JURISDICTION : CORONER'S COURT OF WESTERN AUSTRALIA

ACT : CORONERS ACT 1996

CORONER : SARAH HELEN LINTON, DEPUTY STATE CORONER

HEARD : 15 - 17 JUNE 2021

DELIVERED : 15 DECEMBER 2021

FILE NO/S : CORC 11 of 2017

DECEASED : Child J

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Ms S Tyler assisted the Coroner.
Ms K Ellson (SSO) appeared on behalf of the Department of Communities, WA Country Health Service, Kimberley Mental Health and Drug Service, Central West Mental Health Service and the witnesses Fiona Fisher, Kelly Jones, Amy Ritchie, Michael Saunders, Clare Wood, Lynne Jackson, Eugene Richards, Dr Prudence Stone and Dr John Boulton.
Ms E Langoulant and Ms Alaraibi (ALS) appeared on behalf of Child J's parents.

Case(s) referred to in decision(s):

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Sarah Helen Linton, Deputy State Coroner, having investigated the death of ***Child J*** *with an inquest held at Broome Courthouse, Court Room 1, Hamersley Street, BROOME, on 15 June 2021 - 17 June 2021, find that the identity of the deceased person was* ***Child J*** *and that death occurred on 25 April 2017 at 114 Sanderling Drive, Djugun, from ligature compression of the neck (hanging) in the following circumstances:*

TABLE OF CONTENTS

INTRODUCTION 3
EARLY YEARS IN BROOME 4
CONSIDERATION OF PMH REVIEW 7
CARNARVON 25
RETURN TO BROOME 31
EVENTS LEADING UP TO DEATH 37
CAUSE AND MANNER OF DEATH 38
COMMENTS ON TREATMENT, SUPERVISION & CARE 44
CONCLUSION 53

SUPPRESSION ORDER

The deceased's name, and any evidence likely to lead to his identification, is suppressed from publication. The deceased is to be referred to as Child J in any publication.

INTRODUCTION

1. Child J was a young Aboriginal boy who lived for most of his life in Broome. In his early years he lived with his mother, who struggled to care for him due to her health and social issues. As a result, Child J was taken into the care of the Department of Communities (the Department) when he was only a couple of years old and placed into foster care. He lived with the same foster family in Broome for large parts of his life, as well as spending some periods in the care of various family members. Child J appeared happiest when living with family, but this was unfortunately not always possible.

2. There were concerns about Child J's behaviour, development and speech from an early age. It was suspected he might have Foetal Alcohol Spectrum Disorder, as a result of exposure to alcohol in utero, as well as neurodevelopmental issues due to early exposure to trauma. He was referred to paediatric and mental health services many times over the years. The amount of input he received from these services varied over time, but was noticeably reduced in the last few years prior to his death.

3. There is evidence Child J began self-harming when he was as young 6 or 7 years old. By 2011, when he was about 10 years old, he was reported as having experienced suicidal thoughts. From 2013, when he was approximately 12 years old, there appeared to be further deterioration in his mental state and he was diagnosed with clinical depression. In January 2014, he attended hospital twice in one month after threatening to cut his throat. He was prescribed various medications over this time, but he generally reported that he did not like taking them.

4. There followed approximately one year, after Child J moved to Carnarvon to live with his father, where he had little contact with the Department or intervention by any health services. He and his father appeared reluctant to engage with the services available, but the evidence also suggests he was managing reasonably well at that time and was not in need of major assistance. It is reported that he chose to cease his use of all medications at this time.

5. Child J returned to Broome in early 2016 to visit family. He had apparently expected to return to Carnarvon after a brief holiday, but his father did not come and collect him and, when his father could not be contacted, it was decided he would remain in Broome. Child J moved in with his maternal aunt and her partner. This appears to have marked the beginning of a period of stability for Child J. He began attending high school in Broome, made friends and started a relationship with a girl. Although he changed schools in 2017 due to some behavioural issues, Child J appeared to be maintaining friendships, his school performance was improving and he was making plans for his future.[1] At the end of February 2017, the general consensus was that Child J was doing well and there were no immediate concerns held for him.

6. However, a month later, in March 2017, things changed again as Child J struggled to cope with his first relationship ending. On the evening of 24 April 2017, Child J sent a text message to his former foster mother indicating that he was struggling. She interpreted the message as relating to his feelings over the break up. She reassured him it would be alright and urged him to stay strong. In hindsight, the message may have

[1] Exhibit 1, Tab 2.

been flagging that Child J was experiencing suicidal thoughts, but this was not apparent to anyone at the time.

7. In the early hours of 25 April 2017, Child J left the house with a rope. He tied the rope to a tree and used it to hang himself. He was found by two passers-by who cut him down. They found he was not breathing and had no pulse. Police and ambulance officers attended and confirmed he had died. No suicide note was found, but his mobile phone was found to contain various messages and a screen shot of an illustration of how to tie a noose. Beside him was also a photograph of Child J and his former girlfriend that he had brought outside with him. The general picture was of a young man who took his life in an impulsive act due to an inability to cope with his feelings over his first significant relationship breakdown. His family, friends and support workers were universally shocked and devastated by his sudden death, as they felt it occurred without warning.

8. An inquest is mandated as Child J was a child in the care of the CEO of the Department of Communities at the time of his death.[2] The cause and manner of Child J's death is not in doubt. It was generally accepted that the evidence supported the conclusion that Child J committed suicide by hanging and no other person was involved in his death.

9. I am required to also comment on the treatment, supervision and care Child J received prior to his death, as he was a child in care. In that regard, a primary focus of the inquest was whether there were any missed opportunities on the part of the various services engaged to assist Child J, that might have diverted him from the path that his life ultimately took.[3]

EARLY YEARS IN BROOME

10. Child J was born in Geraldton in July 2001. His mother had three other children, with different partners, so Child J had three half-siblings.[4] His mother had a history of mental health issues and alcohol and drug abuse. It seems likely from the evidence that Child J was exposed to drugs and alcohol in-utero. He showed some signs of Foetal Alcohol Spectrum Disorder (FASD), although he was never formally diagnosed. It was also known that he suffered neglect and trauma in those early formative years.

11. The Department of Communities had a long history of involvement with Child J's family for issues relating to domestic violence, family support and child protection. There had been early allegations of domestic violence and conflict between Child J's mother and father in 2002, which had led Child J's mother to be hospitalised. Concerns regarding Child J were first raised with the Department in October 2002, when his mother was staying at a women's refuge in Broome.[5]

12. Two months later, in early December 2002, Child J was admitted to Broome Hospital with gastroenteritis, severe failure to thrive and severe anaemia. He responded well to

[2] Sections 3 and 22(1) *Coroners Act 1996* (WA).
[3] T 3 – 4.
[4] Exhibit 1, Tab 2; Exhibit 2, Tab 3B.
[5] Exhibit 2, Tab 3A – B, Tab 33, ER2.

feeding in hospital but returned to hospital again a few weeks later given concerns that he again appeared weak and unwell. He was returned to the care of his mother and they travelled to Perth.[6]

13. There were ongoing domestic violence issues and Child J spent a night in emergency foster care in February 2003, before the Department lost contact with her and Child J as she moved between Broome and Perth. Child J's father raised concerns with the Department in late November 2003 about Child J's safety with his mother, as Child J's mother was with a new partner who was alleged to be violent and use illicit drugs. Child J's mother indicated she was prepared to leave her partner, which she did briefly, before reuniting with him.[7]

14. Over time, it became clear that Child J's mother was unable to provide a safe environment for him. On 9 January 2004, Child J's mother agreed for him to be placed into temporary foster care for a period of two weeks, which was then extended to a month. His father was reported to be in prison at this time, so he was not available as an alternative carer. Although there was evidence that usually in the Kimberley the Department is able to place Aboriginal children with family or their wider kinship group, in this case it was unfortunately not possible. Instead, Child J was placed with non-indigenous foster carers Pauline and Sydney Featherstone. The Department was unable to engage with Child J's mother as she moved to Perth to try to escape the violence in her relationship, then became very unwell and had a lengthy psychiatric admission. Therefore, Child J remained with his foster carers, the Featherstones.[8]

15. On 15 February 2007, the Department sought a time limited Protection Order supporting his ongoing placement with Mr and Mrs Featherstone, which was granted. The order was later altered to a Protection Order until he turned 18 years of age.[9] Child J resided for a large part of his life with the Featherstones, and he remained in contact with them until the end of his life.

16. There were early concerns identified regarding Child J's behaviour, development and speech. Mrs Featherstone recalled that when he first came to them, Child J didn't laugh or show emotions as he was so traumatised. She remembered he didn't smile or try to connect with them, but simply sat in front of the television and "was zoned out."[10] He eventually improved and started smiling and talking, so they were happy that he was getting better, although there continued to be issues with his behaviour.[11]

17. Child J was first reviewed by a paediatrician, Dr John Erlich, in mid 2004, shortly after coming into care. He was three and half years old at that time. At that stage, it was suggested that there should not be any assessments done as he had only recently come into a stable home environment and was making good progress, so it was felt premature to do a developmental assessment. However, he was referred to speech therapy and

[6] Exhibit 2, Tab 33, ER2.
[7] Exhibit 2, Tab 33, ER2.
[8] Exhibit 2, Tab 33, ER2.
[9] Exhibit 2, Tab 3B.
[10] T 31.
[11] T 32.

occupational therapy, which he received in 2005 and 2006.[12] Dr Erlich continued to review Child J, and felt he was coming along "literally in leaps and bounds"[13] in his new home environment.

18. When Child J first started kindergarten, and then later as he moved into primary school, Child J would act out his emotions and become violent. He was given some counselling at the primary school but things remained rocky.[14]

19. On 23 March 2006, Child J was referred to the North West Metro Health Service Child and Adolescent Mental Health Service (CAMHS) after ongoing concerns were expressed regarding his negative behaviours. After undertaking some assessments, it was felt Child J had social problems, particularly with family, behavioural problems and problems with peers. A paediatric assessment was completed to rule out any contributing medical issues and to provide strategies to manage his disruptive behaviour. He was discharged from CAMHS on 24 July 2006 with the diagnoses of Separation Anxiety Disorder of Childhood and other Childhood Disorders of Social Functioning. Recommendations were made for further interventions with his carers via the Department.[15]

20. Over the next couple of years, Child J's behavioural problems became more pronounced, including anger management difficulties, sleeping issues and enuresis (bedwetting). The Featherstones did their best to try to manage Child J's behaviours, but they had not received any training for trauma-informed care or caring for children with complex needs, so they had to manage as best they could, working on advice from doctors. Mrs Featherstone said she did receive some training on FASD, which she sought out herself, and she found that helpful.[16] I note Mrs Featherstone did not receive training from the Department in relation to FASD until 2019.[17]

21. At a paediatric review in May 2008 it was recommended that Child J receive psychological interventions and be investigated for possible pathological causes of enuresis. The paediatrician, Dr Fiona Kay, queried whether Child J had antenatal exposure to alcohol and amphetamine for the first time and noted his known exposure to violence prior to coming into care. Dr Kay strongly recommended early psychological intervention for Child J before his mental health and behavioural issues become more significant.[18]

22. The Department of Communities arranged for a full-time school aide to assist with managing Child J's behaviour at school and Mrs Featherstone recalled there were a number of mentors also utilised by the Department to take Child J out to do activities, which he appeared to enjoy.[19] Nevertheless, Mrs Featherstone recalled that things

[12] Exhibit 1, Tab 30B2.
[13] Exhibit 1, Tab 30B2, Letter from Dr Erlich to Cleo Taylor, 24.09.2004.
[14] Exhibit 1, Tab 18.
[15] Exhibit 1, Tab 24.
[16] T 31 – 32
[17] Exhibit 2, Tab 3D, p. 2.
[18] Exhibit 1, Tab 30B2; Exhibit 2, Tab 3B.
[19] T 35.

became worse and he became more violent at home as well as at school. He also struggled to sleep due to the voices in his head.[20]

CONSIDERATION OF PMH REVIEW

23. The school psychologist referred Child J back to CAMHS in May 2009 with concerns regarding aggressive behaviour, agitation, emotional dysregulation and difficulties sleeping.[21]

24. Ms Clare Wood was assigned as Child J's CAMHS case manager. Ms Wood conducted a mental health assessment of Child J on 10 and 11 June 2009 and then wrote a report making several recommendations to the Department and the school. Child J was staying temporarily at a residential facility run by ACS Country Services known as Babagarra Nyirrwa[22] at the time to provide his carer family with some respite. Ms Wood then arranged for a paediatrician to review Child J in Broome in relation to his sleep issues, as well as trying to work towards an in-patient admission for Child J at Princess Margaret Hospital. Ms Wood was advised that Mrs Featherstone had given Child J the antihistamine promethazine (Phenergan) to try to help him sleep, which she saw as a sign of a carer under stress, and she wanted to help to restore good sleep hygiene for Child J as sleep is one of the pillars of mental health.[23]

25. Ms Wood also spoke to Consultant Psychiatrist Dr Prue Stone about Child J's case on 11 June 2009. At that time, Dr Stone worked as a Consultant Child and Adolescent Psychiatrist with the Tele-Mental Health Program, which provided a statewide video-conference psychiatric service to the regions, including the Kimberley. Dr Stone would review children and adolescents referred by the local CAMHS staff. As well as reviewing patients, Dr Stone was also available to provide advice over the telephone to CAMHS staff, as needed. It appears this is what occurred with Ms Wood, who was requesting some advice from Dr Stone about Child J's case.[24]

26. Dr Stone's note of the conversation indicated that Ms Wood provided some of Child J's background history and indicated that at the time of their conversation he was staying in a hostel to give his carers, the Featherstones, some respite. Ms Wood informed Dr Stone of the number of complexities in the family situation of the Featherstones' at that time, and Dr Stone strongly recommended that Ms Wood urge the Department not to place more children with them if Child J was to remain with them.[25]

27. On 24 June 2009, Clare Wood called Dr James Fitzpatrick, a Senior Paediatric Registrar at Kimberley Health, to discuss Child J's case. They discussed the need for short term stabilisation of Child J's behaviour and management of his insomnia while Ms Wood tried to arrange the assessment at PMH. Dr Fitzpatrick suggested a plan to commence

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[20] Exhibit 1, Tab 18.
[21] Exhibit 1, Tab 24.
[22] Exhibit 2, Tab 3D.
[23] T 74 – 77; Exhibit 2, Tab 32.
[24] Exhibit 5.
[25] Exhibit 5.

Child J on clonidine (Catapres), which would need to be monitored by a doctor.[26] The prescription was provide by a GP with ongoing monitoring.[27]

28. Ms Kelly Jones was Child J's Departmental case manager for a six month period from 30 June to 10 December 2009, so overlapping with Ms Wood's involvement in Child J's case. Child J was 7 or 8 years old at that time, but Ms Jones had known him since he was little, before she became his Departmental case worker. Ms Jones remembered Child J fondly as an active little boy with a beautiful smile and a cute sense of humour. At the time she became involved in managing Child J's case, Ms Jones was a Senior Field Worker based in the Broome office. She had a full caseload (15 cases), so the role was a busy one and she felt stretched at times, although she tried to spread her time equally across the cases as best she could.[28]

29. Ms Jones recalled that she saw Child J quite regularly in that six month period, at least once a week and sometimes daily, depending on what was happening in his life. Ms Jones recalled that there were times when she was called to collect Child J from school or from the Featherstone's home when he was displaying challenging behaviours. He was usually upset at these times and she would spend time reassuring him until he calmed down. Ms Jones recalled the major challenges for Child J at this time were his struggles at school, as he didn't engage in school work and only wanted to draw and became violent at times, and struggles with his placement at the Featherstones, where his behaviours were consistently reported to be unmanageable. There were a lot of children with high care needs in their home and Mrs Featherstone had allegedly told Ms Jones that she had 'sedated' Child J to manage his behaviour in this context.[29]

30. In July 2009, Dr John Boulton, a Consultant Paediatrician working in the Kimberley, documented some concerns in regard to the fact the Featherstones were caring for Child J and four other foster children with complex physical and emotional needs. Dr Boulton had been asked by Clare Wood from CAMHS to see Child J in mid-July 2009. He was not the primary paediatric medical specialist for Child J, and his only direct contact with Child J was on two occasions in July 2009.[30]

31. Dr Boulton saw Child J first on 15 July 2009, and again on 29 July 2009. Dr Boulton recalled the focus of the consultations was to explain to Mrs Featherstone and the Department's case-worker the reason for the planned admission to PMH, which included a formal cognitive assessment to determine his degree of cognitive disability, as well as a psychiatric assessment and review of his medications. At that time, the facilities and necessary expertise of staff to complete that assessment were not readily available in the Kimberley. Dr Boulton said the planned admission had been initiated by Ms Wood and not by him, but he supported Ms Wood's plan.[31] Dr Boulton noted that Child J had been started on the medication clonidine by another paediatrician a week prior through a phone consultation, which also could be reviewed as part of the process.

