JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	MICHAEL ANDREW GLIDDON JENKIN
HEARD	**:**	9 JUNE 2020
DELIVERED	**:**	16 JULY 2020
FILE NO/S	**:**	CORC 524 of 2017
DECEASED	**:**	Child RM

Catchwords:

Nil

Legislation:

Children and Community Services Act 2004 (WA)

Counsel Appearing:

Ms K Heslop assisted the Coroner.

Ms R Hartley and Ms T Chee (State Solicitor's Office) appeared on behalf of the Department of Communities and the Western Australia Police Force.

Ms A Bartley and Ms E Langoulant (Aboriginal Legal Service of Western Australia (Inc.)) appeared on behalf of the mother, father and sister of Child RM.

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of a female child referred to as ***Child RM*** *with an inquest held at Perth Coroner's Court, Court 85, CLC Building, 501 Hay Street, Perth, on 8 June 2020 find that death occurred on 16 April 2017 at Sir Charles Gairdner Hospital from ligature compression of the neck (hanging) in the following circumstances:*

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SUPPRESSION ORDER

Suppression of the deceased's name from publication and any evidence likely to lead to the child's identification, including the names of any siblings also in care that may be identified during the proceedings. The deceased is to be referred to as "Child RM".

Order made by: RVC Fogliani, State Coroner (07.02.20)

INTRODUCTION

1. Child RM died on 16 April 2017, from ligature compression of the neck (hanging). She was 17-years of age. At the time of her death, Child RM was in the care of the Director General (DG) of the Department of Communities (the Department).[1]

2. Accordingly, immediately before her death, Child RM was a "*person held in care*" within the meaning of the *Coroners Act 1996* (WA) and her death was a "*reportable death*".[2] In such circumstances, an inquest is mandatory. Where, as here, the death is of a person held in care, I am required to comment on the quality of the supervision, treatment and care the person received whilst in that care.[3]

3. The documentary evidence at the inquest included reports prepared by the Western Australia Police Force (the Police)[4] and the Department[5] as well as Child RM's departmental case notes. Together, the Brief comprised three volumes.

4. The following witnesses gave oral evidence at the inquest:

a. First Class Constable Matthew Price (Officer Price);
b. Constable Wade Saunders (Officer Saunders);
c. Detective Inspector Brett Ranford (Officer Ranford);
d. Ms Helen McFarland, the Department's Director, Secure Care;
e. Dr Vicki Kueppers, forensic pathologist; and
f. Mr Andrew Geddes, the Department's Executive Director, South Metropolitan Community Service Delivery)

5. The inquest focused on the involvement of the Department in Child RM's life and the events that led up to her death, including her interaction with the Police on the night of 15 April 2017.

[1] Exhibit 1, Vol. 1, Tab 27, Report - Ms J Tang (19.02.19), p3
[2] Section 3, *Coroners Act 1996* (WA)
[3] Sections 22(1)(a) and 25(3), *Coroners Act 1996* (WA)
[4] Exhibit 1, Vol. 1, Tab 8, Report - Sen. Const. L Alexander, Coronial Investigation Squad
[5] Exhibit 1, Vol. 1, Tab 27, Report - Ms J Tang (19.02.19)

CHILD RM

Background[6]

6. Child RM was born on 9 May 1999 at King Edward Memorial Hospital.[7] She strongly identified with her Indigenous heritage, namely the people of the Yamatji and Noongar nations, through her mother's family. Child RM was described as a bright, intelligent, outspoken and witty young woman who had a caring nature.[8]

7. The relationship between Child RM's parents was characterised by family and domestic violence compounded by excessive alcohol use. Neither of Child RM's parents was able to provide her with long-term stable care. In the case of her father, the Department was concerned about the risk of Child RM being exposed to sexual harm. In the case of Child RM's mother, the Department's concerns related to excessive alcohol use and family and domestic violence. Although Child RM's mother did maintain periods of sobriety, she was unable to sustain these changes in the longer-term, and thereby keep her children safe.

Overview of medical conditions[9]

8. During her teenage years, Child RM's health was "*generally poor*" and she self-reported drinking up to two litres of alcohol per day. She had serious medical issues, including: anaemia, alcohol-related liver disease; enlarged veins in her oesophagus (oesophageal varices); an ovarian cyst, and abnormally heavy menstrual periods (menorrhagia).

9. Child RM was the subject of numerous physical and sexual assaults, including by much older adult males who she chose as intimate partners, despite that the fact that she was under the age of consent. In August 2012, Child RM was hit by a car whilst intoxicated. On admission to hospital, she tested positive to two sexually transmitted infections (STI) and a safety and well-being assessment (SWA) for sexual assault was substantiated.

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[6] Exhibit 1, Vol. 1, Tab 27, Report - Ms J Tang (19.02.19), pp1-2
[7] Exhibit 1, Vol. 1, Tab 1, P100- Report of Death
[8] ts 08.06.20 (McFarland), pp98-99 & p 124
[9] Exhibit 1, Vol. 1, Tab 27, Report - Ms J Tang (19.02.19), pp6-7

10. In 2013, when discussing separate alleged sexual assaults by an adult male and by a family member, Child RM disclosed she had attempted suicide. In that year, she also tested positive for STI on three occasions but despite encouragement, she declined counselling. She presented to hospital in October 2013 with abdominal pains after excessive alcohol consumption and again in November 2013, with suicidal ideation. She was admitted to hospital in July 2014 with heavy menstrual bleeding and in September 2014, she tested positive to a further STI.

11. In 2015, there were concerns for Child RM's mental health when she was seen by the Nyoongar Patrol Outreach Service with bandages on both wrists. At that time, she appeared to be in a relationship with a man in his late-thirties. In 2016, she was hospitalised twice following family violence incidents and on two further occasions with blood alcohol levels of 0.31% and 0.299% respectively.

12. During her four admissions to the Kath French Secure Care Centre (the Centre) staff did not observe any Child RM engage in any self-harm behaviour. On one occasion she said she would kill herself if her placement was extended, but she later withdrew the comment.[10]

Comment regarding medical treatment

13. Child RM's high risk behaviours and transient lifestyle made it difficult for the Department to effectively support her medical care and it was noted that she would have been eligible for a liver transplant, had she agreed to stop drinking alcohol. As Ms Tang's report to this Court put it, Child RM was:

> [A] highly traumatised young person due to her experience and chronic neglect and repeated incidents of physical, sexual and emotional abuse from an early age and throughout her time in the care of the [Department]. [Child RM's] experience of extreme trauma contributed to her behavioural issues including crime, sexual activity, transience, addiction, violence and poor decision-making skills.[11]

[10] ts 08.06.20 (McFarland), p78 & p98
[11] Exhibit 1, Vol. 1, Tab 27, Report - Ms J Tang (19.02.19), p9

THE DEPARTMENT'S INVOLVEMENT WITH CHILD RM

Overview

14. The Department's involvement with Child RM began in May 2000, when she was 12-months of age. At that time, it was suspected that she was being neglected, however on the basis that her parents agreed to engage with alcohol rehabilitation services, the case was closed. Child RM was placed into foster care briefly in 2001, but was returned to the care of her parents after they demonstrated positive lifestyle changes.[12]

15. During her short life, Child RM was the subject of 67 departmental interactions, 12 SWA and 19 alerts.[13] Between 2001 and 2007, the Department maintained periodic contact with Child RM's parents, one or other of whom variously cared for her and her siblings.[14]

16. The relationship between Child RM's parents was acrimonious and each of them made allegations of abuse against the other. In 2007, the Department was unable to substantiate an allegation that Child RM's father was sexually abusing her, and Child RM declined to make any disclosures.[15]

17. Further allegations of sexual harm involving Child RM were made against her father in 2008,[16] and on 8 September 2008, police removed Child RM and her siblings from their mother's care after she was seen assaulting one of Child RM's siblings. A protection order (until 18 years) was made on 4 March 2009 and Child RM and two of her siblings were taken into the care of the DG.[17,18]

18. During the time that Child RM was in the care of the DG, case workers continued to have safety concerns with respect to Child RM.

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[12] Exhibit 1, Vol. 1, Tab 27, Report - Ms J Tang (19.02.19), p2
[13] Exhibit 1, Vol. 1, Tab 27, Report - Ms J Tang (19.02.19), p2
[14] Exhibit 1, Vol. 1, Tab 27, Report - Ms J Tang (19.02.19), pp2-3
[15] Exhibit 1, Vol. 1, Tab 27, Report - Ms J Tang (19.02.19), pp2-3
[16] Exhibit 1, Vol. 1, Tab 27, Report - Ms J Tang (19.02.19), p3
[17] Exhibit 1, Vol. 1, Tab 27, Report - Ms J Tang (19.02.19), p3
[18] See also: section 37, *Children and Community Services Act 2004* (WA)

19. Caseworkers considered that the trauma and adverse childhood events that Child RM had been exposed to (including parental substance use, neglect and physical and sexual abuse) had contributed to her making poor decisions which placed her at risk of further abuse from her family and others.[19]

20. In December 2011, when Child RM was 12-years of age, she was the subject of an investigation into allegations she had been sexually assaulted in 2011 by an adult male. In 2012, three SWA were initiated in relation to sexual, physical and emotional harm respectively. The allegations relating to sexual harm (historical sexual abuse) and physical harm were substantiated. Child RM, who by now 13 years of age, was regularly absconding from her foster placements and from school, and was "self-selecting" her living arrangements. On many occasions, her caseworkers were unable to locate her.[20]

21. On 13 March 2013, Child RM disclosed a suicide attempt and also that she had been sexually assaulted by an adult male. She also disclosed a sexual assault by a family member when she was seven years of age, but she declined to make a statement to police. The Department received a further report of sexual assault on Child RM by another family member from the Sexual Assault Resource Centre on 26 May 2013. The matter was not pursued because Child RM declined to provide any detail about the incident.[21]

Placements[22]

22. Child RM had a total of 57 Out of Home Care placements of various kinds. Despite placements with general and family carers, residential care and with non-government services, Child RM's challenging behaviours meant that these placements invariably broke down. Her behaviours included: absconding, truancy, alcohol consumption, self-harm and sexual activity.[23]

[19] Exhibit 1, Vol. 1, Tab 27, Report - Ms J Tang (19.02.19), p3
[20] Exhibit 1, Vol. 1, Tab 27, Report - Ms J Tang (19.02.19), pp3-4
[21] Exhibit 1, Vol. 1, Tab 27, Report - Ms J Tang (19.02.19), p4
[22] See also: ts 08.06.20 (Geddes), pp115-118
[23] Exhibit 1, Vol. 1, Tab 27, Report - Ms J Tang (19.02.19), p5

23. Child RM's most stable placement occurred between January 2009 and May 2011. Although a claim by Child RM and her siblings that the caregivers were yelling at them, calling them names and hitting them was not substantiated, the placement broke down. This was said to be due to Child RM's increasingly difficult behaviours and the caregivers' limited capacity to manage these behaviours.[24]

