Coroners Act, 1996

[Section 26(1)]

Western Australia

RECORD OF INVESTIGATION OF DEATH

Ref No: 46/12

I, Evelyn Felicia VICKER, Deputy State Coroner, having investigated the death of ***Adam Michael Hurley-Goodacre*** *with an inquest, held at the* ***Perth Coroners Court, Court 58, CLC Building, 501 Hay Street, Perth,*** *on* ***4 - 6 December 2012*** *find the identity of the deceased child was* ***Adam Michael Hurley-Goodacre*** *and that death occurred on* ***20 February 2007*** *at* ***58 Kilmurray Way, Balga,*** *as a result of* ***Ligature Compression of the Neck (Hanging)*** in *the following circumstances:*

Counsel Appearing :

Jeremy Johnston assisted the Deputy State Coroner
Michael Jenkin (State Solicitors Office) appeared on behalf of the Department for Child Protection

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INTRODUCTION

On 20 February 2007 the deceased, Adam Michael Hurley-Goodacre, (Adam) was located by his father, hanging, in the garage of the residence of Donna Thomas, Adam's father's girlfriend.

Adam had been a Ward of the State since 1996 and was placed with different carers by Family and Children Services, (then part of the Department for Community Development, now Department for Child Protection (the Department)), until October 2006 when Adam rejected residence at a Department approved hostel placement and chose instead accommodation of his choice.

It is as the result of Adam being a Ward of the State until his 18th birthday, on 27 February 2007, the provisions of the Coroners Act 1996 requires there be an inquest into the circumstances of his death. In particular his supervision, treatment and care as a Ward of the State, is to be examined.

The Department changed format in 2007 after a period of considerable dysfunction and difficulty for those both attempting to work for the Department, and those requiring the Department's services. It was a very difficult time for all those involved in the welfare and placement of children requiring protective care.

Adam was a week short of his 18th birthday when he died and the Department had been attempting to transit him to independent community living on leaving their ward ship.

OCTOBER 2006 – FEBRUARY 2007

By October 2006 Adam was less than six months from leaving wardship with the Department and was resident at Fusion House. He was very involved with Rhiannon and the Department was attempting to guide him to independence and self-reliance, without dictating his life. This included refusing him funds for arbitrary expenditure in an attempt to teach him self-reliance in budgeting. Frequently when he requested money his youth worker, mentor, or case worker would provide him with a food voucher, or go shopping with him for clothing, rather than provide cash.

During the period before October 2006 Adam had been oscillating with wanting to live with his father, or at least with the mother of his half brothers, and remaining at Fusion House with Rhiannon.

On 3 October 2006 Adam had a fight with Rhiannon and attempted to hang himself. Rhiannon contacted the police and the police took Adam to Royal Perth Hospital (RPH). Adam was accompanied by his current mentor and case worker from Fusion House.

The Department contacted RPH and advised them Adam was a Ward of the State and before he could be discharged his situation needed to be discussed with the Department. The issue of a referral for Adam to Bentley Adolescent Unit (BAU) was discussed. The Department commenced to make inquiries as to why they had not been advised earlier of Adam's instability, and whether Fusion House would be able to provide appropriate monitoring in the future. A Crisis Care Unit (CCU) referral was prepared in case Adam was released from RPH without admission. The Department wished to ensure a safety plan was in place for his support.

RPH contacted the Department and advised them they considered Adam to be at low risk of suicide and wished to discharge him that night. RPH wished to refer Adam to a Youthlink service for long-term support and CCU advised they would provide an extra Fusion worker to supervise Adam's safety over night. CCU then contacted both Adam's mentor,

and Adam, to advise them of the proposed plan for Adam's safety. Adam however, informed CCU he had spoken with both his girlfriend and his father and he was feeling good and happy with the long-term support plan to be put in place by RPH. He did not require additional input from CCU. Adam was advised if his mood should change CCU was available overnight to assist him.