[26] Exhibit 1, Tab 30B2.
[27] T 78; Exhibit 2, Tab 32 CEW4.
[28] T 55 – 57, 69; Exhibit 2, Tab 31.
[29] Exhibit 2, Tab 31.
[30] Exhibit 2, Tab 30.
[31] Exhibit 2, Tab 30.

32. Dr Boulton saw Child J with Kelly Jones from the Department. Child J was brought in to the clinic again by Mrs Featherstone unexpectedly on 29 July 2009, so Dr Boulton saw him again, in company with another child in her care. Dr Boulton had not been aware Mrs Featherstone had so many children with high level care requirements until that day and he expressed concern about Mrs Featherstone's ability to deliver appropriate care in those circumstances.[32] He noted they were not receiving any respite and had limited support. He questioned the Featherstones' ability to deliver appropriate care in their present circumstances. The possibility of overmedicating also appears to have been considered in that context.

33. Mrs Featherstone was asked about this at the inquest. She denied ever medicating Child J more than prescribed, or using the medication to try to control his behaviour because she didn't have time to manage his behaviour due to the other children with complex needs in her care. Mrs Featherstone said they worked with the doctors to try to find which medication worked for Child J and if it didn't suit him, they would let the doctors know and they would change it. Ultimately, Mrs Featherstone didn't believe any of the medications really helped to manage his behaviour as he was angry and traumatised and needed emotional support more than anything else. She told the case worker, Ms Jones, this at the time.[33]

34. A note from a meeting between Ms Jones and Mrs Featherstone on 23 July 2009, also attended by Clare Wood from CAMHS, suggested the relationship between Mrs Featherstone and Ms Jones was fractured around this time. Ms Jones acknowledged that Mrs Featherstone appeared to struggle to work with her as the case worker for Child J. It appears some of the problems stemmed from a previous incident before Ms Jones worked for the Department, where Ms Jones had reported some concerns about a child in Mrs Featherstone's care. Ms Jones said she worked hard to try and engage with Mrs Featherstone and build a relationship with her from this time and tried to reassure her that they would work together on any issues of concern.[34]

35. Child J had expressed a desire to be reunified with his mother, so Ms Jones worked to achieve that goal while she was his case manager. In the meantime, while Ms Jones had formed the view that the Featherstones clearly loved and adored the children in their care, she had a genuine concern about the number of children with complex needs in their care, and the caring burden this placed on them. She raised her concerns with the carers' services officer, whose role is to support carers, to try to arrange some regular respite breaks for the Featherstones.[35]

36. Ms Jones was also working with CAMHS staff on the planned admission to Princess Margaret Hospital (PMH). Ms Jones had only become aware of the proposal for him to go to PMH on 26 June 2009 as it had been arranged by Clare Wood from CAMHS, based on information provided by Mrs Featherstone and Ms Wood's own assessments of Child J, after he was referred to CAMHS by his school.[36] When she first became

[32] Exhibit 2, Tab 32, CEW10.
[33] T 35 – 36; Exhibit 2, Tab 31 [38].
[34] T 59 – 61.
[35] T 59.
[36] T 74 - 75; Exhibit 2, Tab 32.

aware of the proposed admission, Ms Jones notified CAMHS that, at that stage, the Department did not consent to the admission, as it needed time to obtain and review Child J's medical records. The planned PMH admission was, at that stage, cancelled.[37]

37. Ms Jones consulted Dr Boulton about the plan and received further information from CAMHS, before becoming involved in planning the PMH admission. Ms Jones understood the admission was intended to assess Child J's behaviour and sleep patterns and determine if he needed to be medicated. The planning included Child J's biological mother, given the longer term plan was for Child J to be reunified with her.[38]

38. I note Dr Fiona Kay, a paediatrician who worked with Dr Boulton in the Kimberley, was involved in the discussions around the PMH admission and she expressed some reservations about the plan, commenting that "PMH admission is not always the better solution,"[39] based on her previous experience working in the PMH psychiatric unit, and noted that while it is good for assessment, Child J would be completely out of context in that environment. Dr Kay suggested on 4 August 2009 that consideration should be given to arranging a review by a telehealth conference or with one of the visiting Child and Adolescent Psychiatrists in the Kimberley instead.[40]

39. On 10 August 2009 the Department gave formal permission for the PMH admission to occur and the admission was then scheduled to take place in October 2009. It was planned that Child J would be admitted to the PMH Psychological Medicine Unit and that Mrs Featherstone would be present for one week, so the staff could observe their relationship, then a week with his biological mother for the same, and to see what upskilling she might need to help Child J regulate his emotions.[41] In preparation for the admission, a video conference took place with Ms Wood, PMH staff and Department staff on 26 August 2009, and planning then continued.[42] However, the admission did not, in the end, eventuate.

40. Dr Kay, the Regional Paediatrician, saw Child J again on 27 August 2009. Dr Kay noted Child J's increasingly aggressive behaviour at school and his violent reaction to increased demands on him, or when he was unable to have his own way. Dr Kay indicated Child J showed features of autism spectrum disorder. She supported the ongoing use of clonidine and recommended that Child J undergo an adaptive behavioural assessment to more clearly evaluate his strengths and weaknesses.[43]

41. Mrs Featherstone recalled that it had been suggested that Child J would need to go down to Perth for at least six weeks for the PMH assessment, and up to 12 weeks, in order to try to study his behaviour and get his medication right, which is much longer than what was actually proposed by Ms Wood. It's unclear how Mrs Featherstone came to form this impression of a longer admission, but she indicated her belief that she couldn't go at the time as she had other children to care for. Mrs Featherstone had also

[37] Exhibit 2, Tab 32.
[38] Exhibit 2, Tab 31.
[39] Exhibit 2, Tab 30, JB2.
[40] Exhibit 2, Tab 30, JB2.
[41] Exhibit 2, Tab 31, KMJ16.
[42] Exhibit 2, Tab 31.
[43] Exhibit 2, Tab 30B2, Letter from Dr Kay to Dr Singh, 27.08.2009.

formed the impression that it was suggested that Child J's biological mother could go with Mrs Featherstone, but Mrs Featherstone noted they had different ideas of parenting and she didn't think it would work. Ms Wood clarified that the proposal was for Mrs Featherstone to be present for the initial week, then Child J's mother for the second, so there was no proposed overlap.[44]

42. In the end, the PMH admission did not proceed as it was pre-empted by the reunification of Child J with his mother, and it was decided to wait and monitor how he settled in with his biological family.[45] Ms Wood had left the Broome CAMHS office at this stage and was no longer involved in his case, so she was not around to continue to advocate for it to occur. A new CAMHS case manager, Andy Williams, had taken over the case at this stage. He wrote to Dr Boulton and Dr Kay to indicate that, despite the PMH admission being cancelled, the department still wanted Child J's medication to be reviewed and discontinued. Dr Boulton indicated that Dr Kay was the main person involved in the paediatric care of Child J, so it was appropriate to wait for Dr Kay to return to work to deal with the request. Dr Boulton also noted that another doctor, Dr Fitzpatrick, had prescribed the clonidine originally.[46]

43. Mrs Featherstone recalled that just prior to the decision not to continue with the PMH admission and the reunification of Child J with his biological mother, Child J's behaviour was very violent and the other children she was caring for had to hide at times while he smashed things. They tried to find out what was going on with him and he talked a lot about his family and wanting to be with his mother or father. Mr Featherstone recalled that at that time he was "determined he wanted his family."[47] Although she had been concerned about his mother's readiness to take back the full responsibility for caring for Child J, Mrs Featherstone was supportive of the decision at that stage, as she felt the moving between their house and his biological mother's home had been unsettling for Child J and he would do better with some stability. However, Mr and Mrs Featherstone made it clear they wanted to remain involved in Child J's life.[48]

44. Child J was still prescribed clonidine at this time, and an opinion was sought from a paediatrician about whether it should be continued. Mrs Featherstone said she was very supportive of the medication review as she had felt she received mixed messages about whether he was benefiting from the medication.[49]

45. In October 2009, Child J was back living with his mother and his clonidine dose had been reduced. Ms Jones was visiting daily in the early period of reunification and was satisfied that there were sufficient supports in place.[50] Ms Jones recalled that Child J's behaviours at school had improved and he was completing some school work and able to increase his timetable at this time, suggesting he was quite well settled.[51]

[44] T 86.
[45] T 33, 43 63 – 64; Exhibit 2, Tab 31, KMJ17.
[46] Exhibit 2, Tab 30, JB3.
[47] T 34.
[48] T 39, 63; Exhibit 1, Tab 18; Exhibit 2, Tab 31, KMJ17.
[49] Exhibit 2, Tab 31, KMJ16 - 17.
[50] T 64 – 65; Exhibit 2, Tab 31, KMJ19.
[51] Exhibit 2, Tab 31.

46. On 9 October 2009, Child J was admitted to Broome Hospital with gastroenteritis. During this admission, two doctors reviewed his medication and discussed a plan with Child J's mother to reduce his medications further.[52]

47. In December 2009 the reunification appeared to be going well. Child J's behaviour and mood were noted to have improved and he was sleeping better. He was reported in December 2009 to be attending school full-time and enjoying his school attendance. There were reports Child J was still wetting the bed and a suggestion he had witnessed domestic violence against his mother by an older brother, so steps were taken to manage this. Child J's aunt recalled that he appeared happy to be back with his mother, and to be able to reconnect with his younger brother, but he was still having the occasional outburst.[53]

48. On 28 January 2010, Child J was assessed by Consultant Psychiatrist Dr Prue Stone via videoconference. As noted above, Dr Stone had previously discussed Child J with his CAMHS worker, Clare Wood, but she had not previously reviewed Child J herself. Dr Stone saw Child J with his biological mother and younger brother. The purpose of the review was to assess his eligibility for continued funding for an educational aide in school. Noting that Dr Stone was seeing Child J by video and had not met him before, she found there were some obstacles to a full assessment as his skin was very dark, which made it hard for her to see his facial expressions and identify any potentially abnormal features (which can occur in severe cases of FASD). His speech was also a little difficult to understand at times. At this time, he was no longer on clonidine, but was sleeping normally. He was attending school full-time but no longer had a teacher's aide. His mother's only concern was in relation to his behaviour at school.[54]

49. Dr Stone felt generally she was able to make the necessary assessment requested, which was to consider his eligibility for further educational assistance. Following the consultation, Dr Stone wrote to the Deputy Principal of Child J's school in strong support of continued funding for an educational aide for him. Dr Stone indicated she had formed the impression that Child J suffered from Adjustment Disorder with Mixed Anxiety and Depression and Attachment Disorder, which was very liable to result in emotional dysregulation.[55] Dr Stone commented in a letter to the CAMHS worker who had referred Child J to her, that it was difficult to predict his progress and behaviour at school in the new school year, but hoped he would do well given he was happier now at home.[56]

50. Dr Stone was not asked to review Child J again. At the time of her sole review, Dr Stone was not aware of the earlier proposal to have Child J admitted to PMH for assessment, and at the time she saw him he had recently been reunited with his biological mother and was progressing well, so it was not raised as a possibility. Given he was not doing too badly at that time, and his behaviour was not a problem at that

[52] Exhibit 2, Tab 3D, p. 2.
[53] T 20; Exhibit 2, Tab 24.
[54] T 155; Exhibit 1, Tab 30B3; Exhibit 5.
[55] Exhibit 5, PMS4.
[56] Exhibit 5, PMS 3.

time, she believes there may have been little benefit in such an admission, even if it had been raised.[57]

51. However, Dr Stone did suggest that the planned admission to PMH might have been beneficial if it had occurred at the earlier stage, when first planned and before he returned to his mother's care, as she felt it would have been to his advantage to have had a more detailed assessment and possible differentiation of his symptoms due to FASD and those due to Attachment Disorder arising from his early childhood neglect and exposure to trauma. However, Dr Stone did not believe it was likely to have altered the treatment he received, noting the kind of treatment he received even without that assessment was quite comprehensive.[58]

52. Things appeared to still be going well over the following months, and in April 2010 Child J was reported to no longer require CAMHS involvement. He was said to have few behavioural issues at school and very few problems in the home environment, other than normal childhood issues. He was discharged from CAMHS on 7 April 2010.[59] Sadly, it was not to last.

53. An incident occurred in late May/early June 2010 in which Child J sustained a black eye. This was reported to the Department on 3 June 2010 and an investigation was conducted. In the meantime, Child J was removed from his mother's care and placed in a residential facility.[60]

54. Interestingly, these events fit to some degree with what Ms Wood described as the end of the 'honeymoon period', which CAMHS staff were well aware of and tried to counsel families about to help with the transition from foster carers to reunification with biological parents. Ms Wood explained that often the children will be so pleased to be back with their biological parents that they will not have any misdemeanours and will follow their parents' directions initially. However, after a time, when they are feeling safe in their relationship, that's when some of the mental health concerns may appear. As a result of having felt abandoned by their parents, they will test the parents' love and commitment to them. These can be complex trauma responses to the time they may have been in care, or the reason why they came into care initially, and can be challenging for the parents, as the child's behaviour may appear like they are rejecting their parents.[61] It would appear this was perhaps what was beginning to happen with Child J, which was testing for his mother.

55. Ms Wood indicated that, given how well known this phenomenon is, she would not have taken reassurance from a couple of months of dramatic improvement in the child's behaviour following reunification and closed the case. Rather, she would be more likely to want to give longer support.[62] Therefore, it seems that the closure of the case with CAMHS may have been a little premature, which is unfortunate, as it can always be

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[57] Exhibit 5.
[58] Exhibit 5.
[59] Exhibit 1, Tab 30B1; Exhibit 2, Tab 24.
[60] Exhibit 1, Tab 19; Exhibit 2, Tab 3B, p. 7.
[61] T 83.
[62] T 84.

speculated that with a little more support, perhaps more could have been done to make the reunification work.

56. In any event, following their investigation, on 20 August 2010 the Department found there was substantiated physical harm of Child J by his mother and it was decided that he would not be returned to her care.[63] He remained at the new placement temporarily, but repeatedly told the Featherstones he wanted to come back to their house. They loved him and wanted him back, but they were concerned as they had other children in their care and Child J was often violent. However, after seven months of him repeatedly running to them, they decided to try and take him back into their home again, and the Department agreed. The Department had earlier, in May 2010, told the Featherstones they were limited to caring for only three children, but their capacity was increased back to four children to allow Child J to return to their care.[64]

57. The Featherstones asked the Department at that time if they could transfer to a bigger home, so that Child J could have his own room, or have a room added to their existing home, which might reduce some of the concerns in relation to the other children. They were put on a priority wait list, but the transfer did not eventuate before he left their home again. I return to the reasons for this later in the finding.[65] Mr and Mrs Featherstone also asked the Department to provide more respite, but there were no respite workers available, so it did not occur.[66]

58. The Featherstones took Child J to Perth for the Christmas period, and while out shopping one day he happened to meet his father, who hadn't seen him since he was a baby. Child J had lunch with his father in company with the Featherstones' son, Darren. Mrs Featherstone informed the Department of the chance meeting and let them know that Child J's father wanted to keep in touch with him while they remained in Perth, which was permitted. After they returned to Broome, Child J began to tell the Featherstones that he would like to go to Carnarvon to live with his father.

59. Despite their best efforts, without the extra room and additional respite, the Featherstones found it hard to manage with Child J back in their home due to his aggressive outbursts. He had a few months of respite care in Fitzroy Crossing, but things did not improve.[67]

60. A new referral to CAMHS was made by the Department in February 2011 after Child J developed anxiety and agitation following his return to foster care. He was again diagnosed with Reactive Attachment Disorder of Childhood. It was perhaps not surprising, given he now had renewed trauma associated with separation from his mother. CAMHS provided support to Child J and his foster parents, Mr and Mrs Featherstone. They also provided individual counselling and liaised with the Department, his school, his GP and paediatrician.[68]

[63] Exhibit 2, Tab 3B, pp. 7 - 8.
[64] Exhibit 2, Tab 3D, p. 4.
[65] T 37, 39.
[66] T 39.
[67] T 39; Exhibit 1, Tab 18.
[68] Exhibit 1, Tab 24.