24. The risk-taking behaviours engaged in by Child RM was summarised in a departmental report in the following terms:

> [Child RM] has continually placed herself at high risk including a sexual relationship with a much older male (28 years old), sexually transmitted diseases, engaging in regular alcohol and cannabis abuse, being involved in violent clashes with girls her own age and women, poor physical health, being hit by a car when intoxicated, non-school attendance and disengagement with services. [Child RM] has been diagnosed with alcohol induced liver disease.[25]

25. After her foster placement broke down in May 2011, Child RM was placed with several general foster carers and then in a residential family group home before being placed with a family member. Unfortunately, that placement also broke down and Child RM was again placed in a residential care home in December 2011, from which she frequently absconded.[26]

26. Child RM lived a highly transient lifestyle and from approximately April 2012 until her death, the Department was mostly unaware of her whereabouts. Instead, the Department relied on reports from other agencies as to her welfare. Where possible, the Department provided crisis services and continued to offer Child RM alternative accommodation, but she refused to engage with services she was referred to and expressed a strong reference with living with members of her family, especially her mother, despite the Department's safety concerns.[27]

[24] Exhibit 1, Vol. 1, Tab 27, Report - Ms J Tang (19.02.19), p5
[25] Exhibit 1, Vol. 1, Tab 26, Report – Child death notification, p2
[26] Exhibit 1, Vol. 1, Tab 27, Report - Ms J Tang (19.02.19), p5
[27] Exhibit 1, Vol. 1, Tab 27, Report - Ms J Tang (19.02.19), p4

Comments on placement history

27. Although the Department tried numerous strategies to place Child RM into culturally appropriate and safe care, she repeatedly displayed a preference for living with her mother and sometimes her father. For different reasons, neither Child RM's mother nor her father were able to provide her with a consistently safe environment.[28]

28. The evidence establishes that Child RM was exposed to "*complex developmental trauma*" which appears to have resulted in her engaging in risk taking behaviour. This made the Department's task of establishing a stable placement for her even more problematic. The term "*complex developmental trauma*" refers to multiple, often chronic and prolonged traumatic events that occur during early childhood. These events most often occur within the child's "*caregiving network*" and include: exposure to: chaotic and violent environments, neglect, polysubstance use, family and domestic violence and sexual harm.[29]

29. As Dr Kelly Thompson, (senior clinical psychologist at the Centre), noted in her 2018 Churchill Fellowship Report entitled: *Children at Risk: Examining care frameworks, stay duration and transition planning for children requiring secure care*, (the Report):

> When early life experiences teach children that the world is a dangerous place, and that people can be scary, harmful and absent, these children learn a set of strategies to cope with the overwhelming feelings; often strategies that are unsafe and counterproductive. Their brain becomes wired to identify danger and react in ways to keep them safe; for some children this means constantly being switched on to 'survival mode', limiting use of the higher order brain structures.[30]

30. It was well known that Child RM identified strongly with her mother and had limited interest in placements that did not include her mother. It was also well known that Child RM's mother was unable to provide her with a consistently safe and nurturing environment.[31,32]

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[28] See: Exhibit 1, Vol. 2, Tab 8, KFSCC case notes (18.09.14)
[29] Exhibit 2, Dr K Thompson - Report, Churchill Fellow 2018, Children at Risk, p21
[30] Exhibit 2, Dr K Thompson - Report, Churchill Fellow 2018, Children at Risk, p21
[31] Exhibit 1, Vol. 1, Tab 27, Report - Ms J Tang (19.02.19), p6
[32] ts 08.06.20 (Geddes), pp121-122 and 125

31. Given this complicated picture, one option available to the Department would have been to have worked closely with Child RM's mother in order to build and strengthen her capacity to adequately care for Child RM and protect her from harm. In this regard, Mr Geddes pointed to several "*missed opportunities*". One of these occurred in early 2012, at a time when Child RM's mother had ceased using alcohol, had started counselling and was securing safe accommodation. With the benefit of hindsight, Mr Geddes acknowledged that the Department should have done more to support Child RM's mother to sustain and strengthen the positive lifestyle changes she was making.[33,34]

32. Similarly, with the benefit of hindsight, Mr Geddes also queried whether the Department had done enough to regularly engage with Child RM and develop a deep rapport with her. Mr Geddes also noted that although the Department is committed to *"cultural input"* into every child placement decision, it hadn't "*nailed*" this concept yet. In Child RM's case, the evidence did not clearly establish that placement decisions were consistently guided by these principles. However, Mr Geddes said that the Department was working hard to create better culturally and spiritually appropriate responses for young people like Child RM.[35]

33. Mr Geddes noted that since 2012, the Department has placed far more emphasis on family support and that the introduction of the Intensive Family Support Service was in response to the fact that: "*not enough was being done in that space*".[36]

34. Had the Department provided Intensive Family Support Services to Child RM's mother and had she actively engaged with those services, it is possible that Child RM might have been able to remain with her mother in a safe, supported environment. Setting to one side the many complexities inherent in providing that level of support and in obtaining that level of engagement, it is at least possible that Child RM's life may have had a different trajectory had these things occurred.

[33] Exhibit 1, Vol. 1, Tab 36, Report - Ms L Hale (04.06.20), p5
[34] ts 08.06.20 (Geddes), pp122-123
[35] ts 08.06.20 (Geddes), pp131-132
[36] ts 08.06.20 (Geddes), p123

KATH FRENCH SECURE CARE CENTRE

Background

35. Child RM had four separate placements at the Kath French Secure Care Centre (the Centre), located in a bushland setting in Stoneville about 40 km north-east of Perth. The Centre has been operating in its current form since 2011 and provides "*secure care*" to a maximum of six children from across the State, who are generally 12 to 17 years of age.[37,38]

36. Secure care may be understood to mean:

> [A]n out-of-home-care-service, whereby children are placed involuntarily in a locked, or closed centre in order to provide them with safety and reduce the risk of harm to self or others.[39]

37. The Centre operates as a therapeutic, trauma-informed centre, the aim of which is to provide a safe and nurturing environment in which children can stabilise.[40] The "*sanctuary model*"[41] has been adopted at the Centre and provides a framework for changing organisational culture and providing trauma-informed care, that:

> [A]ddresses the ways in which trauma, adversity and chronic stress influence individual behaviour as well as recognises the ways in which whole organisations can be influenced by trauma, adversity and chronic stress.[42,43]

38. The relevant departmental policy on children entering secure care states that secure care is a "*time limited circuit breaker to stabilise the child's behaviours*" which is achieved by:

> [A] therapeutic model of care that is individually tailored to the child's needs, culturally responsive and takes account of their views.[44]

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[37] Exhibit 2, Dr K Thompson - Report, Churchill Fellow 2018, Children at Risk, p16
[38] Exhibit 1, Vol. 1, Tab 32, Policy on children entering secure care, p2
[39] Exhibit 2, Dr K Thompson - Report, Churchill Fellow 2018, Children at Risk, p16
[40] Exhibit 2, Dr K Thompson - Report, Churchill Fellow 2018, Children at Risk, p17
[41] See: Exhibit 1, Vol. 1, Tab 33, Therapeutic Care Services - Sanctuary Framework (2016)
[42] Exhibit 2, Dr K Thompson - Report, Churchill Fellow 2018, Children at Risk, p29
[43] See also: Exhibit 1, Vol. 1, Tab 34, Evaluation of the KFSCC, Final Report, (19.02.19), pp46-48
[44] Exhibit 1, Vol. 1, Tab 32, Policy on children entering secure care, p1

39. Providing a safe space is a key aim of the Centre, Ms McFarland (Director, Secure Care) observed in the following terms:

> So it's about building safety and helping…(the children)…understand that they are [safe] because the majority of them have been hurt by the adults in their life that should care for them, it's also our responsibility to help them understand…there are people that they can trust and build relationships with…that's how they start to heal.[45]

40. The concept of secure care for children is enshrined in the *Children and Community Services Act 2004* WA (the CCSA). Amongst other things, the provisions in the relevant part of the CCSA deal with the establishment of secure facilities, the basis on which a child may be admitted to secure care and for how long, and the requirements for care plans for children admitted to secure care.[46]

41. The fact that secure care is a placement of "*last resort*",[47] is reinforced by section 88C(2) of the CCSA, which provides that the DG may not place a child into secure care unless there is an immediate and substantial risk of the child causing harm to themselves or another person, and there are no suitable alternatives.[48] The rationale for placement at the Centre being a last resort, was explained by Dr Thompson in the Report in these terms:

> Due to the restrictive nature of this service, and the inherent deprivation of liberty for the child, this is often understood to be a 'last resort' option and one that is used only under exceptional circumstances whereby there are no suitable alternatives for providing a safe environment for the child.[49]

42. Referrals to the Centre are only accepted from departmental caseworkers. The child's caseworker is required to make a formal referral setting out the child's history and perceived risks. If the referral is accepted, the child is apprehended and brought to the Centre.[50,51,52]

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[45] ts 08.06.20 (McFarland), p70
[46] Part 4, Division 5, Subdivision 3A, *Children and Community Services Act 2004* (WA)
[47] ts 08.06.20 (McFarland), p103
[48] Section 88C(2), *Children and Community Services Act 2004* (WA)
[49] Exhibit 2, Dr K Thompson - Report, Churchill Fellow 2018, Children at Risk, p16
[50] ts 08.06.20 (McFarland), p71
[51] See also: Exhibit 1, Vol. 1, Tab 36-1, KFSCC - Tip sheet: planning and general information
[52] See for example: Exhibit 1, Vol. 3, Tab 1, KFSCC Secure care referral assessment form (15.12.16)

43. Within two working days of the child's arrival at the Centre (and usually sooner), the first of several planning meetings is held. The purpose of the initial planning meeting is to establish the goals for the admission and to plan for the child's future care. The child is involved in these planning meetings, either by attending in person, or by being briefed later and given the chance to ask questions and provide feedback.[53,54,55]

44. During the child's admission, an interim planning meeting is conducted to check on progress and towards the end of a child's placement, a final meeting is held to confirm the arrangements for the child's care once they leave the Centre.[56]

45. Presently, a child may be admitted to secure care at the Centre for a maximum of 21 days, which may be extended for a further 21 days in exceptional circumstances. Although, I accept that depriving a child of their liberty is a grave step that should only be taken in extreme circumstances, I am concerned that the current legislative arrangements with respect to secure care are inflexible and may be counterproductive.[57,58]

46. On admission to the Centre, some children may be relieved to be in a secure space. However, for others the experience may evoke feelings of fear, shame, anger or resentment. In any case, regardless of how the child presents when first admitted, it takes time before the child's situation stabilises and they "*relax*" into the routine at the Centre.[59]