The following day, 4 October 2006, CCU provided the Department with a record of its communications with RPH, Fusion House and Adam; while Adam's mentor provided the Department with a critical incident report relating to Adam's suicide attempt on 3 October 2006.[5]

In that critical incident form Adam's mentor advised the Department he had been concerned about Adam's behaviour in the month prior to October. He had arranged for Adam to attend at RPH for an assessment, but was advised on the morning of 3 October 2006 Adam had refused to attend. That was the day upon which he had attempted suicide.

Adam's mentor had advised the appropriate Department office, however, that office was quite dysfunctional at the time and had been happy for Adam's mentor to make suitable arrangements to support Adam. Adam's mentor explained that while he had been at RPH with Adam, Adam had improved in response to concern expressed by both his girlfriend and his father as to his wellbeing.

[5] Exhibit 2, Cheryl Barnett statement attachment 1

Adam's mentor made the following comment –

> *"Adam had issues in controlling and coping with his anger towards himself, his wellbeing was dependent 100 percent on the relationship with his dad and girlfriend".*

The purpose of RPH referring Adam to the BAU was the hope he could be educated to deal with these feelings. Adam's mentor had contacted Adam's youth worker, and between them, they had worked out a strategy to assist and support Adam. Adam's mentor was now advising the Department as to the steps he had taken in response to their request he handle the matter. Adam's mentor specifically raised *"a huge concern for Adam in the massive emotional mood swings he can be in during just one day. On Monday Adam wanted to commit suicide in the morning and when I talked to him in the afternoon he was relatively happy. Similarly on Tuesday morning he attempted suicide, and by the afternoon he was laughing and enjoying himself".*

Adam's mentor also outlined for the Department the specific steps he had taken to care for, and support, Adam.

It was on the day the Department received Adam's mentor's incident note Adam again threatened to kill himself by jumping off the roof of Fusion House. Adam stated he had broken up with Rhiannon the night before, he hated his dad and that the Department and its workers did not care about him. He had smoked dope. Adam stated he felt used and not

wanted. The CCU advised staff at Fusion House to take Adam to RPH. This occurred.

As a result of the events of 3 and 4 October 2006 Fusion House advised the Department they could no longer accommodate Adam safely, and an alternative placement would need to be found. Both Adam's mentor and youth worker were attached to Fusion House. However, they were prepared to continue working with Adam in an effort to support him. Adam ran away from RPH after Rhiannon had come into hospital to end the relationship, but returned after speaking with his mentor.

These events caused RPH to make Adam an involuntary patient under the *Mental Health Act 1996* and he was placed under guard to ensure he did not run away. Attempts were then made to house Adam appropriately whilst an involuntary patient. This required he had a placement in an authorised facility under the Mental Health Act.

The social worker from RPH believed Adam did not understand the seriousness of his behaviour and was now saying he had *"faked it"*. Adam continued to be maintained in RPH as an involuntary patient while awaiting admission to either the BAU or Graylands Hospital.

On 9 October 2006 there was a meeting at RPH to try and determine the best course of action for Adam's future. At the time Adam's file was allocated to a team leader rather than a

specific case worker. Consequently, when it was necessary a case officer attend RPH on behalf of the Department, Rowena Richards, who had only been with the Department and at the Midland office for three days, was asked to attend as Adam's case worker. She did not have time to assess Adam's file and this was her first post-graduate professional employment.

Ms Richards herself, considered this to have been totally inappropriate.[6] It was. Unfortunately, the Department was in the very difficult position at the time of having no-one else available to attend on their behalf. This was due to the dysfunctionality of the Department arising out of a serious lack of staff, and problems at the Midland office in particular.

As a result Ms Richards was largely reliant on Adam's mentors for input, along with that of the Consultant Psychiatrists and nursing staff at RPH.