61. In March 2011, Child J was assessed and said to show clinically significantly problems in the areas of behaviour, impairment, symptomatic problems and social problems. The Children's Global Assessment Scale indicated a major impairment of functioning in several areas and there was a possibility of suicide attempts with clear lethal intent.[69]

62. On 23 March 2011, an inter-agency case conference was held, attended by staff from school health, CAMHS and other mental health services and the paediatrician Dr Boulton. It was noted Child J still had a problem with enuresis but did not qualify for the enuresis clinic. He was also exhibiting serious behavioural issues at school, which his CAMHS worker suggested might be due to an anxiety disorder, noting his history of trauma. Dr Boulton indicated that he had not seen Child J since mid-2009 but he had expressed concern at that time that there was an emphasis on medicalisation of his problems, whereas Dr Boulton thought Child J's behaviour was reactive to the foster care situation.[70] Dr Boulton expressed concern that Child J's foster mother was trying to manage a number of children with intellectual disability and serious behavioural problems related to FASD and psychic trauma. This was a heavy carer burden and it was felt they needed more help.[71]

63. In April 2011 Child J's challenging behaviour at school escalated. He put his hand through a window and was taken by Department staff to the Emergency Department as he was expressing suicidal thoughts. His aunt recalled seeing him at school around this time and noting his destructive behaviour and intermittent sadness.[72]

64. Child J was assessed on 4 April 2011 by a Consultant Child and Adolescent Psychiatrist, Dr Claire Pattison. Dr Pattison noted that at that time, Child J had extreme difficulties regulating his emotions, was extremely sensitive to any perceived negative criticism and had rages. He also had difficulty sleeping and difficulty attending school. Dr Pattison assessed Child J as displaying the symptoms of PTSD, given his developmental trauma, which had been exacerbated by his perception that he had left the Featherstones because they could not cope with him. He also had a conflicted view of his relationship with his mother, given the failed reunification. Dr Pattison noted it would take time and consistency for things to begin to resolve and Mrs Featherstone's responses would be fundamental to that. Mrs Featherstone was noted to be caring and engaged, but stretched given the other children with high care needs in her home. Dr Pattison recommended they be given extra space for the children to grow. Dr Pattison also suggested a low dose of the medication risperidone might be calming for him.[73]

65. In July 2011, Child J saw Dr Shevta Patel for the first time. Dr Patel is a developmental paediatrician and she was working at the time as a visiting rotational consultant paediatrician in the Kimberley for the WA Country Health Service (WACHS). Dr Patel indicated that at that time, in addition to his psychiatric diagnoses that had already been provided, she had a clinical suspicion that Child J had features of FASD. Child J was on risperidone and melatonin at the time of her review. Dr Patel suggested his melatonin

[69] Exhibit 1, Tab 24.
[70] Exhibit 2, Tab 30, JB4.
[71] Exhibit 2, Tab 30.
[72] T 19; Exhibit 1, Tab 30B1.
[73] Exhibit 1, Tab 30B1.

dose be increased, to help him sleep better, and they should aim to reduce his risperidone dose.[74]

66. On 26 October 2011, Child J was assessed by a visiting Child and Adolescent Psychiatrist, Dr Nazrin Lee, who noted Child J had a diagnosis of PTSD and Reactive Attachment Disorder in Childhood. Dr Lee wrote a letter indicating that it was essential that Child J continue to have a teacher's aide to help him regulate his emotions and reduce the intensity of his aggression at school. Dr Lee also emphasised the need for stability in Child J's placement and care as a "stable and safe home environment [was] crucial for his recovery."[75] Dr Lee wrote to Dr Patel indicating her agreement with Dr Patel's opinion that Child J's risperidone medication should be gradually reduced, and Dr Lee suggested it should hopefully be ceased in the future. Dr Lee suggested Child J's dosage of melatonin could then be increased further to help him sleep.[76]

67. In October 2011 there was a planned review by a visiting CAMHS psychiatrist. It was noted that Child J continued to have difficulties with learning, social interaction and emotional regulation at school and required ongoing support from a teacher's aide. It was emphasised that any change in his placement would cause significant emotional and behavioural difficulties for him.[77]

68. In November 2011 a CAMHS indigenous mental health worker began working with Child J individually, and with his carers and the school. Child J apparently responded well to this additional support.[78]

69. A protection order was granted on 10 November 2011 to last until 27 July 2019, when he turned 18 years old. The plan at that stage was to try and keep Child J with the Featherstones, although unfortunately that became impossible.

70. In February 2012 the Featherstones expressed reluctance to continue to care for Child J but the Department had no alternative placement options so he remained with his foster carers.

71. Ms Lynne Jackson, a Senior Mental Health Professional with the Kimberley Mental Health and Drug Service, became involved with Child J's case in 2012 as his CAMHS case worker. She continued in that role with Child J throughout 2012, 2013 and 2014, until she left her position with the service. During that time, Ms Jackson often saw him weekly and would take him for drives and try to establish rapport with him. Ms Jackson remembered Child J as a lovely young man who was usually calm when he was with her, although she was aware he could fly into rages. She also remembered that he "often appeared to be sad."[79]

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[74] Exhibit 1, Tab 30A and SP2.
[75] Exhibit 1, Tab 25A.
[76] Exhibit 1, Tab 25B.
[77] Exhibit 2, Tab 24.
[78] Exhibit 2, Tab 24.
[79] Exhibit 2, Tab 34 [9].

72. Ms Jackson recalled that Child J's major mental health challenges at the time she was involved in his case were:[80]

- A likelihood of having FASD;
- Attachment difficulties;
- Emotional dysregulation and trouble regulating himself;
- Difficulty sleeping;
- Trouble settling down; and
- His need for a great deal of structure and individual attention in his health care, education and home.

73. On 6 June 2012 CAMHS Child & Adolescent Psychiatrist, Dr Ann McDonald, assessed Child J and noted he was progressing reasonably well but continued to experience episodic and unpredictable rages. These were more of a problem at home than at school. Dr McDonald noted that the carer burden for the Featherstones, with three other children with FASD in addition to Child J, was immense. Dr McDonald suggested his medications of risperidone and melatonin could remain, with the suggested addition of quetiapine for really bad days. Dr McDonald wrote a letter of support for continuing support for Child J at school given his possible FASD, PTSD and Attachment Disorder.[81]

74. Child J was regularly reviewed by child psychiatrists and paediatricians throughout. He also had continued contact with the indigenous mental health worker from CAMHS. In addition, there were regular communications between CAMHS and the Department and his school. However, Ms Jackson noted that the remoteness of the Broome location still ultimately limited what specialised services could be provided to Child J. Ms Jackson cited the example of Pathways, a therapeutic program run by CAMHS inpatient services in Perth for children and young people experiencing complex and longstanding mental health difficulties, like Child J. There was a referral, and funding granted, for Child J to do Pathways, and all agencies were supportive of his involvement, but there were barriers to this occurring as it required him to go to Perth, which was difficult to arrange as his foster carers had responsibility for other children.[82]

75. On 12 October 2012, Dr Boulton wrote to Child J's new case worker at the Department, Jacqui Swanson, to express his ongoing concern about Mrs Featherstone's ability to adequately manage all the foster children in her care, including Child J. The letter was prompted by a discussion that Dr Boulton had with Ms Swanson on 9 October 2012 about two other foster children in Mrs Featherstone's care, for whom Dr Boulton was providing medical advice.[83]

76. Dr Boulton emphasised in his evidence at the inquest that he believed Mrs Featherstone was "doing her absolute best in a very devoted way, in a selfless, devoted, committed way within her capacity,"[84] but there were a lot of children with high level needs. It was also not a calm environment in the home, which was problematic for Child J. Dr

[80] Exhibit 2, Tab 34 [15].
[81] Exhibit 1, Tab 30B1; Exhibit 2, Tab 24.
[82] T 98 - 100; Exhibit 2, Tab 34 [13], [16].
[83] Exhibit 2, Tab 30.
[84] T 171.

Boulton noted that all four children had extensive disabilities and at least three really required a full time carer, which raised the question as to how Mrs Featherstone actually managed. Dr Boulton said he respected her commitment to the children and wanted to help her.[85]

77. In that context, Dr Boulton queried whether the level of medication that the children were on reflected their actual needs, or the needs of their foster mother with respect to modifying their behaviour. Dr Boulton raised this in the context of exploring Mrs Featherstone's understanding of the neurological basis for Child J's behaviour, in the sense of the effect of psychic trauma in the first three years of his life and the way it altered his brain in a detrimental way. Dr Boulton felt from his enquiries that Mrs Featherstone had a low level of understanding of the profound lifetime effect Child J's early psychic trauma had on him, and that it was not something he would grow out of quickly or could manage easily.[86]

78. Dr Boulton was wary of medication being prescribed in this context, noting that he felt medication might camouflage an inadequate investigation into what else was happening for the child. This would include the home environment and family dynamic, noting that some of the behavioural problems could be managed by reducing stress in the home environment, without the need to treat through medication.[87]

79. Dr Boulton queried at the time whether it was realistic for Mrs Featherstone to continue to be able to cope with caring for the children, and fulfil their emotional needs, as well as managing her own needs. Dr Boulton also raised concerns about the continuity of medical care and suggested it would be preferable if all of the children had a regular family doctor, preferably at BRAMS, to work in conjunction with Dr Patel, who knew the children well.[88] Dr Boulton did not have any more involvement in his case, so he did not get an opportunity to reiterate his concerns and the use of medication for Child J continued.[89]

80. Dr Mohamed Shaik, a Senior Paediatric Registrar, reviewed Child J on 3 December 2012. Child J's behavioural problems were said to have been in good control at that time with the help of his medication and regular counselling by CAMHS. His medications were continued, including quetiapine as needed for aggressive episodes.[90]

81. Dr Patel assessed Child J on 20 February 2013. He was in Year 6 at Cable Beach Primary School. This appears to be the first time Dr Patel had seen Child J since 2011. On this occasion, Dr Patel assessed him in her private capacity as a visiting paediatrician for the Kimberley Aboriginal Medical Service, rather than with WACHS.[91] Dr Patel noted Child J's past medical history of suspected FASD and PTSD amongst other conditions. Dr Patel noted that Child J had a full time teacher's aide at school and had come a long way. No particular concerns were raised.[92]

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[85] T 172.
[86] T 173 – 174.
[87] T 179.
[88] Exhibit 2, Tab 30, JB5.
[89] Exhibit 2, Tab 30.
[90] Exhibit 1, Tab 30B1.
[91] Exhibit 1, Tab 30A.
[92] Exhibit 29.1.

82. On 17 May 2013, Ms Jackson attended a school conference, during which Mrs Featherstone advised that Child J had been hearing voices and threatening to hang himself. CAMHS developed a safety plan for the school and additional supports were put in place to enable Child J to express his feelings, including regular sessions with a male indigenous support worker and drum beat sessions. Nevertheless, Child J still had a lot of difficulty managing his emotional outbursts and his mood deteriorated further.[93] He was eventually commenced on the antidepressant fluoxetine (Prozac) in June 2013, as noted below.

83. In June 2013, Child J was seen again by Dr Patel. Dr Patel noted Child J's behaviour had started to deteriorate again, and he became very angry if he felt people were blaming him or teasing him. Child J had been maintained on risperidone and melatonin, and quetiapine had been used in the past when he had explosive rages or to help him sleep. Dr Patel made a note that Dr Stone had suggested recommencing Child J on fluoxetine (Prozac) in addition to his other medications. Dr Patel suggested that Child J might benefit from some more contact directly with Ms Jackson and could also benefit from some exercise as a stress reliever. Dr Patel also noted that it was exhausting and challenging for the Featherstones to be managing four children with complex and special needs in one household, although there was no easy solution to this problem, as moving Child J was not the preferred option as he needed stability.[94]

84. Dr Stone did not recall having a consultation with Dr Patel about fluoxetine, but Dr Stone did indicate that she would regularly discuss cases with Dr Patel, so it is likely that they may have spoken about him and discussed his medication. Dr Stone indicated in her statement that fluoxetine is a drug for depression and anxiety, so if he was given the medication, it was for those reasons.[95]

85. On 28 June 2013, Department staff and Mrs Featherstone attended a meeting with Dr Patel. It was reportedly discussed during the meeting that Dr Stone had diagnosed Child J with clinical depression and he was to commence the antidepressant medication fluoxetine.[96]

86. Child J's fluoxetine dose was increased two months later, during a CAMHS psychiatric review, as his depressive symptoms had increased. There was discussion at the time about ceasing his risperidone, as both Child J and Mrs Featherstone reported he was not receiving any benefit from it.[97]

87. On 11 August 2013, Child J was admitted to hospital because he expressed suicidal thoughts. The next day, Ms Jackson visited him in hospital and he told her that he had called the police during an argument with Mrs Featherstone the previous night. He said he was sick of people shouting at him and felt like he wanted to kill himself. Despite feeling this way, he denied having made any attempts. Ms Jackson spoke to Child J

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[93] Exhibit 2, Tab 34.
[94] Exhibit 1, Tab 29.2.
[95] Exhibit 5.
[96] Exhibit 2, Tab 34, LJ2.
[97] Exhibit 2, Tab 3B.

about "the finality of suicide."[98] They also talked about his little brother and Ms Jackson reassured him that people were working to keep him safe and trying to arrange more contact between them. Ms Jackson's impression at this time was that Child J was "depressed and experiencing chronic suicidal ideation in the context of multiple stressors, disrupted attachment and FASD."[99]

88. Child J was reviewed by Psychiatrist Dr Lee on 12 August 2013 in company with Ms Jackson. Dr Lee had seen Child J previously in October 2011, so she was familiar with his case.[100]

89. Dr Lee spoke to Mrs Featherstone before her assessment of Child J, who informed Dr Lee that Child J had been taking fluoxetine in the evenings and was calmer and sleeping better as a result. She reported she did not see any current benefit to his risperidone and melatonin. Mrs Featherstone also advised Dr Lee about some stressors involving Child J's biological father and mother and his concerns about the safety of his little brother.[101]

90. During Dr Lee's review of Child J, he reported feeling angry and sad. He admitted he often threatened suicide when angry but denied any actual intent to harm himself. Dr Lee expressed the opinion Child J had developed depressive symptoms in the context of his recent stressors. She recommended he should take an increased dose of fluoxetine and be reviewed by another psychiatrist to consider gradual reduction, and possible cessation, of the risperidone and melatonin.[102]

91. It was decided that Child J's current placement was inappropriate due to the other children living at the home who also had dysregulated behaviours. On 16 September 2013, Child J was placed at a hostel in Broome run by Life Without Barriers (LWB), known as Pipit Loop Family Group Home, as an emergency placement. The home involved volunteer carers living with up to four children at any one time. His care was coordinated by the LWB Care Coordinator, Ms Laura Clarke, who is a Registered Psychologist.[103]

92. Ms Jackson made the abovementioned Pathways referral at this time, although the assessment and admission to the programme was never able to be commenced. The referral itself was comprehensive and outlined the goals of referral as:[104]

- To obtain a better understanding of Child J's individual needs through wrap-around assessments, including OT, speech, Psychiatry, Clinical Psychology and Education;
- To obtain a better understanding of how the family dynamics may contribute to Child J's difficulties;

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[98] Exhibit 2, Tab 34 [21].
[99] Exhibit 2, Tab 34 [21].
[100] Exhibit 1, Tab 29.4.
[101] Exhibit 1, Tab 29.4.
[102] Exhibit 1, Tab 29.4.
[103] Exhibit 1, Tab 29.6 – 29.10, 29.27; Exhibit 6.
[104] Exhibit 1, Tab 30B1; Exhibit 2, Tab 34, LJ1.

- For full assessment of possible mental health disorders and possible medication review; and
- To obtain guidance on interventions to help Child J at home and at school, through understanding Child J and the system around him.

93. It has been suggested that it was unfortunate it was unable to take place, as it may have been a circuit breaker for his placement situation, as well as providing a good opportunity to form an overall picture of his strengths and weaknesses and the supports needed.[105]

94. Child J did not settle into the hostel. There were ongoing problems with bed wetting and aggressive behaviour. Child J claimed the younger children at the home were noisy and annoying him and picking on him. The following month he was reviewed by a paediatrician and it was noted his mood had deteriorated and he was repeatedly absconding from the hostel to return to the Featherstones.

95. In a Care Plan prepared by Ms Clarke on 13 October 2013, she identified the need for a medication review. Ms Clarke tried to obtain a better understanding of Child J's circumstances, and she discussed with another senior LWB staff member the possibility of conducting a full behaviour analysis as a step towards managing Child J's behaviour in the least restrictive way. This was within the context of Ms Clarke wishing to understand better the reasons for Child J's medication regime.[106]

96. Ms Jackson spoke to Child J's Department case worker on 16 October 2013 and was advised that Child J had tried to return to the care of the Featherstones. He had indicated he was missing them. Child J was also refusing to return to the Life Without Barriers hostel. The Department began to consider other placement options. Ms Jackson consulted a child and adolescent psychiatrist and was given advice to arrange a paediatric review as a paediatrician might wish to consider increasing his risperidone medication dose.[107]

97. At a planning meeting at the Pipit Loop Group Home on 18 October 2013, attended by Ms Swanson and Ms Jackson amongst others, there was discussion about how to manage Child J's interactions with the younger children in order to help him settle at the hostel. Child J also had a planned paediatric appointment with Dr Patel that day.[108]

98. The consultation with Dr Patel took place, as planned. Child J presented as anxious and distressed during the consultation. He said he did not want to go back to the LWB facility and wanted to return to the Featherstones' home. Ms Jackson was present at the consultation and she explained to Child J that the Featherstones got scared and worried when he became angry. Ms Jackson made a note that Ms Swanson was trying to encourage Child J to return to the hostel and Ms Jackson tried to encourage him to find ways to make the hostel work better for him. Dr Patel recorded she had discussed Child J's current medication regime with Dr Stone and it was agreed he should stay on the same dose of fluoxetine, while his melatonin would be decreased and his risperidone

[105] T 188, 195; Exhibit 1, Tab 22 [60].
[106] Exhibit 6.
[107] Exhibit 1, Tab 29.13; Exhibit 2, Tab 34 LJ, Integrated Progress Notes, 16 - 17.10.2013; Exhibit 5.
[108] Exhibit 2, Tab 29.15

dose increased. Dr Patel also expressed the opinion that for Child J's placement at the hostel to be successful, the carers needed to be more mindful of Child J's past medical history of trauma and attachment issues. It was suggested he should have regular planned contact with the Featherstones, whom he referred to as Nan and Pop, as he clearly had formed a close attachment to them.[109]

99. On 21 October 2013 Child J tried to leave the hostel again to return to the Featherstones. Ms Swanson attended with another support worker from the Department and they eventually managed to calm him down and convince him to return to his room. There was another incident on 26 October 2013, when one of the younger children at the hostel began to tease Child J, resulting in Child J striking him. At this time, the carers expressed concern about the safety of the other children at the hostel. The carers also expressed concerns to Ms Clarke, the LWB Care Coordinator, about Child J's medication. They observed that since the increase in his medication he had been "zonked,"[110] going to bed early and sleeping on the floor.[111] Ms Clarke later received specialist reports from Dr Patel and Dr Lee to clarify the position with regard to his medication.