47. Obviously every child is different, but the process of stabilisation can take a week or more. During the next phase of the placement, staff can begin to address child's immediate care needs. However, the temporary nature of secure care placements means that often, just as staff are beginning to make progress with the child, the focus shifts to placement options for the child once he or she has been discharged from the Centre.[60]

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[53] ts 08.06.20 (McFarland), p71
[54] See also: Exhibit 1, Vol. 1, Tab 36.1, KFSCC - Tip sheet: planning and general information
[55] Section 88(I), *Children and Community Services Act 2004* WA
[56] Discussion with Ms McFarland in presence of counsel (12.06.20)
[57] Sections 88D, 133(2)(ca)(i) and 134A *Children and Community Services Act 2004* (WA)
[58] ts 08.06.20 (McFarland), p72
[59] ts 08.06.20 (McFarland), p72
[60] ts 08.06.20 (McFarland), p86

48. Even when a secure care placement is extended to the maximum 42 days, the "*one size fits all*" approach has been found wanting with respect to a number of severely traumatised children. I would include Child RM in that category. The limitations of short secure placements were identified by Dr Thompson in the Report:

> Currently, Secure Care serves to expose children to an opportunity for making safer choices without negative social influences. However, this intervention is only brief, and is not proving sufficient in addressing the underlying complex needs of these children nor in its current form does it appear to provide significant long-term outcomes. The existing research and anecdotal experiences of secure services suggest that current systems are not providing the treatment that is most effective.[61]

49. The Centre's operations were reviewed in 2019 by a private consultancy firm (the Review). That evaluation resulted in a 227-page report, one section of which dealt with the duration of stay in secure care for children with highly complex needs.[62] The Review noted that some staff at the Centre had identified the fact that even with a 21-day placement, the positive gains often made in the middle week are often overshadowed by the fact that in the third week, the child is having to prepare to leave the Centre: "*which often causes anxiety, uncertainty, stress and tends to absorb the child's focus*".[63]

50. One of the Centre's staff was quoted in the Review as saying:

> I believe Secure Care is effective but too focused on being time limited…I think it is often perhaps not long enough…and the length of time should have some level of discretion built in.[64]

51. For some children, readmission to secure care may be justifiable and therapeutic.[65] However, the fact that up to 50% of children in secure care are subsequently readmitted underscores the point that a "*one size fits all*" approach to severely traumatised children is often counterproductive.[66]

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[61] Exhibit 2, Dr K Thompson - Report, Churchill Fellow 2018, Children at Risk, p19
[62] Exhibit 1, Vol. 1, Tab 34, Evaluation of the KFSCC, Final Report, (19.02.19)
[63] Exhibit 1, Vol. 1, Tab 34, Evaluation of the KFSCC, Final Report, (19.02.19), p43
[64] Exhibit 1, Vol. 1, Tab 34, Evaluation of the KFSCC, Final Report, (19.02.19), p43
[65] ts 08.06.20 (McFarland), p104
[66] Exhibit 2, Dr K Thompson - Report, Churchill Fellow 2018, Children at Risk, p9

52. A brief prepared for the State Solicitor's Office by the Department (which was described as an early "*considered report*", but not the Department's final position)[67] stated:

> Given [Child RM] was admitted to secure care on four occasions, two of which were extended due to medical reasons, would reflect that [Child RM] was a child at ongoing risk of harm on her return to the community. [Child RM] would have benefited from remaining in secure care for an extended period of time where she could have received these essential therapeutic services prior to being transitioned back into the community. A provision of therapeutic services would not only have promoted [Child RM]'s safety and wellbeing, it would have likely provided a better opportunity for [Child RM] to sustain positive change and, therefore, make safer choices.[68]

53. Ms McFarland agreed that whilst Child RM would have benefitted from further intensive therapeutic support, that support needed to be provided by an alternative service. This was because the Centre was neither designed, nor appropriately set up to provide that level of support over an extended period.[69] I will address the issue of a service to support children transitioning from secure care to the community later in this finding.

54. With respect to the current maximum secure care placements, Ms McFarland said that in her professional opinion, the 21-day initial placement was "*quite short*" and that if it were longer, there would be less need for extensions to secure care placements.[70]

55. Ms McFarland's opinion was that the maximum initial secure care placement should be 28 days and she expressed the view that it would be reasonable for there to be the possibility of an extension of a further 28 days in special circumstances,[71] a position which Mr Geddes thought was "*compelling*".[72]

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[67] ts 08.06.20 (Geddes), p126 & ts 08.06.20 (McFarland) p84
[68] Exhibit 1, Vol. 1, Tab 28, Brief to State Solicitor's Office, Child RM, p11& ts 08.06.20 (McFarland) p84
[69] ts 08.06.20 (McFarland), pp84-85
[70] ts 08.06.20 (McFarland), p72
[71] ts 08.06.20 (McFarland), p83 and pp105-106
[72] ts 08.06.20 (Geddes), p128

56. I am aware that approaches to secure care vary around the world and that in other jurisdictions, maximum placements may be measured in months and sometimes even years. However, as Ms McFarland pointed out, there are a wide variety of approaches to secure care around the globe, and population and geographical factors play a role in dictating the size of these centres and the facilities they offer. For example, some centres in Scotland and Sweden offer gymnasiums, personal trainers and trades skills training.[73]

57. Further, unlike the situation in Western Australia, some overseas centres have strong links with justice services and so the philosophy of these centres is necessarily different. Some of the centres studied by Dr Thompson in the Report incorporate the transitional or step-down service that has been identified as missing in Western Australia.[74]

58. Regardless of what the maximum secure care placement should be, what is clear to me is that the currently available maximum stay of 42 days (21 days plus 21 days) is no longer appropriate and in many cases, impedes the ability of staff to help children begin to positively deal with the consequences of the trauma they have been exposed to. For that reason, it is my view that the Department should consider increasing the maximum secure care placement available under the CCSA.

59. A further critical issue, and one that was identified by the Review, is the current lack of a staged (or step-down) approach to services for children transitioning from secure care. Before I address this issue, I will outline Child RM's placements at the Centre and then make some observations about my visit to the Centre on 12 June 2020.

[73] ts 08.06.20 (McFarland), p83 and pp85-86
[74] ts 08.06.20 (McFarland), p86

Overview of Child RM's placements at the Centre

60. Child RM had the following four placements at the Centre:[75,76]

a. ***2012:*** 9 - 21 March (20 days)
Admitted aged 12-years, due to high risk and challenging behaviours. After discharge from the Centre, she remained at a placement arranged by the Department for two months before absconding and self-selecting a placement with her mother.

b. ***2012:*** 10 August - 20 September (42 days)
Admitted aged 13-years, after being struck by a car whilst intoxicated. After discharge from the Centre, she remained at a placement arranged by the Department for four weeks before absconding to live with an unendorsed person.

c. ***2014:*** 7 - 26 September (19 days)
Admitted aged 14-years, due to medical issues and because she was engaged in heavy alcohol use and unsafe sexual relationships. After discharge from the Centre, she remained at a placement arranged by the Department for two months before absconding and self-selecting a placement with an unendorsed relative.

d. ***2016 - 2017:*** 20 December 2016 - 30 January 2017 (41 days)
Admitted aged 16-years, due to numerous hospital admissions relating to excessive alcohol consumption. After discharge from the Centre, she remained at a placement arranged by the Department for a few days, before absconding and self-selecting a placement with her father.

Note: Child RM was also referred to the Centre in 2015, but she could not be located during the referral period.

61. As can be seen, Child RM's placements at the Centre generally related to concerns about her high risk and challenging behaviours, her medical condition (including her serious liver disease) and her excessive use of alcohol.

[75] Exhibit 1, Vol. 1, Tab 36, Report - Ms L Hale (04.06.20), pp3-12
[76] Exhibit 1, Vol. 1, Tab 28, Departmental Brief re Child RM (01.04.19), p7

62. The evidence establishes that Department made numerous attempts to link Child RM with services each time she left the Centre. However, these efforts were largely unsuccessful because Child RM rarely engaged with these services and instead, absconded to self-selected unapproved placements.[77] Despite this lack of engagement, there are examples of Child RM demonstrating insight into her situation.

63. For example, in September 2014, Child RM said that an older man (who was 26 years of age), should have "*known better*" when they got together as "*partners*" when she was only 11-years of age. Child RM also observed that her mother's alcohol use meant she was unable to provide Child RM with a safe environment, and that she wanted to leave "*living rough*" behind her and "*look to the future*".[78,79]

64. Child RM was admitted to the Centre for the last time in December 2016. She was very unwell during this admission and it was noted that she was at risk of liver failure. Her placement at the Centre was extended on 5 January 2017 so that her health issues could be further assessed and treated.[80] At that time, it was noted that her family were minimising concerns relating to her illness and that Child RM herself had limited insight into the seriousness of her liver disease.[81,82]

65. Initially, Child RM was visibly upset and angry at the extension of her placement, however her mood lifted over the following week and she began to express concerns about whether she would receive the support she needed and wanted once she left the Centre. During this placement, Centre staff made concerted efforts to link Child RM with specialist medical services and on 19 January 2017, during a gastroenterology review, Child RM was told that if she kept drinking she would die.[83,84]

[77] Exhibit 1, Vol. 1, Tab 36, Report - Ms L Hale (04.06.20), pp3-12
[78] Exhibit 1, Vol. 1, Tab 36, Report - Ms L Hale (04.06.20), p7
[79] Exhibit 1, Vol. 2, Tab 8, KFSCC case notes (12.09.14), (13.09.14) & (15.09.14)
[80] Exhibit 1, Vol. 3, Tab 14, Letter KFSCC to Child RM (05.01.17)
[81] Exhibit 1, Vol. 1, Tab 36, Report - Ms L Hale (04.06.20), pp8-9
[82] Exhibit 1, Vol. 3, Tab 24, KFSCC Discharge summary (30.01.17), p7
[83] Exhibit 1, Vol. 1, Tab 36, Report - Ms L Hale (04.06.20), pp10-11
[84] Exhibit 1, Vol. 3, Tab 20, Email Ms E Gillespie, Secure care officer, KFSCC (19.01.17)

66. Following this consultation, Child RM spoke positively about the future and of "*giving her liver a chance to heal*" and said that once she got a house and a job she would be "*right*". Whilst these sentiments would have been encouraging, staff at the Centre were no doubt cautious, given Child RM's limited insight and the catastrophic impact of the complex developmental trauma she had been exposed to.[85]

67. In order for Child RM to properly address the consequences of that trauma and thereby make a successful transition into the community, she clearly needed to be provided with an intensive and comprehensive range of services. Those services needed to address, in a holistic way, Child RM's medical, psychological, emotional, behavioural and cultural needs.

