CORONERS ACT, 2003

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 21st, 22nd, 23rd, 24th, 27th, 28th and 30th days of November 2017, the 4th, 5th, 6th, 7th, 8th and 11th days of December 2017, the 18th and 25th days of January 2018, the 20th day of February 2018, the 23rd and 26th days of March 2018 and the 14th day of November 2019 , by the Coroner's Court of the said State, constituted of Jayne Samia Basheer, Deputy State Coroner, into the death of Heidi Eileen Roseanne Singh.

The said Court finds that Heidi Eileen Roseanne Singh aged 14 years, late of HenderCare, 3 Roberson Street, Christies Beach, South Australia died at the train line north of Noarlunga Station, Noarlunga Centre, South Australia on the 21st day of August 2014 as a result of electrocution.

The said Court finds that the circumstances of her death were as follows.

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1. Appearances

1.1. The following counsel were granted leave to appear as counsel in these proceedings:

1.1.1. Mr A Kalali - Counsel Assisting the Deputy State Coroner;

1.1.2. Mr C Charles - Counsel for Mr Warrick Singh and Mrs Merva Varcoe;

1.1.3. Mr A Keane - Counsel for the Minister for Education and Child Development, Central Adelaide Local Health Network and Southern Adelaide Local Health Network; and

1.1.4. Mr A Crocker - Counsel for Dr Christopher Lamb.

2. Introduction, Background and Overview

2.1. Heidi Eileen Roseanne Singh (hereinafter referred to as 'Heidi Singh', 'Heidi' or 'the deceased' was born on 24 June 2000. Heidi died on 21 August 2014 aged 14 years and 2 months. At the time of her death, Heidi was under the guardianship of the Minister for Education and Child Development (the Minister).[1]

2.2. The death of Heidi Singh is a 'reportable death' as defined by the *Coroner's Act 2003 (SA)*. Reportable deaths include the death of a person that occurs in South Australia 'by unexpected, unnatural, unusual, violent or unknown cause'.[2] Clearly, Heidi's death was a reportable death and the purpose of this inquest is to examine the cause and circumstances of her death.

2.3. During the inquest, the Court sat for 18 days, it received 102 exhibits and heard oral evidence from 15 witnesses. I have read and considered the evidence along with the oral submissions made by counsel at the conclusion of the proceedings.[3] I have also had the benefit of the detailed written submissions of Mr Crocker and Mr Charles.[4]

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[1] The Honourable Ms Jennifer Rankine MP was the Minister for Education & Child Development from 21 Jan 13 to 03 Feb 15

[2] Section 3(1), *Coroner's Act 2003 (SA)*

[3] Counsel Assisting, Transcript, pages 1937-1963; Mr Charles, Transcript, pages 1964-2001; Mr Crocker, Transcript, pages 2002-2004; Mr Keane, Transcript, pages 2005-2052

[4] Refer 'Submissions on behalf of Dr Chris Lamb' and chronology (38 pages); 'Submissions on behalf of Warrick Singh and Merva Varcoe' (51 pages)

2.4. The standard of proof in coronial inquiries is the civil standard on the balance of probabilities. Where the findings may reflect adversely on an individual, the standard is to be applied in accordance with the principle in *Briginshaw v Briginshaw*.[5]

2.5. Heidi's biological mother was an Aboriginal woman named Mary Singh. A few days after Heidi was born, Heidi's mother placed her into the care of a Caucasian couple, Wolter and Lyn Flink. Heidi's mother was known to abuse alcohol and drugs. Mary Flink had previously placed her 4 year old daughter, Emily, into the care of the Flinks. For all intents and purposes the Flink's became Heidi's parents. She referred to Mr Flink as 'Poppa' and Mrs Flink as 'Nana'. The Flinks also informally fostered other Aboriginal children, however these private care arrangements were never formalised.

2.6. The identity of Heidi's biological father is unclear. A birth certificate does not include the name of Heidi's father.[6]

2.7. Heidi exhibited behavioural problems from an early age. At the age of 3 years she was diagnosed with Foetal Alcohol Spectrum Disorder (FasD).[7] Mrs Flink sought assistance to manage Heidi's behaviour from a general practitioner (GP) (Dr Dowell) and a paediatrician (Dr Lamb). At the age of 6½ years, Heidi was commenced on prescription medication for behavioural management. She remained on medication in various forms until the date of her death.[8]

2.8. Wolter Flink died on Christmas Day in 2008. Heidi was 8 years old.[9] The death of Wolter Flink was the first of many personal losses for Heidi. Thereafter, Mrs Flink assumed sole responsibility for the care of Heidi and the other children in her household. In August 2011, Mrs Flink sought assistance from the Ngartunna Patpangga division of the Southern Child and Adolescent Health Mental Service. The Ngartunna Patpangga service will hereinafter be referred to as the 'CAMHS Aboriginal Service' or 'CAMHS'. The first appointment was held in September 2011 and Heidi remained a client of CAMHS until the date of her death.

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[5] (1938) 60 CRL 336

[6] Exhibit C22e, page 192; Transcript, page 63

[7] **Foetal alcohol spectrum disorder** (FasD) refers to a range of problems caused by exposure of a foetus to alcohol during pregnancy. Dr Christopher Lamb described the characteristics of FasD as including learning/intellectual disability, poor concentration span, impulsive behaviour, emotional and social immaturity, poor short-term memory, low frustration tolerance, mood swings, rage attacks (affective dysregulation), poor judgment and sometimes hyperactivity: Exhibit C30, para [6]

[8] Exhibit C27, page 100; Exhibit C31a, page 1

[9] Transcript, page 5

2.9. In November 2011, Heidi's biological mother died unexpectedly of a drug overdose.[10] Heidi had enjoyed periodic contact with her mother prior to her death. Heidi continued to display significant anxiety, impulsivity, absconding and maladaptive behaviours. There were incidents of explosive anger, head banging, laying in the middle of the road at dusk, walking on train tracks, carrying knives, accessing pornographic internet sites, sexualised behaviour and climbing onto roofs and up high trees.[11]

2.10. Mrs Flink suffered from ill health and by late 2012 her health had seriously deteriorated. Mrs Flink died on 7 April 2013, so at the age of 12 years (almost 13) Heidi had lost the only people she had known as parents. Heidi went to live with Mrs Flink's daughter, Alina Flink (Ms Flink). Ms Flink was the sole parent of four children of her own and, in addition to Heidi, she also assumed care of the other children who had lived in her mother's household. This arrangement lasted for around six months (until 30 October 2013).

2.11. During this period, Heidi was hospitalised on no less than ten occasions.[12] The behaviours which led to hospitalisation included aggression, violent outbursts, threatening behaviour and self-harming (eg. head banging and cutting her arm with a knife). On 3 October 2013 Heidi was admitted overnight to the Women's and Children's Hospital (WCH) pursuant to section 57 of the *Mental Health Act, 2009 (SA)* after allegedly assaulting another child, absconding to a train station, standing behind a truck and threatening suicide.[13] After this incident Ms Flink arranged for Heidi to live with family friends. Families SA (now the Department for Child Protection) and CAMHS were advised of this new informal arrangement.

2.12. For the next eight months Heidi lived with Ms Catherine Malby and Mr Jason Lane, along with their children. However, on 3 June 2014, Ms Malby and Mr Lane relinquished care to Families SA reporting that they could no longer manage Heidi or keep her safe.[14]

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[10] Exhibit C22e, page 19; NB. The cause of death is recorded on the Death Certificate as 'toxic effects of morphine and alprazolam'

[11] Exhibit C31a, page 2

[12] Exhibit C24, page 91; Exhibit C28, pages 65, 76, 73; Exhibit C26, pages 26, 36, 41, 56, 102,106, 113-114, 122, 135-142, 144, 151, 159,191-193, 205, 219, 250-260, 284; Exhibit C22d, pages 44,46,56, 105 ; Exhibit C21e, page 43

[13] Exhibit C21e, pages 43-44; Exhibit C28, page 65; Exhibit C26, pages 102, 106, 113-114, 122, 135-141

[14] Exhibit C31a, page 3

2.13. Heidi was assessed by Families SA as an Adolescent at Risk. No caregivers were identified and Heidi was placed into the interim custody of the Minister. Approval was granted for Heidi to be placed into Emergency Care (hereinafter referred to as 'Emergency Care' or 'the emergency placement'). Emergency Care is provided by Families SA renting accommodation in which a child is cared for by rotating contracted commercial carers from agencies such as HenderCare. Emergency Care is not a secure form of care. For example, if a child absconds, the carer must file a report with South Australia Police (SAPOL) and then alert Crisis Care. Heidi lived in Emergency Care until the date of her death.[15]

2.14. Whilst under the care and protection of the Minister, Heidi frequently absconded. Missing Persons Reports (MPRs) and Critical Incident Reports (CIRs) were frequently made by HenderCare carers. SAPOL and the South Australia Ambulance Service (SAAS) were frequently called to assist in locating Heidi and managing her extreme behaviours. Heidi was presented to Emergency Departments (EDs) of primary hospitals that included the WCH and the Flinders Medical Centre (FMC) on multiple occasions.[16]

2.15. On the evening of 21 August 2014, Heidi absconded from the emergency placement. At around 8:44pm, a train driver was approaching Noarlunga Station and noted a burning object to the left of the tracks. SAPOL was called. The responding officers found the body of a female on the train tracks with the upper torso alight. That person was subsequently found to be Heidi Singh. Further investigations revealed that her body was located at the base of an electrical pylon. The pylon is the place at which electrical current flows from the track conductor to the overhead railings. The top of the mast is approximately five to six metres in height. Inspection of the pylon revealed some small charred/burn marks on the mast, consistent with plastic or burnt clothing.[17]

[15] Rotational care describes any care arrangement in which children are cared for by adults who are employees and who work on a shift basis. Rotational care of two types is delivered in South Australia: Emergency Care (also sometimes referred to as commercial care) and Residential care. In 2016, the Nyland Royal Commission observed that South Australia relies on rotational care more than any other jurisdiction in Australia: Child Protection Royal Commission Report: Volume 1: Summary and Report (August 2016)

[16] Refer Appendix A

[17] Exhibit C2a Post Mortem report of Dr Stephen Wills, page 1

3. Cause of Death

3.1. A post-mortem was conducted by forensic pathologist, Dr Stephen Wills. Dr Wills concluded that the cause of death was electrocution and **I so find**.[18]

3.2. The major pathological findings included burning to the head, torso and upper arms, posterior rib fractures, 7th thoracic spinal fracture, mediastinal haemorrhage and acute intra-alveolar haemorrhage. Analysis of a post-mortem blood sample identified the antipsychotic drug quetiapine at a concentration of 0.04mg, a concentration which is reported to be consistent with therapeutic use. The carboxyhaemoglobin saturation was not elevated above that seen in normal urban dwelling individuals. No alcohol and/or other drugs were detected in screening tests.

3.3. Dr Wills said no obvious electrical contact injuries were present on the upper body, although it is likely that these may have been obliterated by the subsequent burn injury. There was an electrical-type injury, possibly a path of current exit, on the inner aspect and sole of the right foot of the deceased. Taking all the findings at autopsy into consideration, Dr Wills concluded there was no indication that the deceased had inhaled products of combustion, suggesting that she was either already deceased, or at least deeply unconscious, prior to the onset of the fire of her upper clothing.[19]

4. The inquest, the issues and the Child Protection Systems Royal Commission

4.1. The Court received a substantial body of evidence about Heidi's living circumstances in the first 12-13 years of her life.[20] Some of the issues raised by the evidence included the following:

4.1.1. The legality of Heidi's informal care arrangements;

4.1.2. Families SA's policies in respect of children living in informal care arrangements in South Australia;[21]

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[18] Exhibit C2a, page 2

[19] Exhibit 2a, page 3

[20] Refer evidence of Alina Ruth Flink: Transcript, pages 37-143; Exhibits C21, C21A, C21B and C21C (Families SA Contact Files); Exhibits C22A-C22I (Families SA Electronic Records from CM3S Case Management System); Exhibits C25, C25A (Southern Mental Health Southern CAMHS); Exhibit C27: Case notes of Dr Christopher Lamb; Exhibit C27; (Confidential Patient Record, Women's and Children's Hospital); Exhibits C24, C24A (Confidential Medical Record, Flinders Medical Centre)

[21] Written submissions of Mr Charles, pages 5-9; Transcript, pages 1966-1970; Closing submissions of Mr Keane, Transcript, pages 2008-2011

4.1.3. Whether Lyn Flink had any legal authority to transfer Heidi into the care of her daughter, Alina Flink;

4.1.4. Whether Alina Flink had any legal authority to transfer Heidi into the care of Ms Malby and Mr Lane and whether Families SA conducted an appropriate investigation into their suitability to act in *loco parentis*;[22]

4.1.5. The impact, if any, of these informal care arrangements on Heidi's cultural identity and her later mental health;

4.1.6. The adequacy of any action taken in response to the various notifications received by Families SA from 2009 onwards and whether child protection proceedings should have been commenced earlier; and

4.1.7. The extent to which, if at all, relevant Aboriginal organisations and Heidi's Aboriginal kin and extended family members were consulted about changes to her informal care arrangements.[23]

4.2. These are of course significant matters. However, a proper inquiry into these matters is beyond the scope of a single inquest. In any event, many of these and related issues were considered by the Child Protection Systems Royal Commission over which the Honourable Margaret Nyland AM presided between 2014-2016 ('the Nyland Royal Commission' or 'the Royal Commission'). The Royal Commission was established in 2014 to investigate child protection in South Australia. Royal Commissioner Nyland and her team examined the laws, policies, practices and structures currently in place for children at risk of harm, abuse or neglect. The Commission heard evidence from 381 witnesses, received 374 submissions, examined 10,800 documents and conducted 74 stakeholder engagements. The final report made 260 recommendations for improvements to the child protection system.[24] Many of the recommendations addressed systemic issues that have also arisen in this inquest. For obvious reasons, it is not proposed to re-examine these issues and/or to make recommendations about matters which have

[22] Transcript, pages 1964-1965; Written submissions of Mr Charles, pages 1-5
[23] Written submissions of Mr Charles on behalf of Warrick Singh and Merva Varcoe, pages 2-24
[24] Child Protections Systems Royal Commission Report Volume 1: Summary and Report: 'The Life They Deserve' (August 2016)

been covered by the Royal Commission. As foreshadowed by counsel assisting in his opening address, this inquest focused on the period after the death of Lyn Flink (7 April 2013) and, in particular, the quality of care received by Heidi whilst in the custody and under the guardianship of the Minister (3 June 2014 to 21 August 2014).[25]

4.3. The Court heard a great deal of evidence about Heidi's medical management and the multiple ED presentations and admissions that occurred during her short life. Many of the witnesses gave evidence about the same events and also other key events. For ease of reference, I have attached as 'Appendix A' a chart which summarises the key events including periods of hospitalisation. There is no material dispute about the circumstances which led to these events.[26]

4.4. I turn now to assess the salient features of the evidence that was presented to the Court.

5. Evidence of Alina Flink

5.1. Alina Flink was the first witness. It is unnecessary for the purpose of this inquest to describe the evidence in detail. Suffice it to say that Ms Flink provided helpful evidence about Heidi's early life, her parents' dedication to Heidi and the other Aboriginal children whom they informally fostered and the difficulties that were encountered by Heidi after her parents died. It was evident that Mr and Mrs Flink were decent people who genuinely sought to provide the best parental care they could offer to Heidi and the other children. The Court heard that Heidi was particularly close to her father, Wolter Flink. When he died Ms Flink said Heidi was devastated.[27]

5.2. I turn now to the six months when Ms Flink had Heidi in her care. After her mother died on 7 April 2013, Ms Flink was the sole parent of four children of her own. In addition to these family responsibilities she also assumed informal care of Heidi and the other children who had lived in her mother's household. Families SA was informed of the new arrangement.

5.3. Ms Flink provided a clear description of the challenges she faced during that six month period. It is unnecessary to repeat all of the events. Suffice it to say that things came

[25] Transcript, pages 4-27
[26] Refer Appendix A
[27] Transcript, page 53

to a head in early October 2013 on a day when Heidi was in vacation care. Ms Flink said Heidi grabbed a boy from the back of the head and knocked his head on the ground five times because she wanted a ball. She then ran onto train lines where she was located by the police. There had also been a previous incident during which Heidi grabbed a knife and 'went to stab Anna' who was moved out of the way in time to avoid contact. On that occasion, Ms Flink said Heidi ran to her room, took an overdose of prescription medication and STAR Force officers were required to hold her down while awaiting the arrival of an ambulance.[28]

5.4. On 3 October 2013, Ms Flink telephoned Families SA to say she could not continue to care for Heidi. She no longer felt it was safe to have Heidi in the house with her younger three children. Ms Flink made arrangements for Heidi to live with family friends, Ms Malby and Mr Lane. This arrangement was done with the knowledge and agreement of Families SA.[29]

5.5. Ms Flink remained involved in Heidi's life to some degree. Although she was not prepared to accept Heidi back into her care, after she was relinquished to Families SA, Ms Flink said she successfully persuaded the department to allow her to continue having visits with Heidi who would come over for day visits.[30]

5.6. It is clear from Ms Flink's evidence, which I accept, that she did her best to manage Heidi in very difficult circumstances. However, the situation became untenable and it was simply not possible for Ms Flink to manage Heidi's escalating behaviour along with her own four children and other family responsibilities.

5.7. Ms Flink presented as a sincere and pleasant woman. There is no basis to criticise her decision to relinquish Heidi and/or any other aspect of her evidence.

6. Evidence of Dr Christopher Lamb (paediatrician)

6.1. Dr Lamb is a consultant physician in the area of paediatrics. Since obtaining his specialty qualification in 1992, Dr Lamb has worked full-time as a general

[28] Transcript, pages 65-76
[29] Transcript, pages 78-81
[30] Transcript, pages 81-82

paediatrician. Dr Lamb provided a statement to the Court and gave oral evidence at the inquest.[31]

6.2. Dr Lamb's first consultation with Heidi (and Mrs Flink) occurred on 18 January 2007 on referral from GP, Dr Dowell. Dr Lamb was asked to assess Heidi because of difficulties she was experiencing at school, absconding behaviour, anxiety and other behavioural problems.[32] Dr Lamb remained involved in Heidi's care, at least in some capacity, until the date of her death. He conducted periodic reviews on 10 October 2008, 3 March 2009, 7 April 2009, 6 September 2011, 11 October 2012, 11 April 2013, 12 December 2013 and 1 July 2014. These appointments ranged in length from 20-40 minutes.[33] Heidi was brought to the appointments by her carers. Over the relevant period, Dr Lamb met all of Heidi's informal carers.

6.3. I turn now to the first consultation on 18 January 2007. Heidi was then 6½ years old. Dr Lamb was aware of the earlier FasD diagnosis.[34] He concurred with the diagnosis noting that Heidi's impulse control was very poor. On this occasion, Heidi was prescribed 10mg amitriptyline nocte (brand name Endep) twice daily. Amitriptyline is a tricyclic antidepressant which can be used to stabilise mood swings.[35]

6.4. The first review took place on 10 October 2008. It was noted that the 10mg dose of amitriptyline was 'definitely helping to reduce overall anxiety', however, if Heidi had the drug in the morning 'then she tends to become aggressive.[36] In the letter of report to Dr Dowell dated 11 October 2008, Dr Lamb stated:

> 'Unfortunately, I do not think that there is anything which can be offered from a medical perspective. Perhaps Heidi would benefit from review by a psychologist, and *regular focused fifth (sic) psychological therapy*. This could easily be arranged…'[37] (emphasis added)

6.5. After the second review on 3 March 2009, Dr Lamb noted no improvement. Heidi was attending Christies Beach Primary School (Year 2). In the letter of report to Dr Dowell, Dr Lamb reported 'a new form of behaviour' in which Heidi utilised self-harm by

[31] Exhibit C C30, C30a, C30b; Transcript, pages146-283
[32] Exhibit C30, para [3]; Exhibit C27, page 100; NB. Dr Dowell did not give evidence at the inquest
[33] Exhibit C27, pages 85-86,20, 79, 74-75, 65-66, 33-34, 32
[34] Exhibit C27, pages 9698: Letter of Dr Hilary Holmes (Paediatrician) to Dr Dowell dated 16 October 2003
[35] Exhibit C30, paras [3], [6]-[7]; Exhibit C27 at pages 85-86; Transcript, pages 151, 220-221
[36] Exhibit C27, page 79
[37] Ibid

banging her head into a tree as a way to be sent home from school. Dr Lamb stated *inter* alia:

> 'Lyn is reluctant to seek support from CAMHS, or Families SA, as she has had negative experiences with each of these organisations in the past. Nevertheless, these remain the organisations most likely to be able to assist…
>
> …The medical role here is comparatively small. I shall keep Heidi on her small dose of amitriptyline to try and stabilise her moods. *In general terms, this is not really a problem with a medical or pharmacologic* (sic) solution.[38] (emphasis added)

6.6. On 7 April 2009, an entry in Dr Lamb's case notes stated 'Endep 20 makes her worse'.[39] The amitriptyline was discontinued and clonidine (brand name Catapres) was prescribed in lieu thereof. Clonidine is an alpha blocker which is used in small doses to treat children with impulsive aggression.[40] Dr Lamb explained that risperidone (an antipsychotic medication) was another option that can be used to reduce aggression, however, it is a more powerful medication which he said is generally only used in situations where the aggression is of a level that there is a serious risk of harm to self or others.[41]

6.7. On 22 May 2009, Heidi was assessed by psychologist, Ms Kerry Burdett. It appears the assessment was directed primarily at intellectual functioning. The assessment gave Heidi an overall IQ within and below the borderline range and around the 1st percentile.[42]

6.8. There was a significant gap in time before Dr Lamb's next session with Heidi on 6 September 2011. In the intervening period, several things had occurred:

6.8.1. By late October 2009 Heidi had been suspended indefinitely from school;

6.8.2. Heidi was having 'meltdowns' which were managed by Catapres;[43]

6.8.3. On 2 February 2010, Dr Lamb prepared a medication plan for the assistance of Heidi's school. One tablet of Endep (25mg) was prescribed for after-hours school care and one Catapres 100 tablet was also recommended, if needed;[44]

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[38] Exhibit C27, page 74
[39] Exhibit C27, page 20
[40] Transcript, pages 154-155
[41] Exhibit C27, page 20; Transcript, pages 155-156, 222
[42] Exhibit C27, pages 67-69: Confidential Assessment Report of Kerry Burdett dated 22 May 2009
[43] Exhibit 30C, pages 20- 21; Exhibit C27, pages 20-21
[44] Exhibit C27, pages 73-74

6.8.4. A referral to Disability SA was being considered;[45] and

6.8.5. In early September 2011, the CAMHS Aboriginal Service commenced involvement in Heidi's care.

6.9. I turn now to the session dated 6 September 2011. At this time, Heidi was attending St Anne's Special School and appeared to be doing much better at school. The medication regime was 50mcg of Catapres in the afternoon and a further 100mcg in the evening 'to help Heidi settle down and reduce her impulsive aggression'.[46] However, Mrs Flink reported some strange behaviours. In the letter of report to Dr Dowell dated 6 September 2011, Dr Lamb stated:

> 'Heidi is exhibiting some strange behaviours which might be considered attention-seeking and potentially self-harming. For example, Heidi likes to lie on the road in the twilight. She also likes climbing onto the roof of the house. Both of these activities could result in serious injury…
>
> Heidi and Lyn have begun to see a therapist at CAMHS-Helen Fry (sic), the aboriginal worker…'
>
> *There is probably not very much I can do to help Heidi*. I am quite happy with her continuing to take the catapress (sic), if it is beneficial…I have completed the referral package for Disabilities SA.'[47] (emphasis added)

6.10. For the next twelve months there was little contact with Dr Lamb. Mrs Flink and Heidi were having regular sessions with CAMHS social worker, Ms Helen Wyld. It will become apparent that Ms Wyld became Heidi's primary therapist. However, there was little or no liaison between Dr Lamb and Ms Wyld.

6.11. By the date of Dr Lamb's next review on 11 October 2012, Heidi's biological mother had died and Mrs Flink was taking steps to become Heidi's guardian. Dr Lamb discerned no improvement in Heidi's behaviour. She was described as 'defiant and uncooperative' with ongoing aggression in the evenings . A small evening dose of 2.5mg of periciazine (brand name Neulactil) was introduced in addition to the regular Catapres medication. Neulactil is used to treat anxiety/tension and to control symptoms such as impulsiveness and aggression.[48]

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[45] Exhibit C27, pages 70-73
[46] Exhibit C27, page 65
[47] Exhibit C 27, pages 5-66
[48] Exhibit C27, pages 26, 33-34

6.12. On 29 October 2012, Heidi had her first appointment with CAMHS psychiatrist, Dr Hooper. However, Dr Lamb was not notified of the appointment.[49] I will return to the issue of inadequate liaison between key agencies and medical health professionals in due course.