100. On 24 October 2013, Ms Clarke attended a review meeting with Ms Swanson and other Department staff to discuss Child J's ongoing placement at Pipit Loop. Ms Clarke raised with the Department her concern that there was a lot of information that LWB was not aware of about Child J, that they felt it was important to know for planning purposes. This included more information about his medication and its intended purpose, as well as why previous placements had broken down, so they could smooth his transition to living at Pipit Loop.[112]

101. On 28 October 2013, the Department decided to allow Child J to return to the Featherstones. The Featherstones had indicated they were willing to resume care for him again at that stage. Ms Jackson spoke to Mrs Featherstone on 7 November 2013, and she indicated things were going reasonably well and Child J had made no new self-harm threats. However, the next day Mrs Featherstone rang Ms Jackson to inform her that Child J had walked out of school and returned home in an angry mood. He was unhappy about having to share a room at home and had made a threat to hang himself.[113]

102. CAMHS staff made an urgent visit to the Featherstones' home. Mrs Feathestone told them Child J was upset and angry as he was not being allowed to use the Xbox as he had walked out of school, as well as due to the issue about sharing a room. The CAMHS staff were unable to calm him and he made threats to kill himself. Mrs Featherstone was encouraged to monitor him and ensure any means of self-harm were locked away or removed. She was told to take him to the hospital ED if she was concerned for his safety. Ms Jackson called and spoke to Child J a little later that afternoon and he had calmed down a bit.[114]

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[109] Exhibit 1, Tab 30A, SP4; Exhibit 2, Tab 34LJ1, Integrated Progress Notes, 18.10.2013.
[110] Exhibit 6 [44].
[111] Exhibit 2, Tab 29.20 – 29.23.
[112] Exhibit 6.
[113] Exhibit 1, Tab 29.25; Exhibit 2, Tab 34LJ1, Integrated Progress Notes, 4 - 8.11.2013.
[114] Exhibit 2, Tab 34LJ1, Integrated Progress Notes, 8.11.2013.

103. Child J was suspended from school a couple of days later for punching and kicking a boy who was teasing him about his father. He returned to school after a few days, but then had another incident at school on 20 November 2013 where he became angry and aggressive towards staff. School staff expressed some concerns about Mrs Featherstone's response to Child J during these incidents, including a statement that Child J had made that he understood he would be sent to a 'boys home' in Perth if he didn't behave. Ms Jackson saw Mr and Mrs Featherstone on 26 November 2013 to discuss Child J and the reasons why the threat of the 'boys home' could be harmful to Child J given his past experience. They suggested other ways to encourage good behaviour and a plan was made to provide ongoing support.[115]

104. Following further visits by the CAMHS indigenous mental health worker and Ms Jackson, a meeting was held with CAMHS staff and Ms Swanson to discuss some ongoing concerns about Child J's ongoing placement at the Featherstones. There were concerns expressed about the Featherstones' ability to provide for his emotional needs.[116]

105. On 11 January 2014 Child J threatened to kill himself by putting a knife to his throat. He was taken to Broome Hospital ED but he would not openly discuss his issues and say what was troubling him. Child J returned to Broome Hospital on 27 January 2014 and was admitted for two days after he spoke of hearing voices (not thought to be psychotic in nature) and again threatened to cut his throat with a knife and couldn't be calmed.

106. Ms Jackson visited Child J at Broome Hospital on 28 January 2014 and he explained he had felt angry the night before and wanted to go to hospital. He didn't want to talk about the incident but reported feeling 'confused'. He reported that he had a lot of things he liked about living at the Featherstones and he knew Mr and Mrs Featherstone loved him, but he didn't want to go home that day. Mrs Featherstone spoke to Ms Jackson and indicated Child J had become angry after she turned off the television. She observed he was becoming increasingly angry over small things. Mrs Featherstone felt Child J was still too angry to return home that day. Ms Jackson and Ms Swanson had a discussion and Ms Jackson asked Ms Swanson if the Department could become more proactive around addressing issues in the placement of emotional availability, communication, de-escalation and shortage of space at the house. No acute respite care was available, so Child J was kept on the ward for an additional night before being discharged.[117]

107. Child J appeared to settle for a short period, but then on 10 February 2014 Ms Jackson was contacted by his school as Child J was distressed and threatening to kill himself. Ms Jackson went to the school. She spoke to Child J, who referred to hearing voices in his head. He insisted on leaving school, so she took him home. Ms Jackson spoke to Ms Swanson later that day and reiterated the need for better housing for the Featherstones as it could have a significant negative impact as the children had no space to separate

[115] Exhibit 2, Tab 34LJ1, Integrated Progress Notes, 26.11.2013.
[116] Exhibit 2, Tab 34LJ1, Integrated Progress Notes, 29.11.2013 – 20.12.2013.
[117] Exhibit 2, Tab 34LJ1, Integrated Progress Notes, 28.1.2013.

from each other, and Child J really needed his own bedroom. Ms Swanson indicated she would continue to try to resolve the housing issue.[118]

108. Child J was reported as still speaking about the voices in his head a few days later, so Ms Jackson planned to arrange a psychiatric review. Ms Jackson spoke to Child J on 17 February 2014 about the voices, and he indicated he heard them when he was upset or when people were yelling. Child J did not indicate he was having any current thoughts of self-harm.[119]

109. On 19 February 2014, Mrs Featherstone rang Ms Jackson and said that Child J had threatened to stab himself again. He spoke to Ms Jackson himself over the phone. He was sobbing and saying he didn't want to live with the Featherstones anymore. Ms Jackson conducted an immediate home visit, during which Child J repeated his wish to leave the Featherstones' home. He also said he didn't want to live in Broome anymore. Child J told Ms Jackson he wanted his own bedroom and indicated he would like to live with the carers in Fitzroy Crossing, whom he had previously visited. Child J was taken to the CAMHS office, where he calmed quickly. He was collected by his Department case worker after a few hours and returned to the Featherstones. Ms Jackson spoke to him on the telephone later that afternoon and he said he felt good at that time.[120]

110. Ms Jackson initiated a liaison meeting with Department staff and spoke to someone from his school. She also reported she had a telephone consultation with Dr Prue Stone about the voices Child J was hearing. Ms Jackson recalled that Dr Stone suggested they were likely related to trauma and distress as there was no indication of psychosis, and the current treatment plan was to continue.[121] Dr Stone did not recall the conversation but acknowledged it was entirely possible it took place. Dr Stone indicated that, in her opinion, any voices Child J was hearing were unlikely to be due to psychosis because of his age, past history and the lack of other evidence to suggest this. They were, therefore, more likely to be a result of trauma and distress.[122] Dr Stone explained at the inquest that it is quite common for young people to have auditory or visual hallucinations when they are traumatised, whereas it is very uncommon for someone of that age to develop schizophrenia.[123]

111. Ms Jackson spoke to Mrs Featherstone on 4 March 2014. Mrs Featherstone indicated the family had gone camping together over the long weekend and they had struggled with managing Child J's behaviour during the trip. Ms Jackson advised the Department of the situation. The Department informed Ms Jackson a few days later that Child J had been moved to a short term placement over the weekend and they were looking for a new longer term placement in Fitzroy Crossing, which then occurred.[124]

[118] Exhibit 2, Tab 34LJ1, Integrated Progress Notes, 10.2.2014.
[119] Exhibit 2, Tab 34LJ1, Integrated Progress Notes, 14 - 17.2.2014.
[120] Exhibit 2, Tab 34LJ1, Integrated Progress Notes, 19.2.2014.
[121] Exhibit 2, Tab 34LJ1, Integrated Progress Notes, 21 - 26.2.2014.
[122] Exhibit 5.
[123] T 159.
[124] Exhibit 2, Tab 34LJ1, Integrated Progress Notes, 7 - 21.3.2014.

112. Ms Jackson was notified on 21 March 2014 that Child J had settled fairly well in his new placement in Fitzroy Crossing but was missing 'Nan and Pop' Featherstone. He was able to speak to the Featherstones on the phone to maintain some contact. There was a discussion about Child J sleeping too heavily at night, causing the bed wetting, so Ms Jackson consulted a psychiatric locum and was given advice to stop giving Child J melatonin to see if that helped.[125]

113. On 7 April 2014, Ms Jackson was informed by Ms Swanson from the Department that Child J's new placement had appeared to be going well until Child J was brought to Broome for a visit. He then walked to his Aunt Bronwyn's house and refused to leave with his carers. In those circumstances, his new carers indicated they could no longer care for him. This was on a background of some other significant personal matters experienced by the carers that was causing them stress. Child J was taken back to Fitzroy Crossing temporarily while the Department looked for an alternative placement.[126]

114. Child J was reviewed by Dr Patel by way of video conference the next day, being 8 April 2014. It was noted that his carers in Fitzroy Crossing were struggling because of Child J's angry behaviours and he was refusing to do chores at home. Child J explained he felt tired and flat at times and had headaches. Some of the explanation for this was found to be that he was struggling to cope with the intense heat in Fitzroy Crossing. Child J also agreed he often felt angry. It was agreed that CAMHS would support Child J and his carers.[127]

115. Ms Jackson visited Child J and his carers that day in Fitzroy Crossing. The carers made it clear they were unable to care for Child J at that time, due to recent deaths in their family and the consequent grief and cultural responsibilities, as well as Child J's difficulties adjusting to his new environment.[128] The Department agreed to look for a new suitable placement.

MOVE TO CARNARVON

116. In April 2014, after Child J's father came briefly to Broome to spend some time with Child J, Child J moved to stay with his father in Carnarvon. As he was moving out of the Kimberley CAMHS catchment area, he was discharged from that service on 30 May 2014 and a referral was sent to the Carnarvon CAMHS to transfer his care to that office instead.

117. Unfortunately, due to the lack of staffing capacity at the Carnarvon office, a similar Departmental transfer was not possible as a case manager was unavailable to be allocated to Child J in Carnarvon. Therefore, he remained with his Broome case manager, Ms Swanson. Direct support was provided to Ms Swanson in Carnarvon by

[125] Exhibit 2, Tab 34LJ1, Integrated Progress Notes, 7 - 21.3.2014.
[126] Exhibit 2, Tab 34LJ1, Integrated Progress Notes, 7.4.2014.
[127] Exhibit 1, Tab 23 and Tab 30A, SP6; Exhibit 2, Tab 34LJ1, Integrated Progress Notes, 8.4.2014.
[128] Exhibit 2, Tab 34LJ1, Integrated Progress Notes, 8.4.2014.

staff from the Department's Responsible Parenting Program, particularly where face to face contact with Child J was required.[129]

118. Clinical Nurse Specialist Eugene Richards was working for the Midwest Gascoyne Central West Mental Health Service, based in Carnarvon, at that time. He received the referral from the Broome CAMHS team on 2 May 2014. The referral had been prepared by Ms Jackson. It was noted in the referral that Child J was a voluntary client of the service and had been involved with CAMHS for many years. Mr Richards was told Child J had a history of emotional dysregulation and attachment issues and had been diagnosed with a reactive attachment disorder and possible depression, in the context of family circumstances and trauma. He was prescribed risperidone, fluoxetine and melatonin at that time.[130]

119. Along with the referral, Ms Jackson provided a detailed Case Conference report from early 2005, which set out the Department's dealing with Child J's biological mother that had led him to being taken into care, as well as how he had been managed in foster care with the Featherstones. It did not provide any information in relation to Child J's more recent mental health issues and interactions with CAMHS. However, Ms Jackson indicated at the inquest that Child J's full medical records would have been accessible by the Carnarvon CAMHS staff, if they wished to view them.[131]

120. Mr Richards phoned Child J's father on 8 May 2014 and arranged an appointment for Child J to have an initial assessment on 16 May 2014. They failed to attend, so another appointment was booked for 20 May 2014. However, Child J and his father again failed to attend this second appointment. Mr Richards phoned Child J's father about an hour later to follow up. Child J's father didn't answer, so Mr Richards left a message asking him to return his call.[132]

121. Ms Swanson, the Department's case manager for Child J in Broome, sent an email to Mr Richards on 20 May 2014 to inform him that Child J's school had reported he had appeared distressed on a number of occasions, was hearing voices telling him to harm himself and indicated his father had not been giving him his medication in the morning. The School Principal indicated Child J was otherwise settling in well at school and was a lovely young man who did not present any huge concerns, but the Principal was particularly concerned about the medication not being administered. Ms Swanson had spoken to Child J's father, who indicated he let Child J choose if he wanted to take his morning medications, and more often than not he declined them as he said they made him feel tired. Ms Swanson advised Child J's father of the importance of making sure he took the medication regularly until medical professionals advised that he could start reducing his dose.[133]

122. Mr Richards telephoned Ms Swanson in response to the email and advised that Child J had not attended his appointment, although he thought there may have been some confusion as to whether they thought it would be a home visit or at the CAMHS office.

[129] Exhibit 4, MJS1.
[130] Exhibit 2, Tab 33, ER2.
[131] T 102 – 103; Exhibit 2, Tab 33, ER2.
[132] Exhibit 2, Tab 33A.
[133] Exhibit 2, Tab 33A, ER6.

Ms Swanson provided an alternative mobile number for Child J's father and she also confirmed she would check whether a referral had been made for a follow-up appointment with a paediatrician to review his medication.[134]

123. Mr Richards spoke to Child J's father on 23 May 2014 and arranged a new appointment for 26 May 2014, but Child J did not attend this appointment either. Mr Richards rang social worker Laurika Pietersen at the Department's Carnarvon Office Parent Support Service to advise her that Child J was not attending appointments and had not attended an appointment that day. She was planning to see Child J's father in two days' time, so she said she would raise with him the missed appointment.[135]

124. Mr Richards emailed Ms Swanson on 3 June 2014, in response to an email from her, advising that he still hadn't seen Child J as he was not attending scheduled appointments. Mr Richards had not heard anything back from Ms Pietersen at that stage. Mr Richards indicated he needed to see Child J before the scheduled psychiatric appointment with Dr Kimber.[136]

125. Mr Richards spoke to another person at the Department's Parent Support Service, Peta Lappin, on 10 June 2014 to again raise the issue of Child J's non-attendance. Ms Lappin indicated Child J's father was also not responding to their requests to contact them. Mr Richards said he would call back the next week to see if there had been any progress.[137]

126. On 13 June 2014, Mr Richards attended the Department's Responsible Parenting Service as Child J and his father were due to attend a meeting there. Mr Richards hoped to engage with them while they were in the building. However, once again, they did not attend. Mr Richards rang Ms Swanson at the Department's Broome office later that afternoon to tell her that, to date, he had not been able to engage with Child J. He noted that Child J was due to be reviewed by the visiting psychiatrist, Dr Kimber, on 19 June 2014 for further diagnostic clarification, and he was concerned that Child J might miss the appointment. Ms Swanson indicated she would attempt to contact Child J's father. Ms Swanson also received an email from Ms Pietersen that day, referring to the missed appointment and other failed attempts to get hold of Child J's father.[138]

127. Mr Richards finally managed to speak to Child J's father by telephone on the morning of 17 June 2014. He advised Child J's father of the psychiatric review scheduled for the next day with the visiting specialist psychiatrist, Dr Kimber, and explained that this would be an opportunity to review Child J's medication. Child J's father indicated that Child J was apparently getting quite sedated after taking his morning dose and he didn't like taking it. He also expressed a dislike of doctors generally. Mr Richards asked Child J's father to reassure Child J about the interview the next day. Child J's father agreed he would bring Child J in for the psychiatric review at 3.00 pm on 19 June 2014.[139]

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[134] Exhibit 2, Tab 33A, ER1.
[135] Exhibit 2, Tab 33A, ER1.
[136] Exhibit 2, Tab 33A, ER9.
[137] Exhibit 2, Tab 33A, ER1.
[138] Exhibit 2, Tab 33A, ER1, ER12.
[139] Exhibit 2, Tab 33A, ER1.