68. However, because of the unavailability of that kind of comprehensive service "package", what Child RM got was a referral to Indigo Junction, a not-for-profit organisation based in Midland that offers accommodation and support services to young people aged between 15 and 25 years.[86]

69. The programs offered by Indigo Junction included a program called Living Independently for the First Time (LIFT) which provides intensive support to young people leaving the Department's care who are at significant risk of homelessness. Indigo Junction also offered an alcohol and drug service and supported participants to access a range of services that addressed mental health, physical health and financial management issues.[87]

70. As praiseworthy as the services provided by Indigo Junction were, none of the departmental witnesses suggested that those services were designed to comprehensively address the complex, chronic and seemingly intractable issues that impacted on Child RM as a result of the complex developmental trauma she had been exposed to. It is also the case that Child RM was gravely ill during her last placement at the Centre, and her medical issues required urgent and intensive intervention.

[85] Exhibit 1, Vol.1, Tab 36, Report - Ms L Hale (04.06.20), p11
[86] Exhibit 1, Vol.1, Tab 36, Report - Ms L Hale (04.06.20), p11
[87] Exhibit 1, Vol.1, Tab 36, Report - Ms L Hale (04.06.20), p11

71. No doubt as a consequence of her complex developmental trauma, Child RM's inability to engage with services each time she was discharged from the Centre, hampered her ability to make long-term and effective lifestyle changes. Although Child RM briefly engaged with services at Indigo Junction, after a few days she absconded and went to live with her father. Although she said she was unable to afford the accommodation costs at Indigo Junction, Mr Geddes pointed out that these expenses were deducted from benefits Child RM was receiving and her stated reason appeared to be largely an excuse for not continuing to live there.[88] Indigo Junction staff alerted Child RM's caseworker to the fact that she had absconded, but given Child RM's age, it was felt that little could be done.[89]

Visit to the Centre

72. On 12 June 2020, I visited the Centre in the company of Ms Heslop, Ms Hartley and Ms Barter (the counsel who appeared at the inquest). I am very grateful to Ms McFarland and her team for providing me with a tour of the Centre and the opportunity to speak with key staff.[90]

73. During my visit, I was struck by two things. First, staff at the Centre are an eclectic mix of highly skilled professionals. They speak passionately about the challenges of working with highly traumatised children and they demonstrate an extraordinary dedication to their work. This is evidenced by the fact that many of them have worked at the Centre for a number of years.[91]

74. The second thing that struck me were the physical limitations of the building that houses the Centre. It is very clear that the structure was not purpose-built as a child focussed secure facility. This shows in the design of the building and way that the internal spaces tend to work against the Centre's therapeutic aims. For example, it is difficult and time-consuming to move children around within the Centre because there are very few thoroughfares.[92,93]

[88] ts 08.06.20 (Geddes), pp129-130
[89] Exhibit 1, Vol.1, Tab 8, Report - Snr. Const. L Alexander, Coronial Investigation Squad, p4
[90] Email from Ms Hartley to Ms Heslop (09.06.20)
[91] Discussion with Ms McFarland in presence of counsel (12.06.20)
[92] ts 08.06.20 (McFarland), p71
[93] See also: Exhibit 1, Vol.1, Tab 34, Evaluation of the KFSCC, Final Report, (19.02.19), pp90-94

75. As a result of the complex developmental trauma they have experienced, many of the children who come to the Centre display challenging behaviours, including self-harm. For that reason, bedrooms and common areas at the Centre are sparsely furnished and have features such as Velcro curtains to reduce risk.[94]

76. Despite these limitations, staff have worked diligently to make the Centre as homely as possible. Initiatives include brightly painted chalk-friendly walls in the bedrooms and the provision of weighted blankets and soft toys, which have been found to help reduce anxiety.

77. The Centre's daily program includes an array of innovative activities designed to educate children about keeping safe and making appropriate decisions.[95] However, despite these measures, the fact remains that the Centre is essentially a prison, and until recently, it lacked such basic facilities as an appropriately positioned video-conference / meeting room.[96]

78. Having visited the Centre and seen its physical limitations for myself, I agree with Ms McFarland's view that it would not be appropriate for the Centre to attempt to provide therapeutic services to traumatised children over an extended period. Similarly, I agree that the Centre would not be the appropriate location for a "step-down" transitional service of the type identified as required to support children leaving secure care.

The lack of options once a child is discharged from the Centre

79. The evidence makes it clear that the missing piece of the puzzle in terms of addressing the complex needs of traumatised children admitted to secure care, such as Child RM, is the lack of a comprehensive, intensive transitional service which offers treatment to those children when they are discharged from the Centre. The fact that Child RM was admitted to the Centre on four occasions and that by the time of her death she was in need of a liver transplant, demonstrates that issues related to her complex developmental trauma had not been adequately addressed.

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[94] ts 08.06.20 (McFarland), p71
[95] Exhibit 1, Vol.1, Tab 36.4, KFSCC Daily program guide and ts 08.06.20 (McFarland), p89
[96] Discussion with Ms McFarland in presence of counsel (12.06.20)

80. Although there are some services to which children leaving secure care can be referred to, the range of options is limited. This is partly because a number of the services offering support to children are unable to address the range of challenging behaviours that children leaving secure care often demonstrate. The range of services is especially limited with respect to older children like Child RM. When she was leaving secure care for the last time, the only available service she could be referred to was Indigo Junction.[97]

81. As discussed, the purpose of secure care is to provide a safe short-term space for traumatised children to allow them to "*stabilise*". In order for children leaving secure care to successfully transition back into the community, any positive improvements that have been possible during the period of secure care need to be maintained. However, there is also a need to treat the underlying issues relating to that child's lived experience of complex developmental trauma, including any acute and/or chronic mental health issues.[98,99]

82. The Review identified that:

> Many of the barriers to children transitioning from secure care appear to lie with the broader [Out of Home Care] system as it currently operates. These barriers include the lack of a dedicated child and adolescent mental health service for children in care, and an insufficient number of high needs placements – particularly in remote regions.[100]

83. The Review also highlighted the fact that effective transitioning from secure care:

> [R]elies upon the availability of suitable placements and accessible services for addressing the complex needs of the children exiting from secure care.[101]

[97] ts 08.06.20 (McFarland), p86 & p99
[98] Exhibit 1, Vol. 1, Tab 32, Policy on children entering secure care, p1
[99] Exhibit 1, Vol. 1, Tab 34, Evaluation of the KFSCC, Final Report, (19.02.19), pp56-68
[100] Exhibit 1, Vol. 1, Tab 34, Evaluation of the KFSCC, Final Report, (19.02.19), p67
[101] Exhibit 1, Vol. 1, Tab 34, Evaluation of the KFSCC, Final Report, (19.02.19), p68

84. The lack of appropriate placement options for children leaving secure care has already been referred to. However, this is only part of the problem. In addition to a range of specialised, supported accommodation placement options, there is a need for a range of support services (including specialised mental health services) to address the complex needs of these traumatised children.[102]

85. In order to maximise available resources, it is imperative that there is cooperation and collaboration between relevant Government agencies, including those focussed on: health, education and child and adolescent mental health services. A lack of agency cooperation was identified by a number of staff interviewed by the Review team as a major contributor to poor outcomes for children leaving secure care.[103]

86. A further major service gap is the current lack of a dedicated mental health service for children in care. As mentioned, the children who are admitted to secure care have typically experienced complex developmental trauma and need specialised mental health services to address the catastrophic effects of this trauma. The need for a specialised mental health service will obviously need to be addressed in any transitional service that caters to children leaving secure care.[104]

87. Several models for a transitional service were suggested by staff interviewed by the Review. What those approaches appear to have in common is a structured accommodation service supported by a range of targeted therapeutic services, including mental health services, in the context of strong inter-agency partnerships and collaborations.[105]

The proposed complex community care service

88. During his evidence, Mr Geddes said that the Department was working on a complex care model to provide services to children transitioning out of secure care. Under the model, relevant services would be made available to a young person based on an assessment of the level of their need.[106]

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[102] ts 08.06.20 (McFarland), pp105-106
[103] Exhibit 1, Vol.1, Tab 34, Evaluation of the KFSCC, Final Report, (19.02.19), p64
[104] ts 08.06.20 (McFarland), pp106-106
[105] Exhibit 1, Vol.1, Tab 34, Evaluation of the KFSCC, Final Report, (19.02.19), p61
[106] See: Needs Assessment Tool attached to Letter - Acting Deputy DG, Community Services (03.07.20)

89. Mr Geddes also said that the Department was trialling various placement options to ensure that young people transitioning out of secure care receive 24-hour support. With respect to support to Indigenous children, Mr Geddes said that in order to ensure a flexible and responsive system, the Department was co-designing services in partnership with Indigenous community controlled organisations.[107,108]

90. It appears that the concept of an intensive transitional service for children leaving secure care has been spoken about for many years. For that reason there is an obvious level of frustration on the part of workers in the area, that this obvious gap in service has not yet been filled.[109] Mr Geddes agreed that work on the implementation of the service was "*not as well advanced*" as he would have liked.[110,111]

91. When Child RM was discharged at the end of each of her secure care placements, she did not have the benefit of an intensive transitional support service and there is at least the possibility that her trajectory may have been different had such a service had been available to her.

92. During the inquest, I asked for an update on the Department's progress in developing the much discussed transitional service to address the complex needs of traumatised children leaving secure care. The Department provided the Court with an update in a letter dated 3 July 2020 (the Letter). In short, the situation is extremely disappointing. The Letter relevantly states:

> Through the (Out of Home Care) reform, Communities is to commence a co-design for a 'Complex Community Care' service. The service will provide staffed, therapeutic care arrangements for young people with complex/extremely complex needs (NAT Level of 5)…It is envisioned this service will operate as a step down from secure care and the service will work closely with secure care to plan for a supported transition for young people on exit.[112]

[107] See: Needs Assessment Tool attached to Letter - Acting Deputy DG, Community Services (03.07.20)
[108] ts 08.06.20 (Geddes), p128 & p138
[109] See also: Discussion with Ms McFarland in presence of counsel (12.06.20)
[110] ts 08.06.20 (Geddes), p138
[111] See also: Discussion with Ms McFarland in presence of counsel (12.06.20)
[112] Letter - Acting Deputy DG, Community Services (03.07.20), p3

93. The proposed transitional service certainly sounds as if it will address the long identified gap in treatment options available to traumatised children leaving secure care. The disappointing bit is that the Letter states:

> Based on the current endorsed timeframes this service will commence in the last quarter of 2023. The Program Board is currently considering accelerating the timeframes and, if endorsed, it is aimed to have the service operational by July 2022.[113]

94. With the greatest respect to the Department, the need for a transitional service to address the complex needs of traumatised children leaving secure care has been patent for many years. A timeframe which will not see the service introduced until the latter part of 2023, or July 2022 if the proposed accelerated timeframe is endorsed, is simply unacceptable.

95. Even recognising the difficulties inherent in designing a new service to address complex needs, I find it hard to fathom why this process cannot be completed in less than two and a half years, much less three. The Review was published almost 18-months ago and it identified the need for this service, a need that was already well-known at that time.