6.13. The next review did not occur until after Mrs Flink had died. On 11 April 2013 (four days after the death), Alina Flink brought Heidi to see Dr Lamb. The visit was triggered after Heidi was hospitalised after a 'major meltdown' at school. Sedation had been required to subdue Heidi. Ms Flink sought advice from Dr Lamb about how to manage Heidi's behaviour. Dr Lamb wrote to the principal of St Anne's and provided advice about how to manage 'a rage attack' which involved threats to other children or adults. The school was advised to administer 1mg of lorazepam. Lorazepam is a drug which belongs to a class of drugs known as benzodiazepines and it can be used to treat symptoms of anxiety. If there was no response after ten minutes, Dr Lamb recommended a second 1mg dose of lorazepam. If Heidi did not consent to taking the medication, or the medication was not successful, or if Heidi presented a threat to the safety of others, the school was advised to call the police as Heidi may require restraint.[50] The situation was clearly very serious. Indeed, Dr Lamb said that after Mrs Flink died 'things just went completely off the rails'.[51]

6.14. The next review did not take place until 12 December 2013. In the intervening period the situation had continued to deteriorate. For example:

6.14.1. Heidi was destructive at school and she had essentially been excluded from attending Christies Beach High School;

6.14.2. On 10 June 2013, Heidi was taken by ambulance to the FMC after an aggressive outburst at McDonalds; and

6.14.3. On 20 July 2013, she had a meltdown at respite care and hit herself on the head with such force that it caused concussion.

[49] Exhibit C25, page 25; Transcript, page 162
[50] Exhibit C27, page 32; Transcript, page 161
[51] Transcript, pages 165, 217

6.15. On 30 July 2013, Dr Lamb wrote a prescription for risperidone 1mg (½ twice per day), a drug which Dr Lamb had earlier described as being reserved for situations of aggression which comprise a serious risk of harm to self or others.[52] The fact that risperidone was prescribed indicates the degree to which Heidi's behaviour had deteriorated.

6.16. On 19 August 2013, Heidi ran away from her carer. A MPR was raised. At 10pm an emergency mental health assessment was conducted at the WCH. On 20 August 2013, Heidi was re-admitted to hospital.[53]

6.17. On 26 August 2013, Heidi commenced a three-day planned admission to the WCH Boylan Ward. Dr Lamb was not informed about the proposed admission. As I understand it, the admission was arranged by CAMHS. Nor was Dr Lamb included on the distribution list on the discharge summary. This is but one example of the absence of liaison between government agencies, primary hospitals, medical and other health professionals who involved in Heidi's care. Dr Lamb subsequently learned that Heidi's medication regime had been discontinued by psychiatrist Dr Brock and quetiapine (25mg daily) had been prescribed in lieu thereof.[54] Quetiapine is an antipsychotic medication that is used to treat various mental/mood disorders. Dr Lamb expressed no concern about the change in medication or the fact that he was not consulted about the proposed change. On the contrary, since it had been initiated by a psychiatrist during an admission to a dedicated adolescent psychiatric ward, Dr Lamb considered it would have been inappropriate to alter the prescription. In any event, he was very pleased to hear that psychiatric follow-up had been arranged. Furthermore, he considered quetiapine was a suitable medication and noted with approval that it had apparently assisted Heidi. Thereafter, Dr Lamb was happy to provide repeat scripts of quetiapine when required.[55]

6.18. After the Boylan Ward admission, Dr Lamb met with Heidi on two further occasions, namely 12 December 2013 and 1 July 2014.[56] An appointment had been scheduled for 19 November 2013 however Ms Malby and Mr Lane did not attend.[57]

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[52] Exhibit C30, [12]; Exhibit C27, pages 19, 46
[53] Exhibit C20p
[54] Quetiapine is an antipsychotic medication that is used to treat various mental /mood disorders
[55] Exhibit C30, para [13]; Exhibit C27, page 37; Transcript, pages 182-183, 196 237, 243-245 and 259-262; Exhibit C30, para [14]
[56] Exhibit C30, para [18]; Exhibit C27, page 3
[57] Exhibit C27, page 3

6.19. In the lead up to the December appointment, Heidi had been admitted to the WCH on 23 September 2013, 3 October 2013 (Boylan Ward)[58] and 14 November 2013. Families SA had also received a notification that Ms Malby and Mr Lane were not engaging with mental health services.[59]

6.20. On 12 December 2013, Heidi attended the appointment with Ms Malby. She was still under indefinite suspension from Christies Beach High School. Dr Lamb wrote to the school principal urging a compassionate approach and providing advice on how to manage behavioural outbursts with medication. It is clear that Dr Lamb considered it would be to Heidi's advantage to continue to attend school and it was important for her to be treated with compassion. Reference was made to her being 'a victim of a cascade of events which had dogged her heels since the day she was conceived'. The advice regarding 'what to do if Heidi has a rage attack' was as follows:

> 'If Heidi is cooperative for taking medication, then she may have 1mg lorazepam tablet if she is having a meltdown.
>
> If there has been no response after 10 minutes, Heidi may have a second 1mg tables of lorazepam.
>
> If this is not successful, then it may be necessary to call the police. Heidi may require restraint. If, at any stage during the previous process Heidi presents a threat to the safety of others, then the police should be called…
>
> If Heidi engaged in further acts of self-harming, it would be appropriate to call the police so that Heidi can be escorted to the WCH.'[60]

6.21. In this letter, Dr Lamb also referred to Heidi being '*under long-term supervision from child psychiatrist, Dr Hooper*'.[61] In fact, the evidence has established that Dr Hooper had no supervisory role in Heidi's care. His role was limited to periodic consultancies. **I find** that Dr Lamb was clearly mistaken about this fact. (emphasis added)

6.22. Further appointments were made for 14 February 2014 and 10 June 2014 respectively, however Heidi missed these two appointments. During this period, Dr Lamb provided repeat prescriptions for quetiapine on 14 February 2014, 27 March 2014, 14 April 2014 and 20 April 2014.[62]

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[58] Exhibit C27, page 47; Exhibit C23, page 44
[59] Exhibit C27, pages 187, 198; Exhibit C25, page 209
[60] Exhibit C27, page 38
[61] Exhibit C27, pages 3, 37-38: Letter to School Principal, Christies Beach High School) dated 12 December 2013
[62] Exhibit C27, pages 35, 40-42; Transcript, page 194

6.23. By June 2014, Heidi had been placed into the interim custody of the Minister. On 17 June 2014, he was requested by Ms Frangiosa (Families SA) to provide a report.[63] On 24 June 2014, by way of response Dr Lamb sent a brief facsimile transmission which stated:

> 'Not seen since December 2013. Currently on quetiapine 25mg daily supposedly. Supposed to be seeing Dr Hooper, psychiatrist, for follow-up. I probably do not have an active ongoing role. Previous medical report for Guardianship Board December 2012. I first started looking after her in January 2007. Attendance was OK while Lyn was alive.' [64]

6.24. Dr Lamb acknowledged that the response was 'poorly worded'. In my view, it was a cursory response which lacked the detail and specificity that one would ordinarily expect to be provided by a specialist. That said, nothing turns on the point.

6.25. Dr Lamb's final record of attendance on Heidi is dated 1 July 2014.[65] He said he was 'almost certain' that Heidi was present at the consultation although he did not record which of her carers attended. Dr Lamb said he enquired as to what supports were in place and learned there were 'a number of very appropriate supports' in place. These included support worker Helen Wyld who 'had been engaged in therapy with Heidi for a long time'. It was noted that Ms Wyld was also liaising with FMC psychiatry and that Heidi was scheduled to have a medical review at Child Protection Services. Dr Lamb's understanding was that 'there was an arrangement in place for Heidi to see Dr Michael Batterham, psychiatrist'.[66]

6.26. Having considered the evidence, there is no doubt that by this stage Dr Lamb had formed the view that Heidi's needs were being appropriately managed by others and that her management included psychiatric oversight. Under cross-examination by counsel assisting, Dr Lamb was pressed on the topic of the lack of communication between himself and CAMHS. Dr Lamb agreed there was little exchange of information and that he could have done more himself to facilitate a more collaborative approach.[67]

6.27. Thereafter, Dr Lamb had limited involvement in Heidi's case. On 28 July 2014, a copy of the separation summary from WCH was provided to him and on 1 August 2014

[63] Exhibit C27, page 31: Letter to Dr Lamb from Gabby Frangiosa dated 17 June 2014
[64] Exhibit C27, pages 29-30; Transcript, page 198
[65] Exhibit C27, page 4
[66] Exhibit C30, [20]
[67] Transcript, pages 265-267 and 272-274

Dr Lamb provided a further prescription.[68] He subsequently learned with great sadness that Heidi had died.

6.28. Before I leave Dr Lamb's evidence, I will address a couple of further issues that arose during his evidence. The Court heard evidence about a telephone message that Dr Hooper left for Dr Lamb at his rooms on 4 August 2014. There is no dispute that the message was conveyed to Dr Lamb. A handwritten note, presumably written by a member of Dr Lamb's staff, states that 'he [Dr Hooper] would like to discuss current and past medications with CL [Chris Lamb] as he will be seeing Heidi. He [Dr Hooper] hung up before giving his number'.

6.29. Dr Lamb candidly stated that he did not return this call. By way of explanation he said that he did not appreciate its urgency at the time. Dr Lamb expressed regret at the omission. I have no hesitation in accepting that the expression of remorse is genuine.[69] That said, if Dr Lamb had read and absorbed the contents of the separation summary dated 28 July 2014, the urgency would have been immediately apparent. Heidi had been taken by ambulance to hospital with reports that she was 'extremely agitated' and 'hearing voices'. She had been given 17mg of midazolam in the ambulance for sedation. Subsequently Heidi was discharged to HenderCare. The message required a prompt response and the call ought to have been returned.[70]

6.30. The Court also heard evidence that on 19 August 2014, Dr Hooper drafted a letter to Dr Lamb in which he requested a summary of Dr Lamb's involvement with Heidi along with past management strategies and her medication history. He arranged for the letter to be sent to Dr Lamb by a member of his staff. Dr Lamb said he never received that letter. His evidence was that he saw the letter for the first time a week or so before the commencement of the inquest.[71]

6.31. At first blush, the evidence seems self-serving. However, it is noteworthy that the CAMHS case notes do not contain a copy of the signed letter. There is an unsigned draft letter on the file. Dr Lamb's case notes do not contain copies of either the draft or the signed letter. Having regard to the evidence and the explanations proffered by Dr Lamb and Dr Hooper, I cannot exclude the possibility that the signed letter was

[68] Exhibit C 27, pages 13-17, 28
[69] Exhibit C27, page 12; Transcript, pages 205-207, 257-258
[70] Exhibit C27 at pages 3 and 38
[71] Transcript, pages 207-209

either not sent by the person to whom Dr Hooper had delegated the task or, if it was sent and received at Dr Lamb's rooms, it was not placed on the case file and/or brought to Dr Lamb's attention. Accordingly, I accept the evidence of both Dr Lamb and Dr Hooper and attribute the fact that the letter remained unanswered to administrative error.

6.32. In any event, I do not consider the omission to return Dr Hooper's call or provision of the information sought at this late stage would have changed the ultimate outcome for Heidi.

6.33. I found Dr Lamb to be a credible and thoughtful witness who made appropriate concessions. **I find** no basis to criticise Dr Lamb's medical management of Heidi Singh. With the benefit of hindsight, it would have been prudent for Dr Lamb to have initiated contact with CAMHS and Families SA in order to clarify his role, especially once he had formed the view that he had no active ongoing role to play in Heidi's care. A more collaborative approach between medical and health professionals would have been of mutual benefit.

7. Role of Families SA

7.1. Evidence of Stuart Thelnig (Families SA Supervisor, Investigation and Assessment Team

7.2. Stuart Thelnig was employed by Families SA in 2014 as a supervising social worker. Mr Thelnig was based at the Noarlunga office and he supervised the Intake and Assessment Team to which Heidi's case was allocated. Ms Gabriella Frangiosa was the team social worker. Assistance was also provided by departmental psychologist, Ms Madeleine Hayter.

7.3. Mr Thelnig gave oral evidence at the inquest.[72] The evidence can be summarised as follows. The primary role of a supervisor is to support social workers with their caseloads. The supervisor does not carry their own case load. The Court heard that at the relevant time each of the Investigation and Assessment teams at Noarlunga was managing approximately 147 cases. Many of the cases were complex.

[72] Transcript, pages 541-672

7.4. Mr Thelnig confirmed that Heidi was assessed as an Adolescent at Risk and that her case was given a 'Tier 1' classification. This classification is given to only the most urgent of cases. Since it was a Tier 1 case, the initial assessment and investigation had to be completed within 24 hours of initial notification.

7.5. Mr Thelnig explained that when a child first comes into care, the immediate priority is to find accommodation. If no family member or other person(s) are identified as suitable caregivers, Families SA must find a placement for the child. This process is managed by the Placement Services Unit (PSU) of Families SA. In general terms, the options provided by Families SA are:

7.5.1. Foster Care: Foster care is family based care in which a child is placed into a family. One form of foster care is 'Therapeutic Foster Care'. Therapeutic carers are provided with skills training by Families SA. A 'wrap around' team supports the carer. These carers are paid a full-time salary by Families SA to care for a child/children.[73]

7.5.2. Community Residential Care (CRC): CRC is provided in large dormitory style accommodation. Each child has their own room in one of several wings. There may be three to four young people to a wing. Families SA provides training to the carers who work in CRC units.[74]

7.5.3. Transitional Accommodation (TA): TA is similar to the CRC model. A child may spend three to six months in TA for assessment before 'transitioning' to another form of care.[75]

7.5.4. Emergency Care (EC): Emergency care is provided by Families SA in rental accommodation with care provided by contracted rotating carers from agencies such as HenderCare. Emergency Care is not a secure facility. If a child absconds, the carer must file a report with SAPOL and then alert Crisis Care.[76]

[73] Transcript, pages 553-554
[74] Transcript, pages 555, 664-665; In relation to the size and capacity of the various CRC units refer Transcript, page 704
[75] Transcript, page 144
[76] Transcript, pages 555-556, 563-654, 571-573, 666, 692

7.6. The Court heard that best practice is to place a child in family based foster care. However, Mr Thelnig candidly stated that few such placements were available in 2014 and that remains the case at the present time.[77]

7.7. Mr Thelnig described Emergency Care as 'the option of last resort'. He said no social worker likes to see a child placed in emergency accommodation which he described as a place where a child lives 'in isolation and under constant surveillance'. Concern was also expressed about the level of training provided to HenderCare carers. Mr Thelnig said the carers 'did a fantastic job' however he opined that some had minimal training in managing children with complex needs.[78] His evidence was that specialised skills are required to effectively work with young people who have experienced high levels of trauma, grief and loss.

7.8. Mr Thelnig was questioned about Community Residential Care. He explained that, in some circumstances, placing a child into a CRC unit can actually expose them to greater risks such as drugs, alcohol, absconding and learning new maladaptive behaviours from other children in the unit. Conversely, the child who is coming into the facility may expose the children who are already there to extreme behaviours. The effect of the evidence was that the decision whether or not to place a child in CRC is not necessarily a simple one.[79]

7.9. As a supervisor, Mr Thelnig was involved in regular meetings about the management of Heidi's escalating behaviours. It is unnecessary to repeat his evidence about these meetings or the court applications and processes relating to Heidi's case, as these issues were covered in more detail by other witnesses. Suffice it to say that whilst Heidi was in the Minister's care, Mr Thelnig and his team concluded that Heidi's best interests required removal from Emergency Care and relocation to a CRC unit. They advocated strongly on Heidi's behalf, albeit unsuccessfully.

7.10. I turn now to Mr Thelnig's evidence about two genograms which form part of the Families SA case notes. Under cross-examination, it was suggested that both genograms show that a person called Alex Vargo or Varcoe was Heidi's biological father and that efforts should have been made by Families SA to find him and other

[77] Transcript, pages 553-554, 569, 656
[78] Transcript, pages 571-573, 608-609, 571-573
[79] Transcript, pages 556, 667-668

Varcoe family members. Mr Thelnig did not agree that the genograms supported an inference that Heidi's biological father could be identified from the genograms. He said they did no more than indicate that Heidi's father 'may have been' Alex Vargo or Varcoe. He did recall having a conversation 'at some point' about a possible link to this family however he could not point to any notation of the conversation or indeed any records to suggest that the potential connection was followed up.[80]

7.11. When asked about what efforts were made to pursue this avenue of inquiry, Mr Thelnig explained that it was not part of a supervisor's role to explore kinship connections. That role is undertaken by the Families SA Kinship Care Assessment Team (the Kinship Care Team) in liaison with the team social worker (ie. Ms Frangiosa). He added that if the client was of Aboriginal descent, then kinship connections might be followed up by the principal Aboriginal consultant.[81]

7.12. Mr Thelnig acknowledged that a prompt referral ought to have been made to the Aboriginal Family Support Services Incorporated to pursue the possible Varcoe family connection. He agreed that it was important because of the Aboriginal Child Placement Principle. That said, Mr Thelnig maintained that Heidi's immediate safety was the highest priority, at least at the early intake stage.[82]

7.13. I found Mr Thelnig to be an honest and reliable witness who gave helpful evidence to the Court. **I find** no basis to criticise the manner in which Mr Thelnig supervised his team and/or in the discharge of his responsibilities.

7.14. Evidence of Gabriella Frangiosa (Families SA social worker)

7.15. Ms Frangiosa is a social worker who commenced work at the Noarlunga office of Families SA in early 2013. In June 2014, Ms Frangiosa was a social worker in the Investigation and Assessment Team which managed Heidi's case. Her supervisor was Mr Thelnig.[83] Ms Frangiosa gave oral evidence at the inquest.[84]

[80] Exhibit C21b, pages 226, 228; Transcript, pages 601-602
[81] Transcript, page 600
[82] Transcript, page 604-606
[83] Transcript, pages 419, 542
[84] Transcript, pages 414-537

7.16. Ms Frangiosa first met Heidi on 3 June 2014 (the date of which Heidi was relinquished to Families SA by Ms Malby and Mr Lane).[85] Heidi was described as shy and withdrawn. She did not respond to verbal cues and it was difficult to establish rapport.[86] Ms Frangiosa confirmed that Heidi was classified as 'Tier 1' which required investigation and assessment within 24 hours. Ms Frangiosa also confirmed that the immediate priority was to locate a suitable caregiver. If no caregiver is identified, Families SA must find a suitable placement.

7.17. It is an undisputed fact that no caregiver was located for Heidi. It is a separate question whether the efforts that were made to locate kin and extended family networks were adequate. I will come to that issue in due course.

7.18. On 3 June 2014 at 3:08pm, Ms Frangiosa completed and lodged a placement request with the Placement Services Unit (PSU). Family based care (ie. foster care) was nominated as the preferred type of placement.[87]

7.19. On 4 June 2014, pursuant to section 21 of the *Children's Protection Act, 1993 (SA),* the Youth Court of South Australia granted a 7 day order which authorised an investigation and assessment of the case (until 11 June 2014).[88] In the meantime, approval was sought and granted for Heidi to be placed into interim Emergency Care. She was accommodated in a rental house located at 4 Maurice Street, Aldinga Beach. Care was provided by contracted commercial carers from HenderCare who worked in rotating shifts.

7.20. Part of Ms Frangiosa's role was to prepare reports for use in court proceedings. This task required prompt liaison with Heidi's school, medical and other health professionals, along with others who could provide information about Heidi's family background, personal circumstances, medical history, current medication regime and the like.

[85] Exhibit C22e, page 166
[86] Transcript, page 437
[87] Exhibit C35, C35b; Transcript, pages 490-491
[88] Exhibit C22e, pages 89-100

7.21. On 5 June 2014 CAMHS social worker, Ms Wyld, telephoned Families SA and obtained permission to visit Heidi at the emergency placement. From this time onwards, Ms Wyld visited Heidi on a weekly basis.[89]

7.22. On 6 June 2014, Ms Frangiosa completed a referral to the Kinship Care Team as she knew that Heidi had been displaced from her Aboriginal culture since birth.[90] She said the Kinship Care Team provides scoping summaries, however, it was the responsibility of social workers to locate and assess the suitability of any potential caregivers who were identified in the summaries. There was certainly no stand-alone team within Families SA which was tasked with this important responsibility.[91]

7.23. On 11 June 2014, the Youth Court granted a further investigation and assessment order for a period 42 days (to 22 July 2014).[92]

7.24. On 17 June 2014, Ms Frangiosa requested written reports from Dr Lamb and CAMHS social worker, Ms Wyld, for the purpose of pending child protection proceeding applications.[93]

7.25. On 18 June 2014, Mr Thelnig and Ms Frangiosa arranged a referral for a Youth Court family care meeting. The meeting did not take place as no correspondence was received from any of the listed people on the referral, including family and significant others.[94]

7.26. On 19 June 2014, Ms Frangiosa attended at the HenderCare placement to conduct a welfare check. She was accompanied by senior social worker, Ms Stirling. This attendance occurred because on the previous day there had been an incident which culminated in Heidi hitting herself in the face, running to a railway line and running along the tracks. SAPOL was called to assist. On the way back to the placement, Heidi reportedly said she could have killed herself.[95] At the time of the welfare check Heidi appeared well and she was happy to be attending Alina Flink's house on the coming Saturday.[96]

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[89] Exhibit C22e, page 106
[90] Transcript, pages 414, 424-426, 447-448; Exhibit C43 at [20]- [28]; Recommendation 190 of the Nyland Royal Commission
[91] Exhibit C22e, page 242; Exhibit C22e, pages 234-240; Transcript, pages 451-452;
[92] Exhibit C21e, page 7
[93] Exhibit C22e, pages 146-147
[94] Exhibit C21b, pages 219-228; Exhibit C22f, page 42; Exhibit C21e, pages 9-11: NB. Two genograms were annexed to the attached documentation
[95] Exhibit C22e, pages 152-152, 154-155
[96] Exhibit C22e, page 159

7.27. By 23 June 2014, arrangements had been made for Heidi to have a comprehensive health assessment at the Child Protection Service (CPS). These assessments are routinely conducted by CPS when a child is placed under the custody or guardianship of the Minister.[97]

7.28. On the same day, Ms Frangiosa received a written report from Dr Lamb who advised that he probably did not have an active ongoing role in Heidi's care.[98]

7.29. On 26 June 2014, Heidi attended the CPS health assessment. The following day the CPS requested CAMHS to conduct an urgent psychiatric assessment.[99] It was anticipated that CAMHS psychiatrist, Dr Ken Hooper, would complete the assessment. Ms Frangiosa was subsequently advised by Ms Wyld that Dr Batterham was being pursued to conduct the assessment.[100]

7.30. As at 30 June 2014, still no caregivers had been identified for Heidi. Accordingly, pursuant to s37 of the *Children's Protection Act, 1993 (SA),* Families SA initiated an application for Heidi to be placed under the guardianship of the Minister until she attained the age of 18 years.[101] A couple of days later approval was granted for an extension of the interim Emergency Care arrangement.[102]

7.31. On 3 July 2014, Ms Frangiosa received scoping summaries from the Kinship Care Team. Several persons were identified as kin or extended family members. The two genograms which I have mentioned were included in the documentation.[103] One would assume that intensive efforts would have been made to locate and assess the nominated persons. I will come to Ms Frangiosa's efforts to locate kin and extended family networks in a moment.