The decisions arising from that meeting were Adam was not to be put on medication, he needed counselling and support and already had been referred to Youthlink, he was not to be released because he was homeless, and he was to be reviewed daily. This would seem to be an appropriate management strategy in the circumstances in which Adam found himself, and the Department was in, at that time.

Ms Richards maintained contact with Adam by ringing him every day and asking him what was happening and how he

[6] Transcript 5.12.13, page 90

was going. This was appropriate, but does not alter the fact that to Adam, Ms Richards was a complete unknown.

At a meeting in the afternoon of 9 October 2006 the Department acknowledged the situation with Adam not having a specified case worker more recently, but relying on the input of his Fusion House mentor and case workers, had left a gap in their involvement with Adam during this time. Adam was very angry with the Department and this made him very vulnerable to both Rhiannon and his father's input. In addition, his aunty Kae had visited him and disapproved of his behaviour.

The welfare officer from RPH advised the meeting Adam had not been diagnosed as having any mental health issues but did require cognitive behaviour therapy to cope with his emotions and adjustment disorder. A request by Adam's father for his participation in his grandfather's funeral had been denied due to Adam's extreme responses and vulnerability to input from his father and girlfriend.

The plan was to attempt to find somewhere for Adam to be accommodated while he was stabilised. Adam was to be provided with increased mentoring support and extended care options in view of the changing statutory frame work of the Department for support after 18 years of age.

On 13 October 2006 RPH advised Adam was free for discharge, however, the Department had found no where

prepared to accommodate Adam. Adam's father was intending to collect him and take him to the home of Sharon Hall, the mother of Adam's half brothers. The Department was concerned because they understood Adam was very vulnerable to his father, and they were unsure of Ms Hall's commitment to caring for Adam in all the circumstances. It was not an approved placement.

Due to his voluntary status Adam's discharge could not be prevented and he left RPH on 15 October 2006 and stayed with Ms Hall. Rhiannon stayed with him. By 18 October 2006 Adam's father had contacted CCU asking for assistance for Ms Hall.

It became apparent Ms Hall could not cope with some of Adam's extreme emotional responses to stress.

An attempt was made to re-admit Adam to RPH, however, RPH advised the appropriate procedure was for Adam to be assessed by the Psychiatric Emergency Team (PET). PET eventually agreed to do a telephone assessment of Adam while he was at Ms Hall's. Following that assessment PET advised Adam's situation was not psychiatric, but a social problem relating to his relationship with his girlfriend. PET believed the best option was for Adam to be removed from Ms Hall's home and placed in a supervised hostel. As a result at 10:00pm on the evening of 18 October 2006 Adam was taken from Ms Hall's home by the police and placed in emergency accommodation.

On 19 October 2006 Adam attended DCD Midland office and advised his case officer he did not want to go to school and had no clothing. When asked by Ms Richards about the events of the previous evening he advised her nothing had happened, he was just feeling *"full on"* because he had lost *"his grandfather, father and girlfriend"*. He declined to talk about the situation any further.

The emergency accommodation refused to further accommodate Adam as they believed he was a threat to younger children in their care. Adam was provided with a taxi voucher to get to Streetsyde for three nights accommodation. Streetsyde provides emergency accommodation only and three nights is the maximum time for accommodation.

Adam was seen by his regular paediatrician on 23 October 2006. He advised her he was now under the care of a psychologist at Youthlink, though RPH, with whom he communicated well, and his paediatrician effectively discharged him into the care of the psychiatric unit of RPH.

Adam was still homeless and a further three nights accommodation was arranged for him at Streetsyde. The intention was to refer him to Chesterfield House Homeless Youth Centre, however, Adam refused that referral and indicated he wished to live with his father and his father's current girlfriend, Donna Thomas. It was explained to Adam that if he self selected a placement in this way the Department

would not be able to assist him financially, although he would still have the support of his mentor from Fusion House and case worker. Adam indicated that was fine with him, although he also said he did not like them and would prefer other counselling services.

