed schools across the Kimberley to begin trying to tailor and modify services to meet the needs of children who exhibit that disorder.[178]

145. PATCHES Paediatrics, which I refer to in detail below, has clinics in Broome, Derby and Kununurra and the Department of Education school psychology service team is working closely with those clinics to develop an approach which provides teachers with a checklist of behaviours that may be a sign that a child has FASD. This can then be used to identify children who may benefit from assessment by PATCHES clinicians.[179] Also there is a FASD

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[171] Exhibit 2, Tab 2, p. 5.
[172] Exhibit 2, Tab 6.
[173] Exhibit 2, Tab 9.
[174] Exhibit 2, Tab 2, p. 5.
[175] Exhibit 2, Tab 6.
[176] T 53.
[177] T 231.
[178] T 134 – 135.
[179] T 136 - 137.

resource for teachers in the three education sectors: the Department of Education, the Catholic education sector and the independent schools.[180]

146. Mr Robson expressed the view that the schools in the Kimberley are very well resourced due to the student centred funding model, which helps to allow extra strategies to be implemented for students with FASD.[181] Mr Roberts stated that "our obligation is to try and make sure that every youngster leaves school with the capacity to read and write and to add up and take away. That's the very basic minimum," and he expressed the view that HLS' case showed that more should have been done to adjust the school environment and accommodate the things he enjoyed, such as playing music, to ensure that he stayed in school and obtained the basic skills necessary to function in life. I note that HLS attended a Catholic school, so no criticism can be made of the Department of Education, and the reality for Catholic Education WA was that there was only so much they could do when HLS was not attending school.[182]

147. In the end, DCP acknowledged that more could have been done to engage HLS in learning, but they were limited by his extremely challenging behaviours. Far more than the general problems caused by his FASD, it was HLS' chronic solvent abuse that caused the difficulty. Ms Dowling described HLS as the first case she had known of at DCP where he had come into care because of his own dangerous behaviour, rather than the behaviour of a caregiver.[183] Therefore, for good or for bad, his educational needs took a back seat to the need to keep him away from solvents.

Social Support

148. Similarly, HLS' desire for more social opportunities, and in particular an expressed desire to be in Broome, were also given less priority than his physical safety.[184] It was acknowledged by DCP that the relative isolation of the community from more populated areas posed challenges in providing HLS with opportunities to engage in peer related social activities and wider social interaction, but this was accepted as an unfortunate by-product of the need to keep him safe.[185]

149. In any event, the feedback received generally by DCP was mostly positive. HLS was reported by Life Without Barriers staff, who visited regularly, to be thriving in that setting.[186] HLS was said to have a generally good relationship with his carers at La Djadarr Bay and engaged in a lot of recreational activities he enjoyed, such as fishing, hunting, playing football and music. In that sense, La Djadarr Bay was considered to be a safe and supportive home environment for HLS.[187]

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[180] Exhibit 3.
[181] T 140 – 141.
[182] T 143 – 144.
[183] T 233.
[184] T 232.
[185] Exhibit 2, Tab 6.
[186] T 232.
[187] Exhibit 2, Tab 6.

150. Although HLS did not have a big network of peers, HLS did spend time with Mr and Mrs Cox's many grandchildren, and there was evidence he enjoyed playing with them.[188] Further, from December 2012 he also had WIC there, who was a similar age and also was believed to have FASD.

151. It was noted that attempts had been made during HLS' last placement to provide regular access to trips to Broome, on the recommendation of a mental health worker who was working with HLS and believed the lack of social interaction at the time was having a negative effect on his social and emotional wellbeing. The intention was for the trips to Broome to allow him to meet with friends and family and engage in community activities. However, he had taken the opportunity to abscond and sniff solvents and then refused to return to the placement.[189]

152. Mr Patching visited HLS at La Djadarr Bay prior to March 2013 and believed from what he saw and heard that HLS was happy there and receiving adequate care.[190] Nevertheless, he understood when HLS absconded on the last occasion that HLS was adamant he did not want to leave Broome. Mr Patching gave evidence that in his experience this was not uncommon as many of the children who are clients of Life Without Barriers want to be closer to Broome as they find it "pretty boring out in the middle of nowhere."[191]

153. It was believed the attraction of Broome for HLS was not only to "source a more readily available variety of inhalants but also for things like teenage excitement, risk taking, wanting to be with peers." While he was in Broome he would generally roam the streets with other peer group members "just generally having a good time."[192]

154. Ms Dowling spoke to HLS shortly before his death, during the child assessment interview after he had absconded to Broome. HLS made it clear that he didn't want to return to La Djadarr Bay. It was also clear that his reason was that he wanted to stay in Broome and be like other kids, even though he had begun to understand that he was different to other young men his age. Although HLS told Ms Dowling at this time that he would not continue to access solvents if he stayed in Broome, she could have little faith in his assertion, particularly as that same day he absconded again and was found using solvents. She knew he could not resist the temptation of solvent abuse if he remained in Broome, so despite HLS' expressed desire to not return to La Djadarr Bay, Ms Dowling genuinely believed it was necessary to keep him alive.[193]

155. Sadly, while HLS was associating with his peers, he was also gravely endangering his health with his sniffing behaviour, so ultimately it was felt by the DCP that his social isolation was the cost of keeping him safe.