7.32. On 4 July 2014, 5 July 2014 and 6 July 2014, Heidi absconded from the emergency placement at night. MPRs were filed with SAPOL. CIRs were sent to Families SA by

[97] Transcript, page 443; Exhibit C22e, pages 165-172
[98] Exhibit C22e, pages 80, 183-189
[99] Exhibit C22e, page 199
[100] Exhibit C22e, page 200
[101] Exhibit C22e, pages 210-212
[102] Exhibit C22e, pages 226-228
[103] Exhibit C22e, pages 234-242

HenderCare carers.[104] Upon being located, Heidi was returned to the care of HenderCare on each occasion. Due to Heidi's behaviour, on 10 July 2014, Mr Thelnig granted approval for one HenderCare carer to remain on active duty overnight from 11pm to 7am.[105]

7.33. Once the CIRs started coming through from HenderCare, Ms Frangiosa said she realised that things were really deteriorating at the placement. Her belief was that Heidi needed to be removed from the emergency placement for her own immediate safety and relocated to CRC.[106]

7.34. I turn now to the efforts made by Ms Frangiosa to locate and assess the suitability of Heidi's maternal grandmother, Emily Singh as a caregiver.[107] Ms Frangiosa's first contact with Heidi's maternal grandmother was by telephone on 15 July 2014.[108] During the telephone call Ms Singh said she was willing to accept Heidi into her care. Ms Singh also wanted to see her grandchildren in the Riverland. Ms Frangiosa arranged to meet at Ms Singh's home at Wingfield on the following Wednesday at 11am. However, on arrival, Ms Singh refused her entry into the house. A conversation took place inside a car. Ms Frangiosa said after this conversation she concluded that Emily Singh no longer wanted to care for Heidi. The Families SA case notes contain no reference or notes of this meeting, a matter which the witness attributed to workload and possible oversight.[109]

7.35. Nonetheless, Ms Frangiosa made arrangements to meet with Ms Singh for a second time at Wingfield.[110] On re-attending, there was no one at home. A letter was placed in the letterbox which invited Ms Singh to contact Families SA. No response was received. Ms Frangiosa cannot recall whether she followed up the matter any further.[111]

7.36. Under cross-examination by Mr Charles, Ms Frangiosa agreed that during the telephone conversation on 15 July 2014, Emily Singh described Heidi's father as 'Russell

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[104] Exhibit C22e, pages 256-258
[105] Exhibit C22e, page 266
[106] Transcript, pages 454-456; Exhibit C22e at page 246 (Carer's summary of incident) and 247-248
[107] NB. Two persons by the name of Emily Singh were identified in the scoping summaries. One was the child who had been placed into the care of the Flinks aged 4 years (i.e. Heidi's sister). The other was the mother of the late Mary Singh. (i.e. Heidi's maternal grandmother)
[108] NB. A second person named Emily Singh was identified as a sibling
[109] Transcript, pages 452-454 and 462-463; see also Exhibit C 20a, pages 14-15
[110] Exhibit C22e, page 296
[111] Transcript, pages 449-451

Varcoe's son'. She also agreed that one of the genograms indicated that Alex Varcoe was Heidi's biological father, although she did not accept that the second genogram so indicated. The effect of her evidence was that the genograms were contradictory and thus non-conclusive. Nonetheless, it was conceded that Heidi's possible connection to the Varcoe family should have been further investigated.[112]

7.37. On 16 July 2014, a further CIR was filed regarding Heidi's conduct at the emergency placement. Heidi reportedly became aggressive, smashed pictures and punched a hole in a wall. It was alleged that she pushed carers out of her way and stole approximately 40 quetiapine tablets before barricading herself in her room. She then absconded through a window. Police located Heidi on a beach in a drowsy state. She was detained by police and conveyed by ambulance to FMC where she was admitted for five days for a quetiapine overdose. On 21 July 2014, she was discharged into the care of HenderCare.[113] On the same day, in the Youth Court of South Australia, a care and control order was granted which resulted in Heidi being placed under the guardianship of the Minister until she attained the age of 18 years.[114]

7.38. Ms Frangiosa explained that after the overdose, a series of urgent meetings, briefings and discussions were held. The discussions included safety planning for Heidi's discharge from the FMC and alternative accommodation options. The Intake and Assessment Team advocated strongly for Heidi's removal from Emergency Care and relocation to CRC. To her credit, Ms Frangiosa enlisted the support of Dr Batterham who wrote a letter to the Deputy Chief Executive Officer of the Office of Family and Child Safety, David Waterford. Dr Batterham recommended a 'stable placement in a setting which is predictable and responsive' as the most effective therapeutic intervention'.[115] Clearly, the emergency placement did not meet these criteria. High level discussions occurred with the Manager and the Director of Residential Care and the Assistant Director of Families SA. Notwithstanding the strong advocacy that was put forward on Heidi's behalf, it was decided that CRC was unsuitable for Heidi.[116]

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[112] Transcript, pages 525-531; See also evidence of Merva Varcoe: Inquest into the death of Alexander Wayne Keith Varcoe (2003); NB. Families SA social workers receive 'GenoPro' training. GenoPro is a computer training program directed at genograms and their interpretation

[113] Exhibit C22e, pages 309-311, 317-320

[114] Exhibit C22f, page 37

[115] Transcript, pages 385, 532-533; Exhibit C33a; Exhibit C22e pages 333, C22f, pages 5, 11-12, 15, 18, 20, 24, 31

[116] Transcript, pages 457-459, 485, 489; see also consultation with principal social worker, Kathryn Schmidt: Exhibit C22f, p12

7.39. So, Heidi remained at the emergency placement. Ms Frangiosa was frustrated by the decision and she lamented the lack of a secure therapeutic facility for adolescents in South Australia (apart from the Boylan Ward).[117] The effect of her evidence was that her team was left with no choice but to manage Heidi, as best they could, in a setting that was considered unsafe and ill-suited to her needs.[118]

7.40. It seems that 21 July 2014 was a busy day. On that same day, Families SA received a report dated 21 July 2014 from the Aboriginal Family Support Services Incorporated. There is no challenge to the contents of the report which I accept. The report stated *inter alia:*

> '*Heidi was an Aboriginal child with connections to the Ngarrindjeri Peoples of South Australia (through her maternal* heritage*) and that further consultation was required to determine other possible connections to Aboriginal cultural groups*'.[119] (emphasis added)

7.41. It is unclear from the evidence whether this report was brought to the attention of Ms Frangiosa. On 28 July 2014, Ms Frangiosa submitted a memorandum to departmental executives which highlighted the need for a placement which was suited to meet Heidi's special needs. She said:

> 'At this stage, Placement Services Unit has advised there are no suitable placements in Residential Care or Transitional Housing and the only placement available and suitable for Heidi is interim Emergency Care.
>
> Families SA workers have identified that the current Emergency care placement is ***not a safe option for Heidi*** as critical incidents continue to occur, ***placing Heidi and staff at significant risk*** and causing distress within the community. **It is the allocated workers assessment that placement in a CRC unit or TA house would be far more appropriate for this young person, given the level of training and experience that the unit workers have, than continuing her placement in commercial care**…'[120] (emphasis added)

7.42. On the same date, a meeting was held to discuss the situation but only two HenderCare carers attended. On 29 July 2014, Heidi was relocated to emergency accommodation at Christies Beach so as to be closer to the home of Alina Flink and in a more familiar

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[117] Transcript, page 505
[118] Exhibit C21c (Internal Memorandum to Caroline Keogh, Assistant Director, Families SA); Transcript, page 535; see also evidence of Stuart Thelnig: Transcript, page 75
[119] Exhibit C21b, page 230-233
[120] Exhibit C 22f, pages 101-103

geographical area. It was considered safer as Heidi frequently absconded from Aldinga to Christies Beach to seek out Ms Flink.

7.43. As will be seen from the evidence to come, the situation continued to deteriorate. In July 2014, Heidi was hospitalised on three further occasion and on four occasions in August 2014.[121] On each occasion Heidi was assessed and discharged to the care of HenderCare.

7.44. On 4 August 2014, Ms Frangiosa arranged to meet Ms Amy Singh who was listed in the scoping summary as Heidi's Aunt. Ms Singh cancelled the meeting. Ms Frangiosa could not recall whether she tried to recontact Ms Singh and candidly stated that she thought not. Ms Amy Singh was described as 'quite disinterested'.[122] Under cross-examination by Mr Charles, Ms Frangiosa acknowledged that she did not ask Amy Singh about Heidi's three siblings, namely, Warrick, Victor and Clifford.[123] When pressed on the matter, Ms Frangiosa agreed that since Clifford Singh was 17 years old and still under the care of the Minister, it would have been possible to locate him. She could not recall why the link was not pursued and agreed that further efforts should have been made to reconnect Heidi with her siblings.[124]

7.45. Ms Frangiosa was also questioned about an Aboriginal person called Ms Chamberlain. She knew this person and was aware that Ms Chamberlain had expressed concern about Heidi's loss of connection with her Aboriginal kin. Ms Frangiosa could not recall whether she had spoken to Ms Chamberlain about the Varcoe family. With the benefit of hindsight, she accepted it would have been an appropriate inquiry and stated 'I completely agree with what you are saying, we could have made more attempts to locate Mr Varcoe'. Ms Frangiosa also agreed that further inquiries about the Varcoe family could have been directed to the Kinship Care Team.[125] These kinds of concessions characterised the honest and frank manner in which Ms Frangiosa gave her evidence.

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[121] Exhibit C26a, pages 79, 86-87, 92, 99, 100, 104, 108,116-120; Exhibit C26a, pages 100, 104, 108; Exhibit C28, page 38
[122] Exhibit C22e, page 150; Exhibit C22f, page 152; Transcript, pages 438-439, 485-486
[123] Exhibit C21d, page 28; Transcript, pages 514-515
[124] Transcript, page 517
[125] Transcript, pages 529-531

7.46. On 13 August 2014, HenderCare carers brought Heidi directly to the Families SA office (instead of raising their concerns through the usual channels).[126] By this time, my impression of the evidence was that an air of desperation had developed amongst the HenderCare carers. They were clearly struggling to manage Heidi's increasingly volatile and unpredictable behaviour.

7.47. On 18 August 2014 Ms Frangiosa was obliged to seek a three month extension to the Emergency Care placement. Significantly, Ms Frangiosa repeated her warning in plain terms. She said: '…***the current emergency placement is not a safe option for Heidi***' and '***the HenderCare carers … are not trained or skilled in working with young people who have significant behavioural and mental health issues.***[127] (emphasis added)

7.48. It is unnecessary to repeat the tragic events of 21 August 2014. Ms Frangiosa was not at work on that day and she learned about Heidi's death on 22 August 2014.[128]

7.49. It was apparent from Ms Frangiosa's demeanour in the witness box that she has been deeply affected by these tragic events. Indeed, she was unavailable for cross-examination by counsel assisting for medical reasons.[129] No counsel pressed for her return for further cross-examination. Although her evidence was not fully tested, I have no hesitation in accepting Ms Frangiosa as a truthful and credible witness and I accept the evidence that was presented in its entirety.

7.50. In his closing submissions, counsel assisting queried whether Ms Frangiosa had the relevant skills and experience to deal with Heidi's complex needs, albeit the submission did not invite the Court to make an adverse inference.[130] I have considered that submission. In my view, while Ms Frangiosa was young and relatively inexperienced, she demonstrated competence, diligence and a maturity beyond her years. In many respects, I think she was quite courageous and went above and beyond the call of duty in her attempts to advocate for Heidi's removal from Emergency Care. I commend Ms Frangiosa for her diligence and commitment.

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[126] Transcript, pages 545-535
[127] Exhibit C21, pages 50-52
[128] Transcript, pages 499, 503
[129] Counsel did not press for her reattendance to complete cross-examination
[130] Transcript, pages 1957-1958; see also submissions of Mr Keane at Transcript, page 2005

7.51. **In relation to Families SA, I make the following findings**:[131]

7.51.1. Heidi was relinquished to the care of Families SA on 3 June 2014. No caregivers were identified and Heidi was placed into the interim custody of the Minister;

7.51.2. **I find** that Families SA had no dedicated unit for investigating and assessing kinship connections or indeed any separate unit directed at investigating Aboriginal kinship connections. A Kinship Care Assessment Team provided a limited service by providing scoping summaries to the departmental social workers. However, the critical task of identifying and assessing potential caregivers was allocated to busy social workers who were juggling other cases and a range of competing demands. **I further find** that Families SA had no formal guidelines or protocols in place to ensure that this significant responsibility was promptly and thoroughly discharged. I consider this to be a significant failing on the part of Families SA.

7.51.3. **I find** that Heidi's potential link with the Varcoe family and the possibility that Alex Varcoe was her biological father should have been promptly and thoroughly investigated immediately on receipt of the scoping summaries (3 July 2014). **I further find** that on receipt of the Aboriginal Family Support Services Incorporated dated 21 July 2014, Families SA ought to have made an urgent application to the Youth Court to re-open the case and to rescind the care and control/guardianship order that had been made pending further investigations into Heidi's potential maternal family connections with the Ngarrindjeri Peoples of South Australia. An urgent referral should also have been made to the Kinship Care Assessment Team to assist in pursuing these potential kinship avenues.

7.51.4. To the extent that there were any shortcomings in the efforts or approach adopted by the team social worker to locate and assess Heidi's kinship connections, **I find** that these reflect a systemic failure on the part of Families SA rather than a failure of the individual.

[131] NB. These findings will not be repeated in the Summary and Conclusion of this finding

7.51.5. It is not possible to conclude with any level of certainty whether intensive efforts to reconnect Heidi with kin and family networks would necessarily have changed the ultimate outcome. It could have. One simply cannot say. At least it may have given Heidi a sense of belonging and perhaps some hope for the future.

7.51.6. **I find** that Ms Frangiosa recognised that family based foster care was needed for Heidi. However, no foster carers were available in South Australia and certainly no therapeutic foster carers. Nor was any other suitable alternative identified. Accordingly, Heidi was placed into Emergency Care where she remained until the date of her death.

7.51.7. **I find** that Ms Frangiosa and her team advocated unsuccessfully for Heidi's removal from Emergency Care and relocation to Community Residential Care. The decision makers considered CRC was not a suitable form of care for Heidi. I make no criticism of the individuals who made that decision as it involves a balancing of complex competing considerations. It is easy to be wise after the event.

7.51.8. **I find** that on 28 July 2014, Ms Frangiosa was concerned about the escalation in Heidi's maladaptive behaviours and the frequency of the CIRs. Significantly, she warned departmental executives in writing that **Heidi was not safe at the emergency placement**. Urgent removal and relocation to CRC was recommended. **I further find** that on 18 August 2014 (three days before Heidi's death), Ms Frangiosa repeated this warning in formal correspondence.

7.51.9. **I find** that due to the unavailability of foster carers and/or suitable options in South Australia, those who carried primary responsibility for managing Heidi's case were left with no option but to manage Heidi, as best they could, in a setting that was ill-suited to meet her needs. This inquest has squarely raised the question of whether Families SA and the Minister were able to discharge the primary responsibility of providing care and protection to Heidi Singh.

7.51.10. **I find** that Ms Frangiosa was a competent social worker who discharged her duties with diligence and a high level of commitment. There is no basis to criticise her efforts and/or the discharge of her primary responsibilities. On the contrary, **I find** that Ms Frangiosa discharged her duties well and should be commended for the strong advocacy she advanced on Heidi Singh's behalf.

7.52. I should add at this juncture that the Nyland Royal Commission made findings and recommendations directed at reforming processes relating to the identification and assessment of kinship carers.[132] The Commission also recommended the establishment of a dedicated family scoping unit.[133] Since then the Kinship Care program has significantly changed. Firstly, referrals are now made electronically (via the C3MS system) in lieu of paper based referral, a change which has apparently accelerated the referral process. Secondly, in September 2017, the Family Scoping and Engagement Team was created to assist in the scoping process. The team consists of four positions and as at late March 2018, the positions had been filled with Aboriginal staff.[134] It remains to be seen whether these initiatives will be adequate to address the deficiencies identified in this inquest and by the Nyland Royal Commission and whether all of the Commission's recommendations in respect of kinship issues will be fully implemented. In light of the work of the Commission and the subject recommendations it is unnecessary for this court to make any further recommendations in this area.

7.53. Evidence of Madeleine Hayter (Consultant Psychologist, Psychological Services Division, Families SA

7.54. Ms Madeleine Hayter completed a Masters of Clinical Psychology in late 2013. In January 2014, she commenced work as a consultative psychologist in the Psychological Services Division of Families SA. Her role included liaison with in-house social workers and assisting with case direction. Ms Hayter gave oral evidence at the inquest.[135]

[132] Nyland Royal Commission, Recommendations 102-111, 187-190.
[133] Nyland Royal Commission, Recommendation 190
[134] Exhibit C43, [18]-[28]
[135] Transcript, pages 674-788

7.55. Ms Hayter's involvement in Heidi's case commenced on 18 July 2014. It will be recalled that Heidi was hospitalised between 18 and 21 July 2014 due to a quetiapine overdose. At that time Ms Frangiosa and others were advocating for Heidi's removal from Emergency Care.

7.56. On 18 July 2014, Ms Hayter was requested by senior Families SA personnel to provide advice about strategies to assist the HenderCare carers to manage Heidi's behaviour.[136] Since she was a new graduate and also new to the role, Ms Hayter herself sought advice before providing a response.[137] Her recommended strategies included:

7.56.1. Removing access to prescription drugs and dangerous objects such as the bunk bed, razor blades, and sheets;

7.56.2. Distributing worksheets to carers setting out strategies for emotional regulation;

7.56.3. Refraining from rostering new HenderCare workers on weekends;

7.56.4. Ensuring that only carers with the best relationship with Heidi were rostered on weekends (if possible);

7.56.5. Increased the frequency of checks;

7.56.6. Development of a risk management plan with CAMHS involvement in the process; and

7.56.7. Institution of regular meetings of agencies, HenderCare carers and others who were involved in Heidi's care.[138]

7.57. These were sensible strategies but they were short-term strategies. The question must be asked, 'what was the long-term strategy?'. Furthermore, these strategies could not address the glaring problem, namely, the inability of Families SA to provide foster care or to provide skilled therapeutic support for Heidi at the emergency placement.

7.58. Under cross-examination Ms Hayter acknowledged that increasing the frequency of checks actually 'increased Heidi's risk of self-harm'. At the same time, she said failing to conduct regular checks was also a risk.[139]

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[136] Transcript, pages 682, 741-743; Exhibit C21d, pages 5, 52
[137] Transcript, pages 684-685,741; Exhibit C21d, pages 52, 54-56
[138] Transcript, pages 687-688, 717-718, 751; Exhibit C21d, page 46
[139] Transcript, page 722

7.59. Case conferences were held on 21 July 2014, 28 July 2014 and 1 August 2014.[140] Under cross-examination, Ms Hayter said there was intensive discussion in these meetings about the unsuitability of the emergency placement. She stated:

> '***We all acknowledged that it wasn't the right placement for this child***' but '***there were no viable options***'.[141] (emphasis added)

7.60. On 28 July 2014, a meeting was held to assist the HenderCare carers to manage Heidi's special needs. However, only two HenderCare carers attended. Others were unable to attend due to other shifts.[142]

7.61. On 29 July 2014, Ms Hayter forwarded by e-mail a copy of her recommendations to Ms Frangiosa, Mr Thelnig and CAMHS social worker, Ms Wyld along with two attachments. The attachments contained general information about self-harm, suicide risk and responding to self-harm. Ms Hayter highlighted that the recommended strategies were short-term strategies only and '***directed at Heidi's immediate physical safety and keeping her alive***'.[143] (emphasis added)

7.62. In the interim, a placement visit audit was conducted by the Intensive Placement Services (IPS) division of Families SA (on 25 July 2014). One HenderCare carer complained that no written direction had been provided to assist in the management of Heidi's behaviour. Ms Hayter had assumed her recommendations would be communicated to the carers by a Families SA social worker, both verbally and in writing. If the carer's complaint is accurate, it tends to suggest that the recommendations were not communicated or, at the very least, not to the carer who made this complaint.[144]

7.63. I turn now to Ms Hayter's evidence about the implementation and development of the strategies. In the said e-mail dated 29 July 2014, Ms Hayter stated *inter alia*:

> 'In relation to developing specific strategies that are specific to Heidi's needs, *I was wondering whether Helen would be better placed to do this as I have very limited knowledge of Heidi's psychological functioning.* Helen, given that you know Heidi really

[140] Exhibit C22f, pages 35-38, 95-96; Transcript, page 689; Exhibit C21d, pages 5 and 29
[141] Transcript, pages 762-764, 689-692, 728-731, 733, 761; Exhibit C21d, pages 30 and 35
[142] Transcript, pages 728-729
[143] Exhibit C21d, pages 24-27
[144] Transcript, pages 764-765; Exhibit C22f, page 74

> well, I think the carers would benefit from your insights into what works well for her, what strategies to avoid, what are her triggers etc…' [145] (emphasis added)

7.64. I consider it surprising that Ms Hayter sought to delegate this specialised task to a CAMHS social worker. Families SA was the lead agency. In my view, the attempt to delegate this task was an error of judgment. It amounted to an abdication of responsibility. Tellingly, under cross-examination, Ms Hayter said she 'did not want to step on Helen's toes'. Ms Hayter also volunteered that, at least for a period of time, she believed Ms Wyld was a qualified psychologist and that informal assessments of risk were being undertaken.[146] In my view, specific inquiries ought to have been made about Ms Wyld's qualifications to provide ongoing therapy and the effectiveness of any therapy to date. If it was necessary to challenge Ms Wyld's approach, so be it. I also consider that Ms Hayter should have undertaken or arranged for an independent assessment of Heidi's baseline functioning. When probed about these issues under cross-examination, Ms Hayter candidly stated that, as a new graduate, she would have assumed that Ms Wyld's approach was correct. It was of course inappropriate to make such assumptions. Indeed, Ms Hayter herself had identified the inherent dangers of a social worker continuing to see a child such as Heidi, without supervision. She explained that, unlike psychologists, social workers are not required to have intensive supervision as a pre-condition to registration. In practice, this means that a social worker may continue to see a child over an extended period without their approach being scrutinised.[147]

7.65. Having considered the evidence **I find** that Ms Hayter lacked the confidence to take the necessary lead role. I attribute this reluctance to her relative inexperience and the complexity of the matter about which she had been asked to provide advice. This conclusion is reinforced by Ms Hayter's evidence about the involvement of CAMHS. When asked whether she was comforted by the fact that Heidi appeared to be well-known to CAMHS and their staff, she said 'Yes, absolutely'. Ms Hayter added that if CAMHS had not been involved, her approach would have been different and a referral to a private psychologist would have been recommended.[148]

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[145] Exhibit C21d at page 26
[146] Transcript, pages 731, 769-770
[147] Transcript, pages 695-696
[148] Transcript, pages 770-772, 786-787

7.66. I turn now to the evidence given by Ms Hayter about the suitability of Emergency Care. Ms Hayter opined that the best form of care for Heidi would have been a therapeutic foster placement with a family. She said Heidi needed carers who were highly trained with a sound knowledge of trauma, attachment theory and the management of difficult behaviour. She expressed reservations about the level of skill and experience of the HenderCare carers and the rotation of staff was not considered conducive to creating a stable setting. Indeed, Ms Hayter said the aim of establishing a stable care team was never achieved.[149] I note in passing that the Nyland Royal Commission recommended the phasing out of the use of commercial carers in any rotational care arrangement except in genuine short-term emergencies, along with wholesale changes to the model of residential care.[150] I concur with these recommendations.[151]

7.67. Ms Hayter attempted to address the problem by recommending the recruitment of Families SA trained carers at the emergency placement. She ought to be commended for this initiative. It was a practical and sensible suggestion. However, Ms Hayter said it was rejected due to a shortage of staff and resources. I have no reason not to accept this evidence. It had the ring of truth and Ms Hayter was clearly disappointed by the response.[152]

7.68. I found Ms Hayter to be a credible and candid witness who gave direct and unembellished evidence. She was a witness who made appropriate concessions and, when challenged, she made no attempt to shift blame onto others. **I make the following findings**:

7.68.1. **I find** that once Heidi was placed under the care and protection of the Minister, Families SA was the lead agency.

7.68.2. **I find** that the Psychological Services Division of Families SA should have undertaken or arranged for an independent assessment of Heidi's baseline psychological functioning. That assessment ought to have included an assessment of the effectiveness of any therapy that was being provided by CAMHS.

[149] Transcript, page 775
[150] Recommendation 128, Nyland Royal Commission
[151] Recommendations 129-132, Nyland Royal Commission
[152] Transcript, pages 716-717, 779-780

7.68.3. **I find** that the risk management strategies developed by Ms Hayter were sensible however they were really harm minimisation strategies which did not address the fundamental problem, namely, the lack of a stable nurturing placement which provided access to skilled therapeutic support. **I further find** that it was inappropriate to delegate the task of developing these strategies to a CAMHS social worker.

7.68.4. **I find** that Ms Hayter did her best to manage in difficult circumstances. However, the deference she displayed towards Ms Wyld compromised sound decision making in the management of Heidi's case. I attribute this deference to a lack of confidence and Ms Hayter's relative inexperience in the role.

7.68.5. It would be unreasonable to suggest that these shortcomings, taken in isolation, caused and/or contributed to Heidi's ultimate fate.

8. The Aboriginal Child Placement Principle - Children's Protection Act, 1993 (SA)

8.1. It is apposite to make some observations about the Aboriginal Child Placement Principle. Families SA supervisor, Mr Thelnig, was cross-examined by Mr Charles about section 4(5) of the *Children's Protection Act, 1993 (SA)*. The section provides that, in relation to an Aboriginal or Torres Strait Islander child, the Aboriginal and Torres Strait Islander Child Placement Principle is to be observed.

8.2. The principle was developed around 30 years ago from an understanding of the devastating effect of the forced removal of Aboriginal and Torres Strait Islander children from their families and communities. The principle upholds the rights of the child's family and community to have some control and influence over decisions about their children. It also prioritises options that should be explored when an Aboriginal or Torres Strait Islander child is placed into care so that familial, cultural and community ties can remain strong. The importance of the Aboriginal Child Placement Principle is plain and cannot be overstated.

8.3. Mr Thelnig was invited to comment on aspects of the Aboriginal Family Support Services Incorporated report dated 21 July 2014. As I have mentioned, the report states that *Heidi was an Aboriginal child with connections to the Ngarrindjeri Peoples of South Australia* (through her maternal heritage) and that further consultation was

required to determine other possible connections to Aboriginal cultural groups. The report noted the department's intention 'to continue scoping family members to provide a placement for Heidi as per the Aboriginal Child Placement Principle'.[153] (emphasis added)

8.4. It was submitted by Mr Charles in closing submissions that Families SA had 'no regard' to the Aboriginal Child Placement Principle.[154] In my view it cannot be said there was no regard to the principle, however, there were significant deficiencies in consultation and kinship reconnection processes. In my view, the management of Heidi's case whilst under the care of the Minister was inconsistent with the objects and fundamental principles of the *Children's Protection Act, 1993 (SA)* as stated in the now rescinded section 4 of the Act (Fundamental Principles).