Ms Richards, Adam's case worker, commented she liked Adam and it was apparent he used his alleged likes or dislikes of people to obtain his way and his statements were generally quite at odds with his positive responses to the people he stated he did not like. Ms Richards told Adam she would stay in touch with him although she did not support his placement with Ms Thomas.

Ms Thomas did not know there was an order in place restricting contact between Rhiannon and Adam and consequently was not concerned when Adam had Rhiannon stay with him. Both Ms Thomas and Mr Goodacre observed Rhiannon to have quite a destabilising influence on Adam.

Ms Thomas indicated to the court she had understood she had been approved to care for Adam, although this certainly was not the intention of the Department. She felt she had not been advised of any of the difficulties of caring for Adam or his vulnerability and she felt the Department had let her down by not advising her fully of the situation.[7] It is clear the Department did not approve the placement, however, felt they could not stand in Adam's way so close to his 18th birthday.

[7] Transcript 4.12.12, page 70

They understood Adam's father did not reside with Ms Thomas, but due to their relationship presumed Ms Thomas understood Adam's situation.

The Department believed they had further explained the situation to Mr Goodacre on 3 November 2006 when they advised him their role would be limited as Adam had demonstrated he did not wish to be involved with the Department, and they were not in a position to dictate his actions. Mr Goodacre was advised by Ms Richards Adam had a youth worker, a mentor, a psychiatrist at Youthlink, and herself, if Adam wished to obtain the assistance of the Department.

Adam's contacts with his case worker following that meeting were usually in the company of his youth worker, and he tended to demand one-on-one input. Following Adam's failure to attend a pre-arranged meeting to discuss his circumstances it was agreed Adam would not be supported so intensively, until he showed some commitment to engaging with their input.

The next follow-up the Department had with Adam was when he attended the Midland DCP office and said he was staying with his father and Ms Thomas. He advised he had not seen his girlfriend, he was not depressed and wanted to make 2007 *"his year"*. He asked for a food voucher because he had spent his money on shoes and stated he would not be able to eat without a voucher. He failed to make a pre-arranged meeting

and was angry when he attended at a different time and was not able to engage in a meeting.

Adam's Youthlink psychiatrist contacted the Department to advise them Adam had not responded to her letter. Adam only engaged with her when he wanted something, and on her attempts to contact him, his father had said Adam had thrown out his last two mobiles phones because he did not want to be contacted. The Youthlink psychiatrist advised Ms Richards there was nothing else she was able to do that had not already been tried, and all they could do was wait to see if Adam would engage.

The following entries indicate a general inability of those with reference to the Department and its support of Adam to contact Adam at times they tried. Similarly Ms Thomas indicated in court she felt she was not given suitable support from the Department. It is relatively clear from the evidence and Department records Adam was manipulating his relationships between these parties during this time to achieve his perceived short term goals.

On the evidence available it appears he would complain to his case officer about Ms Thomas when he wished to live in his father's flat, and would complain to his father and Ms Thomas about the Department when he wanted their support.

A Leaving Care Plan meeting was planned for 9 January 2007 to advise all relevant parties of the strategies for Adam leaving

care on his 18th birthday, 27 February 2007. Mr Goodacre and Ms Thomas agreed to attend when hearing Adam had agreed to attend. It was held at the Department's Midland office and chaired by Adam Peaty.

It was agreed Adam would continue to stay with Ms Thomas, provided he behaved reasonably and refrained from remaining in his room and not socialising with the family. Adam indicated his preference was to stay in his room. Adam appeared to be loosing interest in his education and was hoping to work at fast food outlets convenient to where ever he was residing.

The review of Care Plan Meeting ended with Adam's father expressing some concerns over Adam's life skills and behavioural problems with respect to his coming independence. It was explained Adam had been provided with access to assistance but Adam had failed to engage appropriately. It was made clear people engaged in this process would be prepared to continue if Adam would cooperate.

