



Western

Australia

RECORD OF INVESTIGATION INTO DEATH

Ref No: 8/15

I, *Barry Paul King*, Coroner, having investigated the death of **Danielle Kiesha Lane** with an inquest held at **Perth Coroners Court, Court 51, CLC Building, 501 Hay Street, Perth**, on **24 and 25 March 2015**, find that the identity of the deceased person was **Danielle Kiesha Lane** and that death occurred on **4 January 2012** at **bushland northeast of Tjirrkarli Community** from **heat stroke and dehydration** in the following circumstances:

Counsel Appearing:

Ms I O'Brien assisting the Coroner
Ms R Hartley and Ms B Allen of the State Solicitor's Office on behalf of the Department for Child Protection and Family Support

SUPPRESSION ORDER

The publication of any information relating to AP's status under the *Community Protection (Offender Reporting) Act 2004* be suppressed until further order.

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INTRODUCTION

1. Danielle Kiesha Lane (the deceased) was an eight year old girl living with her de facto foster mother, Tania Little, and Ms Little's partner, AP, in Tjirrkarli, a small Aboriginal Community northwest of Warburton.
2. AP was registered in the Australian National Child Offender Register (ANCOR) under the *Community Protection (Offender Reporting) Act 2004* in relation to a sexual relationship he had with a 14 year old girl. He was obliged to report to police regularly and to declare that he was residing with a child. While living with Ms Little and the deceased, he was interviewed by police and denied that he had any unsupervised contact with children or that Ms Little cared for any children.
3. At about midday on 31 December 2011 the deceased and AP drove from Tjirrkarli into the nearby bush in a car and became lost. The car became bogged, so they attempted to walk back to Tjirrkarli. They had little food or water.
4. Neighbours in Tjirrkarli searched for the deceased and AP that evening without success and contacted police the next morning to report that they were missing.
5. Police officers in a search airplane spotted the lost car in bushland at about midday on 3 January 2012. Officers and the neighbours from Tjirrkarli drove through bushland towards the location of the car and found the

deceased and AP. The deceased died soon after she was found.

6. On 24 and 25 March 2015 I held an inquest into the deceased's death. The inquest focussed on the following issues:

- a. AP's management as a registered offender in ANCOR;
- b. the involvement of the Department of Child Protection and Family Services (DCPFS) in the deceased's life; *and*
- c. possible recommendations to prevent similar deaths occurring again.

7. The majority of the documentary evidence adduced at the inquest comprised a report of 10 April 2014 by Inspector R J Wilde, the then Assistant District Officer of the Goldfields Esperance District Office of the Western Australia Police.¹ Also received into evidence were:

- a. a report by Dr Paul Luckin, a well-known expert on survival and search and rescue, with the contributions of police search and rescue experts in Queensland, the Northern Territory and Western Australia. Dr Luckin's report addresses the third issue identified above, namely the identification of

¹ Exhibit 1, Tab 2

ways of preventing deaths occurring from vehicle breakdowns in the Western Australian desert;²

- b. attachments to a report by Julieanne Davis, the Executive Director Country Services of the Department for Child Protection and Family Support (DCPFS);³
- c. photographs of the deceased's clothing found in the bush, together with a statement of Forensic Investigation Officer Greg Stuart Ferguson;⁴
- d. a disc of a video recording taken from a helicopter of the bushland around the car;⁵ *and*
- e. a map of the Tjirrkarli Community indicating the location of the car.⁶

8. Oral evidence was provided by:

- a. Senior Constable Paul Dinneen, who had been involved both with the air search for the deceased and AP and with interviews with AP in relation to his registration in ANCOR;
- b. Sergeant Judi Seivwright, who had provided a report in relation to the management of offenders under ANCOR in remote areas and in relation to the management of AP specifically;⁷
- c. Ms Davis, mentioned above;

² Exhibit 1, Tab 27

³ Exhibit 2

⁴ Exhibit 3

⁵ Exhibit 4

⁶ Exhibit 5

⁷ Exhibit 1, Tab 24

- d. AP, who gave evidence via video-link from Casuarina Prison, where he is serving a term of imprisonment for the sexual penetration of a 16 year old girl without her consent; *and*
- e. Brevet Sergeant James Allan, who was involved in the air search and was the first police officer to attend to the deceased when she and AP were found.