128. On 19 June 2014, Child J and his father failed to attend the psychiatric appointment. Mr Richards tried calling Child J's father to find out why they had not attended, but Child J's father did not answer the call. Mr Richards left a message asking him to return his call.[140]

129. Mr Richards gave evidence that it was possible if Dr Kimber had been able to review Child J then there might have been a different emphasis on treatment planning, but this didn't occur as he didn't attend.[141] Mr Richards was uncertain whether he made another appointment for Child J to see a psychiatrist, but there were no documents on the file to suggest that he did. Consultant psychiatrists visited the region intermittently at that time (only about twice a year) and their availability was "very, very limited,"[142] which made it hard, although appointments could also be done by telelink. It does not appear anything more was done to arrange a further psychiatric review, presumably due to the lack of engagement by Child J's father and the need to use the limited resource wisely.[143]

130. Mr Richards rang Ms Swanson on 23 June 2014 and explained that, despite speaking to Child J's father directly, he had not attended the psychiatric review. Mr Richards indicated he would keep Child J's file 'open' until 4 July 2014 to allow them to re-engage, but if he did not hear from the family he would then remove Child J from the CAMHS caseload. A new appointment was eventually made for 3 July 2014.[144]

131. On 1 July 2014, Ms Swanson emailed Mr Richards, copying in Ms Pietersen from the Department. Ms Swanson indicated that she had spoken to the Deputy Principal at Child J's school, who had indicated the school was supportive of Child J attending sessions with Mr Richards during school hours. His escalated behaviours were reported to be fairly regular at school at that stage and he was threatening self-harm and stating he was hearing voices in his head still. The Deputy Principal indicated she was concerned about Child J's safety, as well as the safety of the teachers and other students. It appeared that Child J's father had indicated he was 'weaning' Child J off his medications at that stage.[145]

132. The Deputy Principal indicated her understanding that Child J had attended a recent appointment with a paediatrician, Dr Jack Vercoe. Child J had been referred to Dr Vercoe by his regular paediatrician in Broome, Dr Patel. Dr Vercoe saw Child J with his father once on 18 June 2014. A letter was sent after that consultation to Dr Patel but the Department did not receive the report. Dr Vercoe noted in his letter that Child J appeared pleasant and co-operative. Dr Vercoe recorded that Child J's father indicated to him that Child J had had "enough of medication for the time being,"[146] and Dr Vercoe did not appear concerned about that statement.[147] Dr Vercoe made another appointment to see Child J in September 2014, with a plan to look more into the

[140] Exhibit 2, Tab 33A, ER1.
[141] T 117.
[142] T 116.
[143] Exhibit 2, Tab 33A, ER1.
[144] Exhibit 2, Tab 33A, ER1, ER 14.
[145] Exhibit 2, Tab 33A, ER14.
[146] Exhibit 1, Tab 28.
[147] Exhibit 1, Tab 23; Exhibit 2, Tab 33A, ER15.

expressed concerns about Child J's behaviours at school, but Child J did not attend the appointment.[148]

133. Ms Swanson indicated to Mr Richards that she was very supportive of Child J remaining engaged with CAMHS although she understood the difficulties in trying to engage with him and his father. Mr Richards asked Ms Pietersen if it was possible for someone from the Department to bring him to the appointment, to make sure he attended.[149]

134. Ms Pietersen attended Child J's home on 2 July 2014 and spoke to Child J's father. She informed him that she would be personally collecting Child J from school the next day to take him to attend the CAMHS appointment with Mr Richards. Ms Pietersen informed Child J's father that it was "not seen in a positive light"[150] by the Department that he was not attending appointments, hence the drastic measure being taken of transporting Child J themselves. She explained that Child J was still in care and it was in his best interests to attend the appointments. Ms Pietersen invited Child J's father to attend the appointment as well, but he declined.

135. Ms Pietersen collected Child J from school on 3 July 2014 and took him personally to his first CAMHS appointment with Mr Richards. This was the day before the cut-off date Mr Richards had set for closing the file. Child J was reviewed by Mr Richards on his own. Mr Richards recalled that Child J was very engaging and indicated he was excited about being in Carnarvon and felt much better than he had in Broome. Although he had enjoyed living with the Featherstones, he indicated he had not enjoyed living with the other children in the house. Child J reported that he didn't have a lot of friends at school in Carnarvon yet, but didn't seem troubled by this fact. Mr Richards felt Child J had made considerable progress from when he was in Broome and there was no evidence of a behavioural or emotional disorder. Mr Richards did not identify any risks during this assessment and Child J reported no thoughts of self harm. He noted the recent appointment with Dr Vercoe and Child J's indication he would prefer not to be medicated. He said he generally only took his night time medications to help him sleep. Mr Richards suggested Child J attend for individual counselling sessions. Child J seemed agreeable, although he also indicated he had quite a lot of people at school to help him.[151]

136. Mr Richards saw Child J for the second time on 8 July 2014. He was again brought in by staff from the Department. Child J talked fondly of his father during the appointment and appeared settled and happy. He indicated he was no longer taking any medication and was able to sleep without it. At this stage, Mr Richards considered Child J showed no signs of behavioural or emotional issues and appeared to have integrated well into his life in Carnarvon. Another appointment was planned for 17 July 2014.[152]

137. The 17 July 2014 appointment was cancelled as Mr Richards was unwell. The Department's staff had difficulty contacting Child J's father to make another

[148] Exhibit 1, Tab 28.
[149] Exhibit 2, Tab 33A, ER14.
[150] Exhibit 2, Tab 33A, ER14.
[151] T 124; Exhibit 2, Tab 33A, ER15.
[152] Exhibit 2, Tab 33A, ER1.

replacement appointment. Mr Richards spoke to Child J's father on 1 September 2014. He agreed to bring Child J in the next day, but then did not attend. It does not appear Mr Richards made any further attempts to contact Child J's father and it does not seem that the Department made any more attempts to engage him with CAMHS.[153]

138. On 31 October 2014, given Child J had not engaged with the service since July 2014, Mr Richards contacted Ms Swanson at the Department to inform her that Child J would be discharged from Carnarvon CAMHS Clinic. Mr Richards confirmed in an email that he understood Child J was doing well since the reunification with his father and that all his medication had now ceased. He indicated Child J could be re-referred to CAMHS in the "unlikely event"[154] it was required. Although he had only seen Child J twice, Mr Richards recalled he was able to establish rapport with him easily and had felt comfortable with their level of interaction. Mr Richards gave evidence he felt there might well have been a benefit to seeing Child J for a longer period, but he was not able to get him to come, which is why he was discharged from CAMHS. He would still have been followed up by paediatric services, as they are separate to CAMHS, and Mr Richards noted there was always an opportunity for another referral to be made back to CAMHS at any time if anyone involved with Child J felt it was necessary. However, this did not happen.[155]

139. Mr Richards noted that at the time he was based in the Carnarvon CAMHS office, he was the only CAMHS staff member. There were no social workers or other support workers who could assist him to build rapport with families who appeared sceptical or reluctant to work with CAMHS. He considered that such workers, who would not need to be fully qualified, would be beneficial as therapeutic agents who could help engage with young people and bring them into the service by spending time with the child and their family to build rapport. Mr Richards did acknowledge that he had access at the time to an indigenous mental health worker, but he did not utilise them as he was working with the Department's staff instead to try to get Child J to attend appointments. Mr Richards acknowledged that, in hindsight, it could potentially have been useful to try to see if the indigenous mental health worker could play a role in helping Child J and his father to engage with the service.[156]

140. Information provided by Mr Jamie Robson, the Regional Manager of the Midwest Mental Health and Community Alcohol and Drug Service (which includes the Carnarvon CAMHS service) indicates that there may also have been a missed opportunity at this stage to have a multidisciplinary review to decide whether to more assertively follow-up Child J or allow him the choice of disengagement.[157] It appeared Mr Richards agreed, as he noted that there was no case conference arranged by the Department in relation to Child J while he was in Carnarvon, which could have been an opportunity to come up with a plan to assist him further. Given his case was still case managed by the Broome office, this perhaps made it harder to facilitate such a meeting.[158]

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[153] Exhibit 2, Tab 33A, ER1.
[154] Exhibit 2, Tab 33A, ER16.
[155] T 112 – 114, 119.
[156] T 115, 122 - 123.
[157] Exhibit 10, pp. 4 - 5.
[158] T 116 – 117.

141. There is very little information available about what was happening with Child J in late 2014 and throughout 2015, as CAMHS was no longer involved with him and he did not have a Carnarvon based Department case manager, so it seems he wasn't seen regularly. Information was provided that in May 2015 concerns were raised about Child J's potential exposure to arguments between his father and his father's partner, which prompted some exploration of the issue. One incident had been reported to police in August 2014 and in May 2015 Child J's father's partner had informed the Department she had separated from Child J's father due to family and domestic violence. An investigation was commenced that did not substantiate any emotional harm in relation to Child J. Child J was spoken to, and reported no concerns.[159]

142. Child J had a new case manager at the Department (still based in the Broome office) in May 2015, who made contact with Mr Richards. Mr Richards indicated he hadn't seen Child J since July 2014, but he had no concerns about him and was confident that he did not require medication.[160]

143. In September 2015, Child J had his annual health check up at the WACHS Midwest, Gascoyne Population Health Service. Some concerns were raised that Child J had lost weight, but he otherwise seemed happy and well.[161]

144. In a Viewpoint Questionnaire completed by Child J in November 2015, he reported he felt settled where he was living but did identify some concerns around his safety. However, he was able to demonstrate maturity in making good decisions about how he could keep himself safe around people.[162]

145. In December 2015 some concerns were documented by Child J's school that he had been known to walk out of class with anger on his face, but this does not appear to have been explored further as he then returned to Broome.[163] Child J's father also informed the Department at this time that Child J had ceased all medications and he had not seen any worrying behaviours in some time. His bedwetting had also decreased significantly in frequency.[164]

RETURN TO BROOME

146. On 4 January 2016, Child J returned to Broome and stayed with his Aunty Bronwyn, and her partner Marcus and their children. Bronwyn is his mother's younger sister. It was initially meant to be just a short visit over Christmas, but Bronwyn recalled that Child J refused to return to Carnarvon. She said he made it clear he no longer wished to try and live with either his mother or his father.[165]

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[159] Exhibit 1, Tab 2, p. 2; Exhibit 4, MJS1.
[160] Exhibit 4, MJS1.
[161] Exhibit 4, MJS1.
[162] Exhibit 4, MJS1.
[163] Exhibit 4, MJS1.
[164] Exhibit 4, MJS1.
[165] Exhibit 1, Tab 2, p. 2.

147. Michael Saunders, Child J's Team Leader in the Department's Broome Office, tried to contact Child J's father before Child J returned to Carnarvon, but was unable to get a response. Mr Saunders indicated the Department then decided that Child J could remain in his placement with his Aunty Bronwyn and her partner, along with his younger brother. Mr Saunders consulted with Child J's aunt and Child J, and they were both happy with this arrangement.[166] It appears someone from the Department was then able to make contact with Child J's father, who indicated he also thought it was best for Child J to remain in Broome with his Aunty Bronwyn.[167]

148. Although Child J did not return to the Featherstones' care once back in Broome, he remained close to them and recommenced contact with them once he was back in Broome. He still referred to them as Nan and Pop and would come around to have something to eat and sometimes ask to stay the night. No formal arrangements were felt necessary, as Bronwyn and Mrs Featherstone were happy to make the arrangements informally between them.[168]

149. This appears to have been the start of a relatively positive period in Child J's life, and all of those close to him were very hopeful for his future.[169] Child J's aunt and extended family, as well as the Featherstones, were all happy with his progress. There was a general sense that he had left Broome an unhappy boy, but had returned a much happier young man. He was no longer taking any medications and seemed settled and healthy without them.

150. At the start of the 2016 school year, Child J was enrolled to commence at Broome Senior High School. That year he made friends with a group of people and met a young girl with whom he started his first serious relationship. There were still some issues with Child J's behaviour at school, and he would get angry at times and 'explode', resulting in some suspensions.[170] His aunt, Bronwyn, tried to get him to re-engage with Headspace, but he refused. She suggested he could also see the school psychologist, but Child J would not engage with any mental health services. He appeared to have a good relationship with his Department case workers, so she asked them to try and encourage him to talk to someone, but he didn't want to engage with anyone about his mental health.[171]

151. At the start of 2016, Child J had a new case manager, Samantha Rowe, but it appears that changed at some stage to Dot Greene. Ms Greene then also left the Department. Mr Saunders, as the Team Leader, then managed Child J's case during the year before a new case worker could be appointed. Mr Saunders made several contacts with Child J and Bronwyn and all reports were that he was "settling into school, expanding his social network and exploring his family ties."[172]

[166] Exhibit 2, Tab 2.
[167] Exhibit 4, MJS1.
[168] T 18, 40; Exhibit 4, MJS1.
[169] Exhibit 1, Tab 20.
[170] Exhibit 1, Tab 20 [31].
[171] T 24, 28 - 29.
[172] T 140; Exhibit 2, Tab 2 [20].

152. It was noted in Child J's Care Plan, prepared in January 2016, that there needed to be consideration as to whether Child J be reviewed by a developmental paediatrician, given he had ceased taking medication of his own accord.[173]

153. In his Quarterly Care Report, completed by Mr Saunders on 14 June 2016, it was noted that Child J reported he was happy with where he was living. They were moving to a bigger home, which meant he would have his own bedroom, and in all other respects things were going well. He was in good health and was having a course of dental treatment. At that stage he was doing reasonably well at school and had shown consistent attendance and positive behaviour.[174]

154. On 1 November 2016, Ms Amy Ritchie became Child J's new case manager at the Department. She had only commenced working with the Department the month before, having recently graduated from university with a Bachelor of Psychology, and this was her first time living in the Kimberley. Child J's former case manager had already left before Ms Ritchie commenced in the role, so his case had been sitting with Mr Saunders as the Team Leader in the interim. Ms Ritchie was given case transfer summaries and then had an opportunity to discuss the case with Mr Saunders, before starting to manage Child J's care from that time.[175]

155. Ms Ritchie saw Child J for the first time that day during a home visit. The purpose of the visit was to introduce herself to Child J and his younger brother (whose case she was also managing) and the family carers. Ms Ritchie brought with her some formal documents for Child J that he had requested, as he wanted to open a bank account and get a tax file number so that he could get a casual job. She then helped him to complete this task in the following week.[176] Ms Ritchie's case notes from this first meeting indicate Child J was not in contact with his mother or his father and he didn't want to discuss what had happened with his father. He was living with his Aunty Bronwyn and Uncle Marcus and seemed generally happy, although there were the usual challenges of living in a blended family and being a teenager. He was doing well at school and had plenty of friends. His emotional regulation had improved, although he could still be moody, and he no longer reported sleep disturbances. Plans were made to obtain clothing, bedding, a new mobile phone and other equipment for Child J so he could go on a planned school camp.[177]

156. Ms Ritchie explained that she was required to see Child J quarterly, as a minimum, so in theory she might not have seen him again until 1 March 2017. Ms Ritchie indicated she did not believe seeing Child J on only a quarterly basis was enough to develop a trusting relationship with him, or monitor his care to a high standard, so she made an effort to see him more regularly than the minimum requirement. She actually saw Child J seven times in the six months she was involved in his case. During this regular contact, she was able to take him out in the community to complete tasks relevant to developing his life skills and have conversations with him that were not impeded by the adults in his life. Ms Ritchie's memory of Child J from this time was that he was outgoing, funny

[173] Exhibit 4, MJS1.
[174] Exhibit 4, MJS1.
[175] T 127 - 129; Exhibit 2, Tab 1A – 1B.
[176] Exhibit 2, Tab 1B, AMR2 – 3.
[177] Exhibit 2, Tab 1B, AMR1.

and friendly. He was also very caring. Other than on one occasion, he was also generally in a happy mood when she saw him.[178]

157. Ms Ritchie recalled that the major challenges for Child J's care were dealing with the impact of the trauma he had experienced from neglect, abuse and significant family health and environmental factors, as well as the issue of him being disconnected from family, particularly on his father's side. He made it clear he did not want contact with his biological mother or father. Child J also exhibited a lack of confidence and self-esteem and did not exhibit a willingness to open up about his emotions and feelings. Ms Ritchie recalled that in her conversations with Child J, he talked to her about his likes, dislikes, dreams and wishes, but did not generally speak about any worries or things that bothered him, other than the fact that he did not like Broome Senior High School.[179]

158. On 28 November 2017, Ms Ritchie contacted Bronwyn after being informed Child J's place at the upcoming school camp (which he had been preparing for) had been revoked due to his poor behaviour at school. He had apparently been disruptive and rude in class and had sworn at a teacher, although he denied this behaviour when asked about it by his aunt. Bronwyn indicated that Child J would like to attend a private Broome high school instead, which his aunt supported.[180]

159. His behaviour at Broome Senior High School continued to deteriorate, and he was aggressive towards teachers. He was also moody and unhappy at home. Ms Ritchie and Bronwyn discussed the fact that the honeymoon period had passed and Child J might now be challenging Bronwyn and her rules as part of the process of settling in to his new home. Ms Ritchie was worried about Child J's recent misbehaviour and felt it might be due to his biological mother being in town but not making contact with him. Child J had told Ms Ritchie he knew his mother was in town. However, Bronwyn doubted this was the cause of his recent behaviour change. They discussed the possibility of bringing in mentors who Child J looked up to, in order to give him guidance, and possibly linking him in with Headspace, although he wasn't keen to go there.[181]

160. After making arrangements for the transfer in late 2016, in early 2017 Child J transferred from Broome Senior High School to a new high school. He was reportedly happy about the move as his girlfriend and other friends attended the same school. Ms Ritchie believed Child J saw it as an opportunity for a "fresh start."[182]

161. On 10 February 2017, there was an incident at school when Child J became upset at school. Ms Ritchie collected Child J from school at the request of the Principal, as he was concerned that Child J was upset and withdrawn and the Principal wasn't comfortable having him go home on his own. Child J was withdrawn in the car but didn't want to talk about what was bothering him. Ms Ritchie recalled he became increasingly agitated, the more questions she asked. He did say he was still with his girlfriend and felt comfortable talking to her about things, he liked his new high school

[178] T 129; Exhibit 2, Tab 1B.
[179] Exhibit 2, Tab 1A, [20] and Tab 1B.
[180] Exhibit 2, Tab 1A and Tab 1B, AMR4 – 6.
[181] Exhibit 2, Tab 1A and Tab 1B, AMR4 – 6.
[182] Exhibit 2, Tab 1B [22].

better than the previous school and things were also fine at home. Child J denied any thoughts of self-harm and said he did not know what was wrong.