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[188] T 53.
[189] Exhibit 2, Tab 6.
[190] T 93.
[191] T 95.
[192] T 108.
[193] T 236 - 237.

Cultural Support

156. La Djadarr Bay was considered to be 'on country' for HLS, in the same general area as where he was raised. He was placed with Aboriginal carers who were distant relatives and from the original community where he was raised. They helped him to maintain a strong sense of Aboriginal culture, including exposure to, and promotion of, language and appropriate cultural mores. He undertook activities such as spear fishing, crabbing and didgeridoo making.[194]

157. HLS was also permitted to have contact with his other extended family, although it was perhaps not as regular as desired given the remoteness of his location.[195] Nevertheless, evidence was given on behalf of DCP that if family had made the request to DCP financial assistance could have been provided for petrol, if that's what the family needed to get there, or a remote worker based in the Dampier Peninsula could have been asked to facilitate a family visit.[196]

158. There was some suggestion during the inquest that HLS' birth mother, who had sadly passed away by the time of the inquest, had been concerned about her limited access to HLS while he was at La Djadarr Bay. This did not come out of her statement, but appears to have been her instructions to lawyers from the ALS prior to her death.

159. Ms Dowling, as HLS' DCP Team Leader, gave evidence that she had had dealing with HLS' aunty/foster mother and extended family but had no recollection of HLS' birth family ever contacting DCP about arranging a visit, although she did recall HLS' birth mother having some involvement in his care plan.[197] Ms Dowling was also not aware of HLS ever requesting to contact his birth family while in care, although this would have been facilitated if he had done so.[198]

160. I note that by her own admission HLS saw his birth mother only irregularly over the course of his life, even before he went into care.[199] HLS' birth mother last saw him only weeks before his death, when she took him to Broome Police Station to talk to the police about stealing Mr Ishiguchi's car.[200] There was no evidence that at this stage she had expressed any interest in taking him into her care.

161. Mr Cox was asked whether HLS ever exhibited any sadness about not seeing his birth mother and his evidence was that the only person he ever spoke about was his aunty/foster mother. Mr Cox said they would have been happy for his birth family to visit HLS, but none of them ever did.[201]

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[194] Exhibit 2, Tab 6.
[195] Exhibit 2, Tab 6.
[196] T 247 - 248.
[197] T 248.
[198] T 258.
[199] Exhibit 2, Tab 10.
[200] Exhibit 2, Tab 10.
[201] T 79.

162. HLS' foster mother, on the other hand, was supportive of HLS being place at La Djadarr Bay and understood the risks to his health if he stayed close to town. HLS' most recent care plan had detailed clear ways in which HLS' contact with his foster mother would be supported.[202]

163. I am satisfied that in the context of balancing all of HLS' other needs, DCP did the best it could to ensure that HLS had engagement with his culture and family support. The tyranny of distance prevented regular family contact, but this was necessary to keep HLS safe, and the family members who had been most involved in his life understood this and were grateful to DCP for trying to find a safe and supportive environment where HLS could live.[203]

Training of Carers

164. DCP provided information about the increasing awareness within the Department of the need for integrated services for children with FASD and the risks associated with FASD, including that a person with FASD is more likely to develop other conditions including alcohol and drug addiction and mental illness.[204]

165. Kathryn Dowling, who was HLS' Team Leader at DCP, gave evidence that she had received some formal training on FASD, in the context of a general training course on brain development and trauma, but there was no specific training on FASD available back at the time she was managing HLS' care. Like most of the DCP team, she also stayed connected to the people involved in the Lililwan project, which was running at the time, and she had conversations about FASD with local medical practitioners, including Dr Levi who had been involved in HLS' care since he was born and Dr Bolton, the local paediatrician. It was from those sources that she gained most of her knowledge about how to identify HLS' possible impairments arising from his FASD and to come up with practical strategies for dealing with them.[205]

166. Since that time, Ms Dowling had seen an increase in the information available, through programs such as PATCHES, although no longer worked for DCP at the time of the inquest. However, at the time much of the knowledge about FASD was still emerging in the Kimberley.[206]