THE DECEASED

- 9. The deceased was born on 25 August 2003 at King Edward Hospital in Subiaco to Anne Marie Lane and Rodney Mitchell of the Jameson Community.⁸
- 10. On 25 July 2004 the deceased was taken to Laverton Hospital by her grandmother, Paula Lane, who reported that the deceased's mother had held her upside down and had shaken her. She did not have ongoing injuries, but her grandmother cared for her after that.⁹
- 11. In about 2006 the deceased's grandmother became too sick to look after the deceased. She was staying in a hostel in Kalgoorlie with the deceased and there she met Ms Little.¹⁰ Ms Little took in the deceased who moved with her to different communities, though there is

⁸ Exhibit 1, Tab 18

⁹ Exhibit 1, Tab 22, Tab 5

¹⁰ Exhibit 1, Tab 5

evidence that the deceased also spent some time with her mother in 2008.¹¹

12. In about May 2011 Ms Little and the deceased moved to Tjirrkarli Community to live with AP.¹² Tjirrkarli, with a fluctuating population of 8 to 30 people, is located about 150 kilometres west of Warburton in the Ngaanyatjarraku Shire, also known as the Ngaanyatjarra Lands. The deceased attended the local primary school regularly and was well cared for.¹³ She seemed a happy child.¹⁴
13. The deceased and AP got along well.¹⁵ She would follow him around and called him 'Dad'.¹⁶

EVENTS LEADING UP TO THE DEATH

14. On the morning of Saturday 31 December 2011 one of the other residents of Tjirrkarli, Harold Cocks, went hunting with his partner, Debbie Watson, in their four-wheel drive vehicle. They drove to Dingo Hills, about four kilometres from the community. There he shot a kangaroo and wounded it, but was unable to find it.¹⁷
15. Mr Cocks and Ms Watson returned to Tjirrkarli for breakfast and then went back to look for the kangaroo,

¹¹ Exhibit 1, Tab 25

¹² Exhibit 1, Tab 5

¹³ Exhibit 1, Tab 5, Tab 25

¹⁴ Exhibit 1, Tab 6

¹⁵ Exhibit 1, Tab 5

¹⁶ Exhibit 1, Tab 6, Tab 13 p.35

¹⁷ Exhibit 1, Tab 6

this time taking AP and the deceased with them. They returned to the community at about 10:00am without finding the kangaroo.¹⁸

16. After they had returned to the community, AP decided to have another look for the kangaroo on his own. He told Mr Cocks of his plan and borrowed Mr Cocks' rifle.¹⁹
17. AP had a previously broken-down Holden Commodore that the deceased's mother had allowed him to use on the basis that it belonged to the deceased. He was a self-taught mechanic and was able to repair it to the stage where it was in reasonable mechanical condition, though it had no rear windscreen.²⁰
18. When the deceased saw that AP was going to go out in the car to look for the kangaroo, she asked to go along and he agreed.²¹
19. This was the first time that AP had gone out hunting in the car and the first time that he had taken the deceased. Previously he had gone with Mr Cocks, who was experienced and familiar with the area around the community.²² AP's bush skills were not good.²³

¹⁸ Exhibit 1, Tab 6

¹⁹ Exhibit 1, Tab 6

²⁰ Exhibit 1, Tab 13, p.29

²¹ Exhibit 1, Tab 13, p.41

²² Exhibit 1, Tab 13, pp.33, 37

²³ Exhibit 1, Tab 13, p.36

20. Because AP had not intended to go very far, he took only a plastic water bottle with cordial and two oranges.²⁴ That morning the deceased had eaten one Weetabix cereal for breakfast.²⁵ The maximum temperature that day was about 45 degrees.²⁶
21. AP drove back to the Dingo Hills area and attempted to drive through the scrub, but they soon became lost. After they had been driving for three or four hours, the car started to overheat. AP removed the bonnet of the car and placed it on the back seat. Two of the tyres were then punctured and at about 6:00pm the car became bogged down to the axle.²⁷ They were about 23 kilometres north of Tjirrkarli.²⁸
22. The deceased and AP stayed with the car overnight, sleeping on the roof from fear of snakes.²⁹
23. Meanwhile Mr Cocks had driven back to the Dingo Hills area to search in vain for the deceased and AP.³⁰
24. On the next morning, 1 January 2012, AP attempted unsuccessfully to dig the car out. He drank water from the radiator but the deceased would not.³¹ They decided to walk out.³²