162. Child J went straight to his bedroom when Ms Ritchie brought him home. Bronwyn later established that Child J had become upset after 'dramas' with his girlfriend's friends, who had reportedly said something unkind about one of his cousins.[183]

163. Ms Ritchie suggested he link in with Headspace, but Bronwyn reported she had attempted to get Child J to engage with them in the past and he had refused. She said she would try again, but he wasn't interested in going there.[184]

164. Ms Ritchie referred Child J and his brother for health assessments on 20 February 2017 as part of her review of their Care Plans. Ms Ritchie noted in the referral Child J's previous diagnoses of PTSD, reactive attachment disorder and possible FASD in June 2012, and the fact he had been off all medications since 2014. Ms Ritchie also noted recent disclosure by Child J of occasional urges to self-harm. This information came from a conversation with his school Principal. There was evidence that it was not intended that Child J see a psychiatrist as part of this process. It was said to be an opportunity for his physical and mental health to be assessed, and he could then be referred to a GP if there were issues identified, and from there on to other specialists if required.[185]

165. Also on 20 February 2017, the Department arranged for a Viewpoint Self Questionnaire to be performed with Child J by another case worker. He responded positively to all of the questions and indicated he did not have current thoughts of self-harm or suicide.[186] Child J did provide some slightly concerning answers, one in particular in relation to the question what he would change if he could, to which he replied, "Everything."[187] This was properly identified as concerning in his Case Plan Supervision completed on 5 April 2017, and it was noted that this statement should be specifically followed up as part of the discussion of his Viewpoint results.[188] The Case Plan also suggested helping Child J to create a Life Story Book and to discuss a referral for counselling to Headspace again, which was entirely appropriate. Unfortunately, it does not seem that any of this was completed before his sudden death. It had not appeared urgent, as in general he seemed to be stable and well.

166. A Strength and Difficulties Questionnaire was also completed by Bronwyn, and Ms Ritchie and other staff conducted an annual Care Plan meeting on 22 February 2017. Ms Ritchie remembered Child J being positive and actively engaging in the meeting about his plans for his future when he left the care of the Department. All of the participants, which included Mr Saunders, felt it was a positive meeting and they commented on how well he was doing. Ms Ritchie did not have any major concerns for

[183] Exhibit 2, Tab 1B, [25] & AMR 10 – 11.
[184] T 24; Exhibit 2, Tab 1B, [27] & AMR11.
[185] Exhibit 2, Tab 1B, [27] & AMR12 – 13; Exhibit 4.
[186] Exhibit 2, Tab 1A, [55] – [56].
[187] Exhibit 2, Tab 16.
[188] Exhibit 2, Tab 19.

his health or wellbeing at this time, although there was always a level of ongoing concern given the impact of the trauma in his past.[189]

167. Mr Saunders, who was Ms Ritchie's Team Leader and had previously been managing Child J's case before her appointment so had a good knowledge of his case, recalled from the meeting that Child J's relationship with Bronwyn and her husband was particularly strong. Child J presented as an articulate, confident young person at the meeting, with plans after school to either join the police or the military. Child J understood that he could remain living with his aunt and her family for as long as he needed after he left care in mid-2019, so he did not have concerns about having somewhere to stay in the future. Mr Saunders recalled it was one of the most promising Care Plan meetings he had participated in as part of his many years with the Department.[190]

168. The general consensus was that there were no immediate concerns for Child J. He appeared to be in good spirits and was making future plans. He was making progress at school as his emotional regulation and behaviour had improved and he seemed comfortable in his placement with his aunt and extended family. Planning was to be undertaken for his ultimate transition out of care when he turned 18 years, but this was still some time away.[191]

169. Unfortunately, shortly after this positive meeting, Child J's relationship with his girlfriend broke down in March 2017. His aunt recalled that initially he was sad, angry and heartbroken.[192] It was known from past experience that Child J lacked resilience and often acted out in times of crisis, but on this occasion he still appeared to be coping, at least outwardly. His aunt had believed that after a month or so, Child J had got over the break-up. It was only after his death, when messages on his phone were found, that she realised that this was not the case.[193]

170. Ms Ritchie was on leave in March. When she returned to work, she called Bronwyn on 4 April 2017. Bronwyn indicated Child J was doing well. She did not mention the recent break-up. Ms Ritchie made contact with the Department's Leaving Care Officer to ask they make contact with Child J to start helping him with his future plans. She received a school report on 19 April 2017, which ranked Child J 'high' for most of his subjects in terms of application and behaviour. Everything seemed to suggest to her he was still doing well.[194]

171. Also on 19 April 2017, Ms Ritchie completed a Quarterly Care Report for Child J indicating that he was due for his annual health assessment and should be reviewed by a developmental paediatrician in regard to his mental health, although noting that at that stage he was not demonstrating any emotional or behaviour issues.[195] The health assessment referral had been sent a month or so earlier, but had not occurred.

[189] Exhibit 2, Tab 1A and Tab 1B; Exhibit 4.
[190] Exhibit 2, Tab 2; Exhibit 4 and MJS3.
[191] Exh9ibit 2, Tab 1B.
[192] T 24.
[193] T 25 - 26.
[194] Exhibit 2, Tab 1A.
[195] Exhibit 2, Tab 3D, p. 16.

EVENTS LEADING UP TO DEATH

172. In the days leading up to his death, Child J was reported to be in high spirits and there were no concerns on the part of his family and friends that he might be depressed or suicidal.

173. He had visited the Featherstones' home on the weekend and he appeared happy and "like everything had been lifted off his shoulders."[196] Mrs Featherstone recalled that Child J had rung her sister-in-law to ask if he could come down to stay with her in Perth and go to boarding school. She had said she was willing to discuss it with him.[197] It appeared to the Featherstones that he was planning his future and there was nothing to cause them any concern.[198]

174. Unusually, rather than watching television or playing games, that last evening Child J spent time sitting with his aunt and one of his cousins talking. He appeared bubbly and happy. Bronwyn thought he was in a good place and was looking forward to starting the next school term.[199] Child J went to bed sometime between 8.30 pm and 9.00 pm.

175. There is evidence to suggest that Child J's ex-girlfriend had started a new relationship around this time, with someone who was a good friend of Child J. This appears to have occurred around the time of his death and Bronwyn believes Child J only recently became aware of it.[200]

176. Sometime that evening, Mrs Featherstone received a text message from Child J stating words to the effect, "*I am scared to end it all, it's so hard."*[201] Mrs Featherstone thought he was referring to the break up with his girlfriend, so she reassured him it would be alright and urged him to stay strong.[202]

177. At an unknown time during the early hours of 25 April 2017, Child J left the house with his mobile phone, a rope and a photograph of himself with his ex-girlfriend. He tied the rope to a tree on the verge outside the house and hanged himself.[203]

178. Child J was seen hanging by two witnesses who were driving past. They stopped and used a fishing knife to cut him down. They checked him after they lowered him to the ground and noted he was not breathing and had no pulse. They called emergency services at 4.06 am. Police officers attended first and checked Child J for any signs of life. They found he had no pulse, his pupils were dilated and his body temperature had begun to cool. The police initiated CPR for a period and then checked Child J's vital signs again and found no change. They determined he had died and any further resuscitation attempts were futile. Ambulance paramedics attended shortly after and

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[196] T 40.
[197] T 40 – 41.
[198] Exhibit 1, Tab 19.
[199] T 26.
[200] Exhibit 1, Tab 20 [38].
[201] Exhibit 1, Tab 18 [34].
[202] T 40.
[203] Exhibit 1, Tab 2.

also checked Child J for any signs of life, but found none. His death was confirmed by a SJA paramedic at 4.25 am.[204]

179. Police officers found no suicide note at the scene but noted the framed photograph of Child J and his girlfriend at the base of the tree.[205] When police were later able to access Child J's mobile phone they found a screen shot of an illustration on how to tie a noose.[206]

180. Police officers noticed a set of footprints in the dew that led to the driveway of a nearby house. They knocked on the door and spoke to Child J's Aunty Bronwyn and her husband and showed them the photograph. They confirmed the boy in the picture was Child J, who lived at their house. They were informed of his death by the officers. Child J's aunt and uncle did not want to view his body, so Mr Saunders later formally identified him.[207]

181. The police investigation found no evidence of the involvement of any other person in Child J's death. The police were told by witnesses that Child J had recently broken up with his girlfriend and she had then started dating one of his friends. There was evidence Child J had remained in contact with his ex-girlfriend and was finding it hard to cope with the change in their relationship. The evidence supported the conclusion he hanged himself with the intention of taking his life.[208]

182. The investigating officer, Brevet Senior Sergeant Andrew Henshaw, did indicate that the investigation raised the question whether Child J's mental health issues had been sufficiently addressed, and also what supports he had received in his lifetime, given the tragic outcome.[209]

CAUSE AND MANNER OF DEATH

183. On 28 April 2017 a Forensic Pathologist, Dr Clive Cooke, performed a post mortem examination. The examination showed ligature markings to the skin of the neck and fractures of the superior horns of the thyroid cartilage, consistent with hanging. The lungs were congested, which is a non-specific change which may be seen with asphyxiation due to neck compression. The body organs otherwise appeared healthy.[210]

184. Toxicology analysis did not identify any common drugs or illicit substances or alcohol.[211]

185. At the conclusion of all investigations Dr Cooke formed the opinion the case of death was ligature compression of the neck (hanging). I accept and adopt the opinion of Dr Cooke as to the cause of death.[212]

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[204] Exhibit 1, Tab 2, Tab 5, Tab 10 and Tab 17.
[205] Exhibit 1, Tab 2.
[206] Exhibit 1, Tab 2, p. 6 and Tab 21, p. 77.
[207] Exhibit 1, Tab 3.
[208] T 14; Exhibit 1, Tab 2 and Tab 3.
[209] T 12.
[210] T 13 – 14; Exhibit 1, Tab 6A.
[211] Exhibit 1, Tab 7.

186. All of the evidence pointed to Child J making an impulsive decision to hang himself due to unresolved grief issues following his relationship breakdown. I am satisfied he hanged himself with the intention of taking his life, acknowledging that he had been spoken to in the past about the permanent nature of such an act. I find that the manner of death was by way of suicide.

REPORT OF DR CAUNT

187. Dr Nadine Caunt is a Child and Adolescent Psychiatrist who has worked for over 20 years in hospital, community, public and private settings and has also had many roles in the provision and coordination of training for psychiatrists and child psychiatrists in Western Australia. Dr Caunt is currently involved in a number of committees for the Faculty of Child and Adolescent Psychiatrists and is also the Director of Advanced Training in Child Psychiatry for CAMHS.[213] Dr Caunt was asked by the Court to provide an independent review of Child J's case. Dr Caunt prepared a detailed written report and spoke to the report at the inquest.

188. Dr Caunt expressed her opinion about the treatment and care provided to Child J within the context of the services available in the Kimberley in the 2000's. Dr Caunt noted that, given the very limited services and resources that were available in the region at the time, she felt the people involved in his care did the best that they could have done. Dr Caunt considered the potential 2009 PMH referral and the 2014 Pathways referral, both of which stalled, were lost opportunities for a more comprehensive evaluation of Child J to occur, but she recognised that the opportunities were lost for various reasons that could not be attributed to the health providers.[214]

189. Dr Caunt commented that in Child J's case, there was obvious suspicion of FASD and an acknowledgment that he had, at least, neurodevelopmental vulnerabilities, shortly after he went into care. This prompted early interventions in the form of occupational therapy and speech therapy from a young age.[215] However, he continued to have some difficulties with his social and emotional condition, which was likely due to a combination of FASD and early life neglect.[216] Based upon her own review of all the materials made available to her, in Dr Caunt's opinion Child J's difficulties with emotional and behaviour regulation could best be understood as the result of a neurodevelopmental disorder that was the result of both intrauterine neurotoxicity (through exposure to alcohol and possibly amphetamine in the womb) and complex trauma.[217] There was no evidence of an acute psychiatric disorder, either as a child or prior to his death.

190. Dr Caunt explained that if Child J had been able have a comprehensive assessment, it might have helped him to understand the genesis of his problems, which could have helped him to understand his own strength and vulnerabilities in a way that promoted

[212] Exhibit 1, Tab 6A.
[213] T 186; Exhibit 1, Tab 22.
[214] T 188.
[215] Exhibit 1, Tab 22 [23] – [24].
[216] Exhibit 1, Tab 22 [60].
[217] Exhibit 1, Tab 22 [70].

him feeling 'okay about himself'.[218] The admission to PMH could also have provided a 'circuit breaker' for the Featherstones, and assisted in the continuation of his care placement, which could have been of benefit to Child J, given his later placement instability.[219]

191. Dr Caunt's opinion supported the evidence of Ms Wood. It was clear from her evidence that Ms Wood thought the PMH admission was an important step for Child J in order to provide a formal diagnostic review to identify if there were some developmental issues (such as FASD or other issues), review his medication, explore what aids he needed at school to keep him safe and engaged, and also as a circuit breaker for his foster family, which could help preserve the placement on an ongoing basis. Ms Wood indicated that it was an unusual step to propose this kind of planned admission, but she had believed it was necessary in Child J's case to remove him from the environmental challenges he was facing at that time and observe him over a period of days. Once an understanding could be gained about why his behaviour was escalating, the clinicians could have then provided guidance about how these issues could be managed. Further, by seeing his interactions with his foster mother and biological mother, they could have supported his foster family to adopt a more helpful style of trauma-informed parenting.[220]

192. In relation to the attempted reunification with Child J's mother, which disrupted the planned PMH assessment, Ms Wood commented at the end of her evidence that there is a real challenge around how CAMHS and the Department work together around the reunification process, given it is a critical period for families and they need to have the right wraparound supports. It is clear that staff from both agencies were involved at the time, and felt things were progressing well, but it is also clear that the reunification process broke down relatively quickly, so it did not have a successful outcome and probably caused more trauma to Child J.[221]

193. In relation to the medications prescribed to Child J at various times in his life, Dr Caunt expressed the opinion that the medications were "in keeping with what would usually be prescribed."[222] Dr Caunt acknowledged that some of the medication may have been prescribed to try and dampen down some of his behaviours that were causing difficulties in his relationships, but this would not be uncommon in circumstances where there are not any other short-term interventions available and the child is very distressed and the placement is tenuous.[223]

194. In relation to Child J's move to Carnarvon, where his use of medication ceased and he disengaged from CAMHS, Dr Caunt commented that this was, again a missed opportunity. Dr Caunt noted that Child J had gone through a lot of change in that time, with changes to his management by the Department and a new placement. Although she acknowledged that it was made more difficult by Child J's lack of engagement with services, Dr Caunt emphasised that he was still in the care of the Department, so it was the Department's responsibility to determine whether Child J needed ongoing mental

[218] T 189, 195, 203.
[219] Exhibit 1, Tab 22 [60].
[220] T 85 - 89; Exhibit 2, Tab 32.
[221] T 85.
[222] T 190.
[223] T 190.

health care. It was not his father's decision or even Child J's. Dr Caunt suggested that there could have been a role for involvement of an indigenous mental health worker at that stage, to help improve Child J's engagement with mental health services.[224] I note that this was raised with Mr Richards in evidence, and he acknowledged that in hindsight, it could have been a useful option.