8.5. Under cross-examination, Mr Thelnig agreed that no separate referral was made to the Aboriginal Family Support Services to pursue these potential familial connections. He acknowledged it was an omission by Families SA.[155] In my view it was a significant omission:

8.5.1. Families SA had been aware of the Flink family from at least 2009 onwards;

8.5.2. The department knew that Heidi was an Aboriginal child who had been cared for informally by non-indigenous persons from birth to the age 13 years. It was also known that Heidi identified as Aboriginal;

8.5.3. Families SA was aware that Heidi had Aboriginal siblings and half-siblings. At the relevant time, at least one of these siblings was also under the care of the Minister;

8.5.4. Families SA knew that all of Heidi's non-Aboriginal carers had either died or abandoned her and that her biological mother had also died;

8.5.5. The Kinship Care Team provided detailed information about potential caregivers in the Singh family; and

[153] Exhibit C21b at page 230-233 - Report of Leila Push (Cultural Consultant) and Sharron Williams (Chief Executive Officer), Aboriginal Family Support Services Inc dated 21 July 2014
[154] Transcript, pages1970-1971; see also written submission of Mr Charles, pages 21-23
[155] Transcript, page 606; see also cross-examination of Counsel Assisting, Transcript, pages 659-662

8.5.6. As at 21 July 2014, Families SA was put on notice about Heidi's potential connection with the Ngarrindjeri Peoples.

8.6. **I make the following findings**:

8.6.1. **I find** that the efforts made by Families SA to reconnect Heidi to her kin and extended family networks were ad hoc, poorly regulated and inadequate. Insufficient regard was given by Families SA to the development of structures, guidelines and protocols which actively promoted the Aboriginal Child Placement Principle. This is unacceptable.

8.6.2. It can never be known whether reconnecting Heidi with her kin, culture and community would have changed the ultimate outcome. However, it may at least have given her a sense of belonging and some hope for the future.

9. Role of Child and Adolescent Mental Health (CAMHS)

9.1. Evidence of Helen Wyld (CAMHS social worker)

9.2. Ms Wyld is a qualified social worker who is a descendant of the Mardu people of Western Australia. At the relevant time Ms Wyld was working for the CAMHS Ngartunna Patpangga service (CAMHS Aboriginal Service), a voluntary service that had been set up with the aim of attracting Aboriginal families to CAMHS . The service provided an initial consultation, culturally specific counselling and follow-up appointments.[156] Ms Wyld gave oral evidence at the inquest.[157]

9.3. During the inquest, the service was referred to as a multidisciplinary team however there is little dispute that it was basically only a two-person team comprised of Ms Wyld and Dr Meredith (a psychologist).[158]

9.4. Ms Wyld met Heidi for the first time on 6 September 2011 when Mrs Flink sought assistance to manage Heidi's behaviour.[159] For the first twelve months, Ms Wyld held regular joint sessions with Heidi and Mrs Flink. Although Ms Wyld learned that Heidi

[156] Transcript, pages 1152-1156
[157] Transcript, pages 1006-1290
[158] Transcript, Page 1152-1157
[159] Transcript, pages 1187-1189

was under the care of a paediatrician, no attempt was made to contact Dr Lamb or to obtain Mrs Flink's consent to exchange information.

9.5. Heidi did not engage verbally with Ms Wyld until around mid-May 2012. Their first one on one session was held at that time. Ms Wyld also held individual sessions with Mrs Flink. She also liaised with Families SA, Disability SA and Heidi's school.[160]

9.6. During 2011 and 2012, Ms Wyld learned a great deal about Heidi's background, the Flink household and Heidi's maladaptive behaviours.[161] The plan was to provide ongoing support by having regular sessions. In relation to Heidi, Ms Wyld used a combination of cognitive and behavioural techniques that included grief therapy, story book therapy and counselling directed at behavioural issues.[162] Ms Wyld was probed under cross-examination about her qualifications to provide effective therapy for a child with such complex needs. Ms Wyld considered herself sufficiently skilled to 'help Heidi's development' and to manage Heidi's needs. On several occasions, she repeated her evidence that Heidi was not ready for formalised psychological or psychiatric therapy.[163]

9.7. Although the CAMHS Aboriginal Service had a psychologist on the team, no psychological assessment of Heidi was conducted. Under cross-examination, Ms Wyld said it was 'not normal ... practice for CAMHS psychologists to do psychological assessments of children'. I was surprised by that evidence. One would reasonably expect that a psychologist in the employ of a child and adolescent mental health service would conduct psychological assessments as a matter of course and, if necessary, engage in ongoing clinical sessions. However, it became clear that this is not how the CAMHS Aboriginal Service operated. Dr Meredith had his own caseload and, to the extent that he was engaged in Heidi's case, it was limited to a consultancy role. He did not provide clinical oversight of the case. In any event, Ms Wyld maintained that Heidi was not ready for formalised interventions adding that Heidi would not have related well to a middle-aged man.[164]

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[160] Exhibit C25, pages 32-38, 46-47, 50 ,52,57, 39, 42; Transcript, pages 1176-1177, 1180
[161] Exhibit C25, pages 25, 28-34, 32-38, 46-48, 50-52, 57
[162] Exhibit C25, pages 46, 48; Transcript, pages 1154-1155
[163] For example, Transcript, pages 1178-1179
[164] Transcript, page 1180

9.8. Ms Wyld said there were monthly meetings with Dr Meredith although no notes were taken.[165] I accept that these discussions occurred. However, in the absence of notes or any independent recollection of the content of the discussions by the witness, the Court is unable to assess the utility of these conversations or any advice that may have been provided by Dr Meredith.

9.9. As the evidence unfolded it became clear that Ms Wyld essentially operated as a sole practitioner without direct supervision or guidance. The professional relationship between Ms Wyld and Dr Meredith was quite informal. Mr Keane captured its essence in his closing submissions by the analogy of having 'casual meetings with your colleague … at the water cooler'.[166]

9.10. I should mention CAMHS psychiatrist Dr Ken Hooper at this point. Dr Hooper was a specialist consultant psychiatrist who was employed by Southern CAMHS. Dr Hooper's role included periodic consultancy work to the CAMHS Aboriginal Service.[167]

9.11. Ms Wyld referred Heidi to Dr Hooper for review on five occasions, namely, 29 October 2012, 6 June 2013, 4 September 2013, 3 February 2014 and 30 July 2014. I will come to Dr Hooper's evidence in a moment.[168] Ms Wyld said any referral to Dr Hooper would have been done in consultation with Dr Meredith.[169]

9.12. It was plain from Ms Wyld's evidence and session notes that Heidi's behaviour escalated after the death of Lyn Flink on 7 April 2013. It will be recalled that Dr Lamb made the same observation. Indeed, he said things went completely off the rails. Ms Wyld said she had less contact with Heidi after Mrs Flink's death because Heidi's new carer, Alina Flink, did not seek the same level of engagement with the service. Although the face to face contact lessened, Ms Wyld had frequent telephone conversations with Ms Flink from which she gleaned information about Heidi's progress or, I should say, lack of progress. This information is relevant to Ms Wyld's

[165] Transcript, pages 1160-1262; Exhibit C25
[166] Transcript, pages 2026
[167] Exhibit C40; Transcript, pages 1308,1311-1312, 1158-1161, 1167-1168
[168] Transcript, pages 1231, 1233
[169] Transcript, pages 1028-1029, 1167-1668

subsequent decision making. For example, between early June 2013 and October 2013 Ms Wyld learned that;

9.12.1. On 6 June 2013, Heidi had absconded until 2am and was reportedly hearing voices;[170]

9.12.2. By early September 2013 Heidi's medication needed to be locked up, she was self-harming and had threatened a child with knife. It was reported that Heidi's conduct was frightening the other children in the household;[171]

9.12.3. On 11 September 2013 Heidi had displayed infantile behaviour which included making incoherent and infantile noises for up to one hour; and

9.12.4. On 3 October 2013, Heidi had been hospitalised after an argument with a boy over a ball during which she had reportedly 'slammed his head into the ground [and] punched him in the face'.[172]

9.13. After the October 2013 incident, Ms Flink told Ms Wyld that she did not want her family to live in fear anymore. Ms Wyld made a referral to Dr Hooper with an appointment scheduled for 25 October 2013. By the time the date arrived it will be recalled that Ms Flink had relinquished care of Heidi to her friends, Ms Malby and Mr Lane.

9.14. Ms Wyld never met Ms Malby or Mr Lane and her contact with Heidi reduced even further.[173] Ms Wyld said she tried to engage Ms Malby and Mr Lane with the service with limited success. She described her role in Heidi's care thereafter as a 'monitoring' role.[174]

9.15. That said, Ms Wyld acknowledged that she did have periodic telephone contact with Ms Malby from which she gleaned certain information about Heidi (along with information from other sources such as Alina Flink). This information is relevant to assessing Ms Wyld's subsequent decision making. For example, in the latter part of 2013, Ms Wyld learned: (a) that Jason Lane been ordered by a court to perform

[170] Exhibit C25, page 63; Transcript, pages 1163-1166
[171] Exhibit C25, pages 67, 71, 86.
[172] Exhibit C25, pages 88-89
[173] Exhibit C25, page 88-89
[174] Transcript, page 1052

300 hours community service as a result of a drug conviction; (b) on 31 October 2013 Heidi had allegedly smashed a bottle, threatened the neighbour's children and had been brought home by the police; and (c) on 15 November 2013 Heidi had been hospitalised.[175]

9.16. After the November 2013 hospitalisation, Ms Wyld made another referral to Dr Hooper. The appointment was scheduled for 18 November 2013 but the new carers failed to attend with Heidi. On 21 November 2013, Ms Malby telephoned Ms Wyld and advised that 'a crisis within the family' had prevented attendance at the appointment. A further appointment was arranged.

9.17. The CAMHS notes indicate that, as at 27 November 2013, *current therapy was not being undertaken by the CAMHS service.* The plan was for a final psychiatric appointment to be offered and, if there was no attendance, the file would be closed. A letter to this effect was sent to the carers.[176] On 10 January 2014, Ms Malby reported that:

9.17.1. Heidi had been 'drinking nail polish remover/Windex' albeit she denied it; and

9.17.2. A syringe had been found under Heidi's bed.

9.18. These matters, along with the late 2013 disclosures were not reported to Families SA by Ms Wyld. Rather, on 10 January 2014, Ms Wyld requested verbal permission from Ms Malby to speak with Dr Meredith about strategies for dealing with Heidi's behaviour. When asked under cross-examination why Families SA was not notified of the drug conviction, Ms Wyld said she had no contextual information around the conviction and she did not know whether Mr Lane was still using drugs. She added that Heidi had known Ms Malby for a long time. When asked why she did not report the January disclosures to Families SA, Ms Wyld again pointed to a lack of 'contextual information'.[177] I reject these explanations. Alarm bells about Heidi's safety and welfare should have been ringing.

[175] Transcript, pages 1264, 1266
[176] Exhibit C25, pages 96-97
[177] Transcript, pages 1270-1274

9.19. The contents of an e-mail dated 20 November 2013 suggested that Ms Wyld did not have a great deal of confidence in the willingness of Families SA to intervene unless informal carers were willing to relinquish care to Families SA.[178] I accept Ms Wyld's evidence that she had sought a referral to the Special Needs Unit of Families SA to assist Heidi and had been told that unless Mrs Flink relinquished informal care, Families SA did not consider it had a mandate to act. I also accept that Ms Wyld may well have had other interactions with Families SA which led to a lack of confidence in the agency. However, any personal views Ms Wyld may have had about Families SA's willingness and/or capacity to intervene in such matters did not justify withholding such important information from the primary child protection agency. Whether Families SA would have acted on a notification is an entirely separate matter.[179]

9.20. **I find** that a formal notification should have been made to Families SA with particular emphasis on Mr Lane's drug conviction, the finding of the syringe under Heidi's bed and Heidi's reported self-harming and threatening behaviour.

9.21. Ms Wyld did make a further referral to Dr Hooper with an appointment scheduled in four weeks' time (on 3 February 2014) however I consider this response lacked the necessary degree of urgency.

9.22. I turn now to the role of the CAMHS Aboriginal Service after Heidi was relinquished to Families SA on 3 June 2014. Ms Wyld first saw Heidi around a week after she had been placed into Emergency Care and she continued to visit Heidi weekly 'in a support role'. The last visit was on the date of Heidi's death.[180]

9.23. On 21 July 2014, Ms Wyld referred Heidi to Dr Lamb for a paediatric consultation. The main clinical issues were recorded as 'recent suicidal ideation' and 'two attempts at using medication for overdoses'. The CAMHS notes indicate that Dr Meredith provided risk management advice.[181]

9.24. A 'Team Consultation Record' dated 24 July 2014 refers to a knife threat against carers, a carer being hit with a kettle and theft of medication. There was discussion about a 'consult with Dr Hooper', ongoing review of medication and 'a consult with Stephen

[178] Exhibit C25; Transcript, pages 202,219, 1024-1025,1124-1125
[179] Exhibit C25, pages 94-95
[180] Exhibit C25A, pages 13, 16, 18,32-33; Transcript, pages 1070, 1073, 1080
[181] Exhibit C25a, pages 28, 30-33

Meredith'. Reference was made to meeting with Families SA and 'strategy planning'. An appointment with Dr Hooper was made for 30 July 2014.[182]

9.25. On 25 July 2014, Ms Wyld met with Families SA psychologist, Ms Hayter, to discuss strategies for Heidi's immediate needs/safety, containment when distressed and also longer-term strategies. It is noteworthy that Ms Wyld understood her role at this time was to provide 'general assistance' to the lead agency, namely Families SA. Ms Wyld said the possibility of relocating Heidi from Emergency Care to CRC was raised at every meeting she attended. Ms Wyld supported Heidi's removal from Emergency Care.[183]

9.26. On 31 July 2014, Ms Wyld received from Dr Hooper a detailed summary of his last review of Heidi dated 30 July 2014, along with recommended changes to her management at the emergency placement.

9.27. An interagency meeting was held on 1 August 2014. Ms Wyld attended this meeting. Regrettably, Dr Hooper was unable to attend. Ms Wyld provided a vivid description of the meeting. She said the multiple attendees were talking over each other and 'different factions of Families SA' were engaged in 'their own political dynamics'. Although Ms Wyld tried to communicate Dr Hooper's recommendations, she said little interest was shown in what she had to say. Her conclusion was that CAMHS input was 'not required'. I accept Ms Wyld's evidence about the general tenor of this meeting.[184]

9.28. My impression of the evidence was that multiple meetings, phone calls and exchanges of correspondence were occurring about Heidi's situation, but little was being done to address the underlying causes of Heidi's behaviour and distress. The focus appeared to be on discussing 'the problem' and discussing harm minimisation strategies. On my reading of the evidence, there was an atmosphere of resignation about the fact that Heidi was living in a setting that was widely considered to be ill-suited to her needs.

9.29. In terms of Heidi's presentation in the weeks before her death, Ms Wyld said some of her most positive interactions with the child occurred at this time. Interestingly, she described Heidi as a young person who was showing maturity and growth. She was

[182] Exhibit C25a, page 34
[183] Transcript, page 1106; Exhibit C25a, page 36; Exhibit C25a, pages 28-31; Transcript, pages 1075, 1079-1085
[184] Transcript, pages 1101-1102; see also pages 1139-1140

very positive about wanting to reconnect, especially with her older sister Emily. She spoke about them getting a house together. Heidi was described as open, positive and optimistic about her future, albeit some anxiety was expressed about 'what Families SA were going to do with her and where she would end up'. Heidi's thoughts were 'about family, what about family for me?'.[185]

9.30. Ms Wyld met with Heidi on the day of her death (21 August 2014). Heidi was watching cartoons. She was not very talkative and she was tired. They usually went for a walk or a drive during these visits, but Heidi did not want to leave the house. When Families SA staff (Ms Frangiosa and Ms Hayter) arrived to speak with the carers, Ms Wyld left because she knew that Heidi could become dysregulated if too many adults were present. She said Heidi did not appear distressed on her leaving. I found this evidence helpful in gaining at least some level of insight into Heidi's state of mind at this critical time. Along with the expert evidence, Ms Wyld's evidence assisted in resolving the question of whether Heidi's death was the result of suicide or misadventure.

9.31. Ms Wyld anticipated seeing Heidi again at the next scheduled review with Dr Hooper on 25 August 2014.[186] Of course that review did not occur.

9.32. In his closing submissions, counsel assisting suggested that Ms Wyld's evidence lacked consistency, that she tended to deflect blame onto others and did not make 'correct concessions'.[187] It was further suggested that Ms Wyld was a 'vague, equivocal and unreliable witness'.[188] I reject that submission and prefer the submission of Mr Keane, namely, that it is more likely Ms Wyld was left with too much to do, too much on her own shoulders and that she was operating beyond her own skillset. As suggested by Mr Keane, I have also had regard to human fallibility and the pressure of the courtroom environment.[189]

9.33. For my part, I found Ms Wyld to be a credible witness who did her best to explain her decisions and management of Heidi's case in the context of an organisation which provided her with little support or direction. I am satisfied that Ms Wyld is skilled and

[185] Transcript, pages 1104-1106
[186] Exhibit C25a at page 62; Transcript, pages 1113-1114
[187] Transcript, pages 1954-1955
[188] Transcript, pages 1945, 1954-1955
[189] See closing submissions of Mr Keane, page 2022-2023

diligent social worker who enjoys an excellent reputation. I am also satisfied that Ms Wyld applied her skills to the best of her ability. That said, there were shortcomings in the approach that was adopted as reflected in my findings below.

9.34. **I make the following findings**:

9.34.1. **I find** that the multidisciplinary team within the CAMHS Aboriginal Service was multidisciplinary in name only and that Ms Wyld essentially operated as a sole practitioner without supervision and oversight by a clinician.

9.34.2. **I find** that Ms Wyld continued to act as Heidi's sole therapist for an unduly long period of time with only periodic assistance from consultants such as Dr Meredith and Dr Hooper.

9.34.3. **I find** that direct oversight of Heidi Singh's case ought to have been provided by a suitably qualified clinician such as Dr Hooper.

9.34.4. With the exception of the initial 12-18 month period, I am not persuaded that Heidi was not ready for formalised interventions. **I find** that Heidi was not given the opportunity to develop rapport with a clinician (male or female) and, when appropriate, to engage in regular psychological and/or psychiatric sessions directed at the development of behavioural skills.

9.34.5. **I find** that Ms Wyld placed undue reliance on her owns kills and therapies. Insufficient weight was placed on information that pointed to the possibility that Heidi was suffering from, or developing, a serious psychological and/or psychiatric illness. Insufficient regard was given to the possibility of self-harm or suicide and that an entirely different form of therapeutic care was required to address Heidi's complex needs.

9.34.6. Ms Wyld held regular informal meetings with Dr Meredith to discuss her cases but notes were not taken of these discussions. In the absence of notes and/or any independent recollection on the part of the witness, the Court is unable to assess the nature and quality of any advice that was provided.

9.34.7. **I find** that by mid to late 2013, a pattern of behaviour had emerged that warranted transfer of Heidi's primary care to a psychologist and/or

psychiatrist. Ms Wyld did not identify the need for such a transfer. I attribute this oversight primarily to the flat CAMHS structure in which Ms Wyld operated and the fact that CAMHS expected Ms Wyld to manage a caseload that included complex cases without the benefit of clinician oversight and direction.

9.34.8. **I find** that by 10 January 2014, Ms Wyld ought to have notified Families SA of Mr Lane's drug conviction, the discovery of a syringe under Heidi's bed and the other matters that had been disclosed in late 2013.

9.34.9. In relation to the respective roles of Families SA and CAMHS Aboriginal Service, **I find** there was confusion between the agencies about the roles. Understandably, after Heidi had been placed in the interim custody of the Minister, Ms Wyld considered Families SA to be the lead agency. On the other hand, Ms Hayter (Families SA Psychological Services Division) assumed that Ms Wyld was best positioned to take a lead role. **I further find** that the lack of clarity about the roles and responsibilities of the respective agencies led to assumptions being made by both agencies about the quality of care that Heidi was receiving. It compromised sound decision-making.

9.35. Evidence of Ken Hooper (CAMHS Psychiatrist)

9.36. Dr Ken Hooper graduated with a Bachelor of Medicine and Bachelor of Surgery in November 1998. He is a Fellow of the Royal Australian and New Zealand College of Psychiatrists, a member of the Faculty of Child and Adolescent Psychiatrists and holds an Advanced Certificate in Child and Adolescent Psychiatry. Dr Hooper provided a written statement to the Court and gave oral evidence at the inquest.[190]

9.37. Since 2014, Dr Hooper has been the Senior Consultant Psychiatrist and Head of Unit of the Southern Adelaide Youth Mental Health Network.[191] At the time of Heidi Singh's death he was working as a staff specialist consultant psychiatrist at Southern CAMHS and the WCH Child and Adolescent Health Service. Dr Hooper's role included periodic reviews of clients of the CAMHS Aboriginal Service.[192]

[190] Exhibit C40-Curriculum Vitae; Exhibit C40a; Transcript, pages 1296-1431, 1569-1681
[191] Transcript, page 1308; Exhibit C4
[192] Exhibit C40; Transcript, pages 1308,1311-1312, 1158-1161

9.38. The Court heard that 3.5 psychiatrists, including Dr Hooper, were required to cover a wide geographical area that included Mt Barker, Marion, Onkaparinga, Victor Harbor and Kangaroo Island. At the relevant time, Dr Hooper was managing approximately 185 cases/files.[193] The lack of child and adolescent psychiatrists within CAMHS has been the subject of finding and recommendations by the former State Coroner and the Deputy State Coroner.[194]

9.39. Dr Hooper met with Heidi on five occasions. All referrals were made by Ms Wyld. Under cross-examination, Dr Hooper acknowledged that in the first four sessions he did not undertake a mental state examination and/or psychiatric assessment of Heidi.[195] The witness also confirmed that he did not assume the role of treating psychiatrist or engage in regular sessions with Heidi. His role was limited to periodic assessments as a consultant on referral from Ms Wyld.[196]

9.40. Dr Hooper met Heidi for the first time on 29 October 2012. She attended the session with Mrs Flink and Ms Wyld. Heidi did not really engage in the session and the information that was provided was given by Mrs Flink and Ms Wyld. Concerns were expressed about Heidi's climbing behaviour and her tendency to wander away at night to unknown locations. Other risk-taking behaviour included 'playing chicken' with trains.[197]

9.41. Under cross-examination, counsel suggested that Heidi may have benefited from a referral to a psychologist. Dr Hooper did not consider that Heidi was ready for formalised treatment. In any event, Dr Hooper understood that Dr Meredith was a clinical psychologist who had input into Heidi's care.

9.42. Dr Hooper met with Heidi for the second time on 6 June 2013 (around eight weeks after the death of Lyn Flink). Heidi attended with her new carer, Alina Flink. Dr Hooper described Heidi as uncomfortable and unwilling to participate in the session. She laid on the floor playing a game with her phone. Ms Flink informed Dr Hooper that when Heidi was angry she now 'stares and mumble[s] that she'll kill you' and 'sometimes

[193] Transcript, page 112
[194] Inquest into the death of Jason William Hugo-Horsman delivered on 17 June 2014; Inquest the death of Michaela Jayne Mundy delivered on 12 March 2014
[195] Transcript, pages 1318, 1330, 1337-1338, 1345-1347, 1427,1575-1580; Exhibit C25 at pages 72-74, 110, 140, 163;
[196] Transcript, pages 1392, 1574, 1597
[197] Exhibit C25, pages 54-55; Transcript, pages 1318, 1419-1421, 1425, 1569-1572

she reaches for a knife'.[198] The preliminary diagnosis was acquired brain injury, FasD and emotional dysregulation. Dr Hooper noted that Heidi had been prescribed an evening dose of Catapres and that lorazepam had been prescribed 'for meltdowns'. These medications were considered appropriate and within contemporary practice. Dr Hooper said the plan at that stage would have been for continued involvement by Ms Wyld 'in a support and advocacy role'.[199]

9.43. Dr Hooper's third session with Heidi took place on 4 September 2013 (a few days after Heidi's discharge from the three day planned Boylan Ward admission).[200] Again, Heidi did not engage verbally in the session. Given that her most significant relationships had ended through death or displacement, Dr Hooper viewed the lack of engagement in these early sessions not as oppositional, but rather as a preservative behaviour. Based on the information provided during this session, Dr Hooper increased the quetiapine dose from 12.5mg to 25mg nocte and provided a prescription for the same. Although he had altered the dose, Dr Hooper maintained that Dr Lamb was Heidi's 'prescribing clinician'. Dr Hooper explained that his request for an ongoing referral from Heidi's GP was made solely to facilitate Medicare processes. It was not an indication that he had assumed the role of providing ongoing psychiatric care.[201]

9.44. Dr Hooper did not see Heidi again until 3 February 2014. In the interim period, Alina Flink had relinquished care (3 October 2013), Families SA had received a notification raising general welfare concerns (25 October 2013) and the new carers had failed to bring Heidi to scheduled appointments with Dr Hooper (25 October 2013 and 18 November 2013).[202]

9.45. On 3 February 2014, Heidi attended the appointment with Ms Malby and Mr Lane. Heidi was described as 'verbal, attentive and interactive at times'. Dr Hooper noted that Heidi said she wanted to let go of the past so she could have a future. His overall impression was that Heidi was more forward thinking, stable and adapting well to her new home.[203]

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[198] Transcript, page 1318
[199] Exhibit C25, pages 65, 146; Transcript, pages 1244-1245, 1318-1319, 1321-1326
[200] Exhibit C25, pages 146, 159-160; Transcript, pages 1322-1329
[201] Exhibit C25 at pages 72-74, 140, 163; Transcript, pages 1330-1338 1427, 1578-1580
[202] Transcript, pages 1338; Exhibit C25, page 91
[203] Exhibit C25, pages 101, 103

9.46. Under cross-examination, Dr Hooper agreed that the more positive presentation was an indicator that Heidi might be ready for regular therapeutic sessions.[204] When asked whether he could have conducted ongoing therapeutic sessions with Heidi, Dr Hooper said that he could have but 'it wasn't the standard [CAMHS] model'. Reference was made to time constraints, heavy caseloads and limited resources.[205]

9.47. Dr Hooper provided a repeat script for quetiapine (noting that the dose had been further increased in the intervening period from 25mg to 37.5mg per day). Dr Hooper maintained that Dr Lamb was overseeing the prescriptions for medication.[206] It is noteworthy that there was little or no liaison between Dr Hooper and Dr Lamb. It appears that Dr Hooper's understanding of Dr Lamb's role was based on assumption. Dr Hooper said the plan after this session was to continue the medication regime 'with ongoing support from Ms Wyld'.[207]

9.48. Dr Hooper had no further contact regarding Heidi until she had been placed under the interim care of the Minister. On 27 June 2014 he received messages from the Child Protection Service (CPS) and Families SA advising that an urgent psychiatric assessment was sought from CAMHS.[208] As fate would have it, Dr Hooper was about to commence ten days' leave. Additionally, the governance structure of CAMHS was changing and his tenure with the CAMHS Aboriginal Service was soon to end. Dr Hooper declined the assessment as he was no longer accepting referrals from the service.