²⁴ Exhibit 1, Tab 13, p.36

²⁵ Exhibit 1, Tab 13, p.47

²⁶ Exhibit 1, Tab 2

²⁷ Exhibit 1, Tab 13, p.57

²⁸ Exhibit 5

²⁹ Exhibit 1, Tab 13, p.39

³⁰ Exhibit 1, Tab 6

³¹ Exhibit 1, Tab 13, p.74

³² Exhibit 1, Tab 13, p.60

25. At about the same time, Mr Cocks notified police of the fact that the deceased and AP had not returned to Tjirrkarli by the previous night.³³ Senior Constable (then Brevet Sergeant) Dinneen, as acting officer-in-charge of the Warburton Police Station, quickly organised search arrangements, including a search aircraft.³⁴
26. AP decided to start walking east as he thought that Tjirrkarli was in that direction. He and the deceased took the cordial, oranges, a doona, the rifle and a clear plastic tarp that had been used to cover the missing rear windscreen.³⁵ AP was a smoker so he had a lighter with him.
27. AP used black tape to place an arrow in the top of the car to indicate the direction they intended to go, and he lit a fire in the scrub near the car to create smoke to assist rescuers to find them. He thought of burning the car to make black smoke, but did not want to destroy the car as it was the deceased's.³⁶
28. The deceased had a pair of thongs, but she could only find one of them. It seems that her missing thong was in the back seat of the car under the bonnet. AP gave his thongs to her, but they were difficult for her to use.³⁷

³³ Exhibit 1, Tab 6

³⁴ Exhibit 1, Tab 8

³⁵ Exhibit 1, Tab 13, pp.64-65

³⁶ Exhibit 1, Tab 13, p.39

³⁷ Exhibit 1, Tab 13, p.63

29. The deceased and AP were not able to walk far because of the heat. The temperature was about 44 degrees that day. At one stage there was a brief rain shower so they tried to capture some of the rainwater in the plastic tarp, but were only able to obtain a small amount.³⁸ They spent time sitting in the shade of a tree and later, when it was cooler, they walked a bit further. That night they slept on the ground; the deceased had the doona.³⁹
30. On the next morning, Monday 2 January 2012, the deceased and AP walked further east. They found the track that the car had made on 31 December 2011, so they followed it. By this stage they had run out of water and the deceased had eaten the oranges. AP had started drinking his urine by collecting it in a plastic bottle. The deceased did not drink any.⁴⁰ That night they again slept on the ground with the deceased wrapped in the doona.⁴¹
31. On the morning of Tuesday 3 January 2012 the deceased and AP walked a bit further but were unable to go on. They found shade and AP lit another fire nearby. The deceased lay in the shade, panting.⁴² They were about 12 kilometres from the car.⁴³

³⁸ Exhibit 1, Tab 13, pp.50-51

³⁹ Exhibit 1, Tab 13, p.69

⁴⁰ Exhibit 1, Tab 13, p.74

⁴¹ Exhibit 1, Tab 13, p.76

⁴² Exhibit 1, Tab 13, p.79

⁴³ Exhibit 1, Tab 2

32. At about 12.30pm police in a search aircraft spotted the car. With the help of the officer in the police aircraft, police officers in a four-wheel drive vehicle followed the tracks made by the car on 31 December 2011. At 3.30 pm they found the deceased and AP.⁴⁴
33. AP told the first police officer who approached him, Brevet Sergeant Allan, that the deceased was not in a good way.⁴⁵
34. Brevet Sergeant Allan went to the deceased, who was still lying prone in the shade of a bush. She was unresponsive and was slowly gasping for breath. He tried to pour a little water into her mouth, but she did not move or swallow the water.⁴⁶
35. With the help of Brevet Sergeant Duncan Carter, Brevet Sergeant Allan moved the deceased onto rear seat of the police vehicle in preparation to drive back to Tjirrkarli. As Brevet Sergeant Allan was holding her in the recovery position, she stopped breathing.⁴⁷
36. The two police officers commenced expired air resuscitation and then cardiopulmonary resuscitation while driving back out. AP was also in the vehicle.⁴⁸

⁴⁴ Exhibit 1, Tab 10; ts 8

⁴⁵ Exhibit 1, Tab 10

⁴⁶ Exhibit 1, Tab 10

⁴⁷ Exhibit 1, Tab 10

⁴⁸ Exhibit 1, Tab 10

37. A short time later they met another police search vehicle which had earlier been forced to stop because of a punctured tyre. Detective Senior Constable Tanya Tidey got out of that vehicle and joined Brevet Sergeants Allan and Carter to assist with CPR as they continued to drive out.⁴⁹
38. They then met a third police vehicle which was carrying two nurses. The nurses determined that the deceased was dead.⁵⁰