167. However, it does not appear that the Life Without Barriers carers for HLS had the benefit of similar information and training. The service agreement with DCP specified that training and support for carers was the responsibility of Life Without Barriers.[207]

168. Mr and Mrs Cox were given some limited advice about the management of those who abuse solvents and emergency contacts and procedures in the

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[202] Exhibit 2, Tab 2.5A.
[203] T 335.
[204] Exhibit 2, Tab 2, p. 7.
[205] T 222 - 223.
[206] T 223.
[207] Department of Communities' Closing Submissions dated 7.3.2018 [3] – [6].

event that he found solvents and used them, but that seems to have been the limit of their training in that regard.[208]

169. Mrs Cox gave evidence that she was unaware that HLS had FAS until he was already staying with them, and that the information first came from HLS himself.[209] Mrs Cox denied ever receiving any training or education on FAS or how having FAS might affect HLS.[210] Any skills she had in dealing with him came from her own experience as a grandmother of many, rather than formal training. From her own observation she was aware that he couldn't really read or write but also noted that he had skills in other areas, such as music.[211]

170. Mrs Cox also gave evidence that she was not told by any agency about HLS' problems with sniffing inhalants or solvents, but rather this information came from his family.[212] As a result of this information, they had developed a strategy of locking up sprays, petrol and any other substance that might be inhaled.[213] They were also vigilant about checking if they heard noises at night, and one night this had led Mrs Cox to discover HLS sniffing fuel from the lawnmower.[214]

171. Unlike his wife, Mr Cox gave evidence that he had some limited understanding of FAS and its effect on HLS, which came from having known HLS as a child in the community. He had also done mental health training through his job with the Department of Housing, which helped him to understand some of HLS' learning difficulties.[215] However, Mr Cox said he had not been given information about FASD from Life Without Barriers or DCP.[216]

172. As for dealing with his solvent abuse, Mr Cox gave evidence he had been advised not to scare or frighten HLS if he was found sniffing.[217] They also changed their lifestyle significantly to manage the risk, having to be vigilant about keeping watch over him. They tried to keep him occupied as much as possible, getting him to help with maintaining the yards and working in the shed when Mr Cox and Mr Ishiguchi were fixing cars.[218]

173. Mr Ishiguchi gave evidence the only training he received from Life Without Barriers was first aid training.[219] He was aware that HLS had FASD but was not given any information about how to manage his particular needs as a result of that diagnosis. He did, however, recall being told how to manage HLS' solvent abuse issue, by limited his access to petrol or spray cans.[220]

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[208] Exhibit 2, Tab 6.
[209] T 51.
[210] T 62.
[211] T 52.
[212] T 52.
[213] T 52 – 53.
[214] T 62.
[215] T 64 – 65.
[216]216 T 81.
[217] T 66.
[218] T 73 - 74.
[219] T 149.
[220] T 149.

174. Mr Andrew Geddes, the current DCP Executive Director for Country Services and Therapeutic Care, gave evidence at the inquest about the current training available on FASD for DCP staff and to an extent to Life Without Barriers staff, as a partner agency. Mr Geddes indicated that there is a FASD library available to staff and online learning has also been developing as a resource for information on FASD. As part of the online learning, Mr Geddes believes there is a module on care of complex children that can be accessed by carers.[221]

175. Mr Geddes accepted that the challenge is in providing the relevant information in a language that all carers can understand, that also matches the cultural context and environment that the young person is in.[222] Mr Geddes noted that some of DCP's best planning around FASD comes from getting the team of people involved in a child's care together, such as the carers, case worker and family, and arranging for a paediatrician to provide joint learning about FASD to the group. Each person can participate in learning how that young person needs to be parented and to understand how to provide the best learning opportunities for the child.[223]

176. As noted above, Life Without Barriers are also expected to provide their own training and support to carers under the service agreement.[224] Mr Grant Roberts, who was the Program Manager for Life Without Barriers at the time HLS was being provided with services, and is still with Life Without Barriers now, gave evidence that there was little formal training available in relation to FASD until recently. In the last two years Life Without Barriers has begun to provide formal training for all support staff in relation to dealing with children diagnosed with FASD. Mr Roberts described the training as adequate, in the context that a lot more information is emerging about FASD every day and what it means for the children who are diagnosed with it.[225]

177. Mr Roberts also gave evidence that training is now available for Life Without Barriers carers in terms of dealing with children with solvent abuse problems. DCP provide ongoing modules of training that are available to all carers and the training includes looking at the root causes of it as well as how to deal with somebody under the influence of such substances.[226] However, back in 2012/2013 such training was only available in Perth.[227]

178. No further information was provided by Life Without Barriers as to what training was available to HLS' carers at the time he was placed at La Djadarr Bay.