9.49. On the same date Dr Hooper sent an e-mail to the Clinical Director of Regional CAMHS, Mr Clive Skene, to clarify whether Dr Batterham's clinical role was limited to consulting for FMC patients.[209] It was hoped that Dr Batterham would be able to undertake the urgent assessment. Dr Hooper was unable to recall the contents of any response except to say that it was not by e-mail.[210] When asked under cross-examination why he did not make direct contact with Dr Batterham himself, Dr Hooper said there was a lot of confusion within CAMHS at that time and a staffing crisis in

[204] Exhibit C25, pages 101; Transcript, pages 1340-1344
[205] Transcript, pages 45-1347; Exhibit C25, page 110
[206] Transcript, pages 44-1345
[207] Transcript, pages 1345-1346
[208] Exhibit C25a, page 20; Transcript, pages 1348-1351
[209] Exhibit C25a at page 20-21; Transcript, pages 1347-1353
[210] Exhibit C25a, pages 20-21; Exhibit C40b; Transcript, pages 1353,1369-1370

Southern CAMHS.[211] He said there was no clarity about how the clients of the CAMHS Aboriginal Service would be managed, or who would manage them. There was confusion about whether Dr Batterham could take over Heidi's care and whether the CPS would have an ongoing role. My impression of the evidence was that it was a chaotic and disorganised period within CAHMS and that psychiatric resources were stretched to their absolute limits.[212]

9.50. On 28 July 2014, Dr Hooper attended a case conference with representatives from Families SA and HenderCare. The meeting focused on alternative care options and de-escalation strategies.[213]

9.51. Dr Hooper met with Heidi for the last time on 30 July 2014. Although over four weeks had passed since the CPS urgent request, the psychiatric report had not been undertaken. Heidi was slow to warm at first but once she settled, Dr Hooper described her as 'verbal and more articulate than he had ever seen her before'. Heidi's capacity for verbal expression was described as 'remarkable' and her views/insights into herself and her environment as 'quite sophisticated'. Heidi was finally willing to open up and communicate.[214]

9.52. Significantly, during this last session Heidi confided in Dr Hooper about the things that were causing her frustration and anger. She spoke of her desire to have visits from her friends and her frustration at not being allowed such visits.[215] She spoke of being precluded from participation in meaningful activities. Heidi said she missed her 'Nana' (Lyn Flink) and her biological parents. She was distressed that photographs of her loved ones had been lost or mislaid during a recent house move.[216] As for the HenderCare carers, Heidi said it felt like they were stalking her, watching her 24 hours a day and writing down her every move. These feelings were contrasted with the freedoms she had enjoyed when living with Alina Flink and her family. As to the Boylan Ward, Heidi said it was a place that was more suited to 'freaking psychos, cutters, anorexics...'. She spoke of her fear that the HenderCare/Families SA staff

[211] Transcript, pages 1302-1303,1357-1359, 1377-1378
[212] Transcript, page 1597
[213] Exhibit C25a, page 39
[214] Exhibit C25a, pages 45-50
[215] See also cross-examination, Transcript, pages 931-935
[216] On 29 July 2014, Heidi had been relocated from Aldinga to new emergency accommodation at Christies Beach: Exhibit C40a at pages 12-18; Transcript, pages 1359-1363

would send her back there. Heidi said, 'I don't feel sad, I feel angry … angry at everything'. Dr Hooper recalls 'feeling somewhat privileged that Heidi would disclose these things to him'.[217]

9.53. In relation to the emergency placement, Dr Hooper candidly stated that it would be difficult for Heidi to thrive in such an environment. Indeed, he said most people would find the situation in which Heidi found herself 'intimidating and difficult'.[218] One can only imagine the impact it had on a child with Heidi's vulnerabilities. Dr Hooper explained that mood fluctuations were most likely a response to loss, change and also her containment. Dr Hooper opined that *it was frustration that largely drove Heidi's aggression and self-harm* and *increasingly vigilant monitoring would likely increase Heidi's frustration, aggression and anger.* In short, it was the more enforced relationships whilst under the care/guardianship of the Minister that Heidi struggled with the most. Dr Hooper said these difficulties were clearly articulated by Heidi on 30 July 2014.[219] (emphasis added)

9.54. I turn now to the mental state examination undertaken by Dr Hooper on 30 July 2014. During the session Heidi mentioned that she was hearing voices. Dr Hooper completed a mental state examination, albeit CAMHS did not use detailed proforma documents to record such matters and he apologised for the brevity of his notes. Dr Hooper did not assess the symptoms as indicative of psychosis. In reaching this conclusion, Dr Hooper had regard to the fact that Heidi denied suicidal ideation or plans to harm or kill herself and she spoke of the future positively. Together they explored the benefit of coordinating a progressive decrease in the vigilance of the monitoring regime at HenderCare. Dr Hooper was encouraged by Heidi's expressed desire to change and 'the presence of age-appropriate cognitive processes provided hope that Heidi could benefit from consistently present, understanding and genuinely caring mentors…'.[220]

9.55. Dr Hooper considered prescribing an SSRI antidepressant however he said there was insufficient clinical evidence of a major depressive disorder to justify the commencement of such medication.[221] Dr Hooper's view was that Heidi most likely

[217] Transcript, page 1361
[218] Transcript, page 1363
[219] Transcript, page 1367
[220] Exhibit C40a at page 16
[221] Transcript, pages 1395-1396

experienced depressed feelings in reaction to her situation, rather than her having a pervasive biological or endogenous depression.[222]

9.56. Quite clearly, during this last session, Dr Hooper had made a breakthrough with Heidi. Excellent rapport was established. It would have been an opportune time for Heidi to commence regular therapeutic sessions. However, as fate would have it, Dr Hooper was moving on. A question arises as to why Dr Hooper did not conduct the psychiatric assessment that had been deemed urgent by CPS on 27 June 2014. At the very least, **I find** he should have made inquiries about the status of that assessment and, if necessary, assumed responsibility for it himself.

9.57. On 31 July 2014, Dr Hooper sent an e-mail to Ms Wyld in which he set out detailed recommendations.[223] The contents of the e-mail are self-explanatory and need no repetition. Suffice it to say that Dr Hooper emphasised the importance of HenderCare/Families SA carers being notified that *increasing vigilance would increase Heidi's risk* and there was *an urgent need for a decrease in vigilance to allow Heidi to increase her sense of autonomy and increase her safety*.[224] (emphasis added)

9.58. Dr Hooper was unable to attend the multi-agency meeting held on 1 August 2014. That is regrettable as Dr Hooper's professional standing and gravitas is likely to have resulted in greater focus being placed on the urgent need for implementation of these recommendations. It is unclear precisely why Dr Hooper could not attend. I have attributed it to the pressure of competing work demands. As I have already mentioned, Ms Wyld was unable to convey the importance of Dr Hooper's recommendations.

9.59. Dr Hooper gave evidence about other matters including the suitability of the emergency placement. He also commented on some opinions expressed by Dr Ford. In light of the evidence of other witnesses and my assessment of the expert evidence, it is unnecessary to canvass these matters.

9.60. I have no hesitation in accepting the evidence and opinions expressed by Dr Hooper. He was a truthful and credible witness. The Court was invited by Mr Charles to find that Dr Hooper exhibited indecision and vacillation regarding proposed changes to

[222] Under cross-examination by counsel assisting, Dr Hooper added that he had discussed the possibility of commencing an antidepressant with a peer review group and the consensus of the group was against it; Transcript, page 1396
[223] Exhibit C25a, pages 101-102
[224] Exhibit C40a, pages 6 14-16; Transcript, pages 1366-1368, 1395-1400

Heidi's medication.[225] I am not persuaded by that submission. In my view, Dr Hooper's management of Heidi must be considered in context and with due regard to the flawed CAMHS structure in which he was operating.

9.61. **I make the following findings**:

9.61.1. In 2014, Dr Hooper was a specialist consultant psychiatrist whose role included providing consultancy services to the CAMHS Aboriginal Service. Dr Hooper conducted five reviews of Heidi between October 2012 and July 2014, on referral from Ms Wyld.

9.61.2. During the relevant period, Dr Hooper was not requested by Ms Wyld to conduct a full psychiatric assessment and/or to assume an ongoing role in her psychiatric care.

9.61.3. There is no basis to criticise the reviews that were conducted by Dr Hooper and/or the advice he provided to the CAMHS Aboriginal Service.

9.61.4. On 4 September 2013, Dr Hooper increased Heidi's quetiapine dose from 12.5mg to 25mg. There is no basis to criticise Dr Hooper's clinical judgment regarding the increased dosage or his authority to do so. Nonetheless, it would have been prudent to discuss the proposed change with Heidi's paediatrician, Dr Lamb, particularly since Dr Hooper maintained that Dr Lamb was primarily responsible for overseeing Heidi's medication regime. This is but one example of the lack of collaboration between clinicians and the other health professionals who were involved in Heidi's care.

9.61.5. On 27 June 2014, Dr Hooper declined to accept a referral from the CPS to conduct an urgent psychiatric assessment. Given that his consultancy role with the CAMHS Aboriginal Service was soon to end, **I find** this decision was not unreasonable. That said, I find that on 30 July 2014, Dr Hooper ought to have made inquiries about the status of the urgent psychiatric assessment and, if necessary, assumed responsibility for conducting the assessment

[225] Written submissions of Mr Charles, pages 43- 44

himself. It is not suggested that a timely conduct of the assessment would necessarily have changed the outcome for Heidi.

9.61.6. Overall, **I find** no basis to criticise Dr Hooper's medical management of Heidi, particularly in light of the flawed CAMHS structure within which he operated.

9.62. Evidence of Dr Michael Batterham

9.63. Dr Batterham is a consultant liaison psychiatrist for the CAMHS Consultation Liaison Service at the Flinders Medical Centre (FMC). Dr Batterham gave oral evidence at the inquest.[226]

9.64. Dr Batterham treated Heidi on two occasions (11 June 2013 and 16 July 2014) and he provided advice by telephone on a third occasion (9 August 2014).

9.65. Dr Batterham first met Heidi at the ED of the FMC on 11 June 2013 (two months after Lyn Flink had died). It will be recalled that Heidi had been hospitalised overnight due to an aggressive outburst in a supermarket and suicidal ideation. Whilst at the hospital, Heidi was observed speaking into a banana as if it were a telephone and saying things like 'Don't talk. Don't listen to them … I'm going to kill myself'.[227] Dr Batterham conducted a mental state examination and found no evidence of any thought disorder or delusions. The banana conversation was considered more indicative of a disassociated state than a psychotic illness. Nor did Dr Batterham find Heidi to be depressed or agitated. The diagnosis was situational crisis with angry outbursts, FasD and associated intellectual problems along with a complex social situation. Dr Batterham concluded that Heidi 'will remain at chronic risk of emotional outbursts and suicidal gestures when stressed'.[228]

9.66. Dr Batterham's next contact with Heidi occurred on 16 July 2014. This was the first day of Heidi's five day admission to the WCH on account of the quetiapine overdose. On 18 July 2014, at the behest of Ms Frangiosa, Dr Batterham wrote to the Deputy Chief Executive Officer of the Office of Family and Child Safety, Mr David Waterford.

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[226] Transcript, pages 286-409
[227] Exhibit C24, page 99; Transcript, pages 293, 368, 370-377
[228] Transcript, page 305

It will be recalled that Ms Frangiosa was advocating for Heidi to be removed from Emergency Care and relocated to CRC. The letter stated *inter alia:*

> 'I am not convinced she [Heidi] has a depressive disorder given how quickly she became reactive once she found she was not going to HenderCare last night. *She will be at chronic risk of suicidal behaviour/gesture when upset* and a hospital admission to Boylan against her will is likely going to be counterproductive and increase her risk in the medium term.
>
> *Stable placement in a setting which is predictable and responsive will be the most effective therapeutic intervention.*'.[229] *(*emphasis added)

9.67. In the early hours of 9 August 2014, Dr Batterham received a telephone call from WCH psychiatrist, Dr Yanni.[230] This was the date on which Heidi had been located by police with reports of auditory and visual hallucinations. Dr Batterham did not take notes of the conversation. His best recollection is that the admission was triggered by 'some sort of emotional disturbance' in circumstances that were 'not dissimilar' to Heidi's presentation on 16 July 2014. He recalled discussion about a planned admission to the Boylan Ward and an increase in the quetiapine dose. These was also discussion about Heidi reportedly hearing voices. However, since this issue seemed to resolve quickly when Heidi's stress levels reduced, the symptoms were considered indicative of a dissociative or stress related illness rather than a psychotic illness. In the absence of any notes of independent recollection of the conversation by the witness, it is difficult to comment about the advice that may have been provided by Dr Batterham. In my view, for obvious reasons, notes should be taken of all such conversations and placed onto the patient's file. Heidi was discharged into the care of HenderCare with recommended follow up by CAMHS psychiatrist, Dr Hooper.[231]

9.68. Dr Batterham had no further involvement with Heidi.

9.69. Dr Batterham was cross-examined about the CPS request for an urgent psychiatric assessment dated 27 June 2014. He had no recollection of being asked to undertake this assessment. He said it amounted to a request for a second opinion and ordinarily such a request would be recorded in the case notes There is no such notation. On the

[229] Exhibit C24, 278; Exhibit C25a, pages 81, 194; Transcript, pages 327, 329, 391, 394-399; N.B. A copy of the letter was faxed to Dr Hooper
[230] Exhibit C26a, page 99
[231] Transcript, pages 359-360, 404, 407

available evidence, I am satisfied that Dr Batterham was not requested to conduct the assessment.

9.70. Dr Batterham presented as a credible and reliable witness who gave his evidence in a direct and straightforward manner. **I find** no basis to criticise Dr Batterham's medical assessments of Heidi.

10. Evidence of Susan Dawn Bailey (Mental Health Nurse, Women's and Children's Hospital)

10.1. Ms Bailey is a mental health nurse who conducted mental health assessments of Heidi at the WCH on three occasions, namely, 8 April 2013, 26 July 2014 and 20 August 2014.[232] A statement was provided to the Court and Ms Bailey gave oral evidence at the inquest.[233]

10.2. Ms Bailey explained the process which leads to the conduct of a mental health assessment at the ED:

10.2.1. The patient is first seen by a clinician and assessed. If the patient meets the criteria for detention under the *Mental Health Act 2009* they are assessed in the ED by a psychiatric registrar and, if admitted, they will see a psychiatrist on the ward;

10.2.2. If the patient is not admitted, the clinician may recommend a mental health assessment. The mental health care nurse will be notified of the pending assessment and details of the patient are provided;

10.2.3. Prior to conducting the assessment, the mental health nurse will generally access the mental health database and log books from which details of the patient's past presentations can be obtained (eg. ambulance report(s), discharge summaries and the like). Hard copies of the patient's hospital notes are also available.

10.3. I turn now to the mental health assessment process. In the case of a child or adolescent, Ms Bailey's practice is to speak first with the patient in the presence of his/her carer(s).

[232] Exhibit C37; Transcript, pages 791-869
[233] Ibid

Collateral information may be obtained from the carer(s). Ms Bailey ensures that she also speaks with the patient alone so as to provide an opportunity for disclosure of information the patient may not wish to impart in the presence of a carer(s).[234]

10.4. On some occasions, Ms Baily said psychiatric advice may be required. If so, there is an ED Psychiatric Registrar available up to 11pm. After 11pm, the on-call psychiatrist can be contacted. Ms Bailey explained that if a child/adolescent is assessed as 'high risk' or suffering from a mental health disorder such as psychosis or severe depression, it is usual to contact a psychiatrist to request an overnight admission. The nurse does not have authority to direct an overnight admission without direction.[235]

10.5. Ms Bailey conducted three mental health assessments of Heidi. Except for the assessment dated 20 August 2014, it is unnecessary to canvass the evidence in great detail. Suffice it to say that on each occasion Ms Bailey found no grounds to detain Heidi or to seek psychiatric guidance. On each occasion, Heidi had settled by the time of the assessment and she denied any current suicidal ideation. Based on Heidi's appearance, behaviour, conversation, affect (ie. mood), perception and cognition, it was concluded that she was fit for discharge.

10.6. Ms Bailey was cross-examined closely about the extent to which information gleaned from the mental health database and other records form part of the mental health assessment. The general thrust of the cross-examination suggested that Heidi's history of crisis presentations should have raised significant concerns about her immediate safety and, that on 20 August 2014, she should have been admitted for a psychiatric assessment. Ms Bailey disagreed. The effect of her evidence was that it is not uncommon for young people to have multiple ED presentations. Indeed, she said many young people present to the ED far more frequently than Heidi (eg. three times per week) with chronic ongoing issues. The witness agreed that the patient's history is relevant and forms part of the assessment. However, Ms Bailey repeatedly said the assessment is ultimately determined by the way in which the child/adolescent presents at the time of assessment and whether they have appropriate supports in place on discharge into the community. Ms Bailey said it was fair to describe her role as dealing with acute short-term management rather than long-term management which is

[234] Transcript, pages 793-795, 798-799, 854-857
[235] Transcript, pages 865-866

generally managed in the community by a CAMHS psychiatrist or a private psychiatrist or psychologist.[236]

10.7. I turn now to Heidi's presentation on 20 August 2014. On this occasion, Heidi had been brought to the ED by SAPOL. She was accompanied by two HenderCare carers.[237] Heidi was assessed by Dr Musa and then referred to Ms Bailey for a mental health assessment. Under cross-examination, Ms Bailey agreed that she would have known that Heidi had been hospitalised on four occasions since she had last seen her on 26 July 2014 and the circumstances which led to those hospitalisations.[238] In relation to the assessment itself she said:

> 'I observed that Heidi was lying on the bed with her feet down the wrong end of the bed and her head down the other end. I observed that as she saw me coming she looked up and started smiling at me. I observed her to be very reactive and smiling. She wanted to talk to me about general things such as what she had been doing and movies. I also observed some cheerful banter going on between her and her carer until I requested to speak to Heidi alone…'[239]

10.8. The conversation then continued in the absence of the carer:

> 'After I have spoken with Heidi about general things, she then told me about what happened at school. She told me that she had an argument with a girl at school and she was feeling very angry and annoyed. She told me that she ran away to the railway line. She explained to me that sometimes these sorts of incidents happen with some of the kids at school. *She stated that she had thought about killing herself down at the railway line*. She said that she had a 'meltdown' but she was now feeling better. She denied having taken any tablets or an overdose.'[240] (emphasis added)

10.9. The above information was elicited by specific questions directed at exploring Heidi's state of mind.[241] Ms Bailey noted that Heidi was settled and cooperative, she had good eye contact and the conversation was of a normal rate and flow. Heidi smiled often. She was reactive and denied symptoms of depression such as loss of appetite or difficulty sleeping. Ms Bailey saw no evidence of psychotic behaviour. Heidi presented as no longer agitated or angry and Ms Bailey concluded that the crisis had resolved. She said there were no grounds to detain Heidi and her clinical judgment was

[236] Transcript, pages 824, 863-864, 867-868
[237] Transcript, page 105
[238] Transcript, pages 832-833
[239] Transcript, pages 816-817, 838
[240] Transcript, page 838
[241] Transcript, pages 819-820

that Heidi was not a danger to herself or others. Accordingly, Heidi was discharged into the care of HenderCare.[242]

10.10. At 10:18pm on 20 August 2014, Ms Bailey sent an e-mail to Ms Wyld and Dr Hooper. A summary of the attendance was provided and Ms Baily advised that the carers had requested a psychiatric review to be conducted.[243] Under cross-examination, Ms Bailey said she did not understand the carers to be asking for an assessment to be conducted at the hospital. Nor did she observe any reluctance to receive Heidi back into their care. In any event, Ms Bailey said if she had formed the view that Heidi needed an immediate psychiatric assessment, she would have arranged for it to occur at the time.[244]

10.11. It is noted that as at 26 July 2014 Ms Bailey believed, albeit mistakenly, that Dr Hooper was Heidi's treating psychiatrist. On the available evidence, it is not possible to determine with any certainty whether this mistaken belief had any effect on Ms Bailey's decision-making processes. It is one factor which would no doubt have been viewed as a support on discharge but it is not possible to say whether it was a definitive factor. I consider it more likely that Heidi's presentation and demeanour at the time of assessment carried greater weight in the decision that it was safe to return Heidi into the community.

10.12. Mr Charles was critical of Ms Bailey for not seeking collateral information from the carers. The effect of his final submission (and Dr Ford's opinion) was that Heidi's past history and recent presentations warranted a far more cautious approach. It was suggested that on 20 August 2014 Heidi ought to have been admitted overnight for psychiatric assessment.[245] I disagree. Observations of this nature are easily made with the benefit of hindsight. I am satisfied that Ms Bailey had due regard to Heidi's history at the time of assessment. She was satisfied that the acute crisis had passed and that Heidi had appropriate supports in the community. I find no basis to criticise the decision to discharge Heidi into the care of HenderCare.

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[242] Transcript, page 818, 820; Exhibit C37, page 4
[243] Exhibit C26a, pages 105, 138; Transcript, pages 818-819, 839-840
[244] Transcript, pages 841-842, 863-865
[245] Transcript, page 1989

10.13. Ms Bailey presented as a truthful and candid witness. I accept her evidence in all material respects and **I make the following findings**:

10.13.1. Ms Bailey conducted a mental health assessment of Heidi Singh on three occasions, namely 8 April 2013, 26 July 2014 and 20 August 2014.

10.13.2. **I find** no basis to criticise the clinical judgment of Ms Bailey including her decision to discharge Heidi to the care of HenderCare on 20 August 2014.

11. HenderCare

11.1. Evidence of Jasmin Irene Hazel Daw - overview of HenderCare

11.2. In June 2014 Ms Daw was the Manager of Children's Services at the HenderCare Foundation. She had no direct involvement in Heidi's care. Ms Daw's evidence addressed general matters relating to the operation of HenderCare.

11.3. In 2014, HenderCare's business included providing care workers to Families SA. All residential care is provided by carers who work on rotating shifts. New employees are required to have a minimum qualification of a Certificate III in Children's Services, a Certificate IV in Youth Work or its equivalent.[246]

11.4. HenderCare provides information about the child/adolescent. This information is placed into a red folder which is kept at the placement.[247] A communication and log book is also kept there. If the Intensive Placement Support (IPS) team of Families SA becomes involved, a separate folder is provided to store directions of IPS regarding a child.[248]

11.5. HenderCare protocols required carers to regularly review all of the above information. It is also expected that information pertaining to a child will be provided by verbal handover at the time of shift changes.[249]

11.6. In 2014, carers did not have access to the Families SA computer management system. This meant they were unable to electronically access information about the placement

[246] Exhibit C44, page 2
[247] Exhibit C44, page 1
[248] Exhibit C43, page 3
[249] For an explanation of the process of making entries in the log book refer evidence of Renee Swan: Transcript, pages 970-977, 980-981; see also evidence of Patronella Beukman: Transcript, pages 889-890; Exhibit C43, page 3

and the child. Ms Daw explained that the Families SA social worker provided direction to carers 'on all important issues relating to the child'. This was done by telephone and occasionally by e-mails (directed to the carer's personal e-mail address). If carers needed to file a report to Families SA, such as a Critical Incident Report, it was completed manually and a carer would deliver it to a Families SA or HenderCare officer.[250] If carers were required to attend meetings with Families SA, HenderCare did not require them to take notes and/or to provide a report to HenderCare about the outcome of the meeting. Rather, the Families SA social worker would generally take notes and provide any necessary information to the carers. On occasion, hard copies of information would be provided to the carers by HenderCare and Families SA. I was surprised this evidence. The system for communicating and recording information seemed inefficient and archaic.

11.7. Since 21 December 2017, HenderCare has introduced a mobile telephone application which allows carers to log into the allocation system and to view documents relevant to the placement and the child which is no doubt a welcome improvement.