CAUSE OF DEATH AND HOW DEATH OCCURRED

39. On 6 January 2012 forensic pathologist Dr G A Cadden conducted a post mortem examination and found no gross pathology or trauma that would explain the death.⁵¹
40. Toxicological analysis detected no alcohol or common drugs.⁵²
41. Post mortem biochemistry carried out with respect to the vitreous humour was consistent with dehydration and potentially consistent with a degree of muscle breakdown which would occur in a hyperthermic situation.⁵³
42. Having regard to the circumstantial history and observations of the people attempting to rescue the

⁴⁹ Exhibit 1, Tab 10

⁵⁰ Exhibit 1, Tab 3, Tab 10

⁵¹ Exhibit 1, Tab15

⁵² Exhibit 1, Tab15

⁵³ Exhibit 1, Tab15

deceased, Dr Cadden considered that there was sufficient information to suggest that the cause of death was 'consistent with heat stroke and dehydration'.⁵⁴

43. On the basis of the information available to me, I find that the cause of death was heat stroke and dehydration.
44. As to the manner of how death occurred, I find that death occurred by way of misadventure.

AP'S MANAGEMENT UNDER ANCOR

45. The evidence of Senior Constable Dinneen and Sergeant Seivwright established that, despite carrying out reasonable investigations, WA Police were unaware that AP was living with the deceased in Tjirrkarli.
46. Police had interviewed AP regularly and specifically asked him if he was residing with a child. On each occasion, including occasions during the time in which he was living with Ms Little and the deceased, he said that he was not.⁵⁵
47. Senior Constable Dinneen had twice interviewed AP in Tjirrkarli. AP did not declare to him, as he was required to do, that the deceased was living with him. Senior Constable Dinneen looked for signs of children at AP's house but saw none. He considered that, due to the operation of the *Community Protection (Offender*

⁵⁴ Exhibit 1, Tab15

⁵⁵ Exhibit 1, Tab 24

Reporting) Act 2004, he was not empowered to search AP's house or to question neighbours in order to investigate whether a child was living with AP.⁵⁶

48. In any event, a post mortem examination of the deceased by consultant paediatricians from the child protection unit of Princess Margaret Hospital found no evidence of sexual assault.⁵⁷ In oral evidence AP denied having touched the deceased in a sexual way⁵⁸, and there is no evidence to indicate that he took the deceased into the bush with an intention to do so.
49. It is also worth noting in passing that neither the offence in relation to which AP was placed on ANCOR nor the offence for which he was serving a term of imprisonment at the time of the inquest involved a sexual assault of a young girl.
50. Prior to being sentenced for the latter offence, AP underwent psychiatric and psychological assessment. The sentencing judge, Derrick DCJ, considered the resultant reports and was not satisfied that AP had any deviant sexual interest in female children or children generally.⁵⁹
51. In these circumstances, I can see no causative connection between the deceased's death and the management of AP under ANCOR.

⁵⁶ Exhibit 1, Tab 23

⁵⁷ Exhibit 1, Tab 16, Tab 20

⁵⁸ ts 56

⁵⁹ Exhibit 1, Tab 26

THE INVOLVEMENT OF THE DCPFS

52. Ms Davis reviewed the DCPFS' assessment and service provision to the deceased. She noted that the DCPFS acknowledged that the child protection practice and response in relation to the deceased's circumstances were poor. Practice was not child-focused and there was apparent non-compliance with policy and practice guidelines.⁶⁰
53. Despite several contacts of departmental staff with Ms Little and the deceased in 2010, a proper assessment of the deceased's welfare was not conducted.⁶¹ For example, a senior community child protection worker was told that Ms Little was visiting AP, but no investigation was undertaken to determine AP's background.⁶²
54. The DCPFS' shortcomings appear to have been the result of a lack of both funding and leadership in its Goldfields district, issues which have been addressed, commencing in 2008.
55. Ms Davis considered that a thorough safety and wellbeing assessment of the deceased should have been undertaken to ascertain what next step, if any, was needed.⁶³ If appropriate, a protection order could have been sought and, if one were made, the deceased could

⁶⁰ Exhibit 1, Tab 25

⁶¹ Exhibit 1, Tab 25

⁶² ts 33 per Davis, J

⁶³ ts 33 per Davis J

have been formally placed with a suitable family or community member following assessment of an identified carer.⁶⁴

56. However, when asked if a different response by the DCPFS to the deceased's circumstances could have led to a different outcome, Ms Davis stated that the issue was highly speculative, the deceased was living in a remote area, and the outcome could have been the same had she been in care with relative carers or not.⁶⁵ I accept that observation.
57. In my view, despite the self-acknowledged failings by the DCPFS, there is no evidence to indicate that the deceased's welfare was detrimentally affected as a result.