179. It was apparent during the inquest that the primary focus of everyone involved in the decision to place HLS at La Djadarr Bay was restricting his access to solvents and inhalants as his life was endangered every time he started sniffing. The evidence established that HLS' carers at Life Without Barriers had a good understanding of the risk sniffing presented to HLS'

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[221] T 272 – 273.
[222] T 279.
[223] T 273.
[224] T 273.
[225] T 106 – 107.
[226] T 107, 112.
[227] T 111.

health and they were vigilant about locking up the source and monitoring him to ensure he did not find a way to access them.

180. However, what came through at the inquest was that Mr and Mrs Cox and Mr Ishiguchi were not given training in how to manage other aspects of HLS' behavioural and developmental problems arising from his FASD. They had known him since he was a child, so they had an understanding that he had impaired cognitive functioning, but they were not given tools to help him to navigate his environment. Instead, they reverted to the child-rearing techniques they already knew, which the experts suggested might not have been suited to a child with severe FASD.

181. There was evidence at the inquest that children like HLS can benefit from techniques such as using visual cues, rather than verbal, and consistency in the messages given by carers. Also, a deeper understanding of FASD can help carers manage their expectations and avoid making assumptions that a child is simply being 'bad'. It is not clear that such training would have ultimately avoided the tragic consequences in this case, but anything that could have been done to foster a strong relationship between HLS and his carers would have benefitted him in the long term.

Abuse in care allegations

182. In some ways related to the issue of training of HLS' carers at La Djadarr Bay are some allegations made against Mr Cox and Mr Ishiguchi by HLS and WIC.

183. In April 2012, while HLS was still at the Plantation, he had alleged abuse by one of his carers in the form of being slapped, apparently in the context of not wanting to return to the Plantation. The allegation was denied and shortly afterwards HLS was moved to La Djadarr Bay.[228]

184. On 1 February 2013 WIC disclosed that he witnessed HLS being 'flogged' by Laurie Cox after he and HLS were found sniffing solvents. Child Assessment interviews were conducted with both WIC and HLS on 7 February 2013. HLS' disclosure was initially consistent with the account of WIC. He said he had had been hit on the head two or three times with the empty can he had been caught sniffing from. HLS described the hit as "a bit hard" but there was "no hurt and no blood." HLS was remorseful and felt ashamed about his sniffing behaviour; he said he had apologised to Laurie for sniffing and said he would quit. Department staff did not observe any bruising or open wounds on HLS.[229]

185. While WIC said he was scared at the time the event occurred that he might also be punished, he indicated he felt safe at the placement and identified Laurie Cox as a safe person and strong man. HLS expressed a similar view and said he also felt safe with David Ishiguchi, who was his main carer at that stage.[230]

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[228] Exhibit 2, Tab 4, pp. 3 – 4.
[229] Exhibit 2, Tab 4, p. 4 and Tab 5, pp. 59 – 60.
[230] Exhibit 1, Tab 17; Exhibit 2, Tab 4, p. 4.

186. It was decided after investigating that the Department's staff would work with Life Without Barriers and the carers and WIC and HLS to identify and implement different strategies to manage HLS' addiction to sniffing solvents. There was a suggestion that LWB staff should take up discussions with HLS' carers about their style of management techniques and how to discipline HLS.[231] This incident in some ways underscores the issue of training for HLS' carers, where a deeper understanding of FASD and the powerful attraction of solvents due to HLS' exposure to alcohol in the womb might have helped Mr Cox to understand HLS' difficulty regulating his behaviour. It was a positive step that training was to be provided, but it would have been beneficial if it was provided at an earlier stage.

187. On 26 February 2013 Ms Dowling advised the Acting District Director of another allegation, this time involving David Ishiguchi. Both WIC and HLS had alleged to a Life Without Barriers worker that David Ishiguchi had pointed a gun at them. The boys were interviewed separately by DCP staff, including Ms Dowling. The boys gave conflicting information regarding the events. It was concluded that the boys had concocted the story together to justify stealing David Ishiguchi's car, which they had used to abscond a few days earlier.[232]

188. Following an investigation it was recommended on 1 March 2013 that enquiries be made about any gun ownership by Mr Ishiguchi and further care assessments might be required, but this does not appear to have progressed at the time of HLS' death.[233] No other action was taken as the allegations were not considered to have been substantiated.

Documentation

189. An internal review conducted by the Department found significant gaps in completion of the required quarterly reports for HLS, in particular up until June 2011, although it was apparent that there had been communication between the Department and Life Without Barriers staff. However, six monthly progress reports were completed by Life Without Barriers staff and his file contained Residential Care Plans and Individual Care Plans.