195. Ms Jackson, who saw Child J as a Senior Mental Health Professional at CAMHS in Broome, had qualifications in social work and a master's degree in Mental Health Science (Child Psychotherapy). She worked in Broome for about eight years and had a relatively long involvement with Child J, given the changeover of many of the other professionals who were involved in his life. She impressed me as a person who tried very hard to listen to Child J and advocate for him, as well as provide consistent support for him. Ms Jackson was aware that Child J had a very difficult early life and a number of different placements, which meant he had very little continuity of care.[225]

196. Ms Jackson acknowledged that Child J's medication was constantly under review and there were regular discussions with the psychiatrist and the paediatrician around what would be the right combination or mix of medication for him to try and make life easier for him. There were also discussions about stopping medications. However, Ms Jackson expressed concern that his medications were stopped without medical supervision when he was in Carnarvon, as she would have expected any cessation to be closely monitored.[226]

197. Ms Jackson also expressed some reservation about the fact he was assessed only briefly in July 2014 and there were found to be no concerns for his mental health. Ms Jackson noted that Child J had experienced very longstanding difficulties with very short periods of stability before a new challenge (which could be a difficulty at school or at home) arose, so any reassurance that was taken in Carnarvon of how he was presenting on a particular day needed to be considered in the context that he would sometimes seem to be going well but then have very frequent setbacks.[227] Ms Jackson had not foreseen an upcoming discharge for Child J from the CAMHS when she was involved in his case, but she acknowledged that it depended upon what other supports were in place for him and what other monitoring was being done.[228]

198. Ms Jackson was not herself involved in Child J's case at the time he was in Carnarvon, as his case was with the Carnarvon CAMHS office. Ms Jackson's involvement with Child J had formally ended when he moved to Fitzroy Crossing in March 2014, although she had been kept up to date and had some contact with Child J while he was in Fitzroy Crossing. His case was then transferred to the Carnarvon CAMHS office. Although she was no longer involved with managing Child J at that time, she believed his case had many complexities and she felt it would have been important to continue to monitor him in the long term. Ms Jackson acknowledged that CAMHS is a voluntary

[224] T 194.
[225] T 104; Exhibit 2, Tab 34.
[226] T 101 - 102.
[227] T 102 -103.
[228] T 108.

service, but felt there were ways to encourage him to engage and keep an eye on him, even if it was through communication with his school.[229]

199. Despite the missed opportunity for further mental health engagement with Child J in Carnarvon, upon his return to Broome, Child J appeared to be doing well, with many new positives in his life. Nevertheless, Dr Caunt identified the period when Child J was again having difficulties at school and expressing some suicidal thoughts as a further missed opportunity to attempt to engage him with mental health services. I note he was offered a referral to Headspace by his Aunty and Ms Ritchie, but he was reluctant to engage. Dr Caunt noted that Child J had a neurodevelopmental disorder, and had experienced long-term difficulties with multiple placements, so he was unlikely to have sought help on his own, or to have proffered his emotional distress easily to a new person. However, she felt if there had been an opportunity for someone to develop a confiding relationship with him over a period of time, it might have been beneficial.[230] Dr Caunt noted that having had so many caseworkers with the Department, made it unlikely that he would see his new Departmental case worker as the person to go to when distressed.[231]

200. Dr Caunt commented that given Child J's "individual vulnerabilities, the lack of stability of care placements, number of involved workers and sense of discontinuity in life, it was hard to imagine that he ever had a relationship in which he was able to make meaning of his experience."[232]

201. Dr Caunt spoke about the potential for the implementation of a "life story book" for someone like Child J, who has experienced a lot of changes in his caregivers, as it provides a sense of continuity through an external object, which can give the young person a narrative of their life that can be shared with a new case worker and establish a relationship more quickly.[233] I note there was mention of developing a life story book with Child J in his last Care Plan, but there hadn't been an opportunity to action it with him before his death.

202. Dr Caunt expressed the opinion that the consequences of Child J's early attachment disorder, and his experiences in care, likely reduced his capacity to develop supportive relationships and seek help at times of crisis and distress. Therefore, when he "encountered the inevitable difficulties of adolescent relationships, he had few coping strategies, and this conferred a vulnerability to mental health symptoms and suicide."[234]

203. Dr Stone agreed that one of the major concerns in Child J's history was his large number of Child Protection case managers and living placements, as identified by Dr Caunt. Dr Stone believed this "profound lack of consistency of care mirrored the lack of consistency in his personal life," and this was a powerful determinant of his outcome.[235] Dr Stone believed that what Child J "lacked throughout was any kind of

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[229] T 103 - 104.
[230] T 194.
[231] T 194 – 195.
[232] T 14.
[233] T 201.
[234] Exhibit 1, Tab 22 [47].
[235] T 160.

stable therapeutic relationship with any one person."[236] Dr Stone noted that Lynne Jackson did provide quite regular supportive therapy, but she could not provide psychotherapy, and in any event she was not still involved with Child J at the time he tragically ended his life.[237] Like Dr Caunt, Dr Stone believed that Child J's break-up with his girlfriend may well have been of greater significance to him than others, given his past experiences of loss.[238]

204. Dr Patel also referenced in her statement the challenges associated with providing paediatric and psychiatric care to indigenous children in remote and rural areas, particularly those who are subject to protection orders, as well as the challenges in relation to FASD. With the benefit of hindsight, and without wishing to direct criticism to any particular person or agency, Dr Patel agreed with other witnesses that Child J's position was not likely helped by the lack of continuity in his carers, case managers and treating team over the years.[239]

205. Dr Caunt's overall comment was that the professionals involved in Child J's treatment and care in Broome had tried to provide comprehensive individualised care, but "his emotions and behaviours were never sufficiently contained within an enduring relational context for trauma to be adequately addressed."[240] This was due to a complex interplay of factors, with no specific criticism being made of any particular agency or individual involved in Child J's care. While there were a number of missed opportunities to assess him more closely and try to identify the root of why he was struggling to manage his behaviours and emotions, there was still of lot of engagement with Child J by the Department and health workers, marred primarily by the lack of continuity of his care. This was acknowledged to be an ongoing problem in the Kimberley and other remote parts of Western Australia, with no easy solution.

206. Ms Jones, who is still working in the child protection area, although is now based in the Northern Territory, was asked about the high number of case workers who managed Child J during her evidence. Ms Jones indicated that the number of case workers did not surprise her, and she believes that level of staff turnover is common in child protection work broadly. Ms Jones observed that child protection work is challenging and it is not for everyone in the long term, making staff retention difficult. She also noted that it is difficult to find foster carers, so although the Department is mindful of not overloading carers, it sometimes needs to be done in the short term. Ms Jones noted that the remote location of some of the child protection work, such as in the Kimberley, limits some of the services and supports that are available, which also makes it difficult for staff.[241]

207. Mr Saunders agreed that it is very difficult work, made harder by the attrition of staff who often find the work too challenging, particularly in the regions like the Kimberley.[242]

[236] T 160.
[237] T 161.
[238] Exhibit 5.
[239] Exhibit 1, Tab 30A.
[240] Exhibit 1, Tab 22 [79].
[241] T 66.
[242] T 141 – 147.

208. Dr Roland Main, Acting Clinical Director of the Kimberley Mental Health & Drug Service, provided a report in relation to Child J's mental health care provided by the Kimberley Mental Health & Drug Service, which includes CAMHS. Dr Main's report provided some information about the mental health services provided to Child J and also responded to some of the comments made by Dr Caunt in her report. Dr Main noted that Child J was not involved with the Kimberley CAHMS in the last years of his life, as no referral was received after he was discharged from Carnarvon CAMHS and then later returned to Broome. Accordingly, the references to his care related to his younger years, rather than immediately prior to his death.

209. Dr Main acknowledged the truth in Dr Caunt's comments that earlier intervention might, in hindsight, have benefitted Child J on occasion, but also noted the limited services available in the rural setting at the time. Similarly, Dr Main acknowledged that greater continuity of care might have benefitted Child J, by affording a greater understanding of his world, as well as opportunities for earlier intervention and longer term engagement. However, in a similar vein to Ms Fischer, Dr Main advised that continuity of care remains a significant problem everywhere, but more so in rural settings, which I infer is for similar reasons involving the difficulty in attracting and retaining staff. For example, Dr Main advised that a position of regional CAMHS psychiatrist has been created in WACHS Kimberley but has not been substantively filled, despite two previous recruitment campaigns and a third about to start at the time of the inquest.[243]

COMMENTS ON TREATMENT, SUPERVISION & CARE

210. I make my comments on Child J's supervision, treatment and care within the context of being guided by the opinion given by Dr Caunt above. Dr Caunt made no specific criticisms of any individuals involved in Child J's care, and I do the same. There are, however, areas where it was noted that there was an opportunity for more to have been done.

211. Child J was first placed into the care of the Department on 9 January 2004 when he was a small child of only a few years of age. I note he was taken into care with his mother's consent, as despite some earlier support from the Department, she felt unable to properly care for him due to her mental health and substance issues. It was generally accepted that he had suffered neurological damage through exposure to substances in utero and early psychic trauma, before he came into the care of the Department, that affected him throughout the rest of his life.

212. Ideally, Child J should have moved into kinship care based foster care when he first came into care, but there were no family members available in a position to care for him at the time, so he went into non-familial and non-indigenous foster care. Child J had a total of 34 separate living arrangements in his short life, including a period of reunification with his mother in 2011 and a period of time living with his father in 2014 - 2015, neither of which resulted in a permanent care arrangement.[244]

[243] Exhibit 3.
[244] Exhibit 2, Tab 2.

213. It was noted in Child J's Care Plan in January 2016 that 2013-2016 had been a period of significant transition and change for Child J and he needed support in reconciling all his experiences, and the feelings that had been a part of it, which included possible rejection from his carers and father. The Department's stated aim was to try to ensure a return of stability and consistency in his care environment, which was done by placing him in a kinship care placement with his maternal Aunty, which he knew could continue even after he left care.[245]

214. As well as upheaval in his placements, Child J had experienced a lack of continuity through his Departmental case managers. It was estimated that he had 30 case managers in the 14 years he was in care. Mr Saunders from the Department acknowledged that, even in the most stable period in his life in Broome at the end, he still had three separate case managers.[246] Mr Saunders agreed that they were often short-staffed in the Kimberley, which placed pressure on staff.[247] For example, Mr Saunders acknowledged there was often a lack of handover between case managers, as there was no overlap between outgoing and incoming staff, so new staff were often reliant on the stored information rather than personal knowledge of staff. The pressures of the job, and staff shortages, also contributed to high staff turnover, although there were many and varied reasons why staff did not always remain long-term in the Department's Kimberley office.

215. A witness commented that Child J had a high number of placements, broken attachments and exposure to trauma, which "may lead to the sense of abandonment and loss and his risks of self-harm and suicide would be increased."[248] A picture was painted of a young man who had likely had his brain development affected by pre-natal and post-natal factors when he was very young, and over the years he had continued to suffer from disruption and trauma.

216. Despite all of this, the general evidence was that he had avoided any substance use and trouble with the law, which often follow this kind of life history, and in the last year and a half of his life Child J appeared reasonably happy and well-adjusted. He was also described as funny, caring and "a bright young boy who had his whole life ahead of him."[249] He was not on any medication prior to his death, but his Aunty Bronwyn felt he had improved without the medications, going from drowsy to being clear headed, bright and focussed.[250]

217. While these positive changes are a credit to Child J's resilience, and the love and support he received from so many people in his life, the expert evidence indicates that the trauma he had experienced in his life had led to an underlying inability to cope with emotional crisis. Sadly, this seems to have been what has led to Child J's sudden and unexpected death.

[245] Exhibit 4, MJS1.
[246] T 140.
[247] T 141.
[248] Exhibit 2, Tab 2 [39].
[249] Exhibit 1, Tab 2, p. 3.
[250] T 23.

218. Child J had experienced thoughts of suicide when younger. However, in his most recent self-reported questionnaire, he noted in relation to suicide and suicidal ideation, "No, this is for other people,"[251] not for me.[252] Nevertheless, it appears that when faced with a time of emotional crisis, brought on by the loss of a very important first relationship, he resorted to earlier thoughts of self-harm and suicide. He gave no warning of this change to anyone, perhaps in part because of his lack of a long-term confidante with whom he had built a relationship, but also because teenage boys are notoriously private and reluctant to talk about their feelings. It does seem he may have tried to reach out to his foster mother, with whom he had perhaps had the closest relationship in his life, but he did not provide enough detail to alert her to what he was planning.

219. In the end, Child J acted without warning, as is so often the case in youth suicide, and now we are left only to look back in hindsight and wonder if there was more that could have been done to avert this tragedy, that has affected so many people.

220. Child J's Aunty Bronwyn gave evidence that she felt the Department could do more, in the form of family visits and more face-to-face time with the child, as well as supporting the child to engage with services.[253] She also expressed the opinion that other carers of traumatised children could benefit from more training about identifying issues of concern and signs of depression or suicidal behaviour. In Child J's case, Bronwyn had felt he was the happiest she had seen him, which was why she was very confused about what occurred. Sadly, she gave evidence she feels that she failed him.[254] I can reassure her that no one would suggest that is the case, as it is clear that she and her family did their very best to provide love and support to him.

221. As identified above, Ms Wood was very supportive of the planned PMH assessment, which she had felt could serve the dual purpose of a full assessment of Child J's physical and emotional needs, and an opportunity to assess the dynamic of his care environment. Dr Caunt agreed.

222. Ms Jackson, who as I noted above was very involved in Child J's care for a longer period than most, was asked whether, with the benefit of hindsight, she could identify any missed opportunities that might have changed the ultimately tragic trajectory of Child J's life. Ms Jackson considered the Pathways Program might have been an opportunity for him to receive intensive assessment and support, which may have made a difference .[255] Ms Jackson was also aware that there had been discussions about finding alternative housing for the Featherstones or even building an extra bedroom, so that he could have his own room as a refuge from the other children when he needed some time out to manage his emotions. This wasn't able to be achieved while Child J was still in their care, which seemed to add some pressure to the carer placement.[256]

223. The Department provided information at the inquest that the attempts to find alternative housing had been frustrated by a lack of alternative housing that the Featherstones

[251] Exhibit 2, Tab 2 [28].
[252] T 146.
[253] T 22.
[254] T 22.
[255] T 105.
[256] T 104, 106.

found acceptable. The Featherstones were reluctant to leave their neighbourhood, where they were settled, so attempts were made to try to extend the house instead. Unfortunately, it had not progressed before Child J left their home.[257]

224. Ms Ritchie indicated that, from her perspective as Child J's new case manager in the last period of his life in Broome, his previous mental health issues and diagnosis of FASD were noted, but he was not on medication and had no involvement with CAMHS when she became involved in his care. Ms Ritchie recalled reading a report that indicated he had been discharged from CAMHS in Carnarvon because the practitioner believed he no longer needed mental health support or medication.[258]

225. Ms Ritchie had made a referral for a comprehensive health assessment to be completed leading up to Child J's death, but it was still pending at the time he died. She was not sure why it had not occurred, as she had made the referral in February, but she was not concerned at the time as he did not appear to have any urgent health needs. Ms Ritchie had also suggested more than once that Child J should engage with Headspace or CAMHS, but he was resistant to the idea so it had not progressed. She had asked the school about what role a school psychologist might be able to play when he had been upset in February 2017, but this doesn't appear to have led to anything more as Child J seemed to settle again. Therefore, it seemed from Ms Ritchie's perspective that she was aware that it would be beneficial for Child J to have some mental health support, but he was not keen to engage and there were no red flags to make it urgent.[259]

226. Although Ms Ritchie acknowledged there were issues with Child J having had so many case managers before her, she said she did feel like they were building quite a strong rapport and he was quite open in his discussions with her over the seven or eight visits they had. She was aware he had a girlfriend, who was someone he felt he could talk to, but she was unaware that the relationship had ended as she was on leave in March when the break-up occurred.[260] Ms Ritchie stated that she was absolutely devastated when she heard the news of Child J's death, and his passing has affected her greatly. She had seen no indication that he would do such a thing, and so the news that he had hanged himself came as a major shock to her.[261]

227. By the time she gave evidence at the inquest, Ms Ritchie was no longer with the Department. She went on stress leave about a year after Child J's death, before resigning.[262] Acknowledging she was no longer a Department employee, Ms Ritchie was asked if she could suggest ways that the Department might have been better able to support Child J. Ms Ritchie suggested lower caseloads for the case managers, so that they could be in a position to see every child in their case load once a week and further build rapport.[263] This was consistent with the suggestion of Child J's aunt that more contact between the child, support family and case manager would be beneficial.

[257] T 207 – 208.
[258] T 130.
[259] T 131 – 133, 138; Exhibit 2, Tab 1A.
[260] T 134 – 135.
[261] Exhibit 2, Tab 1A [68].
[262] T 127.
[263] T 135.