RECOMMENDATIONS IN RELATION TO PREVENTING DEATHS IN SIMILAR CIRCUMSTANCES

58. The Court was fortunate to obtain the expert report of Dr Luckin in relation to survival strategies for people in remote communities who become stranded in harsh environments.
59. Dr Luckin annexed to his report a list of basic instructions of what people in remote communities should do when they leave their communities to go into the bush or to visit someone else. He suggested that the instructions be placed on notice boards in community

⁶⁴ Exhibit 1, Tab 25

⁶⁵ ts 36 per Davis, J

centres, schools, shops, police stations and public places. The crucial instructions are:

- a. ensure that a responsible person knows where you are going;
- b. carry plenty of water; *and*
- c. if the vehicle breaks down, stay with the vehicle.

60. A copy of Dr Luckin's annexure is annexed to this finding.
61. Dr Luckin also suggested that training packages on survival when lost or stranded should be available to community elders, leaders and teachers for subsequent use by them. He suggested that the training would need to be culturally sensitive and if possible delivered by trained Aboriginal community members.⁶⁶
62. Brevet Sergeant Allan, who has now been in the Warburton area for three years, agreed that the information in Dr Luckin's annexure would be beneficial to the communities in the Ngaanyatjarra Lands. He said that education regarding this issue is certainly something that people need there. He thought that it would be readily feasible for police officers to liaise with all relevant agencies in order to distribute the public information notices suggested by Dr Luckin.⁶⁷

⁶⁶ Exhibit 1, Tab 27

⁶⁷ ts 63 per Allan, J

63. Brevet Sergeant Allan also suggested that the information provided by Dr Luckin could be conveyed by police officers in local schools.⁶⁸

64. I note that incidents involving people becoming stranded in inhospitable regions in Western Australia are far from rare. Too often these incidents end in death.

65. In these circumstances, I make the following recommendations:

RECOMMENDATION 1

That Western Australian Police devise a public notice based on Dr Luckin's annexure and take steps to ensure that copies of the notice are placed on public notice boards throughout Western Australia where there is potential for people to become stranded in remote areas.

RECOMMENDATION 2

That Western Australian Police officers who service remote communities liaise with community leaders with a view to arranging for the training of community members about survival when lost or stranded.

B P King
CORONER
17 April 2015

⁶⁸ ts 63-64 per Allan, J

ANNEXE A. SAMPLE PUBLIC EDUCATION NOTICE.

WHAT TO DO WHEN YOU LEAVE THE COMMUNITY

- such as to go bush, to go hunting, to visit someone else.

ALWAYS CARRY WATER WITH YOU. If you are in a car, always keep a big container of water in the car – **AT LEAST 10 LITRES** for two people;

- **20 LITRES IF YOU OFTEN CARRY MORE THAN 2 PEOPLE.**

Tell someone WHERE you are going, and WHEN you will be back..

Tell them if you are;

- 2 hours late; check to see if you are back, ask if anyone has seen you.
- 4 hours late; start looking for you,
- 6 hours late **TELL THE POLICE YOU ARE MISSING.**

Make sure your car is FIXED and WORKING PROPERLY, and is suitable for the trip you are making.

- Make sure you have plenty of **FUEL** in the car, more than you need for the trip.
- Check you have a good **SPARE TYRE**, a jack, and tools to change it.

Take some form of communication; an EPIRB (an emergency rescue beacon), two-way radio, a mobile phone if they work along the route you are taking, a satellite phone if you can get one.

VEHICLE BREAK-DOWN.

If the vehicle breaks down, becomes bogged, or runs out of fuel;

STAY WITH THE VEHICLE; THIS HELPS PEOPLE TO FIND YOU.

- Do not leave your vehicle.
- use the vehicle for shade and protection
- use the vehicle's mirrors to signal aircraft or other vehicles,
- light smokey fires, using green leaves to make smoke, burn vehicle seats, seat covers, one of the tyres
- clear an area around the vehicle,
- use stones, logs, anything else to write **SOS** in very big letters near the vehicle
- spread shiny things like a space blanket a short distance from the vehicle.

TELL SOMEONE RESPONSIBLE WHERE YOU ARE GOING.

CARRY PLENTY OF WATER IN YOUR VEHICLE ALL THE TIME.

IF YOU BREAK DOWN, DO NOT LEAVE THE VEHICLE.