190. A care plan meeting was scheduled by HLS' Department Case Manager on 14 March 2013 but HLS died that day.[234]

191. Mr Geddes was asked if he had concerns about the documentation relating to HLS and he indicated that, while he would like to see the care plan completed on a 12 monthly basis, he understood that there can be challenges to meeting that timeframe, particularly in the Kimberley where there are challenges due to geography, weather and continuity of staffing.[235] In the case of HLS, while there was no clear documented plan updated, there was ongoing communication between the agencies and an informal plan, so

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[231] Exhibit 1, Tab 21; Exhibit 2, Tab 4, p. 4 and Tab 5, p. 63.
[232] Exhibit 2, Tab 2, p. 6.
[233] Exhibit 2, Tab 2, p. 4.
[234] Exhibit 2, Tab 2, p. 8.
[235] T 276.

Mr Geddes was satisfied that the most important features of planning were done for HLS.[236]

Concluding comments on supervision, treatment and care

192. HLS came into care as his behavioural issues were escalating. He was becoming a teenager, even if his developmental age was somewhat younger, and the teenage years are a challenging time for most children. For HLS, the challenge was even greater as he had a chronic solvent abuse problem and functional and behavioural problems arising from FASD.

193. From that perspective, DCP and Life Without Barriers were faced with a very difficult task to find him a safe and fulfilling environment in which to live. He had been placed in an ideal environment at the Plantation, but there had still been a breakdown in the placement after a relatively short period when HLS absconded.

194. The undesirable option of sending HLS to Perth had been avoided a second time by the willingness of Mr and Mrs Cox, family to HLS, agreeing to take HLS to La Djadarr Bay. Again, the placement met many of the criteria for an ideal placement. However, as evidenced by the tragic later events, ultimately the placement did not manage to keep HLS contented and safe.

195. However, the evidence supports the conclusion HLS made an impulsive choice that day to walk out into the mangroves, a decision that could not have been easily predicted.

196. Based on the information available I am satisfied that HLS' supervision, treatment and care was appropriate and of a reasonable standard. I agree with the observation of Mr Geddes that it was better for HLS to be kept on his country and in his community than sent to Perth, far away from his home, even if it meant that in Perth he would get care from people with specialist training in FASD and behavioural management. The environment HLS was placed in at La Djadarr Bay was familiar, caring and culturally appropriate, all of which was vitally important. However, I find more could have been done to educate his carers about FASD so that they could learn ways to manage HLS' behaviour and help him to succeed.

197. It is apparent that there is a lot more information available now in the Kimberley about FASD, as I discuss below. I am satisfied that the various agencies involved in HLS' care have learnt from these sad events and are open to learning more about FASD and implementing strategies to provide the best outcomes for children diagnosed with FASD in their community.

FASD – MOVING FORWARD

198. A focus on prevention, early diagnosis and intervention for FASD is gaining momentum in regional and remote Western Australia. Prevention is

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[236] T 277.

obviously the key. If consumption of alcohol during pregnancy is ceased, then there won't be children born with FASD.[237] However, the reality is that there are already many children and adults in Australia living with FASD and, sadly, more will be born in the future. Accordingly in addition to prevention, robust strategies for diagnosis and management are vitally important.

199. I heard evidence from two experts in the field of diagnosis and management of children with FASD in Western Australia, Dr Raewyn Mutch and Dr James Fitzpatrick. Both are specialist paediatricians who, amongst other things, have been involved in significant FASD research projects through the Telethon Kids Institute, such as the Lililwan Project in the Fitzroy Valley.[238]

200. Dr Mutch was one of the original clinicians involved with developing the FASD diagnostic tool for Australia.[239] In Dr Mutch's experience, paediatricians in Australia today are more aware of the need to look for, and diagnose, FASD, but in her view it is still not enough and there is a lot more to do.[240]

201. Dr Fitzpatrick, who continues to do a lot of work in the far north of this State, indicated that there is a broader awareness throughout the Kimberley of FASD and a much more widespread acceptance that FASD is an important driver of disadvantage and needs to be addressed. Dr Fitzpatrick believes that in the next two to three years the Kimberley will be much closer to achieving decent coverage of FASD diagnostic and therapy service provision.[241] Nevertheless, Dr Fitzpatrick's expectation for what should be provided is still "a lot higher than what is happening on the ground."[242]

202. One of the difficulties with treating the effects of FASD is that it is a spectrum and every person who is diagnosed will be affected in a different way. Some features, such as speech and language difficulties, are very common, but there may be many other effects, including hearing loss, visual difficulties, executive function difficulties, adaptive skill problems as well as many others. The severity of the effects will also vary from person to person. Accordingly, diagnosis requires a detailed individualised assessment of the person to identify the effects of prenatal alcohol exposure on them as an individual and from understanding those, specific treatments can then be identified that are suited to that person.[243]

203. Dr Mutch described the process as "requiring routine, close, repeated follow-up and review of their developmental achievements across the course of their lifespan and prospective work to try and prevent the complications that they are at risk of acquiring."[244]

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[237] T !78.
[238] T 174 – 175; Exhibit 5.
[239] T 174.
[240] T 181 – 182.
[241] T 312 – 313.
[242] T 315.
[243] T 182 – 183.
[244] T 192.