11.8. Evidence of Simone Hammond - written direction from IPS dated 24 July 2014

11.9. Ms Hammond has worked in the Emergency Care sector for around twelve years and commenced work at HenderCare in approximately 2010. A statement was provided to the Court. Ms Hammond was not required to give oral evidence.[251] The most salient feature of Ms Hammond's statement relates to a written direction received from the IPS division dated 24 July 2014. The direction stated:

> '**Heidi is not to enter the carers room for any reason**
>
> IPS Worker requested that the office door be locked at all times and that the carer only carry the office door key on them
>
> Filling (sic) cabinet key to be placed in a secret place that carers only know
>
> Carers to only open filing cabinet when the office door is shut and locked
>
> **The young person is not to see carers getting the medication**
>
> **Knives to be in the locked filing cabinet, only taken out to use and immediately washed and returned to the filing cabinet.**

[250] Exhibit 38, 'PB1'
[251] Exhibit C45

> IPS Worker requested that this information be texted/emailed to all carers working at the placement.'[252]

11.10. The document provides some insight into the nature of the challenges faced by the HenderCare carers. Several signatures appear on the document presumably so as to acknowledge its contents. On the available evidence, with the exception of Ms Beukman, the Court is unable to ascertain the identity of the signatories.[253] Nothing turns on this point.

11.11. Evidence of Renee Marie Swan - events of 21 August 2104

11.12. Ms Swan is a qualified social worker and Emergency Care worker. As at August 2014 she had been employed by HenderCare for about six years. A statement was provided to the Court and Ms Swan also gave oral evidence at the inquest.[254]

11.13. The Court heard that Ms Swan was one of the carers who was rostered to care for Heidi during the last three weeks of her life. She was on duty on the evening of Heidi's death.[255]

11.14. On Thursday 21 August 2014 Ms Swan commenced work at about 2:45pm. She was rostered with Ms Beukman (Patty). Heidi was collected from school just after 3pm and they arrived at the placement at around 3:35pm. Heidi watched cartoons and ate ice cream with strawberries.[256] At about 3:40pm, Ms Wyld arrived for her regular visit. Heidi and Ms Wyld generally went for a drive however on this occasion Heidi did not want to go. Heidi continued to watch cartoons.[257] A short time later, Ms Frangiosa arrived along with another Families SA social worker. Ms Swan said they had attended to inspect some bars at the side of the house that were considered to be a hanging risk. Heidi went to her room while the social workers were there. Once they had gone she came out of her room and resumed watching television. By this time preparations had commenced for the evening meal. It was a roast dinner. While dinner was cooking, Heidi and the carers watched a movie entitled 'Sister Act 2'.[258]

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[252] Exhibit C21c, page 49
[253] Exhibit C21d, page 49; Transcript, pages 949-951
[254] Exhibits C39, C39a; Transcript, pages 959-1004
[255] Exhibit C39
[256] Transcript, page 964
[257] Transcript, pages 977-978
[258] Exhibit C39, pages 3-4

11.15. Heidi ate her dinner. She said yes to 'seconds' although she did not return to eat the meat that had been cut up and left on her plate. The relevance of this will become apparent in a moment. Shortly before 7pm, Heidi left the room and walked down the hallway. Ms Swan thought she was going to the toilet. It was dark by this time. The carers were still finishing their dinners. A short time later Heidi was heard singing in the back yard. It was not unusual for Heidi to sing.

11.16. The carers went outside and called out to Heidi. There was no response. Ms Swan went back inside, retrieved a torch and the search for Heidi continued. Ms Swan heard some twigs breaking. At this point she heard Heidi 'having a conversation with herself'. The conversation went along these lines: 'Jump the fence' (in quite an aggressive tone) and then 'But I can't get up there' (in a frustrated tone). Ms Swan said Heidi repeated this second phrase a few times and that each reply sounded 'a bit more desperate'. The carers called out to Heidi to ask if she wanted to come back inside. They offered her medication. There was still no response. Heidi was then told she had five minutes to come back inside. Ms Swan explained that the strategy of providing Heidi with some personal space had often worked in the past.

11.17. The carers went inside to prepare the medication. A telephone call was made to HenderCare to seek advice but there was no answer. Ms Swan left a voicemail message.[259] It was around this time that Ms Swan heard Heidi making unusual noises. She shone the torch from the back door and saw Heidi. Her demeanour was described as follows:

> 'Heidi was hunched, looking at me with a 'dark' look, showing her teeth. She looked possessed and she hissed at me through her teeth. She ran off into the bushes again and hid. She was making grunting sounds and said in a really low voice 'you'd better run away whilst you still can', and then began laughing hysterically.'[260]

11.18. Ms Swan had never seen Heidi exhibit such behaviour.[261] There was discussion about calling an ambulance. SAPOL was contacted and an ambulance was called at around the same time. Ms Swan estimated that when the decision was made to call police and ambulance services, the incident had been unfolding for about 15 to 20 minutes.[262]

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[259] Exhibit C39, page 5
[260] Ibid, page 6
[261] Transcript, page 964
[262] Transcript, page 960-961

11.19. Under cross-examination, Ms Swan said she was concerned for her own safety 'because of her [Heidi's] mental state…'.[263] At this point Heidi approached the back door. Ms Swan described the situation:

> 'Patty and I were in the kitchen. She came in - she poked her head in and smiled. It wasn't a nice smile and I was afraid. It was like she wasn't there. Heidi slammed the sliding door and was banging on the glass, looking at us. She opened the door and came inside. She went to the plate where her cut up meat was that she hadn't come back for earlier. She grabbed the fork and began scratching her right arm with it. She then began stabbing her right arm with the fork. She sat down at the table. I was still on the phone to the ambulance, so I let them know what she was doing'.[264]

11.20. While Heidi was banging on the glass door, medication was offered. It was also offered when Heidi came into the kitchen. Heidi responded once only. She said, 'I want the lorazepam'.

11.21. Under cross-examination, Ms Swan said Heidi did not seem like the girl she had worked with on previous occasions. She described Heidi as being 'in an unusual mental state' adding that while self-harming with the fork, she was saying things like, 'Here, eat this, it's good for you'. Then she pointed the fork across the table to an empty space.[265] At one point Heidi stood up. Ms Swan grabbed the fork and put it in the sink. Heidi then went to the front door. Ms Beukman offered her some medication and a cup of water. Heidi was given one tablet (presumably lorazepam) and she requested another. That request was declined, a decision Heidi appeared to accept. Heidi left the house through the front door. Ms Swan and Ms Beukman asked her to come back inside. Heidi did not respond. She began talking to herself again in a raised voice, walked through the front yard and then ran along Robertson Road heading east towards Dyson Road.

11.22. When last sighted Heidi was on Carey Road. By this time, it was about 7:30pm. Given Heidi's mental state, Ms Swan said they were not sure whether to follow her. They decided to follow and set off south along Dyson Road on foot. Ms Beukman was still on the phone to the police who advised them to return to the placement. They did so

[263] Transcript, page 984
[264] Ibid
[265] Transcript, page 983

and met with the police at around 7:45pm. Heidi had not been located.[266] That was the last time Ms Swan saw Heidi. The incident was recorded in the log book. [267]

11.23. Evidence of Patronella Beukman

11.24. Ms Beukman is a Youth Support Worker who commenced working for HenderCare in approximately 2012.[268] Two statements were provided to the Court dated 22 January 2016 and 4 December 2017 respectively.[269] Ms Beukman also gave oral evidence at the inquest.[270]

11.25. Ms Beukman did regular shifts at both the Aldinga and Christies Beach placements. She described Heidi as follows:

> 'Heidi could be a challenging child to work with. She had a tendency to go from being very calm and quite (sic) to very angry and agitated. Heidi's change in behaviour was often times (sic) extreme and unpredictable. You would never know what was going to happen in a given shift.
>
> In addition, Heidi regularly talked about death and wanting to kill herself, stating that she did not want to be here which I took to mean being alive. Heidi seemed to me from what she said, to be fascinated with death, sometimes commenting about what it would be like to be dead.
>
> On a number of occasions I recall Heidi appear to hear voices, sometimes talking to herself and answering her own questions.
>
> Heidi's behaviour would often escalate and over time I became used to calming her down by sometimes walking with her, or sitting quietly with her or talking with her. I was not always successful in de-escalating her behaviour.
>
> Over the time I cared for Heidi she attended hospital many times and would routinely abscond from the placement. FSA [Families SA] directions were to call the police whenever Heidi's behaviour hindered our ability to keep her safe. For example, if Heidi barricaded the door in her room we would call the police or if she absconded, became violent, or self-harmed.'[271]

11.26. Ms Beukman confirmed that various carers filed CIRs on 18 June, 1 July, 17 July (two reports), 23 July (two reports) and 8 August 2014. These reports were triggered by behaviours that included Heidi absconding, barricading herself in her bedroom, a

[266] Exhibit C39 pages 7-8; Transcript, page 983-984
[267] Exhibit C201 (entry 21/08/14); Transcript, pages 977-979
[268] Exhibit C38, 'PB 1' at [8]; Transcript, pages 875, 909-910
[269] Exhibit C38-The initial statement was taken by police on 22 August 2014. It is unclear why the statement was not signed until 22 January 2016
[270] Transcript, pages 871-958
[271] Exhibit C38, 'PB 1' at [12]- [16]; see also Transcript, page 875-876, 877-878

disclosure that she enjoyed petrol sniffing, agitated behaviour, standing in the middle of a road and an incident in which Heidi allegedly assaulted Ms Beukman with a kettle.[272]

11.27. In relation to the CIRs, it was Ms Beukman's practice to call HenderCare first to seek advice. Depending on the severity of the situation, SAPOL may be contacted before HenderCare.[273] On some occasions Ms Beukman attended at hospitals.[274]

11.28. Due to the ongoing behavioural issues, Ms Beukman confirmed that the HenderCare carers attended several meetings. These included a school meeting (18 June 2014), a case conference (21 July 2014) and three meetings directed at the assistance of carers (28 July, 5 August and 12 August 2014). Ms Beukman specifically recalled that on 28 July 2014 Dr Hooper described Heidi's living situation as 'like a caged animal'.[275] No official HenderCare notes were taken at these meetings. It was confirmed that the Families SA social worker prepared summaries/minutes of the meetings.[276] It was unclear whether these summaries/minutes were circulated to carers as a matter of course.

11.29. I turn now to the events of 20 and 21 August 2014. It will be recalled that Heidi was assessed at the WCH on 20 August 2014 and discharged to the care of HenderCare. Ms Beukman attended at the hospital with another carer on that occasion.[277] Ms Beukman did not recall speaking with any doctors at the hospital. However, she did recall her colleague, Renae Szczurko, 'was insistent that the nurse who assessed Heidi arrange for a psychiatric assessment…'.[278] The carers also wanted Heidi's medication regime to be reviewed. It was unclear whether Ms Szczurko was requesting an overnight admission. Ms Bailey did not interpret the request in this way. Her impression was that the carers were content to accept Heidi back into their care.[279] Ms Beukman said Heidi was calm on the way home. The carers made dinner and then Heidi watched television. Heidi had one dose of quetiapine and went to bed.[280]

[272] Exhibit C38, 'PB 1' at [27]-[34]; 'PB 3' (copies of Critical Incident Reports)
[273] Ibid at [35]
[274] Transcript pages 947-948
[275] Transcript, page 951
[276] Exhibit C38, 'PB 1' at [21]- [22]; Transcript, pages 883-887, 897-898
[277] Exhibit C38, page 2
[278] Exhibit C38, 'PB 1' at [39]; See also Transcript, pages 902-906
[279] Exhibit C38, 'PB 1' at [39]; See also Transcript, pages 902-906
[280] Exhibit C38, page 3

11.30. On 21 August 2014, Ms Beukman (and Ms Swan) took Heidi to school. She was calm and talkative. When they collected her in the afternoon, Ms Beukman recalled that Heidi was a bit difficult about getting into the car. She complained about the music that was being played. Heidi was told that she had a doctor's appointment however she did not want to see the doctor. It is unclear whether they attended the appointment. My impression was that they did not. Ms Beukman said that things seemed to settle down and she too recalled Heidi eating some ice-cream and watching television.[281]

11.31. Ms Beukman provided a detailed account of the subsequent events. The account is entirely consistent with Ms Swan's account. It is unnecessary to repeat Ms Beukman's version of events. Suffice it to say that I accept the account of both witnesses as accurate and reliable.

11.32. There was an additional detail that Ms Beukman recalled. When Heidi asked for the lorazepam she said she wanted her 'book of death'. Heidi went into her bedroom to find this book. Under cross-examination, Ms Beukman explained that Heidi had a book in which 'she wrote down things and she drew'. She called it 'her book of death'. The witness could not say whether the book was retained after Heidi's death.[282]

11.33. The last time Ms Beukman saw Heidi she was running onto Carey Road. Heidi was wearing her school uniform.[283]

11.34. <u>HenderCare training and communication protocols</u>

11.35. The inquest did not canvass the content of respective training of HenderCare carers and Families SA carers. Thus it was not possible to undertake a comparative assessment of the quality of training that was provided. I am satisfied that the HenderCare carers who cared for Heidi had the minimum required qualifications to work as youth workers. That does not mean that they were equipped to manage a child with Heidi's complex needs.

11.36. Ms Swan, for example, had no recollection of receiving any training directed at managing a young person who suffered suicidal ideation, self-harming behaviour, hallucinations, FasD or managing children with a mild intellectual disability. Heidi had

[281] Ibid; Transcript, pages 899-900
[282] Transcript, page 900
[283] Exhibit C38, pages 3-5

all of these traits. Ms Swan said she completed one subject at university about grief and loss however she could not recall undertaking specific training for managing children who have experienced grief and loss.[284] Clearly, Heidi was a child who had suffered significant grief and loss.

11.37. Ms Beukman received some additional training between 2012-2014. However, it was limited to attendance at one day training modules in areas that included first aid, critical incidents, working with Families SA, non-violent crisis intervention, CPR, medication management and missing persons.[285]

11.38. Having considered the whole of the evidence, I am persuaded that the HenderCare carers were not provided with a level of training that properly equipped them to manage a child with Heidi's complex needs. That observation should not be construed as a criticism of the HenderCare carers. They did their best to manage in difficult circumstances. However, the reality is that Heidi's behaviour was extreme and her needs were complex. Heidi needed skilled youth workers and therapeutic management and support. At times, **I find** that the HenderCare carers were placed at risk of significant harm and some carers feared for their own safety. That is unacceptable and these carers should not have been placed in such a situation without adequate training, skills and support. Short-term crisis management strategies (as provided by Families SA) and attempts to upskill HenderCare carers on the run was no substitute for adequate training and experience.

11.39. In relation to the communication of information to carers there was a degree of informality in the way information sharing was managed. Ms Swan struggled to recall the contents of information that was received (eg. Ms Hayter's management strategies).[286] Ms Beukman said, in the beginning at least, she did not think there was 'a direct verbal or even written statement of how to manage her [Heidi]':[287]

> 'Q. What was your overall opinion about written directions, whether they were written or not, about managing Heidi's behaviour?
>
> A. It came late, it didn't come from the beginning where we could actually follow that, it came later on, that's all I can recall, because we were all so flustered, we couldn't do a proper handover because we didn't know what she's going to do in the next

[284] Transcript, pages 986-987
[285] Exhibit C38, 'PB 2'; Transcript, page 914
[286] Transcript, pages 890-891, 925-926, 948, 968-969, 990, 992, 998-999, 1003
[287] Transcript, pages 927-928

> shift, if her behaviour is going to be different, how to manage her is going to be different, how the carer's own personal experience of something else is going to try something different. So, I don't think in the beginning there was a direct verbal or even written statement of how to manage her.'

11.40. Ms Beukman was unsure whether she saw Ms Hayter's e-mail of strategies dated 18 July 2014 albeit she recalled that some of the documented strategies were implemented (eg. the sheets were removed from Heidi's bed and there was an increase in the frequency of checks).[288] Ms Beukman also recalled signing the HenderCare instruction dated 24 July 2014.

11.41. Overall, I was left with the impression that the procedures adopted by Families SA and HenderCare for disseminating information were inadequate and lacked mechanisms to ensure that the information was read, understood and consistently implemented by carers.

11.42. **In relation to HenderCare, I make the following findings**:

11.42.1. HenderCare is an organisation which, as part of its business, provides Emergency Carers to Families SA.

11.42.2. In relation to Heidi Singh, HenderCare provided active and passive carers who cared for Heidi in emergency rental housing from 3 June 2014 to the date of her death.

11.42.3. HenderCare requires all new employees to have a minimum qualification of a Certificate III in Children's Services and a Certificate IV in Youth Work or its equivalent. The HenderCare carers who did regular shifts with Heidi held these qualifications.

11.42.4. **I find** that the communication protocols that were adopted by HenderCare were relatively informal. There was no clear mechanism in place to ensure that the information that was provided to carers by Families SA and HenderCare was read and fully understood by the carers. **I further find** that HenderCare had no compliance or auditing mechanism in place to ensure that information and directions were consistently applied and implemented.

[288] Transcript, pages 926-927, 937

11.42.5. During the inquest, several witnesses opined that the Families SA trained youth workers had a superior level of training and skills to the HenderCare carers. On the available evidence, I am unable to resolve that question. The evidence was insufficient to allow for a comparative assessment of their respective training, skills and experience.

11.42.6. Having considered the whole of the evidence, **I find** that the HenderCare carers had basic qualifications as youth workers and some had additional qualifications. That said, I find they did not have an adequate level of training, skills and experience to manage a child with Heidi's complex needs. In my view, this exposed the carers and the child at an unacceptable level of risk. At the very least, even if skilled therapeutic care was not available at the placement, the HenderCare carers needed the support of youth workers with advanced training and skills.

11.42.7. **I find** no basis to criticise the efforts of the individual HenderCare carers who acted diligently, in good faith and to the best of their ability in difficult circumstances. That said, I agree with the recommendations of the Nyland Royal Commission that the use of commercial carers in any rotational care arrangements, except in genuine short-term emergencies, should be phased out (Recommendation 128), a streamlined model of residential care should be developed which includes care for children with high therapeutic needs (Recommendation 145(c)) and that no child should be housed in a residential facility with more than four children, except where necessary to keep a sibling group together (Recommendation 149 (b)).

11.42.8. In relation to the events of the evening of 21 August 2014, **I find** that prior to Heidi absconding, Heidi exhibited some disturbing behaviours which included talking to herself, laughing hysterically, baring her teeth, hissing through her teeth and self-harming with a fork.

12. Expert evidence - Dr Caunt

12.1. Dr Caunt is a Fellow of the Royal Australian and New Zealand College of Psychiatrists. Her qualifications include a Certificate of Child and Adolescent Psychiatry. Dr Caunt has a breadth of experience in mental health services in both government and private

practice and is currently employed as the Director of Training in Child Psychiatry at the Health Department, Perth, Western Australia.[289]

12.2. Dr Caunt was requested by counsel assisting the State Coroner to provide an overview report in relation to the management of Heidi Singh prior to her death.[290] Dr Caunt also gave oral evidence at the inquest.[291] Dr Caunt's evidence was not challenged. The salient features of the evidence can be addressed by a series of questions which I set out below. Before addressing those questions, I will turn first to address some general observations made by Dr Caunt during her evidence.

12.3. Shared care models

12.4. Dr Caunt noted that until mid-2013, Heidi's mental health management reflected a shared care model. The psychosocial aspects of care were managed by the CAMHS Aboriginal Service. Primary health carers and Dr Lamb managed Heidi's emotional and behavioural disorders (secondary to FasD).

12.5. Psychiatric diagnosis of children vs adults

12.6. Dr Caunt explained that a distinction needs to be drawn between the diagnosis of adults and children. In child psychiatry, uncertainty of diagnosis is not unusual and must be tolerated. Since the brains of children are still growing and developing symptoms that may indicate a psychiatric illness may actually evolve into normal mental health. Thus 'there is a lot of watchful waiting' before any clear diagnosis can be made.[292]

12.7. Foetal Alcohol Syndrome Disorder (FasD)

12.8. Dr Caunt explained that FasD is not a psychiatric diagnosis, albeit the condition can be treated by psychiatrists. In Heidi's case, Dr Caunt opined that as a result of FasD (and possibly poor prenatal care and exposure to other neurotoxic substances), Heidi had disturbances in cognitive, emotional and social development which resulted in significant functional difficulties. She said Heidi's vulnerability to develop these

[289] Transcript, pages 1436-1437
[290] Exhibit C31a
[291] Transcript, pages 1433-1567RT)
[292] Transcript, pages 1440-1441

difficulties was increased by the environment in which she was raised, her losses and the associated stressors.[293]

12.9. I turn now to specific questions that were addressed by Dr Caunt.

12.10. Was Heidi suffering from a psychiatric condition?

12.11. Dr Caunt expressed a clear opinion on this matter. Her opinion was that there was insufficient symptomatology for a psychiatric diagnosis to be made with any degree of certainty.[294] To the extent that a diagnosis could be made, Dr Caunt nominated chronic adjustment disorder with mixed disturbance of conduct and emotions.[295]

12.12. In relation to depression, Dr Caunt considered it possible that Heidi had a major depressive episode (in addition to the chronic adjustment disturbance) however this condition could also not be diagnosed with any degree of certainty, particularly in light of Heidi's 'highly changeable presentation'.[296]

12.13. Dr Caunt addressed the issue of a possible psychotic illnesses. It was considered unlikely that Heidi's abnormal perceptual experiences were indicative of a psychotic illness (eg. affective psychosis or schizophrenia). Dr Caunt explained that it is not uncommon for adolescents with a history such as Heidi's to experience 'psychotic breaks', that is to say, 'mini experiences of psychosis' where contact with reality is temporarily lost. These breaks do not amount to a psychotic illness. Rather, Dr Caunt attributed Heidi's abnormal perceptual experiences to traumatic grief on a background of FasD.[297]

12.14. Was Heidi's medication regime appropriate? Should lithium have been considered as part of her management?

12.15. Dr Caunt made no criticism of Heidi's medication regime. The types of medications that were prescribed were said to be consistent with clinical consensus guidelines.

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[293] Transcript, pages 1476-1481, 1503-1508
[294] Exhibit C31a, page 4
[295] Ibid
[296] Transcript, page 1444
[297] Exhibit C31a at page 5; see also Transcript, pages 1440-1448

12.16. Dr Caunt made some further observations about the use of medication as a first line of treatment. Significantly, Dr Caunt stated that in child psychiatry, *psychological and* '*environmental management*' *of challenging behaviour and mental illness is the preferable first line treatment*.[298] That said, in the absence of resources to deliver such interventions (or where they have failed), Dr Caunt explained that medication is often used as the first line of treatment. In Heidi's case, it was considered likely that medication was prescribed for sedation and behavioural control. The witness also acknowledged that it may not have been possible to deliver psychological interventions in an emergency setting. Dr Caunt noted that on 20 July 2014, Dr Hooper had considered trialling an antidepressant. Given the circumstances, Dr Caunt said it was not inappropriate adding that it was 'probably what most people would have done'.[299] (emphasis added)

12.17. It was submitted by Mr Charles that Dr Caunt's evidence on this topic in effect amounted to a concession that Heidi ought to have been prescribed antidepressants.[300] I do not read Dr Caunt's evidence in this way. It is unhelpful I think to focus on one narrow aspect in time. I prefer the submission of Mr Keane, namely, that it is inherently problematic to focus on 'the last instance when nothing else works'. The correct focus is to examine interventions that may have addressed the underlying causes of the risk-taking behaviour which led to this tragic outcome.[301]

12.18. Dr Caunt did not support the use of lithium at the time of Heidi's death or prior thereto. She pointed to the risks associated with use of lithium such as the danger in overdose. Even if there had been a clear diagnosis of depression or other mood disorder, Dr Caunt said there are other less toxic and less risky options to trial before lithium.[302]

12.19. <u>Should Heidi have undergone more prolonged inpatient admissions in a mental health unit</u>?

12.20. The WCH Boylan Ward is the only secure child and adolescent inpatient unit in South Australia. It has twelve beds for children aged 10 to 18 years. Dr Caunt opined that such facilities are generally not set up for inpatient treatment or therapeutic treatment.

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[298] Transcript, pages 1455, 1482-1487, 1557-1558, 1564; Exhibit C31a, pages 4, 7
[299] Transcript, page 1558
[300] Written submissions of Mr Charles, pages 38-39
[301] Transcript, pages 2024-2025
[302] Exhibit C31a at page 7; Transcript, page 1563

On the contrary, they are usually focused on 'acute phase crisis resolution and reintegration into the community wards' and are staffed accordingly.[303]

12.21. According to Dr Caunt, the admission of a child to a secure inpatient setting involves a complex assessment of balancing the risks to the child and community from the behavioural manifestations of a mental health disorder and the potential adverse impacts of hospitalisation of the child in such a unit. Nonetheless, Dr Caunt concluded that a more prolonged admission into the Boylan Ward may have been beneficial:

12.21.1. Firstly, it may have provided more intensive mental health guidance and the development of cognitive-behavioural interventions for Heidi

12.21.2. Secondly, medications could have been trialled and any adverse side effects assessed; and

12.21.3. Thirdly, the assessment may have assisted in the development of crisis/safety plans.

12.22. It is difficult to argue against these propositions. I consider Heidi would have benefited from a prolonged inpatient stay particularly at an early stage.