A meeting was arranged with Adam by the case manager covering for Adam's youth worker. Adam attended that meeting and admitted he did not know how to budget, and he did not understand what was meant by the "enrolment process" with respect to his desire to become an apprentice. The new youth worker agreed to help Adam and did indicate to Adam he needed to cooperate because his normal youth

worker had been trying to achieve these things with him and he had continually let her down. One of the disturbing things about the conversation was Adam's belief he was a bad person because bad things happened to him. He could not comprehend many things are normal life stressors which everybody experiences.

Adam was staying with Ms Thomas and his father. The youth worker considered Adam had a tendency to dramatise to get attention because he was not able to articulate his feelings clearly. Adam appeared to feel unloved.

Adam's case worker, Ms Richards, was leaving the Midland office and attempted to call Adam to explain she was leaving and someone else would be taking her place. Adam did not answer his phone and she was unable to say goodbye to him and to reassure him that her leaving was not anything to do with him. Ms Richards emphasised in the notes that whoever worked with Adam in the future needed to keep trying to encourage him to engage with the supports and assistance towards independent living.

Following the Leaving Care Plan meeting the Department did not have direct contact with Adam. Contact was always through the youth worker who belonged to one of the community groups in touch with Adam. Due to Adam making his own decisions with respect to his placement, and the support he was prepared to engage with, there was very little

the Department could do to positively assist Adam unless he sought their input.

In the week prior to his death Adam was staying with Ms Thomas and his father. Ms Thomas' evidence was he was not an easy householder to accommodate due to his desire not to participate in the family, however, she understood he had been in difficult situations.

Ms Thomas explained in the weeks before Adam's death, which included Valentines Day, there had been contact between Adam and Rhiannon. Apparently, Adam had bought presents for Rhiannon and was hopeful of reigniting their relationship. Adam believed there would be a future in the relationship, however, Rhiannon again failed to keep contact with Adam and this caused Adam enormous angst. There appears to have been some suspicion on Adam's part Rhiannon may be seeing another person.

Ms Thomas was not aware of the extent of Adam's involvement, and its effect on Adam until the time of his death.

20 FEBRUARY 2007

It is not clear whether it was overnight from 19 February or early on 20 February 2007 Adam was extremely upset.[8] Whilst I am sure this was centred on Rhiannon, he was in the position of anything upsetting him when he was very

[8] Transcript 4.12.12, page 84

distressed. Due to Adam's difficulties in communicating and articulating his feelings I am sure this would have been very difficult to cope with in a household accommodating other children. There was apparently some sort of exchange between Ms Thomas and Adam as a result of him punching a hole in his bedroom.

Ms Thomas and Mr Goodacre reacted in a normal parental manner by Mr Goodacre sitting and having a talk with Adam about his problems.

In hindsight, Mr Goodacre agrees Adam was totally besotted with Rhiannon, and so immature with respect to life skills he had difficulty in comprehending his future, while so mesmerised.

Mr Goodacre certainly attempted to talk with Adam and did have a long talk with him, however, in Mr Goodacre's view there had to be some outcome from his bad behaviour and later, when Ms Thomas and Mr Goodacre needed to go out, it was decided Adam should stay behind. They took Ms Thomas's children. Adam asked if he could go and when that was declined as a form of attempting to teach Adam the consequences for his actions he retreated to his room. This was not unlike the things Adam's case worker had attempted in the past when he came requesting cash because he had not budgeted appropriately for his life needs. Everybody was attempting to provide Adam with life skills by making him understand there were consequences to his behaviour.

It is apparent that while Ms Thomas and Mr Goodacre were out Adam found some wine and consumed it. He then, I believe impulsively, went into the garage and used a washing line cord to hang himself from the roof beams.

He was located by his father because Ms Thomas dropped Mr Goodacre off while she went to attend to other matters. Mr Goodacre located Adam almost immediately. He called Ms Thomas and she returned to assist until the ambulance and police had been called.

Adam could not be resuscitated.