96. In my view, the needs of the vulnerable and traumatised children who are leaving secure care cannot wait until 2023 or even 2022, and a greater level of priority should be attached to the development of the complex care service. I therefore suggest that the Department urgently revises the relevant timeframes with a view to introducing the service as soon as possible, and certainly before the end of 2021.

Comments on Child RM's management at the Centre

97. The evidence supports the view that on each occasion Child RM was placed in secure care, the reasons for admitting her were sound. The evidence also establishes that the care, supervision and treatment provided to Child RM during the periods that she was in secure care was appropriate.

[113] Letter to the Court from the Acting Deputy DG, Community Services (03.07.20), p3

98. The issue in this case is not about how Child RM was managed whilst she was in secure care. The issue is about the support she received once she was discharged from the Centre. As I have discussed, Child RM did not have the benefit of the complex community care service which the Department intends to introduce. Given the complexities of this case, it is impossible to know how Child RM's life might have been impacted if this service had been available to her. However, there is at least the possibility that her life may have taken a different course had she had access to the service.

99. The complex care service being worked on by the Department must obviously be culturally appropriate and trauma-informed. The service must also work collaboratively with existing agencies and address chronic and acute issues impacting on traumatised young people, especially those related to mental health and polysubstance use.

The need for a cultural therapeutic specialist

100. The Review found that 54% of the 120 children admitted to the Centre between 31 May 2011 and 30 April 2018, identified as Indigenous. By being placed in secure care, many of these children were removed from country, community and extended family.[114]

101. In order to address the cultural and spiritual needs of Indigenous children at the Centre, staff have undergone cultural competency and appreciation training and an Aboriginal Practice Leader currently visits the Centre weekly to consult with staff. In addition, the Centre has developed a relationship with a local Indigenous Elder who comes to the Centre to talk to children who feel "*spiritually scared*", including Child RM.[115]

102. The Review recommended that the specific cultural needs of Indigenous children be further addressed by assessing the cultural competency of staff and by ensuring that each Indigenous child's culture and identity plan is informed by consultation with a relevant Aboriginal Practice Leader.[116]

[114] Exhibit 1, Vol. 1, Tab 34, Evaluation of the KFSCC, Final Report, (19.02.19), pp35-36
[115] ts 08.06.20 (McFarland), pp87-88
[116] Exhibit 1, Vol. 1, Tab 34, Evaluation of the KFSCC, Final Report, (19.02.19), p40

103. Following the Review, a working group proposed identifying options to assess the cultural competence of staff and to address any identified learning needs. The working group also suggested identifying options to increase the number of Indigenous secure care staff, including the employment of an Aboriginal Practice Leader to support Indigenous staff at the Centre and to foster the development of a culturally competent practice.[117]

104. On 24 January 2020, Ms McFarland submitted a business case to justify the employment of a cultural therapeutic specialist at the Centre (the Specialist).[118] However, notwithstanding the fact that almost six months have passed since the business case was submitted, I find it disappointing that as at 3 July 2020, the Department's response to a request for an update on the business case was that it was still:

> [B]eing considered by [the Department's] Community Services Leadership Team alongside other demand funding requests.[119]

105. Ms McFarland said she was "*hopeful*" about the outcome of the business case she submitted,[120] and Mr Geddes said that the appointment of the Specialist would be a very positive step and that in his view there was: "*a definite need for that consistent cultural input*".[121] As mentioned, in Child RM's case, there is limited evidence that her planning meetings at the Centre were attended by, or were consistently informed by input from, an Indigenous worker.[122,123]

106. Given the undisputed positive benefits of appointing the Specialist, I urge the Department to take action to address what is an obvious and pressing need. Specifically, I suggest that the Department conclude its deliberations on the business case as soon as possible and then take all necessary steps to employ the Specialist.

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[117] Letter to the Court from the Acting Deputy DG, Community Services (03.07.20), pp5-6
[118] ts 08.06.20 (McFarland), pp88-89
[119] Letter to the Court from the Acting Deputy DG, Community Services (03.07.20), p6
[120] ts 08.06.20 (McFarland), pp88-89
[121] ts 08.06.20 (Geddes), p133
[122] ts 08.06.20 (McFarland), p89
[123] Exhibit 1, Vol. 3, Tab 7, KFSCC Child meeting minutes (various)

Other initiatives being taken by the Department

107. The Department advised that it has taken a number of initiatives aimed at improving its operations with respect to vulnerable youth. Those initiatives include:[124]

a. ***Revised senior leadership structure:*** the new structure includes the positions of Chief Financial Officer, Chief People Officer and Deputy Director General Governance, Integrity and Reform. Within this new structure Communities has signalled its focus on its partners with the creation of new divisions dealing with Indigenous outcomes and strategy and partnerships;

b. ***Cultural partnerships:*** a goal of the Out of Home Care reforms underway in the Department is that a greater number of Indigenous community controlled organisations will be used to provide those services;

c. ***Indigenous led decision making:*** during recent debate in Parliament on amendments to the CCSA, the Government indicated that Communities would trial a program known as the Aboriginal Family Led Decision Making (AFLDM). The trial is progressing through a series of roundtable discussions in July and August 2020 and it is anticipated that a successful AFLDM program will have positive impacts on the experiences and outcomes of Indigenous young people in care;

d. ***Improving cultural competency:*** a range of measures have been implemented to improve the cultural competency of departmental staff with a view to fostering better engagement with Indigenous families and organisations including the establishment of the Aboriginal Cultural Council (ACC). The ACC provides advice to the Department's leadership team on inclusion strategies and cultural competencies. The ACC also has input into the Reconciliation Action Plan and assists the Department to develop a deeper understanding of Indigenous culture and society; and

e. ***Specialist child protection unit (SCPU):*** the new unit will up and running by the end of 2020 and will be co-led by two senior practitioners (at least one of whom will be Indigenous). The aim of the SCPU is to provide child protection expertise at a senior level and to drive improved outcomes for children in care and their families.

[124] Email from the Department to Counsel Assisting (10.07.20)

THE EVENTS OF 15-16 APRIL 2017

Incident on the bus

108. During the evening on 15 April 2017, Child RM was in the vicinity of the large screen near the State Library in Northbridge with her mother, boyfriend and others. Child RM was drinking with some girls about her age and after her boyfriend walked off, she told her mother that she was going to go to her father's home.[125]

109. Child RM's mother thought that Child RM did not look happy and: "*just wanted to make her own way home to her father to have a rest and a sleep*".[126]

110. At about 7.00 pm, Child RM's boyfriend was behaving in a disorderly manner in the vicinity of the State Library and was issued with a move on order by police. A short time later, he was located within the boundaries of the move on order, with Child RM. Witnesses reported that he had assaulted her, but Child RM denied she had been assaulted and no visible injuries were observed. Child RM's boyfriend was arrested and charged with breaching the move on order and was then released on bail at about 9.20 pm.[127]

111. At about 10.30 pm on 15 April 2017, a Transperth bus driver approached a bus stop near the McDonald's restaurant in Mirrabooka. He noticed Child RM and her boyfriend were arguing and that when they got onto the bus, they were yelling abuse and pushing and punching one other. The bus driver contacted Transperth security and initially declined to move the bus. Child RM told him that she and her boyfriend would stop fighting and the bus driver agreed to set off. However, shortly after the bus set off, Child RM's boyfriend pressed the bell and shouted that he wanted to get off the bus.[128,129,130,131]

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[125] Exhibit 1, Vol.1, Tab 8, Report - Sen. Const. L Alexander, Coronial Investigation Squad, pp1-2
[126] Exhibit 1, Vol.1, Tab 11, Statement, Child RM's mother, paras 2-22
[127] Exhibit 1, Vol.1, Tab 8, Report - Sen. Const. L Alexander, Coronial Investigation Squad, p4
[128] Exhibit 1, Vol.1, Tab 18, Statement, Mr N Brar, paras 4-12
[129] Exhibit 1, Vol.1, Tab 10, Statement, Child RM's boyfriend, paras 3-4
[130] Exhibit 1, Vol.1, Tab 19, Statement, Ms M Kiplagat, paras 9-12
[131] Exhibit 1, Vol.1, Tab 8, Report - Sen. Const. L Alexander, Coronial Investigation Squad, p5

112. Child RM and her boyfriend began fighting again and the bus driver stopped the bus on Yirrigan Drive near Chesterfield Drive. Child RM repeatedly asked the bus driver to set off again, but he declined to do so because he was waiting for Transperth security officers to arrive.[132,133]

113. Child RM and her boyfriend began fighting again and as Child RM's boyfriend was getting off the bus via the front door, he spat into the bus driver's face through the metal security grille. Child RM and her boyfriend then got off the bus and one of the other passengers on the bus saw Child RM's boyfriend push Child RM to the ground and kick her.[134,135,136,137]

114. The interactions between the bus driver, Child RM and her boyfriend were captured by CCTV cameras in the bus. The CCTV footage shows Child RM moving back and forth in the bus unaided and speaking to the driver in what seemed to me to be a coherent and sensible manner. Due to their placement, the CCTV cameras on the bus do not capture Child RM being assaulted by her boyfriend after leaving the bus.[138,139,140]

Police attendance

115. As a result of two separate reports to police about two people matching the description of Child RM and her boyfriend, who were fighting or behaving in a disorderly manner, police officers attended the McDonald's restaurant in Mirrabooka at about 11.00 pm on 15 April 2017. They were unable to locate any persons of interest, but received a report about a couple causing trouble on a Transperth bus and one of them having spat on a bus driver. From the restaurant carpark, police could see the bus parked a short distance away and they attended the scene.[141,142,143]

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[132] Exhibit 1, Vol.1, Tab 18, Statement, Mr N Brar, paras 12-15
[133] Exhibit 1, Vol.1, Tab 8, Report - Sen. Const. L Alexander, Coronial Investigation Squad, p5
[134] Exhibit 1, Vol.1, Tab 19, Statement, Ms M Kiplagat, paras 13-15
[135] Exhibit 1, Vol.1, Tab 10, Statement, Child RM's boyfriend, para 5
[136] Exhibit 1, Vol.1, Tab 18, Statement, Mr N Brar, paras 16-18
[137] Exhibit 1, Vol.1, Tab 8, Report - Sen. Const. L Alexander, Coronial Investigation Squad, p4
[138] Exhibit 1, Vol.1, Tab 19, Statement, Ms M Kiplagat, paras 14-15
[139] Exhibit 1, Vol.1, Tab 8, Report - Sen. Const. L Alexander, Coronial Investigation Squad, p5
[140] Exhibit 1, Vol.1, Tab 17, IAU Report, p25
[141] Exhibit 1, Vol.1, Tab 8, Report - Sen. Const. L Alexander, Coronial Investigation Squad, pp4-5
[142] Exhibit 1, Vol.1, Tab 24, Statement, Sen. Const. M Price, paras 4-9 and ts 08.06.20 (Price), pp13-14
[143] Exhibit 1, Vol.1, Tab 23, Statement, Const. W Saunders, paras 3-8 and ts 08.06.20 (Saunders), pp31-32