12.23. Whilst Heidi was under the care of the Minister, what type of placement was suitable?

12.24. Dr Caunt expressed a firm view on this topic. The effect of her evidence was that the emergency placement was ill-suited to meet Heidi's complex needs. It did not provide a safe and stable environment in which psychological interventions directed at emotional regulation could be delivered by skilled clinicians. Dr Caunt said *Heidi needed a safe and stable environment with staff who were well trained in therapeutic models and psychological based therapies*:

> 'The cure is not to put them in there, *it's about the work that happens while they're in there…* it's not about the placement and the carers, *it's about the process that occurs in there…*'[304] (emphasis added)

[303] Exhibit C31a at page 8; Transcript, pages 1455-1458
[304] Transcript, pages 1553-1554

12.25. Under cross-examination, Dr Caunt emphasised Heidi's need for therapeutic treatment. She said, 'counselling for her grief and loss was not the priority'. Rather, *the priority was to deliver psychological interventions directed at emotional regulation*. Such interventions would have given Heidi time to settle down and process what had happened to her adding that Heidi needed to develop 'some attachment figure' to replace the things she had lost. Dr Caunt said *this need could not be met by a rotating care arrangement.*[305] Indeed, Dr Caunt described the emergency placement as '*even more disruptive than the changes from Lyn to Alina*' and that it led to a period of '*increased destabilisation*…'.[306] (emphasis added)

12.26. I accept Dr Caunt's opinion and note it is entirely consistent with inferences that may reasonably be drawn from the evidence of witnesses who sought to manage Heidi in the emergency setting. This is a damning piece of evidence. I am satisfied that a vulnerable Aboriginal child who was under the care and protection of the Minister was placed into a setting that was neither stable, nor able to meet her complex needs.

12.27. Dr Caunt was cross-examined about the decision not to relocate Heidi to CRC. It was acknowledged that, for the decision makers, there was no right way. Whichever way you looked at the issue, risk could be manifest.[307]

12.28. Given the circumstances, Dr Caunt suggested there were some alternative options. One option would have been to implement strong therapeutic interventions at the emergency placement or at least assess Heidi so that the necessary interventions might occur.[308]

12.29. <u>Was there a mental health plan in place and, if yes, was it workable</u>?

12.30. Dr Caunt noted that Families SA and CAMHS had each documented aspects of safety planning that would form part of a mental health care plan. Dr Caunt said these plans could have been workable however, in order to be effective, the plans needed to be 'clearly documented, jointly negotiated, goal oriented and consistent between agencies'.[309] Dr Caunt observed that it was unclear which organisation (or person) was chiefly responsible for the coordination of mental health care between the two main

[305] Transcript, pages 1450-1451
[306] Transcript, pages 1448-1449
[307] Transcript, page 1493
[308] Transcript, pages 1491-1492
[309] Exhibit C31a at pages 9-12

agencies and this lack of clarity may have impacted on the effectiveness of the documented safety planning.[310] I agree. Furthermore, it is plain from the evidence that the primary hospitals did not have the benefit of a clearly documented safety plan.[311]

12.31. The role of CAMHS and Families SA

12.32. Dr Caunt made some candid observations about the CAMHS structure and staffing arrangements. In terms of resources she said there is less and less money available in this sector and a *serious shortage of child and adolescent psychiatrists.* As I have said, this shortage has been the subject of adverse comment by the former State Coroner in other inquests. (emphasis added)

12.33. To place this opinion into context, Dr Caunt explained that in child psychiatry the recommended full-time figure internationally to adequately staff outpatients is four psychiatrists per 100,000 people. Currently the national Australian average is 1.6 per 100,000. In South Australia and Western Australia, the staffing ratio is 1.3-1.4 per 100,000.[312] According to Dr Caunt, this shortage leads to psychological support for young persons like Heidi being 'deferred down to people with less training, with the consequence that the person with the least training (eg. a social worker) is left "holding the baby" with inadequate support and supervision'.[313] Dr Caunt said that 'a point is reached at which this becomes untenable'.[314]

12.34. Dr Caunt did not consider it unusual that the CAMHS model of care engaged a psychiatrist as a consultant, rather than the lead, to the multidisciplinary team. However, she said the model has the potential for confusion of roles and a lack of clarity about who holds accountability and clinical risk. It will be observed that the opinion expressed by Dr Caunt is consistent with the observations and findings I have made in respect of Ms Wyld and Dr Hooper.

12.35. By way of example of the shortcomings of this approach, Dr Caunt pointed to Ms Wyld's decision that Heidi was 'not ready' for formalised interventions. Even if

[310] Transcript, pages 1496-1498
[311] Transcript, pages 1496-1498
[312] Transcript, page 1464
[313] See Exhibit C 31b 'Review of Review of South Australian Child and Adolescent Mental Health Services' (November 2014) in which the 'flat structure' of CAMHS was noted.
[314] Transcript, pages 1458-1462, 1513-1518, 1545-1548; See also Exhibit C31b 'Review of South Australian Child and Adolescent Mental Health Services, Women's and Children's Health Network, Final Report, November 2014

Heidi had not been deemed ready for cognitive interventions, Dr Caunt said it may have been useful to introduce a psychologist with whom she could develop a relationship, prior to initiating such interventions. I agree. It is difficult to see how a child can develop rapport with a psychologist and/or psychiatrist in the absence of an opportunity to do so. Dr Caunt also expressed surprise at the absence of any recorded session notes with the CAMHS psychologist.[315] Dr Caunt said there was a need for clarity about the ongoing role of a psychiatrist. Given the documented history, it was considered that an earlier comprehensive psychiatric assessment would have been in order.[316]

12.36. Dr Caunt was unclear about the exact nature of Dr Hooper's role within the CAMHS Aboriginal Service and thus felt unable to judge how much personal responsibility he had to assertively ensure that Heidi's psychopharmacological management was appropriate and ongoing.[317] Given Dr Hooper's limited involvement and the documented uncertainty about his short and long term capacity, Dr Caunt considered the actions he took to provide consultation and advice about transitioning Heidi to another psychiatrist were appropriate.[318]

12.37. Dr Caunt noted that during the last two sessions with Dr Hooper, Heidi was engaging verbally. She said this was an indication that Heidi '*was clearly going to be able to be engaged with some sort of therapeutic relationship such as a psychologist within CAMHS, Family and Children's Services or non-government organisations*'.[319] (emphasis added)

12.38. In relation to Families SA, Dr Caunt described the advice given by the departmental psychologist was 'based in sound principles' adding that more consultation directly with Heidi and the HenderCare carers, as well as intensive behavioural analysis, could have been undertaken. Dr Caunt repeated her evidence that the absence of a clearly documented and easily accessible risk and safety management plan was problematic.[320]

12.39. Once Heidi had been taken into the care of Families SA, Dr Caunt's considered the management plan may have benefited from psychiatric oversight**.**

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[315] Transcript, pages 1540-1542, 1556, 1559
[316] Transcript, pages 1535-1539
[317] Transcript, pages 1532-1534
[318] Exhibit C31a, pages 15-16
[319] Transcript, pages 1550-1551, 1556
[320] Ibid

12.40. Heidi's mental state on 21 August 2014

12.41. Dr Caunt opined that at the time Heidi absconded from the placement on 21 August 2014, she was 'not…in charge of herself'. Heidi was described as being in a dissociated state and at a high level of risk.[321] That said, Dr Caunt did not consider it likely that Heidi made a connection between the pylon and the danger of electricity or that she acted with pre-medication. Heidi's developmental issues and her history of impulsive behaviour without regard to risks pointed against such a conclusion.

12.42. Is there a case for the establishment of a secure adolescent mental health facility in South Australia?

12.43. The Court heard that in Western Australia there is a secure therapeutic residential care facility for children and adolescents, namely, the Kath French Facility. Dr Caunt noted that South Australia has no such facility. Her evidence was that, if set up correctly, such a facility can be of extreme benefit for young people who, because of their behaviour, place themselves or others at significant risk of harm. Dr Caunt said that secure containment models create an opportunity for skilled clinicians to engage the young person in therapeutic work which is designed to enable them to live in a community with a lesser level of risk and a lesser level of intervention for behaviour management.[322]

12.44. The evidence given by Dr Caunt is consistent with recommendations made by the Nyland Royal Commission in August 2016. The report made 260 recommendations about improvements to the Child Protection system in South Australia. Recommendation 152 states:

> 'Develop a secure therapeutic care model, supported by legislation, to permit children to be detained in a secure therapeutic care facility but with an order of the Supreme Court required before a child is so detained. The model should include regular evaluation of outcomes for children.'[323]

12.45. The recommendation has been accepted by the South Australian Government in principle however implementation has not commenced. As at 2018 'a number of

[321] Transcript, pages 1501-1502
[322] Transcript, pages 1465-1467
[323] Child Protection Systems Royal Commission: 'The life they deserve': Recommendation 152

alternative therapeutic options to support children at significant risk of harming themselves or others have been pursued by government instead of a secure facility'.[324]

12.46. Dr Caunt was an impressive witness who gave her evidence in a clear and balanced manner. I accept her evidence in its entirety.

13. Expert evidence - Dr Ford

13.1. Dr Ford has been a Fellow of the Royal Australian and New Zealand College of Psychiatrists since 1989. Dr Ford has a wide range of experience in the practice of psychiatry. From 1999 to the present time he has taught as a senior lecturer in psychiatry at the University of Adelaide. Currently, Dr Ford works in private practice.[325]

13.2. Dr Ford was asked by counsel assisting the State Coroner to provide an overview report in relation to Heidi Singh's management prior to her death. Dr Ford also gave oral evidence to the inquest.[326]

13.3. I will commence this analysis with Dr Ford's evidence about Heidi's early management. When Heidi first came to the attention of CAMHS, Dr Ford said it would have been appropriate to involve a psychologist so that Heidi could 'begin learning some behavioural skills'.[327] I agree with Dr Ford and his view concurs with the opinion of Dr Caunt. Dr Ford suggested that at least by late 2013, Heidi should have been undergoing Cognitive Behaviour Therapy (CBT) delivered by a qualified psychologist. He was surprised that no comprehensive psychiatric assessment had been undertaken and he favoured oversight of Heidi's case by a psychiatrist.[328]

13.4. Dr Ford suggested that a more prolonged admission to a unit such as the WCH Boylan Ward would have been beneficial for Heidi. An extended stay in the Boylan Ward for minimum of seven days for observation and vigorous assessment was recommended. I agree that such a stay would have been in Heidi's interests.[329] It will be recalled that Dr Caunt also supported an extended admission.

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[324] See South Australia, Department for Child Protection, Responses to Child Protections Systems: 'A Fresh Start' (2018)
[325] Exhibit C41, pages 16-19
[326] Exhibit C41; Transcript, pages 1682-1771
[327] Transcript, page 1719
[328] Transcript, pages 1709, 1741-1742, 1744
[329] Transcript, page 1702

13.5. On the topic of the suitability of the emergency placement Dr Ford concurred with the view expressed by Dr Caunt. In a nutshell, he said *the emergency placement was inadequate to meet Heidi's complex needs.* Dr Ford mentioned that South Australia no longer had the facilities that had existed in the 1990's. These facilities were described as follows:

> 'They were large homes that had a homely atmosphere with well trained staff who were good at diffusing conflict …There was liaison with psychiatric portals and there was usually liaison with employers, a lot of liaison with educational institutions …Regrettably some of those institutions became caught up in the institutional abuse scandal but I think we threw the baby out with the bathwater…' [330]

13.6. I turn now to some areas in which there was, or appeared to be, a divergence of opinion between Dr Ford and Dr Caunt.

13.7. <u>Psychiatric diagnosis</u>

13.8. Dr Ford agreed with Dr Caunt that in child psychiatry, psychiatric diagnoses often need to be quite fluid as circumstance do change. He disagreed with Dr Caunt's opinion that there was insufficient symptomatology to diagnose a psychiatric condition (including a major depressive episode) with any degree of certainty. On the contrary, Dr Ford's opinion was that:

13.8.1. Heidi met the DSM-IV criteria for a major depressive episode; and

13.8.2. The possibility that Heidi suffered from psychotic depression at the time of her death could not be excluded.[331]

13.9. It is noted that under cross-examination Dr Ford conceded that one could not diagnose a major depressive episode with any degree of certainty. At best, Dr Ford said he was 'pretty confident' about his conclusion.[332] The evidence seemed equivocal at best.

13.10. In relation to a psychotic illness, although such illnesses are uncommon in children, Dr Ford could not exclude the possibility that Heidi suffered from psychotic depression at the time of her death.

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[330] Transcript, pages 1716-1717
[331] Transcript, pages 1753-1754
[332] Transcript, pages 1748-1749

13.11. Under cross-examination, Dr Ford was asked to further comment on Heidi's behaviour shortly before she absconded from the HenderCare placement on 21 August 2014. Based on the descriptions of her behaviour, Dr Ford considered that Heidi was 'extremely angry, extremely dangerous' although it was difficult to ascertain whether this was a 'purely behavioural episode or whether she was psychotic'. This passage of evidence was also equivocal.[333]

13.12. Medication regime

13.13. Dr Ford was familiar with the work of paediatrician, Dr Lamb. It was evident that Dr Ford had a great deal of respect for Dr Lamb and his ability to manage very ill children. However, he noted a lack of clarity between clinicians about who had primary responsibility for prescribing medication. Dr Ford was also surprised to learn that there was little or no communication between CAMHS and Dr Lamb or indeed between CAMHS and Heidi's general practitioner.[334]

13.14. Dr Ford disagreed with Dr Caunt's opinion regarding the medication regime. He advocated for a far more rigorous medication regime and rated it at 'the top of the list of priorities'.[335] By around mid-July 2014 (if not earlier), he said Heidi's drug regime should have been *augmented*, in an inpatient setting, by the addition of the SSRI[336] antidepressant medication, fluoxetine. SSRI's, carefully administered, can be lifesaving in significantly depressed children and adults.[337] He noted with approval that on 30 July 2014 Dr Hooper was considering the commencement of fluoxetine

13.15. It was explained that an SSRI acts to inhibit the uptake of serotonin in the brain. Dr Ford postulated that adding an SSRI would have improved Heidi's mood and reduced dysphoric and negative thoughts and agitation. He advocated in favour of its use in Heid's case, *even in the absence of a diagnosis of a major depressive episode*.[338] Dr Ford maintained that a more vigorous medication regime would have enabled Heidi to engage 'even with the rotating shifts at HenderCare and possibly with the psychologists and certainly Dr Hooper'.[339] Indeed, Dr Ford went so far as to say that

[333] Transcript, pages 1715-1716, 1753-1754
[334] Transcript, pages 1715-1716
[335] Transcript, pages 1696, 1705-1707
[336] Selective Serotonin Reuptake Inhibitor: SNRI's are a class of medications that are effective in treating depression. SNRIs are also sometimes used to treat other conditions, such as anxiety disorders and long-term (chronic) pain, especially nerve pain
[337] Transcript, pages 1750-1751, 1765
[338] Transcript, pages 1758, 1767-1768
[339] Transcript, pages 1696, 1705-1707, 1710-1711, 1733-1736

interventions with medication and assessment, along with the other measures he had mentioned in his report, 'would have made Heidi's death preventable'.[340] I will come to the question of whether Heidi's death was preventable in due course. (emphasis added)

13.16. Dr Ford further stated that fluoxetine and quetiapine work well together, particularly in the treatment of depression. Reference was made to the research data regarding the combined use of fluoxetine and quetiapine which was described as 'rock solid.' Dr Ford disagreed with Dr Caunt's contention that the said data was not available as at 2014, stating that it dates back 20 years or so.[341] On the available evidence it is neither possible nor necessary to resolve this particular issue.

13.17. In relation to quetiapine, Dr Ford suggested that a slow release form of the drug which lasted for 24 to 36 hours would have been preferable for Heidi as it decreased the frequency of doses. He also maintained that a higher dose was warranted. On the available evidence I am unable to form a view about this proposal.[342]

13.18. During submissions, Mr Charles urged the Court to accept Dr Ford's opinion about the introduction of an antidepressant (regardless of whether there had been a diagnosis of major depressive disorder).[343] I am not persuaded that submission or that the regime prosed by Dr Ford would necessarily have achieved the outcomes for which he contended. In my view, the opinion given in respect of Heidi's medication regime was speculative and amounted to conjecture. **I find** no basis to criticise Heidi's medication regime or the fact that it was not augmented by the addition of an antidepressant. In reaching this conclusion I have had regard to the discussion of the topic in the inquest into the death of Jason William Hugo-Horsman.

13.19. The mental health assessment - 20 August 2014

13.20. Dr Ford was also critical of Ms Bailey's mental health assessment on 20 August 2014.[344] Dr Ford opined that Heidi was at risk of a completed suicide at that time. Dr Caunt did not express an opinion on this topic. Dr Ford opined that a thorough psychiatric

[340] Transcript, page 1767
[341] Transcript, page 1733
[342] Transcript, pages 1755-1757
[343] Transcript, page 1487
[344] Transcript, pages 1709-1710

assessment was warranted along with 'a lot of observations, a gathering together of available material and, very likely, commencement of an antidepressant'.[345] I do not agree with Dr Ford's opinion. It is a conclusion that is easily reached with the benefit of hindsight. In my view, the opinion had insufficient regard to Heidi's changeable presentation and her tendency to settle quickly at hospital once the immediate crisis had passed or the fact that the ED medical and health professionals were operating without the benefit of an agreed risk and safety management plan for Heidi.

13.21. Dr Ford and Dr Caunt were both suitably qualified to give expert opinion evidence in this matter. I have carefully considered the opinions advanced by both witnesses. In the areas in which there was a divergence of expert opinion, I prefer the opinions of Dr Caunt. I found her opinions on the contested matters more persuasive and I also consider that Dr Caunt is better placed by reason of her qualifications and experience to provide an expert opinion in respect of those particular matters.

13.22. **In relation to the expert evidence I make the following findings**:

13.22.1. I accept the possibility that Heidi was suffering from a major depressive episode or psychotic depression at the time of her death. I am not satisfied that a psychiatric diagnosis can be established with any degree of certainty.

13.22.2. **I find** that Heid's abnormal perceptual experiences were most likely the result of temporary breaks with reality (ie. mini psychotic episodes) arising from traumatic grief on a background of a neurodevelopmental disorder, namely, Foetal Alcohol Syndrome Disorder (FasD) rather than evidence of a psychotic illness.

13.22.3. **I find** that a comprehensive psychiatric and psychological assessment should have been undertaken at an early stage and that Heidi's case ought to have been subject to psychiatric oversight. **I further find** that Heidi should have been introduced to a psychologist and/or psychiatrist at an early stage so that she could develop a relationship with the clinician(s) prior to initiating formalised interventions.

[345] Transcript, pages 1711-1712, 1762-1763

13.22.4. **I find** that a prolonged admission to the WCH Boylan Ward for a minimum of seven days for observation (as suggested by Dr Ford) and careful assessment was warranted. It would have provided an opportunity to trial medications and to develop a coordinated management and treatment plan.

13.22.5. I am persuaded by Dr Caunt and Dr Ford (along with the evidence of several other witnesses to whom I have referred) that the Families SA emergency placement was ill-suited to meet Heidi's complex needs. Heidi needed a safe and stable placement where skilled therapeutic interventions could be delivered. Such care could not be delivered in the emergency placement. **To be clear, I find that Families SA was unable to provide safe and stable accommodation and/or therapeutic care to a vulnerable 14-year-old Aboriginal child who was under the guardianship of the Minister at the time of her death.**

13.22.6. **I find** no basis to criticise Heidi's medication regime or the fact that it was not augmented by the addition of an SSRI antidepressant.

14. Evidence of Prudence McEvoy (Clinical Director of Child and Adolescent Mental Health Services)

14.1. Dr McEvoy is a child and adolescent psychiatrist of some 25 years' experience. She is a member of the Royal Australian and New Zealand College of Psychiatrists and has extensive experience in public mental health. Dr McEvoy has held the position of Director of advanced training for child and adolescent psychiatry in South Australia and she holds a Diploma of Psychotherapy. Currently, Dr McEvoy is the Clinical Director of the Child Adolescent Mental Health Service (CAMHS).[346]

14.2. The Court received a statement from Dr McEvoy who also gave oral evidence at the inquest.[347] In preparation for giving evidence, Dr McEvoy read and considered the CAMHS materials relating to Heidi Singh and the overview reports.[348] Her only direct engagement in Heidi's case was a request to convene a multi-agency case conference

[346] Exhibit C44 at [1]; Transcript, pages 1779-1780
[347] Exhibit C42; Transcript, Transcript, pages 1779-1869
[348] Transcript, page 1780

which ultimately did not take place.[349] Dr McEvoy's evidence was directed primarily at CAMHS governance issues and related matters.

14.3. The role of Clinical Director of CAMHS was created in response to the coronial inquests into the deaths of Michaela Jane Mundy[350] and Jason William Hugo-Horsman[351] and the Review of South Australian Child and Adolescent Mental Health Services which followed those inquests. A final report of the CAMHS review was delivered in November 2014 (the Gruner Review).[352] A taskforce was established to implement the findings. This task force also had regard to the Root Cause Analysis (RCA) that was undertaken in relation to Heidi Singh.[353]

14.4. <u>The CAMHS restructure and new model of care</u>

14.5. Dr McEvoy explained that as at January 2018, the taskforce was '*moving towards the implementation*' *of a CAMHS restructure.* The restructure includes a new Model of Care. It was openly acknowledged that the restructure 'cannot be done overnight'. Dr McEvoy candidly stated that CAMHS services are underfunded and the current and proposed changes must be made within the current budget. The point was repeatedly made that *there are no increases to the current budget for the purpose of implementing these changes*. (emphasis added)

14.6. With this proviso, the Court heard that the new Model of Care identifies CAMHS as a tertiary level mental health service which prioritises the most complex and mentally unwell people. These people include children, adolescents and their families, Aboriginal and Torres Strait Islanders (young people) and children who are under the Guardianship of the Minister (GOM children). The Model of Care recognises the high levels of morbidity in these priority groups.

14.7. The new model is enabled by a multidisciplinary team which includes psychiatrists, mental health nurses, psychologists and other health professionals. Psychiatrists have been identified as the clinical lead in teams.

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[349] Ibid at [2]
[350] Inquest 25/2013 into the death of Michaela Jayne Mundy delivered on 12 March 2014
[351] Inquest 26/2013 into the death of Jason William Hugo-Horsman delivered on 17 June 2014
[352] Exhibit C31b; Transcript, pages 1838-1851
[353] Exhibit C42 at [15], [15.1]- [15.9, [16]- [19]; A Root Cause Analysis (RCA) is a systematic process for identifying 'root causes' of problems or events and an approach for responding to them. RCA is based on the basic idea that effective management requires more than merely 'putting out fires' for problems that develop, but finding a way to prevent them.