228. Mr Saunders gave evidence that the Department is currently reviewing the caseload, with a view to considering the complexity of the cases being managed, as well as the number, but it was a work in progress at the time of the inquest.[264]

229. I note also that Ms Ritchie's referral for a comprehensive health assessment appears to have stalled for no apparent reason. The referral was received by the WACHS Kimberley office and allocated to a WACHS Community Health Nurse to action but no evidence could be found of any attempted contacts or missed appointments relevant to this referral, suggesting it was not actioned prior to Child J's death in April. The information provided by WACHS at the inquest indicated that the expectation was that an attempt would be made to see Child J within 30 days of the referral. It's not clear why this did not occur. It was not, however, intended to be a psychiatric assessment, so it is unclear whether any health assessment would have been likely to discern if Child J's mental state was deteriorating.[265]

230. Mr Saunders noted that in Child J's Quarterly Care Report dated 19 April 2017, he was also due to be reviewed by a developmental paediatrician. He believes this did not occur as there were no paediatricians available in Broome at the time. This is consistent with the general evidence about a lack of health resources and staff in the Kimberley.[266] Mr Saunders indicated that he had considered a referral to Headspace, but had not considered a referral to CAMHS at that time as he felt Child J did not exhibit the kinds of mental health issues that required the level of care provided by CAMHS. Mr Saunders was also aware that CAMHS had a waiting list at that time, so Headspace were a better option in the short-term.[267] Headspace still had skilled clinicians and Aboriginal clinicians, who were well situated to help Child J, but in the end, Child J could not be convinced to engage with Headspace, so it did not progress.[268]

231. Mr Saunders indicated that Child J's death was an "absolute surprise"[269] to him and he "felt a sense of numbness"[270] after he was informed that Child J had committed suicide. In hindsight, Mr Saunders agreed that there were missed opportunities to re-engage Child J with mental health services when he returned to Broome, particularly noting the new rejection he had experienced from his father. However, he noted that the Department's staff can't make a young person accept mental health treatment unless they are very unwell, so all they could do was try to encourage him to go to Headspace, without alienating him.[271]

232. Mr Saunders gave evidence at the inquest that Child J's death was devastating, not only for his family and friends, but also several of the Department's staff, including himself. He has learnt from Child J's death that the Department's staff need to be more on guard, and not lulled into a false sense of security when things seem to be going well. He noted

[264] T 142.
[265] Exhibit 8.
[266] Exhibit 4 [15].
[267] T 150.
[268] T 150.
[269] Exhibit 4 [23].
[270] Exhibit 4 [23].
[271] 151.

that while they all want happy stories, they need to be more vigilant, knowing the long-term damage that early experienced trauma can cause.[272]

233. Mr Saunders noted that the Department's staff were unaware of his relationship breakdown prior to Child J's death. Mr Saunders commented that we all know the devastation of a young person at the end of their first intimate relationship, and the impact this would have had on somebody like Child J, who had experienced so much rejection in his life, was likely to be much greater. Mr Saunders indicated that knowledge of his relationship ending would have been a major red flag to him, but unfortunately neither he nor Ms Ritchie was privy to this information at the time.[273]

234. Ms Fiona Fischer, the current Regional Executive Director for the Kimberley Region for the Department, gave evidence at the inquest. Ms Fisher has worked for the Department in the region since 2007 in various roles, although she did not have direct involvement in Child J's case. Ms Fischer sat through all of the evidence called at the inquest and noted that what stood out for her was the commitment that was demonstrated to Child J by all of the people who were involved in his case, and she expressed the belief that Communities staff did everything possible to meet Child J's needs, within the context of the resources available to them. Ms Fischer acknowledged that there is always a challenge in meeting carers' expectation in terms of support and what is possible based on available resources, but Ms Fischer felt that a significant amount of support was provided to Child J and his foster carers.[274]

FASD, TRAUMA & CHILD SUICIDE IN THE KIMBERLEY

235. There appeared to be a general consensus amongst the experts that a formal diagnosis of FASD for Child J would be unlikely to have altered his treatment, as what structural supports that were then available had already been put in place, and the medication that he was prescribed was standard for a child with that degree of behavioural problems.[275] However, the likelihood that he had FASD, and had certainly experienced trauma, was still relevant to what occurred. It was said that a formal diagnosis of FASD for Child J would have been ideal as it could "have contributed to an understanding of Child J's difficulties, particularly as part of a comprehensive assessment of his neurodevelopmental impairments in the context of postnatal exposures to trauma."[276] This was helpful, even though it is unlikely to have resulted in significantly different, or greater, resource funding for Child J.

236. Dr Boulton was a very experienced Senior Regional Paediatrician before his retirement, with particular experience in the Kimberley. Dr Boulton provided some additional information to assist me to understand the context of FASD and trauma in Child J's case, which is sadly representative of so many children in the Kimberley. Dr Boulton explained that,

[272] T 145 – 148.
[273] T 148 – 149.
[274] T 206.
[275] T 161; Exhibit 2, Tab 30, JB6.
[276] For example, Exhibit 7.

one of the key features of children with FASD is its damaging effect on emotional self-regulation, impulse control and the ability to anticipate the consequences of one's actions. All adolescents are at risk of doing things that a person with maturity would not do, and such impulsivity and risk-taking is exaggerated in adolescents with FASD.[277]

237. Dr Boulton observed that after returning to Broome, Child J's failed experiences of reunification first with his mother, then his father, "would have eroded further what vestigial sense of identity he had." Being faced with the greater complexity of the world, despair arising from his past experiences and lack of hope for the future, and a much-reduced or absent impulse control, was a "lethal combination"[278] for Child J. Dr Boulton commented that the "endemic level of child and adolescent suicide in the Kimberley, with no sign of diminishing, is evidence for this."[279]

238. Similarly to some of the evidence given by Mr Saunders, Dr Boulton provided evidence that research over the past 20 years has provided empirical evidence that the first year of life represents a critical period, during which exposure to trauma can affect "detrimentally the child's emotional and cognitive development throughout childhood , and likely far beyond with respect for the risk of severe depression and self-harm."[280] The trauma can affect the way the child's brain develops, in that it actually interferes with the normal level of maturation of the front of the brain known as the prefrontal cortex, which influences executive function (decision-making, planning and learning social inhibitions).[281] This has lifelong repercussions. Dr Boulton indicated that in Child J's case, by the time he was placed into foster care at three years of age, "the neurological base of his emotional and cognitive development would have been damaged and only an environment designed for remediation could have made any difference,"[282] which his foster family's home environment was not.

239. Dr Boulton disagreed with the comments in relation to a lack of continuity of care for Child J, at least in terms of his medical care, stating his continuity of medical care was optimal within the limited resources that were available in the region. Dr Boulton attributed the disruptions to his medical care to the breakdowns in his living placements, and potentially some understandable reluctance on the part of some of his carers to seek medical assistance, rather than a failure by the health services.[283] Dr Boulton noted that, although Child J did see a number of different paediatricians and child psychiatrists, all the paediatric medical specialist staff were members of a cohesive team and communicated frequently with each other. Therefore, there was a good exchange of information, and understanding of agreed practices, to alleviate any difficulties arising from the involvement of a number of specialists.[284] Dr Boulton gave evidence that "people knew exactly where everybody was, what everybody was doing and everybody

[277] Exhibit 3, Tab 30 [35].
[278] Exhibit 2, Tab 30 [36].
[279] Exhibit 2, Tab 30 [36].
[280] Exhibit 2, Tab 30, JB6, see citation.
[281] T 174.
[282] Exhibit 2, Tab 30, JB6.
[283] Exhibit 2, Tab 30, JB6 – JB7.
[284] Exhibit 2, Tab 30, JB8.

turned up on time …. And it worked very well."[285] Dr Boulton also noted that this was in the context of wraparound supportive services from CAMHS and the Department.[286]

240. Many of these practitioners, including Dr Fitzpatrick and Dr Boulton, were involved in the Lililwan Study in the Fitzroy Valley in the late 2000's, which documented the endemic nature of FASD in that region. In this study, the researchers showed that one third of children had some degree of cognitive disability from maternal alcohol abuse during pregnancy. Dr Boulton referred to a significant finding from this study, and more recent initiatives following on from it, in relation to the need to enhance the emotional self-regulation of children with FASD.[287]

241. Dr Boulton commented that,[288]

> *the deficit in self-regulation is, within the range of disabilities for children with FASD, the one that leads to the most serious outcomes because of acting-out and often violent impulsive behaviour with the child having no understanding of the consequences of their actions. Examples include running away and coming to lethal harm, often fatal criminal activity … and self harm and suicide.*

242. Dr Boulton also discussed at the inquest a recent study from South Australia, published this year, which found a far greater risk of death during the period from adolescent to early adulthood amongst people who have been under child protection services. The cause of most of the deaths was drug and alcohol abuse and suicide. Dr Boulton commented that the study showed that there are major structural factors that affect the risk of suicide amongst children, both indigenous and non-indigenous, who have been in out-of-home care. Dr Boulton described this problem as a "one of the worst unseen and unrecognised tragedies on the national radar at the moment."[289]

243. Dr Boulton's comments about the issues with children in out-of-home care are supported by the recently released *Family Matters Report 2021,*[290] which highlights the ongoing impact of poverty, homelessness, intergenerational trauma and social exclusion on Aboriginal and Torres Strait Islander families, resulting in 21,523 Aboriginal and Torres-Strait Islander children being in out-of-home care at 30 June 2020. Each year that number is increasing, despite various commitments from governments, suggesting the responses so far have been inadequate.

244. From his personal perspective, and based upon his vast experience in this area, Dr Boulton expressed the view that there is a difficulty in integrating child protection and preventative health services, from a structural point of view, which makes it hard to provide optimal support to families. Further, there is an "irremedial tension between, on the one hand, the dedicated staff of the Department and health, and on the other hand,

[285] T 168.
[286] T 168.
[287] Exhibit 2, Tab 30, JB9.
[288] Exhibit 2, Tab 30, JB9.
[289] T 182.
[290] The Family Matters Report 2021: Measuring Trends to Turn the Tide on the Over-Representation of Aboriginal and Torres Strait Islander Children in Out-of-Home-Care in Australia, launched 9 December 2021; The Family Matters Report 2021 - Family Matters.

the Aboriginal population in remote regions that suffers the profound effects of transgenerational trauma as a result of the complete disruption of the social fabric of their society in little more than 100 years ago in the Kimberley."[291] Dr Boulton described the tragedies of the premature loss of children like Child J as the "bitter fruit of this profoundly deep conflict."[292] Dr Boulton expressed a sincere desire that the people in this country will move towards a mechanism and vehicle, whether it be constitutional recognition or something else, that will allow a true reconciliation so that other children like Child J do not experience a similar tragedy.[293]

245. Currently, there is a much better understanding of the risks in regard to alcohol consumption in pregnancy and there are a number of universal screening points that detect children at risk of FASD and other neuorodevelopmental impairments. However, there are limited services in the Kimberley to complete the necessary comprehensive assessment, which requires a multidisciplinary team, including psychological testing. Accordingly, the Disability Services section of the Department has worked with WACHS to trial an initiative to address this, which is currently underway. I am advised it is hoped this will improve opportunities for thorough neurodevelopmental assessment, and thus linkage to relevant services, in future cases. However, the extent of those services is still generally limited in the Kimberley, given it is a remote regional setting.[294]

246. The recurring theme in the evidence of all of the witnesses was a profound sense of sadness that Child J, a young man who had suffered so much in his short life, but had also shown so much strength and promise, had succumbed to the same endemic features that have been a recurring theme in a number of inquiries and inquests arising in the Kimberley, as well as other parts of Australia.

247. In September 2021, some months after this inquest was heard, the Government of Western Australia released its first annual progress report in relation to its *Commitment to Aboriginal Youth Wellbeing*, which is a response to the State Coroner's Inquest into the deaths of 13 children and young persons in the Kimberley, and a related Parliamentary Inquiry into Aboriginal youth suicide in remote areas.[295] This report followed on from the WA Government's Statement of Intent released in May 2019 and two community engagement workshops held in the Kimberley. It was noted that not all of the 86 recommendations from the Inquest were unanimously supported at the workshops. As a result, the Government distilled its response to 12 commitments, to address the broad intent of the recommendations and outline a more holistic approach to Aboriginal youth wellbeing.[296]

248. I understand the Government is supporting regional responses through Regional Aboriginal Suicide Prevention Plans, being developed by Aboriginal community-controlled organisations under the Western Australian Suicide Prevention Framework

[291] T 183.
[292] T 183.
[293] T 183.
[294] Exhibit 7.
[295] *Commitment to Aboriginal Youth Wellbeing*, Progress Report: A Response to the State Coroner's Inquest into the deaths of 13 children and young persons in the Kimberley, and Learnings from the Message Stick: the Report of the Inquiry Into Aboriginal Youth Suicide in Remote Areas, September 2021.
[296] *Commitment to Aboriginal Youth Wellbeing – Progress Report 1*, p. 5.

2021-2025. However, it is acknowledged that these plans alone will not address this complex issue.[297]

249. The suicide rate in the Kimberley remains particularly high, with the most recent data available estimating that the suicide rate among Aboriginal people in the Kimberley is twice as high as the suicide rate among all Indigenous Australians. That is within the context that the suicide rate for Aboriginal people remains more than double that of non-Aboriginal people. The risk is particularly high for young people in the Kimberley.[298] It is to be hoped that a region specific Aboriginal Suicide Prevention plan for the Kimberley can try to address these terrible statistics. I note that the Kimberley projects identified so far include the Kimberley Juvenile Justice Strategy and a Preventing FASD Project, which is of obvious importance in the Kimberley, given what is now known about the high proportion of children with FASD in that region. There is no cure for FASD, but early identification and interventions can decrease the risk of adverse secondary outcomes.[299]

250. Most of the concerns raised in the submissions filed on behalf of Child J's biological parents, in terms of looking forward to changes for the future, are encompassed within the Government's Commitment, as acknowledged in the submissions.[300] I have no doubt that Child J's parents, and his broader network of foster family and friends, are heartened by the fact that so much more is being done in this space to prevent further deaths of children like Child J. Lessons can be learnt from his case that can inform these initiatives moving forward.

CONCLUSION

251. Child J had a very difficult start to life, with likely exposure to drugs and alcohol in utero, then neglect, physical abuse and emotional abuse as a small child. The trauma he experienced prior to entering care led him to suffer lifelong neurodevelopmental, emotional and behavioural issues. Child J received specialist medical and psychological interventions but the success of these efforts was limited, possibly due to the inability to find him a stable home environment where he was happy and settled. His trauma was likely compounded by the failure to reunify him successfully with first his mother, then his father, at different times in his life.

252. Despite these challenges, Child J remained very attached to his extended family, particularly his maternal Aunty Bronwyn, and his foster carers the Featherstones. They provided ongoing love and support to Child J throughout his life, even when he wasn't living with them. Prior to his death, Child J had begun living with his Aunty Bronwyn and her family and he was seen to be happy and future focussed. He also still had good support from the Featherstones, with whom he remained close. It appeared to everyone involved in his care that Child J was in a good place with a bright future for, perhaps, the first time in his young life.

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[297] *Commitment to Aboriginal Youth Wellbeing – Progress Report 1*, p. 5.
[298] *Commitment to Aboriginal Youth Wellbeing – Progress Report 1*, p. 7.
[299] Exhibit 7.
[300] Submissions filed on behalf of Child J's mother and Child J's father, dated 15 October 2021.

253. Unfortunately, the long term effects of the trauma, emotional abuse and instability in his early life meant Child J lacked emotional resilience and was prone to impulsive behaviour. Therefore, when faced with the difficult emotional situation of his first relationship breakdown, Child J appears to have reverted to feelings of hopelessness and suicidal thoughts, which he had experienced in his earlier years. Unfortunately, he did not disclose these thoughts to those close to him.

254. Ms Wood, who had been Child J's CAMHS worker earlier in his life, indicated that when she first met Child J, he was searching for really secure relationships, the kinds of relationships that caregivers usually provide. She believed when he started a relationship as a teenager, he would have invested emotionally in that person in the hope they would make him feel safe and secure. Accordingly, when the relationship broke down, his feelings of rejection and abandonment would have been heightened. His heartbreak, which can feel overwhelming for any teenager, would have been enhanced by his background of trauma and his inability to regulate those emotions and seek out someone to talk about the hurt and pain he was feeling. Ms Wood indicated that, as a mental health care professional, if she was aware of a relationship break-up in a young man like Child J, she would want to be checking in to see how he was going.[301] However, we know at this time he had been resisting his aunt's requests to engage with Headspace or the school psychologist or similar, so unfortunately there was not someone with that kind of expertise assessing him around the time of his death.

255. It also appears that Child J was reluctant to open up and share how he was feeling with anyone close to him, so his family and friends were unaware of the full extent of his feelings until it was too late. On the night of 24 April 2017, Child J seemed settled and happy to his family, although he did reach out to his former foster mother, who sent him some words of support. Several hours later, he took a rope and used it to hang himself. His family, friends and support workers were unified in their shock and grief.

256. Tragically, Child J's case is not an exceptional story for a young indigenous man in this State. As I have mentioned above, the reasons why young Aboriginal people choose to take their lives are complex and multi-faceted and they have been explored in other forums at a level much deeper than I am able to go in this inquest. There are no simple solutions. The WA Government has indicated its commitment to implementing changes that will hopefully not only change the future for the coming generations of young Aboriginal and Torres Strait Islander children in this State, but also help those who are currently facing the many challenges that Child J experienced. For that reason, the government must act quickly, if we are to make meaningful efforts to try to save the current generation.

S H Linton
Deputy State Coroner
15 December 2021

[301] T 91 – 93.