116. The bus driver told Sergeant Harmer (Officer Harmer) and Officer Saunders that Child RM's boyfriend had spat on him. Meanwhile, Child RM had walked away from the bus and appeared to be angry with her partner. She was yelling things at him like: "*pull your head in, stop it, let's just go*". Officer Price's impression was that Child RM was fed up and just wanted to go home.[144,145,146]

117. Officer Price asked Child RM to come back to the bus and she did so. He asked her what had been going on and she replied: "*just normal relationship stuff*". As Officer Price and a female officer, First Class Constable Roberts (Officer Roberts) spoke with her, Child RM told them about various events in her life. She said she had been drinking with her mother earlier and wanted to go home.[147]

118. Officer Price's impression was that Child RM was seeking to demonstrate that she could look after herself. He saw no signs that suggested to him that she was heavily intoxicated. Although he could smell "*a little bit of alcohol*" on her breath, she was responsive to his questions, was not slurring her words and was not unsteady on her feet.[148]

119. As Officer Price and Officer Roberts were speaking to Child RM, her boyfriend, who appeared to be heavily intoxicated and was behaving aggressively, was arrested for allegedly assaulting the bus driver and placed into the back of a police van. Child RM began shouting at officers to let her boyfriend go and was visibly upset. Eventually, however, she appears to have accepted that it was inevitable that her boyfriend would remain in police custody overnight. She told the officers she wanted to go to her father's home and that she planned to see her boyfriend after his court appearance the following day.[149,150,151]

[144] Exhibit 1, Vol.1, Tab 8, Report - Sen. Const. L Alexander, Coronial Investigation Squad, p5
[145] Exhibit 1, Vol.1, Tab 24, Statement, Sen. Const. M Price, paras 10-14 and ts 08.06.20 (Price), p15
[146] Exhibit 1, Vol.1, Tab 23, Statement, Const. W Saunders, paras 9-12 and ts 08.06.20 (Saunders), pp32-33
[147] Exhibit 1, Vol.1, Tab 24, Statement, Sen. Const. M Price, paras 10-23 and ts 08.06.20 (Price), pp15-16
[148] Exhibit 1, Vol.1, Tab 24, Statement, Sen. Const. M Price, paras 10-23 and ts 08.06.20 (Price), pp15-16
[149] Exhibit 1, Vol.1, Tab 8, Report - Sen. Const. L Alexander, Coronial Investigation Squad, p5
[150] Exhibit 1, Vol.1, Tab 24, Statement, Sen. Const. M Price, paras 24-30 & 38-40 and ts 08.06.20 (Price), pp16-17
[151] Exhibit 1, Vol.1, Tab 23, Statement, Const. W Saunders, paras 13-17 and ts 08.06.20 (Saunders), p33 & p35

120. Although he had asked for her date of birth, Officer Price "*didn't do the maths roadside*" and the police system he checked for alerts relating to Child RM did not indicate that she was under the age of 18 years[152] (albeit by only a matter of a couple of weeks). Officer Price noticed a red mark on Child RM's face and asked her if she had been assaulted. She denied that she had been assaulted and said she had collided with a pole on the bus when it had braked. She told Officer Price that her partner was her "*protector*" and "*was always there to look after her…*and*…had never lifted a hand to her*".[153,154]

121. Officer Price was unaware of any information suggesting that Child RM had been assaulted by her boyfriend and after he took her details, he and Officer Roberts spoke with Child RM for about 10 minutes.[155,156] When interviewed by investigators from the Internal Affairs Unit (IAU) on 6 July 2017, Officer Harmer said that he had spoken to the bus driver and the passengers on the bus who mentioned that there had been "*a bit of punching and shoving*" between Child RM and her boyfriend.[157]

122. At some stage, Officer Saunders says he heard someone say that Child RM and her boyfriend had been having an argument or a fight on the bus. At the inquest, Officer Saunders said he was unsure if any of the officers at the scene had made any enquiries about the possibility of an assault on Child RM by her boyfriend. At the time of the incident, Officer Saunders was the most junior officer at the scene and said that with the benefit of hindsight, and his additional training and experience since the incident, he would now have handled things "*slightly differently*". He said he would now probe further to try to determine what kind of fight or argument had occurred between Child RM and her boyfriend, and whether there had been any physical violence, although neither had complained of an assault and neither had any obvious injuries.[158,159]

[152] See ts 08.06.20 (Saunders), p39
[153] Exhibit 1, Vol.1, Tab 8, Report - Sen. Const. L Alexander, Coronial Investigation Squad, pp4-5
[154] ts 08.06.20 (Price), pp17-18 & 20
[155] Exhibit 1, Vol.1, Tab 8, Report - Sen. Const. L Alexander, Coronial Investigation Squad, pp4-5
[156] Exhibit 1, Vol.1, Tab 24, Statement, Sen. Const. M Price, paras 33-36 and ts 08.06.20 (Price), pp17-18
[157] Exhibit 1, Vol.1, Tab 17, IAU report, pp3-4
[158] Exhibit 1, Vol.1, Tab 23, Statement, Const. W Saunders, para23
[159] ts 08.06.20 (Saunders), p34; pp37-38 & pp42-43

123. Although he was unaware that Child RM was under the age of 18 years at the time he spoke with her, Officer Price was mindful of the fact that it was late at night and that she was a young woman who was alone. Consequently, he and Officer Roberts offered Child RM a lift to her father's home in Balga in the police sedan that had arrived on the scene, (as opposed to the back of a police van), but she declined. Officer Price knew where Child RM's father lived in Balga, having attended there on other occasions. He pointed out to Child RM that she was about 2 km from that location and urged her to accept his offer of a lift, but she continued to decline, saying she preferred to walk.[160,161]

124. As a result of his interactions with Child RM, Officer Price formed the view that she was "*calm and seemed happy*" and he had no concerns for her welfare.[162,163,164] However, at the inquest, Officer Price agreed that if he had been aware that Child RM had lied about her boyfriend assaulting her, then he would probably have made a further effort to try to get her to agree to accept a lift to her father's home.[165]

125. Officers Price agreed that it would have been useful if the police computer system (TADIS) had contained an alert indicating that a person of interest was under the age of 18-years. Officer Price also agreed that it would be useful if TADIS contained an alert that a young person of interest was under the care of the DG, so that police could call the Crisis Care to check whether there were any concerns.[166,167]

126. In an email to Ms Heslop dated 29 June 2020, Ms Hartley advised her instructions were that the TADIS system was being decommissioned at the end of 2020 and was being replaced by two computer systems called "*OneForce Search*" and "*PS Core*" respectively. Ms Hartley advised that both of the new systems will display the date of birth and age of any person of interest.[168]

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[160] Exhibit 1, Vol.1, Tab 8, Report - Sen. Const. L Alexander, Coronial Investigation Squad, pp4-5
[161] Exhibit 1, Vol.1, Tab 24, Statement, Sen. Const. M Price, paras 40-41 and ts 08.06.20 (Price), p19
[162] Exhibit 1, Vol.1, Tab 8, Report - Sen. Const. L Alexander, Coronial Investigation Squad, pp4-5
[163] Exhibit 1, Vol.1, Tab 24, Statement, Sen. Const. M Price, paras 40-42 and ts 08.06.20 (Price), p19 & pp28-30
[164] Exhibit 1, Vol.1, Tab 17, IAU report, p29
[165] Exhibit 1, Vol.1, Tab 24, Statement, Sen. Const. M Price, para 42 and ts 08.06.20 (Price), pp22-23 & pp28-30
[166] ts 08.06.20 (Price), pp22-23
[167] 08.06.20 (Ranford), p60
[168] Email from Ms R Hartley (State Solicitor's Office) to Ms K Heslop (29.06.20)

127. Regarding alerts on TADIS relating to whether a child is in care, I agree with Mr Geddes' observation, that there may be issues with a blanket approach to this issue because of the confidentiality provisions in the *Children and Community Services Act 2004* WA.[169]

128. However, Mr Geddes noted that there have already been occasions when the Department has notified police of concerns relating to a young person in care. In addition, formal and informal interactions related to child safety do occur between caseworkers and police, especially in regional areas. There have also been occasions when the Department has reported a child in care as a missing person, when their whereabouts could not be established. In any event, Mr Geddes agreed that police already have the ability to contact Crisis Care at any time they have concerns about a child they encounter.[170]

129. There is no record of the time that Child RM left the area where the bus was parked. However, based on the time that Child RM's boyfriend was logged as being received at the Mirrabooka police station after his arrest, it appears that she would have walked off in a westerly direction along Yirrigan Drive in Mirrabooka on 15 April 2017, shortly before 11.15 pm.[171,172,173]

Child RM is found, resuscitation efforts and death

130. At about 11.35 pm on 15 April 2017, a man was in the front garden of his home on Ravenswood Drive in Mirrabooka, having a cigarette with a friend. The man's house was about four houses down from the intersection of Ravenswood Drive and Yarun Place and the men noticed that cars travelling west on Ravenswood Drive were driving very slowly. Just then, a Caucasian male walked past and when the men asked him what was going on, he said he didn't know. It was at that point that the two men saw a silhouette, which one of them thought was a doll, near a tree on the corner of Arun Place and Ravenswood Drive.[174,175]

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[169] See: s237 of the *Children and Community Services Act 2004* WA
[170] 08.06.20 (Geddes), pp133-135
[171] Exhibit 1, Vol.1, Tab 8, Report - Sen. Const. L Alexander, Coronial Investigation Squad, p5
[172] Exhibit 1, Vol.1, Tab 24, Statement, Sen. Const. M Price, paras 42-43 and ts 08.06.20 (Price), p19
[173] ts 08.06.20 (Heslop)
[174] Exhibit 1, Vol.1, Tab 12, Statement - Mr M Parkes, paras 3-15 & ts 08.06.20 (Parkes), p10
[175] Exhibit 1, Vol.1, Tab 13, Statement - Mr M Merchant, paras 3-6 & 11-20

131. As they approached the figure hanging in the tree, the men realised it was a female. One of the men called emergency services and shortly afterwards, a police car with its lights and sirens on approached along Ravenswood Drive. The officers in the police car were responding to an earlier emergency services call from another member of the public, and were directed to the scene by the two men. The officers noted that Child RM was in a crouched kneeling position with the right side of her body against the tree, approximately 380 metres from where she had earlier been spoken to by police.[176,177,178,179]

132. When found, Child RM's arms were limp and by her sides and her eyes were closed. A garden hose was looped under her chin, the upper part of her ears and the back of her head and was then tied with a knot and looped over a fork in the branches. The hose had been knotted twice, forming a noose.[180]