204. There is currently no specific FASD diagnosis clinic in WA within the public health system. Much of the current diagnostic work is done by two private organisations with which Dr Mutch and Dr Fitzpatrick are associated, FASD Care and PATCHES Paediatrics respectively. PATCHES is active in the Kimberley, so it is more relevant to the circumstances of this inquest.

205. Dr Fitzpatrick explained that assessment and diagnostic capacity for FASD in the Kimberley has improved over time. Paediatric services in the State Health Services have increased as part of this positive trend, but given the very high level of developmental problems in children in the Kimberley, the State services do not have capacity to provide all the required services to those children any time soon. Instead, other services such as PATCHES Paediatrics work with the WA local health services and other agencies, such as the Aboriginal Medical Service, to try and coordinate diagnostic clinics. These clinics, which are staffed by multidisciplinary teams, go to places like Broome, Derby, the Fitzroy Valley and Kununurra to provide assessments for FASD, autism and other related conditions.[245]

206. The assessments do not occur as part of a general screening process for all children, but rather the children are usually referred by an agency, which can be a court, a school or a child health nurse or medical service.[246] Dr Fitzpatrick did not suggest that there should be general screening for FASD amongst all children and, rather, agreed that targeted screening is appropriate. He suggested the best approach would be for screening to occur in pregnancy, which would identify children considered at risk, as well as by identifying other high-risk populations, such as children who come into care.

207. Submissions provided on behalf of WACHS indicate that within WACHS areas universal screening of, and support for, pregnant women for alcohol use are in already in place and are intended to continue. This is consistent with the first part of Dr Fitzpatrick's recommendation.[247]

208. Dr Fitzpatrick also recommended that for a newborn, development screening and behavioural screening could then be done once the child is over 12 months of age. WACHS has indicated developmental screening is currently undertaken for children aged 6 to 48 months by community children health nurses employed by WACHS or Aboriginal Medical Services, depending on the region.[248] WACHS has also submitted that it would be appropriate for all children identified as at risk of neurodevelopmental impairment on the basis of antenatal exposure to alcohol or early life trauma, identified from the pregnancy screening, be assessed by a paediatrician for developmental and behavioural impairments at one year of age and again in the year prior to school entry.[249] I consider this to be an appropriate course and, in line with the submission of WACHS, I make the following recommendation.

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[245] T 305.
[246] T 306 - 307.
[247] WACHS' Submissions dated 22 March 2018 [22].
[248] WACHS' Submissions dated 22 March 2018 [19] – [20].
[249] WACHS' Submissions dated 22 March 2018 [22].

RECOMMENDATION

I recommend that the WACHS continues to provide universal screening of, and support for, pregnant women for alcohol use and all children identified through that screening as being at risk of neurodevelopmental impairment on the basis of antenatal exposure to alcohol and/or early life trauma be assessed by a paediatrician for developmental and behavioural impairments at age 12 months and in the year prior to school entry.

209. For children coming into care, Dr Fitzpatrick suggested there should be a screening process on entry into care, irrespective of any screening done previously, as it is an opportunity to examine the child in the moment they are coming into care, so any developmental or behavioural problems that might compromise care placement can be immediately identified and resourced appropriately.[250]

210. Dr Fitzpatrick suggested such screening could be done within DCP by a psychologist or social worker who would implement child development screening tools. Only following screening would there potentially be a need to get specialist agencies involved, preferably when a group of children had been identified so that diagnosis can be done in a cost effective and efficient manner.[251] This suggestion would require some limited additional training for existing DCP staff, but Dr Fitzpatrick suggested for professional staff it would likely only require a few days training period for behavioural scales, although more might be required for development scales, but once trained it would enable the Department to have a standardised way of approaching the issue.[252]

211. In submissions from DCP it was indicated that the Department does not support universal screening for FASD of all children entering into care across Western Australia. However, DCP supports a more targeted approach to the provision of services and support for children taken into care, with preliminary assessments and screening of children undertaken by DCP district psychologists and referrals for comprehensive IQ and functional capacity assessments where and when required. This appears to be somewhat consistent with Dr Fitzpatrick's recommendation. However, in my view it would be preferable, at least in the Kimberley where FASD is known to be prevalent, for the staff conducting the screening to utilise the sort of screening tools suggested by Dr Fitzpatrick. I note that Mr Geddes indicated during his evidence he was open to this course, and I would hope that more is done by the Department to pursue such a simple and practical course by consulting with Dr Fitzpatrick to see if his suggestions can be implemented.