Mr Goodacre was understandably distraught. From his perspective he had only just re-established a parental style relationship with Adam and now it was over. Ms Thomas also was distressed because Adam seemed unable to cope with normal life stressors and she felt she had not been adequately prepared for this. She had not understood Adam would not respond as expected to normal parental transactions.

CONCLUSION AS TO THE DEATH OF ADAM

Adam was a 17 year old, adolescent, Ward of the State.

Adam had been emotionally involved with different surrogate mother figures during his life and this had caused him significant emotional angst when his long-term and stable

foster placements ended. The Department had no control over the ending of those placements.

The Department itself, during the latter part of Adam's life, had been in a state of considerable dysfunction and disarray. It made caring for children as vulnerable as Adam almost impossible. Despite this they achieved a considerable amount

[10] Transcript 4.12.12, page 83

of continuity for Adam through his placements and schooling, but consistency was lacking.

In late 2006 Adam formed a deep attachment for another young person, his girlfriend, who appears to have been as unstable emotionally as Adam had become as a result of his life experiences. Adam seems to have developed no resilience to life stresses, despite having regular contact with a paediatrician, mentors, case workers and youth workers, all of whom consistently attempted to engage him, and so guide him.

I accept the final family placement with Kae Kelly appeared appropriate for Adam who, through that placement, had contact with Allan Goodacre who had been a consistent figure in his life from childhood. I appreciate all concerned believed this to be an appropriate placement. Adam appeared anxious to please Ms Kelly and remain as part of that family group. It seems to have been largely as a result of Ms Kelly's insistence Adam's visits with his father were supervised.

In hindsight, this may have been excessively controlling and prevented Adam from experiencing normal adolescent problems and difficulty with parental relationships. However, there is no doubt everybody was trying to engage and help Adam.

I am satisfied that by the time he was 17½ years of age Adam had very few life skills and no insight as to how detrimental

that was to his ability to make informed decisions. His desire to live independently of Departmental placements was an example of Adam not understanding the support he needed was emotional, not just financial.

Adam's relationship with his girlfriend Rhiannon, also a vulnerable adolescent, was extremely detrimental to his stability. It is not unusual for adolescents to form over whelming relationships. Adam's self harming behaviours certainly seemed to relate to times of instability with his girlfriend and was one of the reasons the Department attempted to restrict their contact.

I am satisfied that on 20 February 2007 Adam was very distressed over his latest difficulties with Rhiannon and reacted very emotionally to any attempts to console him or rationalise his behaviour.

When his father and Ms Thomas left the house after the discussion about life experiences Adam consumed alcohol which was available, although not readily, in the household and I believe, impulsively, hanged himself as an expression of his distress.

I have to assume he intended the consequences of his actions due to the preparation he needed to engage in with setting up the ligature. I am concerned, however, at the consumption of alcohol and Adam's life demonstration of a lack of insight into the consequences of his behaviour on occasions. I accept he

understood he would die, I am just not convinced he had the cognitive foresight to think clearly about the intent he had formed.

I find death arose by way of Suicide.

COMMENTS ON THE SUPERVISION, TREATMENT AND CARE OF ADAM

I have referred a number of times to the difficulties experienced by the Department during the period of, particularly, Adam's adolescence. The difficulties for staff working in the Department during that period certainly made it almost impossible to provide constancy of contact with vulnerable children.

In Adam's case, due to the changes with both his foster family placements and schooling, the lack of consistency with Departmental workers must have impacted on his ability to engage with individuals. There were few individuals in his life consistently for long enough for him to fully trust them or their judgment.

Certainly his mentor from Fusion House and the youth worker from the Hills Community Groups attempted to maintain contact with Adam, even when he was no longer placed with establishments to which they were attached. In view of the difficulties with Adam's placements, which I accept were not the Department's fault, I am of the view the Department did

surprising well, but a lack of continuity was not optimal for Adam.