133. One of the men who found Child RM helped police to remove the hose from her neck and as she was lowered to the ground, she groaned and moved her left arm. One of the police officers noticed a small amount of dried blood on Child RM's forehead and a forensic field operations officer subsequently observed a faint ligature mark to Child RM's neck. The officers performed CPR until ambulance officers arrived.[181,182,183]

134. Ambulance officers arrived and took over resuscitation efforts, which included: CPR, the insertion of an airway, the use of a defibrillator and a LUCAS machine, and the administration of adrenalin and other medications. Child RM was taken to Sir Charles Gairdner Hospital (SCGH) but she could not be revived and was declared deceased at 12.39 am on 16 April 2017.[184,185,186,187]

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[176] Exhibit 1, Vol.1, Tab 12, Statement - Mr M Parkes, paras 16-24 & ts 08.06.20 (Parkes), pp10-11
[177] Exhibit 1, Vol.1, Tab 13, Statement - Mr M Merchant, paras 10-18
[178] Exhibit 1, Vol.1, Tab 8, Report - Sen. Const. L Alexander, Coronial Investigation Squad, pp1-2 & p6
[179] Exhibit 1, Vol.1, Tab 25, Printout from Google Maps showing relevant locations
[180] Exhibit 1, Vol.1, Tab 8, Report - Sen. Const. L Alexander, Coronial Investigation Squad, pp1-2 & p6
[181] Exhibit 1, Vol.1, Tab 12, Statement - Mr M Parkes, paras 22-26 & ts 08.06.20 (Parkes), p11
[182] Exhibit 1, Vol.1, Tab 8, Report - Sen. Const. L Alexander, Coronial Investigation Squad, p2
[183] Exhibit 1, Vol.1, Tab 13, Statement - Mr M Merchant, paras 23-25
[184] Exhibit 1, Vol.1, Tab 14, Statement - Mr M Pitter (Clinical Support Paramedic), paras 8-34
[185] Exhibit 1, Vol.1, Tab 16, St John Ambulance Patient Care Record
[186] See also: Exhibit 1, Vol.1, Tab 15, Statement - Mr G Mews (Area manager/paramedic), paras 8-28
[187] Exhibit 1, Vol.1, Tab 3, Death in Hospital Report (16.4.17)

Internal Affairs Unit investigation

135. Following Child RM's death, an investigation was conducted by the IAU into the conduct of police who interacted with her on the night of 15 April 2017. The investigation examined whether police had properly considered Child RM's safety and wellbeing (the duty of care issue) and secondly, whether police should have filed a domestic violence incident report (the DVIR issue).[188]

136. The IAU report, which was authored by Sergeant Becker and Officer Ranford, concluded that neither of the issues under investigation (i.e.: the duty of care issue or the DVIR issue) had been established, and that the two "*allegations*" were "*unfounded*"[189] meaning that the "*acts complained of did not occur or failed to involve police personnel*".[190]

137. In relation to the duty of care issue, the IAU report noted that Child RM made no complaint to police of having been assaulted and had no apparent injuries that suggested that she had been, other than a small mark or abrasion on her cheek. The IAU report noted that although police thought Child RM was affected by alcohol, they did not consider she was intoxicated and she presented as: "*coherent and aware of her surroundings*".[191]

138. The IAU investigation found Officers Price and Roberts had offered to drive Child RM to her father's place but that she had declined. The IAU report noted that the officers had offered Child RM a lift because:

> [I]t was the right thing to do in the circumstances as she was being left alone after the arrest of [her boyfriend]. Neither officer had any specific concerns for her welfare at that stage. [Child RM] gave no indication that she was considering suicide or self-harm and they were satisfied that she was capable of walking home and that it was safe for her to do so.[192]

[188] Exhibit 1, Vol.1, Tab 17, IAU Report, pp2-3
[189] Exhibit 1, Vol.1, Tab 17, IAU Report, p32 & p34
[190] Exhibit 1, Vol.1, Tab 35, Memorandum, Sgt. J Gadenne (Family violence unit), p1
[191] Exhibit 1, Vol.1, Tab 17, IAU Report, p29
[192] Exhibit 1, Vol.1, Tab 17, IAU Report, p30

139. The IAU report noted that on the face of it, Child RM's blood alcohol level of 0.189% was high and raised concerns about her level of intoxication. However, whilst all of the police and civilian witnesses say that Child RM was affected by alcohol, none of them say she was intoxicated.[193] In his statement to police, Child RM's boyfriend says that: "*[Child RM] had passion pop and only one drink. She was a bit intoxicated*.[194]

140. In my view, CCTV footage from the Transperth bus shows Child RM speaking coherently and walking unaided up and down the bus. I therefore accept that the assessment of police officers who interacted with her on the night of 15 April 2017, namely that she was not heavily intoxicated.

141. As to the effects of alcohol on people who regularly consume large amounts, Dr Kueppers, a forensic pathologist who conducted a post mortem examination of Child RM's body, noted that people who regularly drink excessive amounts of alcohol become habituated. This means that receptors in that person's brain become more tolerant and the effects of alcohol are less noticeable.[195]

142. The IAU report noted that the only option available to police on the night of 15 April 2017, that was not offered to Child RM was the use of a mobile phone to call for assistance. However, as the IAU report notes, it is unknown whether this offer would have been accepted if it had been offered.[196]

143. With respect to the duty of care issue, the IAU report concluded that:

> Benchmarking the actions of the involved police officers against the relevant policy and duty of care responsibilities, the investigation has found that the actions of the involved officers were reasonable in the circumstances and no breaches of policy have been identified.[197]

[193] Exhibit 1, Vol.1, Tab 17, IAU Report, p30
[194] Exhibit 1, Vol.1, Tab 10, Statement, Child RM's boyfriend, para 12
[195] ts 08.06.20 (Kueppers), p113
[196] Exhibit 1, Vol.1, Tab 17, IAU Report, p32
[197] Exhibit 1, Vol.1, Tab 17, IAU Report, p32

144. As to whether police should have recorded a DVIR on the night of 15 April 2017, the IAU report notes that none of the officers regarded the incident as a domestic violence incident (DVI) because "*no complaints of assault were made and no offences were detected at that time*".[198]

145. Although two passengers on the bus told police that they had seen Child RM's boyfriend assault her after she got off the bus, they could not recall when they had given police this information.[199] However, as I have noted, it is clear that police were aware that there had been "*a bit of punching and shoving*" between Child RM and her boyfriend and that they were in possession of this information on the night of 15 April 2017.[200]

146. Despite this, the IAU report found that the information police obtained at the time of the incident did not clearly establish that an offence had occurred and that "*adequate investigation was conducted at the scene in relation to the DVI*". As a result, the IAU investigation concluded that the actions of the officers were reasonable in all of the circumstances.[201]

147. At the inquest, Officer Ranford (one of the authors of the IAU report), noted that on the night of 15 April 2017, police had information that there had been "*punching and shoving*" between Child RM and her boyfriend. He said that with the benefit of hindsight, he would:

> [D]efinitely expect there to be more action, at least some more intensive questioning of [Child RM] based on what the bus driver told [Officer] Harmer.[202]

148. At the inquest, Officer Price conceded that he would have made further attempts to encourage Child RM to agree to allow police to take her to her father's home, had he been aware of her true age and the fact that she had been recently assaulted by her boyfriend.[203]

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[198] Exhibit 1, Vol.1, Tab 17, IAU Report, pp33-34
[199] Exhibit 1, Vol.1, Tab 17, IAU report, pp18-21
[200] Exhibit 1, Vol.1, Tab 17, IAU report, pp3-4
[201] Exhibit 1, Vol.1, Tab 17, IAU report, pp3-4 & pp33-34 and ts 08.06.20 (Ranford), pp47-48
[202] ts 08.06.20 (Ranford), p48 and see also: ts 08.06.20 (Ranford), p56
[203] ts 08.06.20 (Price), pp28-30

149. The IAU report was reviewed by officers from the Family Violence Unit (FVU). In a memorandum (the FVU memo), Officer Gadenne confirmed that the FVU were satisfied with the response of the officers who dealt with Child RM on the night of 15 April 2017, "*based upon the information available to officers at the time*". However, the FVU took issue with the IAU finding of "*unfounded*" with respect to the "*duty of care*" allegation. The FVU considered that a finding of "*not sustained*" was more appropriate, meaning that: "*the investigation failed to disclose evidence to clearly prove or disprove the allegations made in the complaint*".[204]

150. The FVU considered that contrary to the findings of the IAU investigation, the allegation relating to whether a DVIR should have been recorded on the night of 15 April 2017, should have been sustained, noting that:

> The focus of attending officers was on the alleged physical assault of a bus driver and despite the associated evidence of family violence they did not intervene and conduct a required investigation aligned to legislation and policy at the time.[205]

151. The FVU memo notes that the IAU report was returned with their comments and that the Superintendent of the IAU had concurred with its views. At the inquest, Officer Ranford confirmed that the IAU report relating to Child RM would be the subject of a further review by the IAU in the near future.[206]

152. The FVU memo cautioned that its assessment of the actions of the attending officers had "*placed a 2020 perspective*" on their conduct and that since 2017, a great deal of work had been done within Police to highlight DVI issues and to enhance the police response when attending these incidents.[207] In September 2019, a new blackboard training product for family violence was provided to all police up to the rank of Senior Sergeant, except recent graduates who now receive this training at the Police Academy.[208]

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[204] Exhibit 1, Vol. 1, Tab 35, Memorandum, Sgt. J Gadenne (Family violence unit), p1
[205] Exhibit 1, Vol. 1, Tab 35, Memorandum, Sgt. J Gadenne (Family violence unit), p2
[206] ts 08.06.20 (Ranford), p65
[207] Exhibit 1, Vol. 1, Tab 35, Memorandum, Sgt. J Gadenne (Family Violence Unit), p2
[208] Exhibit 1, Vol. 1, Tab 35, Memorandum, Sgt. J Gadenne (Family Violence Unit), p2

153. In addition, the FVU is developing family violence assessment tasks for completion by probationary constables. The FVU considers that these initiatives will help to ensure that family violence incidents are correctly identified and responded to. Further, the FVU and the IAU have agreed to work collaboratively to ensure that all allegations of misconduct relating to family violence issues are adequately investigated and that "*outcomes are aligned to agency expectations of family violence response*".[209] In addition, IAU reports dealing with family violence are now routinely reviewed by the FVU.[210]

154. In passing, I note that the IAU reports frame the issues under investigation as allegations. For example, in this case, the "*duty of care issue*" was expressed in the following terms:

> On Saturday April 15 2017…(names of officers)…failed in their duty of care obligations to [Child RM] by failing to properly consider her safety and wellbeing…contrary to Regulation 605(1)(a) of the *Police Force Regulations* and the Western Australia Police Code of Conduct part titled *Duty of Care*.[211]