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[250] T 308.
[251] T 308 309.
[252] T 309.

212. As for practical steps for helping DCP staff in a broader way, Dr Fitzpatrick suggested that official workshops could be run by DCP once or twice a year with carers so that they could all learn about FASD and early life trauma; what it looks like and strategies for support.[253] Dr Fitzpatrick believes such workshops are important for carers as it can give them a deeper understanding that FASD is a brain based disorder, rather than simply a child who can't behave well. Greater knowledge will help them to extend compassion to the person, as well as equipping them with a set of tools and strategies to use to help them manage the child's behaviour.[254]

213. Dr Fitzpatrick's evidence was that such training is still emerging in the Kimberley. PATCHES Paediatrics has developed a carer support program specifically related to FASD early life trauma, which has modules on FASD and how it affects behaviour and cognition. It is currently being delivered by their staff based in the Kimberley. He also referred to a group in the Fitzroy Valley who are working on some trauma based therapy, and school based programs.[255]

214. All of these are positive steps, but Dr Fitzpatrick also emphasised that there is a need for more funding to enable adequate service provision in the regions' many remote communities. Dr Fitzpatrick noted that some of this funding may come from NDIS funding, where children are diagnosed as having severe impairments that qualify for disability services.[256]

215. There was discussion about the possibility of inclusion of FASD in the National Disability Insurance Scheme with a number of witnesses during the inquest. Dr Mutch and Dr Fitzpatrick both expressed an opinion about the viability and consequences of such an inclusion.

216. Dr Mutch's opinion was that inclusion of FASD in the National Disability Scheme would be a fantastic outcome because currently many of the young children with FASD sit around borderline cognition levels, so they are not recognised as having an intellectual disability and hence are not entitled under normal circumstances to school aid, but because of the way their brain works they struggle to learn. If FASD was recognised as a disability in its own right, then they would be entitled to wraparound services, irrespective of their IQ, which would mean their specific needs could be met. This would mean access not only to allied health care but also psychiatrists, psychologists and the like.[257]

217. Mr Roberts from Life Without Barriers also raised the issue, noting that without FASD being considered a disability, it causes difficulties, as "without the Disability Services Commission providing a launch base"[258] for funds, "it's very difficult in the Kimberley to …. get any type of support."[259]

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[253] T 309 – 310.
[254] T 310 – 311.
[255] T 312.
[256] T 312.
[257] T 194.
[258] T 122.
[259] T 122.

218. Dr Fitzpatrick was more cautious about suggesting that FASD should automatically trigger eligibility under the NDIS. His evidence was,[260]

> If the question was put to me, "Should every person diagnosed with FASD meet eligibility criteria for the NDIS?", I would say probably not.

219. Dr Fitzpatrick explained his response on the basis that he still believes there is a need to demonstrate significant functional impairment, severe enough to constitute a disability.[261] Such was the case with HLS, who was found after assessment to have a disability qualifying him for funding under the former Disability Services Commission.

220. Nevertheless, Dr Fitzpatrick did acknowledge that the NDIS would benefit from more training of their workforce of assessors in FASD so that FASD is better understood and not so easily dismissed.[262]

221. In that sense, Dr Fitzpatrick is advocating for a "sensible middle ground,"[263] where more is done by the clinicians to demonstrate the functional impairments of the individual child in order to trigger eligibility, but with a greater effort on the part of those involved in the WA NDIS to understand the implications of a FASD diagnosis and the likelihood that a person with FASD will require supports.

222. I discussed with Dr Fitzpatrick whether a more practical option might be for a diagnosis of FASD to trigger eligibility, in the same manner as a diagnosis of autism, in the sense that both are spectrum disorders and the level of support required by NDIS can be determined by identifying where the individual then fits on the spectrum. Dr Fitzpatrick agreed that this would be a simpler option for clinicians, who currently have to spend a lot of time ensuring that they write their reports in the same language as the NDIS eligibility coordinators. However, he understood that there might well be resistance from the NDIS as it will potentially strain resources.[264]

223. To a large extent, the discussion is really hypothetical from my point of view, as in the case of HLS, his functional impairment was so severe that he was found to have a disability that qualified for disability services support. Therefore, he did not face the difficulties of other children with FASD, whose impairments are less severe and hence do not qualify in their own right.

224. Given HLS did receive disability services support, and given the differing opinions of the two experts as to the benefits of a FASD diagnosis being an automatic trigger under NDIS, I do not propose to make a recommendation in this regard.