At the times, before Adam was made a Ward of the State, when he needed an accessible consistent responsible parent, his father, Mr Goodacre, was not available due to his own difficult circumstances. This fostered the beginnings of Adam's awareness of his father.

I am satisfied from a reading of the contemporaneous records in the extensive file for Adam, the Department was quite genuine in its concern with Adam's responses to his father. I understand Mr Goodacre does not accept this but the Department was quite proactive in attempting to provide Adam with an environment which would foster a positive outcome with his father. Certainly the placement with Kae Kelly was an attempt by the Department to give Adam the perception of a real connection with his family of origin. From Adam's perspective the placement with Ms Kelly, as Allan Goodacre's wife, provided Adam with continuity of contact with his father's family. The Department had no reason to doubt Ms Kelly's assessment of Adam's tension around visits with his father.

There is a contemporaneous file note recording Ms Kelly's questioning as to why Adam had been allowed unsupervised contact with his father. Adam's case worker was new and did not know Adam was supposed to have supervised visits. It was Ms Kelly's concern which alerted the case worker to the

ordered supervised visits and, at Ms Kelly's instigation, they were reinstituted. In her review Ms Barnett is quite open in saying the Department did not perceive Mr Goodacre as a danger to Adam. That was not the cause for concern. The concern was Adam's reported wariness and tension surrounding visits with his father.

There is no suggestion Mr Goodacre was a *"bad"* father. It was more his inability to be constant or consistent in his contact with Adam when Adam was young which caused a wariness in Adam which then had to be taken into account when dealing with Adam. Added to that was Adam's desire for a "mother figure" and his concern to please a mother figure which appears to have affected his emotional development to some extent.

It was evident during the inquest Mr Goodacre had some difficulty understanding the concept of the need to consider the best interests of Adam as being different from implying Mr Goodacre was a bad parent. Mr Goodacre seemed to think it was a concern with him, rather than a concern with Adam's emotional wellbeing, which caused the problems. Mr Goodacre also had difficulty with conceptualising the difference between a fact and a statement alleging a different fact. This made it hard to explain a tendency on Adam's behalf to make different statements of fact to different parties about the same thing in an attempt to achieve an outcome he wanted, which may not be in his best interest.

The difficulty with Mr Goodacre having a positive impact on Adam's life as he approached adulthood was the fact Adam had never had a normal parent/child relationship. In a conventional parental role stressors and disagreements are accepted as part of the relationship and occur with good parenting. Mr Goodacre certainly understood this, but did not understand it was something Adam did not trust. In his experience parental figures had not been constant in his life and so he did not trust "parents" had his best interest at heart.

I have found Adam's death to be one of the most tragic I have had to examine. In view of the difficulties experienced by the toxic environment in the Department at significant times in Adam's life, I consider staff went to considerable efforts to try and give Adam some consistency and stability. Everybody, including Adam's father, who left Adam in placements Adam said were his preference, tried to act in Adam's best interest. I suspect his suicide attempts, and eventual suicide, reflect no more than the tragedy of extreme emotions experienced by many adolescents at coming to terms with emotional rejection. It is just in Adam's case everybody tried so hard, and yet no one actually managed to engage with Adam in a way that was protective in his hour of need.

I consider the Department in the circumstances with which they were faced with Adam's placements, and indeed Adam's father, and Ms Thomas at the late time she became involved

with Adam, tried their very best to care for Adam. Adam had no concept of how to care for himself.

There are no recommendations I can see with respect to this matter other than to acknowledge the Department has attempted, through its restructure, to address ongoing care issues, placement issues, resourcing and constancy of case workers.

Ms Barnett stated the Departmental Midland office, which had most contact with Adam, now has a much more stable work force. This is a positive for staff and must be a positive for the children in their care. These children are in care through no fault of their own and are vulnerable by the very fact they are in care.

It is only to be hoped the Department will be appropriately resourced to provide the level of care this community expects for its vulnerable children.

EF VICKER
DEPUTY STATE CORONER

1 February 2013