155. Once the IAU has completed its investigation, it makes findings relating to what are described as "*issues*" but which are in fact, as the above example demonstrates, actually framed as allegations. The possible findings available at the conclusion of an IAU investigation include: "*unfounded*", "*not sustained*" and "*sustained*".[212]

156. In my view, it would be more appropriate for IAU reports to express the issues under investigation in a less accusatorial manner by inserting the word "*whether*" at the beginning of each of the issues being investigated. At the inquest, I asked Officer Ranford for his view of this suggestion and he said that framing the issues to be investigated in this way would "*probably be a bit more palatable for the subject officer*".[213]

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[209] Exhibit 1, Vol. 1, Tab 35, Memorandum, Sgt. J Gadenne (Family Violence Unit), pp2-3
[210] ts 08.06.20 (Ranford), p63
[211] Exhibit 1, Vol. 1, Tab 17, IAU Report, p2
[212] ts 08.06.20 (Ranford), p50
[213] ts 08.06.20 (Ranford), p67

Comments on police interaction with Child RM

157. At the time he spoke to Child RM, Officer Price was unaware that she was under the age of 18 years (albeit by only three weeks), and had just been assaulted by her boyfriend. I accept that on the basis of the information that Officer Price had at the relevant time, he had no basis to detain Child RM, either under the provisions of the *Mental Health Act 1996* WA, or otherwise.[214]

158. However, had police questioned the bus driver and/or the bus passengers more closely, they would almost certainly have discovered that Child RM had been assaulted by her boyfriend once she got off the bus. This may have prompted police to file a DVIR that night, rather than the following day after they had conducted further inquiries and watched CCTV footage from the bus (which was unavailable on the night because it had to be downloaded).[215]

159. In addition, police may have also issued Child RM's boyfriend with a police order, prohibiting him from contacting Child RM for a period of 72 hours. However, as already noted, police arrested Child RM's boyfriend on the night of 15 April 2017, and held him in police custody overnight. Further, Child RM had stated a number of times that she intended to go to court the following day to see him.[216,217]

160. As Officer Ranford pointed out, police were dealing with a dynamic situation and their focus was on the alleged assault on the bus driver by Child RM's boyfriend. Further, because Child RM's boyfriend was behaving aggressively and thrashing about inside the police van, a concerted effort was being made to get him to a police station so he could be processed.[218] It seems that even if police had sought further information about the nature of the fight or argument that had taken place between Child RM and her boyfriend, at best this may have prompted a further effort by them to persuade Child RM to accept the offer of a lift to her father's home.[219]

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[214] Exhibit 1, Vol.1, Tab 17, IAU Report, p31
[215] ts 08.06.20 (Ranford), p53 & p64 and see also: ts 08.06.20 (Price), p27
[216] ts 08.06.20 (Price), pp20-21
[217] Exhibit 1, Vol.1, Tab 23, Statement - Const. W Saunders, paras 19-20 & para 27
[218] ts 08.06.20 (Ranford), p49
[219] ts 08.06.20 (Ranford), p57

CAUSE AND MANNER OF DEATH

161. After Child RM's death, a Forensic Field Officer attended SCGH and observed a faint ligature mark around Child RM's neck. There were scratches to both sides of her face and a small amount of blood associated with an injury to her inner lip.[220]

162. On 24 April 2017, Dr Kueppers (Forensic Pathologist) conducted a post mortem examination of Child RM's body and found a few minor skin injuries to Child RM's face and hands, but no significant injury was otherwise apparent.[221]

163. At the inquest, Dr Kueppers amplified the comments in her post mortem report. She said she did not observe any defensive injuries that suggested that Child RM had been in a struggle before her death. Dr Kueppers also noted that the mark she observed on Child RM's right cheek was a "*very superficial, very subtle abrasion*" which could have occurred after death, including by means of friction with the bark of the tree Child RM was hanging from.[222]

164. Dr Kueppers confirmed that homicidal hangings, where another person hangs the deceased person were extremely rare and that it was very difficult for one person to overpower another, unless there was a significant disparity in their size, or the person being hanged was unconscious.[223]

165. Having consulted with her colleagues, Dr Kueppers said she was only aware of one example of a homicidal hanging in Western Australia in the past 30 years, and that case involved a small child. Dr Kueppers confirmed that none of her post mortem findings suggested that Child RM had been hanged by another person.[224]

[220] Exhibit 1, Vol.1, Tab 8, Report - Sen. Const. L Alexander, Coronial Investigation Squad, p2
[221] Exhibit 1, Vol.1, Tab 5, Supplementary Post Mortem Report, p1
[222] ts 08.06.20 (Kueppers), pp108-109 & p111
[223] ts 08.06.20 (Kueppers), p109
[224] ts 08.06.20 (Kueppers), p109

166. During her examination, Dr Kueppers found no evidence of internal neck injury and there was no observable ligature mark around Child RM's neck. Dr Kueppers noted that it was not uncommon for there to be no ligature mark in hanging cases, especially where, as here, the ligature used was smooth.[225]

167. Although Child RM's heart was normal, there were signs of early coronary artery disease (coronary artery atherosclerosis). Child RM's liver was scarred (hepatic cirrhosis) and her spleen was enlarged, most likely as a result of increased venous pressure (portal hypertension) caused by advanced chronic liver disease.[226]

168. Neuropathological examination found no significant abnormalities in Child RM's brain,[227] and toxicological examination found that Child RM had a blood alcohol level of 0.189% and a urine alcohol level of 0.215%.[228] Dr Kueppers explained that the urine alcohol level is often higher and one of the reasons is that water gets filtered back into the bloodstream before it gets excreted into the bladder.[229]

169. At the conclusion of the post mortem examination, Dr Kueppers expressed the opinion that the cause of death was ligature compression of the neck (hanging).[230] I accept and adopt Dr Kueppers' conclusion with respect to the cause of Child RM's death and further, I find that Child RM's death occurred by way of suicide.

170. Although the cause of Child RM's death may be clear, the reason she decided to take her life is unfathomable. When she was last seen by police, about 20 minutes before being found, Child RM was "*calm and seemed happy*".[231] There were no concerns for her welfare and she had said she was planning to see her boyfriend the next day. I can only speculate that her impulsive act of taking her life was in some way connected to the complex developmental trauma she had clearly experienced.

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[225] ts 08.06.20 (Kueppers), p110
[226] Exhibit 1, Vol.1, Tab 5, Supplementary Post Mortem Report, p1
[227] Exhibit 1, Vol.1, Tab 7, Neuropathology Report
[228] Exhibit 1, Vol.1, Tab 6, Toxicology Report
[229] ts 08.06.20 (Kueppers), p109
[230] Exhibit 1, Vol.1, Tab 5, Supplementary Post Mortem Report, p1
[231] Exhibit 1, Vol.1, Tab 24, Statement, Sen. Const. M Price, paras 40-42 and ts 08.06.20 (Price), p19 & pp28-30

RECOMMENDATIONS

171. In light of the observations I have made, I make the following recommendations:

> ***Recommendation No.1***
>
> The Department should consider whether the *Children and Community Services Act 2004* WA, should be amended to provide for a maximum secure care placement of greater than 42-days.

> ***Recommendation No.2***
>
> In order to adequately address the needs of young people with complex/extremely complex needs, including those transitioning from secure care, the Department should fast-track the implementation of its proposed complex community care service (the Service). Given the obvious and urgent need for the Service, the current endorsed commencement date, namely the last quarter of 2023, is manifestly inadequate as is the Department's "accelerated" start date of July 2022 which is currently under consideration.

> ***Recommendation No.3***
>
> In order to ensure the cultural safety of children and staff at the Kath French Secure Care Centre (the Centre) and provide staff with access to a high level of cultural competence the Department should, as a matter of urgency, endorse the business case submitted by the Director, Secure Care on 24 January 2020 and take all necessary steps to employ a cultural therapeutic specialist at the Centre.

172. At my request, Ms Heslop forwarded a draft copy of these recommendations to lawyers for both the Department and Child RM's family on 8 July 2020. By emails dated 8 July 2020 and 10 July 2020 respectively, lawyers for Child RM's family and the Department advised the Court that all three recommendations were supported.[232,233]

[232] Email from Ms Heslop to the Department and Aboriginal Legal Service of WA (Inc.), (08.07.20)
[233] Emails from Aboriginal Legal Service of WA (Inc.), (08.07.20) and State Solicitor's Office (10.07.20)

CONCLUSION

173. Child RM was a 17-year old girl who took her life on 16 April 2017. At the time of her tragic and inexplicable death, her liver was so badly affected by her excessive alcohol intake that she required a liver transplant.

174. Despite the fact that the Department arranged 57 placements for her, Child RM persistently left these placements and returned to live with family members, especially her mother and sometimes her father. These "*self-selected*" placements were not approved by the Department, and for good reason.

175. Whilst I have no doubt that her mother loved Child RM dearly, by reason of her own experiences with trauma and her substance use issues, Child RM's mother was unable to satisfactorily and consistently provide her with the safe environment and the level of care that Child RM clearly needed.

176. For other reasons, Child RM's father was similarly incapable of providing Child RM with a safe environment. Despite this, Child RM clearly loved her family and wanted to maximise the amount of time she spent with them.

177. Although I am satisfied that the Department did what it could to address Child RM's complex needs there were missed opportunities, where additional support from the Department may have altered Child RM's trajectory. However, given the complexities of Child RM's presentation, it is impossible to know whether, had that additional support been provided, the outcome in this case would have been different.

178. This case clearly highlights is that there is an unacceptable gap in the services currently available to traumatised children with complex needs, such as Child RM. I accept that there is a role for secure care placements, especially in circumstances where a child poses a serious risk to themselves and/or others.

179. I also accept that because secure care placements necessarily involve depriving a child of their liberty, such placements should be as short as possible. However, the evidence suggests that in many cases, the current limit of 42-days (an initial period of up to 21-days with a possible extension of up to 21-days), is too short and results in an unacceptable return to secure care rate of up to 50%.

180. When a child is discharged from secure care, there are currently very few options available to address that child's complex treatment and care needs, and this is especially the case for older children such as Child RM. In the absence of a comprehensive "*step-down*" service that is able to provide a range of ongoing intensive treatment, the needs of these traumatised children, including their mental health needs, are not being met.

181. The lack of a comprehensive "*step down*" service for children leaving secure care has been spoken about for many years and should be urgently addressed. The Department has advised that it is currently working on a plan to address this gap in services and that a complex community care service should be available by the end of 2023 or possibly by July 2022. In my view, neither of those timeframes is acceptable and the introduction of the transitional service must be prioritised.

182. I have made recommendations relating to the maximum length of placements in secure care, the urgent need for a comprehensive "*step down*" service and the need for a cultural therapeutic specialist at the Centre. It is my sincere hope that these measures may, if implemented, provide the family of Child RM with some solace for their terrible loss.

MAG Jenkin
Coroner
16 July 2020