225. However, I do make the comment that, from my layman's point of view, it is difficult to understand why there is a distinction between a diagnosis of autism or FASD, with the former qualifying automatically for funding and

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[260] T 316.
[261] T 316.
[262] T 316 – 317.
[263] T 317.
[264] T 316 – 318.

the latter not. Both are spectrum disorders and both have varying effects on behaviour and development. I can see no practical reason why a diagnosis of FASD, now that it is a formal diagnosis, should not qualify as a disability, [265]enabling an assessment to then be made as to the practical level of support that the particular individual requires as a result of that diagnosis. For some children, like HLS, the effects of the disorder may be very severe and a high level of support will be required. For others, it may be as simple as some early speech therapy and occupational therapy, to prevent long term problems developing.

226. Moving back to service provision generally for children with FASD in the Kimberley, Dr Mutch made the statement that "[r]emoteness is not an excuse for limited service provision."[266] In saying that, Dr Mutch acknowledged that there are costs involved in providing the types of services necessary to improve the experience of children with FASD in remote areas, where many such children are based. However, Dr Mutch pointed to the considerable financial costs of incarcerating a person, which her recent experience screening youth at Banksia Hill Detention Centre shows is a common outcome for young people with FASD who do not receive early intervention. Therefore, there are long-term financial benefits to the community that can outweigh the early costs of such service provision. That is without mentioning the emotional benefits to the community that flow from reduced crime and youth incarceration.[267]

227. Mr Geddes accepted, on behalf of DCP, that remoteness is not an excuse for not providing services, but he did note observe that with "the specialised nature of providing care to a traumatised young person that may have further complex needs through a diagnosis of fetal alcohol spectrum disorder, it's not often an issue of money, but an issue of actually having the …trained personnel to be able to provide such a service around the clock for 24 hours." It is for that reason that these wraparound services tend to be set up in Perth, where there is access to a broader level of staffing that can be drawn upon. Replicating such a service in a remote location is a lot more difficult from a staffing point of view.[268]

228. It was for that reason that Mr Geddes, who had not been involved in HLS' care, expressed his opinion that he was heartened to see that an option had been found that allowed HLS to remain in the Kimberley, on his country, and still receive one-on-one care, as in his experience usually in cases where a child has complex needs the child is required to relocate to the metropolitan area, which did not always lead to the best outcome for the child.[269] In Mr Geddes' experience, it is often the "connection to culture and family, feeling like they belong, and a care arrangement that accepts them for who they are" that makes the most difference to a child in care.[270] In that sense, Mr Geddes gave evidence that "scaffolding local people to deliver" services is a great option."[271]

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[265] T 317.
[266] Exhibit 2, Tab 1B [2].
[267] T 203, 320.
[268] T 284 – 285.
[269] T 276.
[270] T 278.
[271] T 286.

229. In the case of HLS, Mr Geddes was “quite confident that the best decision was to make sure that he stayed in country, … with people that understood him,”[272] rather than necessarily with people who had a more clinical approach that addressed his FASD behaviours, based in Perth.[273]

230. In the case of HLS, it is clear that a lot of thought went into how his needs could be met once he went into DCP Care, even though in 2012/2013 there was less knowledge about FASD and less services available generally. Sadly in the case of HLS, even with early diagnosis and the best of intentions, he struggled to meet milestones and function in the general community.

231. In addition to a strong focus on prevention, Dr Mutch spoke of the need to prioritise early diagnosis and intervention of FASD, in order to give children born with FASD the best opportunity to “live a successful life.” This is surely a worthwhile objective and I am heartened by the evidence I have heard in this inquest that, at least in the Kimberley, there is a concerted effort by various agencies and individuals to achieve this. Their efforts should be funded generously by the Western Australian government, as every dollar spent now will be rewarded with better outcomes for these children in the future, which will benefit the community as a whole.

CONCLUSION

232. Due to the toxic effects of alcohol when he was in his mother’s womb, HLS was born with a disability that made it much harder for him to grow and learn and regulate his behaviour. Unlike many children with FASD of some sort, HLS’ syndrome was picked up early in his life. Nevertheless, the hurdles he faced were very difficult to overcome, even with specialist support.

233. HLS was fortunate to be born into a loving extended family. His aunty effectively became his adoptive mother when he was a baby, and throughout his life she was there to love and support him. However, his behaviour due to the effects of FASD, in particular his chronic solvent abuse, eventually meant that she couldn’t keep him safe. She put him into the care of DCP, in the hope that their greater resources might achieve what she could not.

234. Sadly, despite the efforts of DCP staff to place HLS in a safe environment where he was still connected to his country and people, he died suddenly on 13 March 2013. The events surrounding his death were tragic and difficult to predict. They are a reminder of the vulnerability of children with FASD.

S H Linton
Coroner
26 April 2018

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[272] T 278.
[273] T 278.