14.8. Dr McEvoy acknowledged there has been no significant increase in the number of psychiatrists. There were 18 psychiatrists prior to the Mundy inquest which delivered its finding in 2014. Five years later, the number has increased to only 18.5 psychiatrists *which is around half of the number that is recommended by the Faculty of Child and Adolescent Psychiatrists*. In South Australia, the situation is compounded by a shortage of private child and adolescent psychiatrists. Notwithstanding these low numbers, Dr McEvoy emphasised that psychiatrists are now part of the CAMHS assessment process and considerable effort has been made to 'redistribute psychiatry time' across CAMHS. It was not entirely clear how this redistribution is effected. Psychiatrists also discuss cases with clinicians and are available for consultation, advice and, if necessary, to conduct reviews.[354] (emphasis added)

14.9. I turn now to the evidence directed at clinical governance of CAMHS. The key changes can be summarised as follows.

14.10. *Multi-disciplinary case reviews*

14.11. CAMHS *has now implemented* 'multidisciplinary team reviews'. These reviews occur every three months. The teams are also encouraged to undertake a multidisciplinary review at the intake stage with the aim of commencing an appropriate care plan from the outset. There is also capacity for clinicians to escalate a case within the team itself via the team psychiatrist and team manager.[355] (emphasis added)

14.12. *Complex Case Review Committee*

14.13. A Complex Case Review Committee (CCRC) *has been established*. It comprises senior CAMHS clinicians with a disciplinary mix, the Women's and Children's Health Network (WCHN) patient ethicist and representatives from the Department of Child Protection (DCP) and the Department of Education and Child Development (DECD). The CCRC meets twice per month and typically reviews four cases per month. Additional urgent reviews can be organised if required. If the DCP is involved with the client who is being discussed, the case worker and supervisor will be invited to participate.[356] It is noted that the CCRC is not limited to reviewing children who are under the guardianship of the Minister (GOM children). (emphasis added)

[354] Exhibit C42 at [10]-[12]; Transcript, pages 1780-1782, 1812-1813; 1841-1843
[355] Transcript, pages 1781-1782, 1815-1816
[356] Exhibit C42 at [13]; Transcript, pages 1782, 1816-1817

14.14. *Escalation pathways*

14.15. If, in spite of these processes, a high risk to the client remains or there are other systemic difficulties or unresolved issues, *a case may be escalated by the CRCC directly to Dr McEvoy* as the Clinical Director. In cases in which the DCP is involved, if necessary, cases may be escalated to Dr McEvoy as the Chair to a Regional Director within DCP. (emphasis added)

14.16. *On call psychiatrist/hospital liaison service*

14.17. *CAMHS now has an 24/7 on-call psychiatrist*. Dr McEvoy said most of the assessments in EDs are now done by the on-call psychiatrist. The process of engagement is facilitated by mental health nurses having access to a central database called CBIS which provides more detailed background information about the patient and faster communication with the CAMHS intake team.[357] (emphasis added)

14.18. *Centralised triage service*

14.19. *It is intended to* establish a centralised triage. Once established, families and others who access CAMHS will ring a central number and access well-trained clinicians (ie. a specialised team) who will determine the priority of cases and whether CAMHS is the most appropriate service.[358] The service will be linked with the current after-hours emergency mental health team. The aim is to provide one entry point for families and others who access CAMHS. *Funding for the service must come from within CAMHS and its current budget*.[359] (emphasis added)

14.20. *Interagency Therapeutic Needs Assessment Panel*

14.21. It is *proposed to establish* an Interagency Therapeutic Needs Panel for the assessment of GOM children. It is noted that the Nyland Royal Commission recommended:

> 'Invest in the ongoing development of a therapeutic needs assessment panel led by Child and Adolescent Mental Health Services for children in care whose therapeutic needs are identified in their initial health assessment' (Recommendation 86); and

[357] Transcript, pages 1800-1801
[358] Transcript, page 1799
[359] Exhibit C42 at [13]- [14]; Transcript, pages 1802-1804, 1806-1810

> 'Develop an interagency panel modelled on the Exceptional Needs Unit's management assessment panel to support case management of those children in care whose therapeutic needs are identified in their initial health assessment'. (Recommendation 87)

14.22. I should mention that Ms Simmons informed the Court that a coordinator position has been funded and that work has commenced on setting up the panel.[360]

14.23. This initiative was described as the 'first step in establishing a true interagency therapeutic services system' which could create a continuum of care from infancy through to adolescence, at least in respect of GOM children. Again, Dr McEvoy confirmed that *no additional resourcing has been made available for this proposal* and it was acknowledged that the panel is only in the early stages of its development.[361] (emphasis added)

14.24. *The Ngartunna Patpangga (CAMHS Aboriginal Service)*

14.25. Dr McEvoy explained that in 2014, the CAMHS Aboriginal Service did not really operate as a multi-disciplinary team. That is plainly evident from the evidence received by the Court. She said the service still exists today however it is now treated as a critical part of CAMHS. This means the service must follow CAMHS processes. As far as Heidi's management was concerned, a number of shortcomings of the service were acknowledged by the witness. For example: (a) the complexity of Heidi's case was not identified at the intake stage; (b) CAMHS social worker, Ms Wyld, was not working with another clinician; and (c) Dr Hooper operated only as a consultant psychiatrist to the service. It was therefore difficult to have an appropriate level of psychiatric oversight. Dr McEvoy contrasted this with the current situation. If Heidi's case was being managed within CAMHS today, Dr McEvoy is confident that the following processes would occur:

14.25.1. The case would be identified as complex at the intake stage;

14.25.2. A referral would be made to the CCRC. The case would be triaged by Dr McEvoy herself and a colleague. A case review would be booked;

[360] Transcript, pages 1822, 1825-1826, 1831, 1834, 1913-1914
[361] Exhibit C42 at [23]- [24]; Annexure 'PLM-2'; Transcript, pages 1789, 1821-1825

14.25.3. All relevant people would be invited to the review (eg. Heidi's GP, Dr Lamb, Ms Wyld, Dr Hooper, a DCP representative, an education representative, etc);

14.25.4. A management plan would be formulated and implemented early in the process and recommendations would be documented. The plan may include individual therapeutic work with a psychologist or a psychiatrist;[362]

14.25.5. The CCRC would meet every three months. In Heidi's case, Ms Wyld and Dr Meredith would participate in that process and, given the ongoing issues, such a case would be escalated by the team manager and clinician;

14.25.6. There would be oversight by a psychiatrist;

14.25.7. If an Interagency Therapeutic Needs Assessment Panel was established, Heidi's case would have been referred to the panel as soon as she came into the care of the Minister (without reference to the CCRC);[363]

14.25.8. An Interagency Therapeutic Needs Assessment Panel would have determined that the emergency placement was unsuitable and the case would be escalated to an Executive Director of the Department of Child Protection who would be commissioned to find a more suitable placement.[364]

14.26. *Formalised agreements and MOU's*

14.27. Dr McEvoy then addressed a particular challenge that exists in the present system, namely, the absence of any formalised agreement or memorandum of understanding (MOU) between all relevant agencies. Dr McEvoy described formal partnership agreements with agencies such as DCP as crucial to ensuring a holistic coordinated therapeutic system of care for GOM children. Significantly, although the CCRC can make recommendations and Dr McEvoy can advocate at a high level, *there is no power to ensure that recommendations are implemented.* (emphasis added)

14.28. Dr McEvoy said MOUs exist at the policy level, but not at the operational level.[365] Her evidence was that more MOU's are needed, *particularly around service delivery*

[362] Transcript, page 1811, 1818-1820, 1833, 1862-1864
[363] Transcript, pages 1783-1786, 1788, 1796-1797, 1804-1806, 1811-1815, 1845-1847
[364] Transcript, page 1826-1829; NB. Ms Simmons (DCP) stated that confirmed that funding had been provided by the DCP for a co-ordinator position for the panel and the MOU is in the final stages of preparation for sign off: Transcript, page 1910
[365] See for example Exhibit C43, 'CRS-3'

models. Dr McEvoy cited with approval, the Queensland service model called 'Evolve'. This model arose as a result of a Royal Commission in 2004, the outcome of which led to *a large injection of funds into therapeutic services* for guardianship children. Dr McEvoy described the model as an interagency partnership between the Departments of Health, Child Protection, Education and Disability Services. Dr McEvoy believes that the State of South Australia is the ideal size to establish an 'exciting and innovative' service, albeit it was acknowledged that a large injection of funds would be required.[366] (emphasis added)

14.29. As I understood the evidence, an MOU directed at establishing an Interagency Therapeutic Needs Assessment Panel is underway. The DCP has agreed to fund a position (for twelve months). That said, Dr McEvoy described this initiative as 'the tip of the iceberg' and really only a first step towards the development of an overarching interagency therapeutic services model. I should add that the evidence of Ms Simmons (DCP) reinforced, in my view, the need for formalised interagency agreements.[367] I will come to the evidence of Ms Simmons in a moment.

14.30. To summarise, as things presently stand, Dr McEvoy acknowledged that service coordination is difficult and care can be fragmented. The fragmentation occurs because therapeutic services are provided through a range of private and government agencies and non-government organisations (NGOs).[368] In short, *there is no coherent therapeutic program or service model for the most complex guardianship children.* (emphasis added)

14.31. <u>The emergency HenderCare placement</u>

14.32. Dr McEvoy was questioned by counsel assisting about current accommodation options and access to therapeutic care for children such as Heidi. Dr McEvoy acknowledged there is a current dilemma. It was conceded *there is simply not enough therapeutic care*, particularly for children like Heidi who come into formal care very late in their life. To use Dr McEvoy's words, *the system lacks the* '*nurturing wrap around service that the child would need in order to feel safe*'.[369] (emphasis added) Under re-

[366] Exhibit C42 at [13]; Transcript, pages 1791-1793, 1830
[367] See for example Transcript, pages 1875-1909
[368] Exhibit C42 at [20]
[369] Transcript, page 1835

examination by Mr Keane, Dr McEvoy highlighted *the critical need for suitable placements and thus the need for an interagency model*. Dr McEvoy opined that *the long-term solution requires a whole paradigm shift away from crisis management to a focus on early intervention.* The effect of Dr McEvoy's evidence was that *the present system does not adequately cater for the therapeutic needs of a child like Heidi*. This is a significant piece of evidence which I have no hesitation in accepting. **I am persuaded** that the current system of Emergency Care which utilises rotating contracted carers cannot cater for the complex needs of a child like Heidi Singh. Although the restructure of CAMHS has resulted in some positive changes and there are further proposals to be implemented, it is obviously 'not an overnight fix'. The best that can be said is that the present direction is geared towards a much higher level of clinician oversight with the long-term goal being to create a true interagency therapeutic services system which can provide a continuum of care from infancy through to adolescence, at least in respect of children who are under the interim care or guardianship of the Minister. (emphasis added)

14.33. In the meantime, children and adolescents will need to be managed within the current CAMHS system and, as Mr Keane stated in his closing submissions, while the aim is for commercial care to be phased out, there will always be a need for Emergency Care.[370] In the meantime, the use of commercial carers in emergency accommodation continues. The long-term vision of Dr McEvoy will necessarily require a whole-scale paradigm shift, political will and a large injection of funds before it can be realised. Dr McEvoy opined that it would 'require government saying this amount of money needs to be quarantined to develop a therapeutic care model in South Australia. Anything else that is done around that is great, but I…think that's what's needed' along with a business plan or business case to look at the potential health cost savings.[371]

14.34. Secure care facility

14.35. Dr McEvoy does not support the Nyland Royal Commission Recommendation for the development of a secure therapeutic care model (Recommendation 152):[372]

> 'A Secure Welfare Unit raises many questions … With regards to Heidi, I have had discussions with senior colleagues in South Australia and interstate and there was a

[370] Transcript, page 2005
[371] Transcript, pages 1857-1858
[372] Exhibit C42 at [25]-[26]

> consensus that such a unit would not have been beneficial to, and may have significantly harmed, Heidi. Certainly, secure accommodation *should only be considered when there is already an adequately resourced therapeutic care system for GOM children.* This requires a continuum of care offering therapeutic services to infants, young children and their carers as they enter care. Therapeutic intervention should then be available at times of transition for these young people, including where placement changes are occurring and as soon as behaviour concerns are identified. At this time, because there has not been a coherent system of therapeutic response for this vulnerable group, there is now a cohort of very behaviourally disordered adolescents in care placed in residential care facilities who engage in risk-taking behaviours including substance use/abuse and self-harm and who present frequently to our Emergency Departments. They are also often in contact with the juvenile justice system. They require a carefully constructed management plan across all agencies, most importantly including their residential care workers. Therapeutic care for children under the care of the Minister from infancy to adolescence is currently shared across SA Health and DCP as well as with private providers and NGO's. This leads to inconsistencies in governance and a lack of a shared therapeutic framework based on evidence based interventions for developmental trauma. *The provision of such a model, albeit complex and immediately costly, would have future benefit both in economic, but more importantly, in human terms particularly if over time the investment was at the front end when children first enter care.* Unfortunately therapeutic care/intervention was not a focus of the Nyland Royal Commission recommendations' (emphasis added)

14.36. Under cross-examination by counsel assisting, Dr McEvoy said if appropriate attention had been paid to other factors in Heidi's life, including the placement, the risks to which she was exposed could have been reduced. Dr McEvoy does not believe that Heidi's behaviour would have changed in a secure welfare unit and it would most likely have deteriorated again as soon as she was released. The question of how long to keep a child in a secure unit was identified as a 'huge ethical and legal dilemma'. Dr McEvoy suggested that the notion of a secure unit may be superficially attractive however it was contended that the money would be far better invested into early intervention and therapeutic services. Dr McEvoy said in effect that *the real need is for therapeutic care services.* Indeed, Dr McEvoy expressed disappointment that therapeutic care and intervention for children under the guardianship of the Minister was not the focus of the Nyland Royal Commission. Dr McEvoy said there should be a better placement/therapeutic model for children who are dysregulated and traumatised. It must have the capacity to keep them safe without 'rely[ing] on them being locked up'. It was recommended that the model be placed under the governance of the DCPs in partnership with health. (emphasis added)

14.37. In summary, *Dr McEvoy said money needed to be quarantined to develop a therapeutic care model in South Australia with a parallel assessment being undertaken by a health economist as to potential health cost savings*.[373] (emphasis added)

14.38. Is there a need to develop a new therapeutic care model in South Australia?

14.39. Mr Keane submitted that in light of the changes that have already been made, there is no reason to think Heidi's case would not be identified at an early stage. That may well be so. I accept that the initiatives that have already been implemented are steps forward. That said, the fact remains that several key proposals have not been commenced (eg. a centralised triage service and the establishment of an Interagency Therapeutic Needs Assessment Panel).

14.40. It will be recalled that Nyland Royal Commission recommended the establishment of a secure facility, a recommendation with which Dr Caunt agreed. I have considered the Commission's findings and the recommendation along with the views expressed by Dr Caunt and Dr McEvoy. On balance, **I am not persuaded** that the establishment of a secure therapeutic facility in South Australia is the best way forward to address the needs of behaviourally disordered adolescents. **I am persuaded** that an urgent need exists to develop a new Therapeutic Model of Care in South Australia with immediate focus on the needs of children who are in the interim care or guardianship of the Minister.

14.41. In the meantime, the reality is that such children will continue to be placed in commercial care arrangements and in Emergency Care. There will no doubt be children like Heidi who will need skilled therapeutic support. It is the responsibility of government to provide it.

14.42. In short, while it is accepted that some positive changes have been implemented within CAMHS and other proposals are planned in the future, I consider it necessary to exercise a degree of caution about the adequacy of the current measures and whether they will be enough to reduce or prevent the likelihood of another tragedy such as the one that has been the subject of this inquest. This conclusion is reinforced by the fact

[373] Transcript, pages 1794, 1855-1856

that many of the recommendations of the Royal Commission which are relevant to the issues arising in this inquest are yet to be developed and/or implemented.

15. Evidence of Claire Rachel Simmons (Acting Director, Child Protection Services)

15.1. Ms Simmons is a clinical psychologist. She graduated from the University of Adelaide in 1997 with a Masters in Clinical Psychology. At the time of giving evidence, Ms Simmons was the Acting Director of Quality and Practice at the Department for Child Protection. Prior to that role she was a Principal Clinical Psychologist with the DCP.[374] A statement was provided to the Court and Ms Simmons gave oral evidence at the inquest.[375]

15.2. In her current role, Ms Simmons is responsible for providing practice support to the DCP field as well as implementation of practice improvement initiatives. The role oversees the business units located in the Directorate.[376] Ms Simmons had no direct role in Heidi's case. Her evidence was directed at issues of policy and procedure relevant to interagency workings between DCP and CAMHS.[377] It also addressed care facilities for adolescents, commercial care, kinship care and informal care arrangements along with suicide and self-harm procedures.[378]

15.3. Many of these issues have already been discussed during this finding. Ms Simmons' evidence assisted the Court to better understand the evidence that had been given by various witnesses on a range of topics. Except for one area, it is unnecessary to canvass the evidence in any detail for the purpose of this finding. Suffice it to say that I have had regard to the evidence of Ms Simmons for the purpose of making findings and recommendations.[379]

15.4. Ms Simmons' evidence addressed aspects of commercial care. Although it is the process of being phased out, the reality is that it will take some time because of the number of children who are in care. Ms Simmons estimated that around 90-95 children in South Australia remain in commercial care arrangements. She said 'small numbers' of these children *could remain in such care for extended periods of time, even several*

[374] Exhibit C43, [1]-[2]; Transcript, page 1872
[375] Exhibit C 43; Transcript, pages 1871-1935
[376] Exhibit C43, [3]
[377] Exhibit C43 at [5]-[8]; Transcript, page 1876
[378] Exhibit C43 at [9]-[38]
[379] Exhibit C43 at [5]-[38]; Transcript, page 1873

years. Ms Simmons described them as 'stuck there' while efforts are made to find a much more suitable placement option. (emphasis added)

15.5. In Heidi' case, Ms Simmons agreed that the emergency placement was unsatisfactory. She candidly stated that commercial care is '*unfortunately an option of last resort and I certainly am not going to give evidence that it's meeting children's needs*'.[380] HenderCare staff were not considered sufficiently trained to deal with Heidi's complex needs, although Ms Simmons added that even if the facility was staffed 24/7 with psychologists there would still be difficulties meeting the therapeutic needs of these children. Their needs were described as 'astronomical'. (emphasis added)

15.6. Ms Simmons referred also to a reshaping of residential care which comprised the closing down of larger facilities, building of others and a restructuring of facilities so that wings are smaller. That said, Ms Simmons acknowledged that children who are placed in commercial care, including CRC, are often incredibly traumatised and vulnerable which leads to dysfunctional and harmful behaviour. Ms Simmons agreed with Dr McEvoy that there is a need for emphasis on early intervention:

> '…with all that I know about trauma and brain development and child development if you intervene earlier you have a much greater success of a positive outcome than you do with an older child who has set patterns and vulnerabilities that are sometimes a decade in the making, and there is no quick fix for that, you are trying to undo what the environment has done to that child over a long period of time.[381]

16. Summary

16.1. I do not propose to repeat the specific findings that I have set out during this inquest finding. Those findings speak for themselves.[382]

16.2. Heidi Singh started life in the most difficult of circumstances. A few days after her birth she was relinquished by her biological Aboriginal mother into the informal care of a Caucasian couple, Mr and Mrs Flink. At the age of 3 years Heidi was diagnosed with Foetal Alcohol Syndrome Disorder (FasD). By the time she was 13 years old both of her parental figures had died and Heidi had been abandoned by all subsequent carers. Her biological mother had also died.

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[380] Transcript, pages 1919-1921, 1923, 1925-126
[381] Transcript, page 1928
[382] See pages 32-34, 38-39, 41, 49-50, 57-58, 64, 73-74 and 87-88

16.3. Not surprisingly, Heidi exhibited behavioural problems from an early age. She was only 6½ years old when prescription medication was commenced to manage her behaviour. By the time Heidi was 11 years old, the CAMHS Aboriginal Service was involved. However, pharmacological and CAMHS intervention did little to address the underlying causes of Heidi's distress or to change her maladaptive behaviours.

16.4. At the age of 14 years, Heidi was placed into the interim custody of the Minister (on 3 June 2014). At this time, it would be fair to describe Heidi as lost, traumatised and in desperate need of a nurturing foster care placement or, if that could not be provided, a safe and stable placement with access to skilled therapeutic support.[383]

16.5. Despite some efforts being made to reconnect Heidi with kin and extended family networks, no caregivers were found. Heidi spent the last few months of her life living alone in a strange environment with care provided by rotating contracted commercial carers.

16.6. Heidi frequently absconded from the emergency placement. She often placed herself and others at risk of significant harm. Some HenderCare carers went to work in fear for their own safety. They did their best to manage Heidi, however, the carers did not have the training, skills or experience to manage a child with such complex needs. As I have said, that is not a failing of those particular individuals. Rather, it reflects the system within which they operated. On many occasions, the HenderCare carers had no choice but rely on South Australia Police and the South Australia Ambulance Service to manage Heidi's behaviour and convey her to hospital when things were out of control. Medical and health professionals managed the acute crises in EDs and during hospital admissions. Heidi also spent time in the WCH secure Boylan Ward. It is of course not possible for this inquest to quantify the cost to the community of these services. Such an analysis would require the services of a health economist. Common sense would suggest that the costs must have been astronomical. Notwithstanding these interventions, the evidence presented in this inquest has demonstrated that there was no discernible improvement in Heidi's behaviour or mental state.

16.7. These findings did not examine in any detail the assessments and decisions that were made during the ED presentations and hospital admissions. That was not a deliberate

[383] Transcript, pages 1961-1962

oversight. During submissions, various criticisms were made about aspects of these assessments. In my view, it is artificial to isolate and criticise the decision of any single clinician, nurse and/or other health professional at one narrow point in time. Such professionals are required to operate in busy EDs and, in this case, they were required to manage acute crises without the assistance of a clearly articulated crisis/safety management plan. **I find** no basis to criticise the medical assessments of Heidi on these occasions and/or any decisions that were made to discharge Heidi into the care of her various carers, including HenderCare.

16.8. This inquest has exposed the 'silo' driven approach that existed within the lead agencies such as CAMHS, Families SA and others who were involved in Heidi Singh's care. There was a distinct lack of collaboration. The schools focused on Heidi's welfare in the educational context. EDs focused on acute mental health concerns. The CAMHS social worker focused on providing a supporting role and general counselling. The CAMHS psychiatric consultant focused on periodic reviews without any ongoing role in care (noting that the CAMHS model neither supported nor facilitated such engagement). The paediatrician focused on pharmacological management without liaison with other clinicians who were also prescribing medication. There was no clarification between them about who carried primary responsibility for overseeing Heidi's medication regime. Families SA focused on short term harm minimisation strategies and, to use the words of the Families SA consultant psychologist, 'keeping Heidi alive'. Multi-agency meetings were held. Internal memorandums were prepared. Voluminous e-mails were exchanged. Hours of time was spent talking about 'the problem'. During this hive of activity very little changed for Heidi. She remained living in a placement that was neither safe nor stable and which did not provide access to skilled therapeutic support.

16.9. In a nutshell, the team which was primarily responsible for Heidi's day to day care was left with no choice but to manage her needs, as best they could, in a setting which many of them considered to be unsafe.

16.10. Families SA social worker, Ms Frangiosa, warned departmental heads on two occasions that Heidi was unsafe. Urgent removal from Emergency Care was recommended to protect Heidi's immediate safety. The second warning was given three days before Heidi's death. Yet nothing changed.

16.11. There has been a CAMHS review. Steps have been taken to restructure the organisation to allow for early identification and clinical oversight of cases such as Heidi's. A range of initiatives have been commenced. Others are still in the planning phase. The present direction is towards a much higher level of clinician oversight with the long-term goal of creating a true interagency therapeutic services system (at least in respect of GOM children). These are commendable long-term aims, however, as I have stated, a whole scale paradigm shift, political will and a significant injection of funds would be required from government in circumstances where no additional funding has been provided even for the relatively modest proposals arising from the CAMHS restructure. Those initiatives must be achieved within current budgets. So, while the CAMHS initiatives are welcomed, one must exercise a degree of caution in assessing or predicting whether these steps will be enough to reduce or prevent the likelihood of another tragedy such as the death of Heidi Singh.

16.12. The Nyland Royal Commission concluded that under-investment over many years has hindered service provision in this area noting that little reliance has been placed on developing the evidence base for interventions and strategies. The child protection system itself was described as based on 'an outdated model'. A striking observation made by the Royal Commission was the 'yawning gap' between policy requirements and the day-to-day practice in many areas, along with the lack of investment in growing the knowledge base of the workforce tasked with managing this complex work.[384]

16.13. Many children remain in commercial care in South Australia. Plainly, there is still a serious shortage of foster carers and therapeutic foster carers. There is still a chronic shortage of child and adolescent psychiatrists. The challenge in reforming the system remains for current and successive governments.

16.14. In this case, a 14-year-old Aboriginal child died alone, without ever knowing her own culture and community. She languished in Emergency Care without the assistance of a dedicated team within Families SA to focus on Aboriginal children in State care and the Aboriginal Child Placement Principle. She died without the chance to be supported

[384] Child Protection Systems Royal Commission Report: Volume 1: Summary and Report (August 2016)

in her time of need by a loving foster family and without access to skilled therapeutic support. In my view, it is a deeply shameful situation.

16.15. Was Heidi Singh's death a preventable death?

16.16. The question of whether Heidi's death was preventable is a complex one. One could argue there were many opportunities for intervention which could potentially have prevented her death. The opportunities for intervention date back to early in her childhood and extend to the period during which Heidi was in the care of the Minister. The inherent complexity of this question can be demonstrated by posing the following questions:

16.16.1. If South Australia had a legislative system which required the identification of all children living in informal care arrangements and which delivered support programs, would this have changed the outcome for a child like Heidi?

16.16.2. If Heidi's informal carers had actively promoted reconnection with her Aboriginal kin and extended family networks would the course of Heidi's life have been different?

16.16.3. If CAMHS had recognised the need for the transfer of primary care to a psychiatrist and/or psychologist and regular therapy had been commenced, at least by 2013, would Heidi have been able to work through her losses and stabilise her behaviour?

16.16.4. If, at the intake stage, Families SA had made concerted efforts to investigate Heidi's potential links with the Varcoe family and the Ngarrindjeri Peoples, would a suitable caregiver have been located? Would Heidi have found a sense of belonging which operated as a protective factor?

16.16.5. If a nurturing foster family had been available on 3 June 2014, or soon thereafter, would the trajectory have changed?

16.16.6. If Heidi's case had been overseen by a clinician such as Dr Hooper would the outcome for Heidi have been different?

16.16.7. Given that Heidi had always lived in households with other children, would Heidi have been safer in Community Residential Care?

16.16.8. If South Australia had a secure therapeutic care facility in which Heidi could have been placed for stabilisation at times when her immediate safety was at risk, would she have been at less risk on discharge back into the community or Emergency Care?

16.16.9. If skilled therapeutic care had been provided at the emergency placement, could this initiative have prevented Heidi's death?

16.16.10. If the urgent psychiatric assessment requested by CPS on 27 June 2014 had occurred in a timely manner, could this have altered the outcome?

16.16.11. If Dr Hooper had been able to provide ongoing clinical care of Heidi from 30 July 2014 onwards, would Heidi still be here today?

16.16.12. If Dr Ford's proposed medication regime had been trialled in a secure setting for an extended period and then implemented in the community, could this have prevented Heidi's death or were her maladaptive behaviours of such long-standing duration that her risk-taking behaviour would have continued?

16.17. Such questions demonstrate the inherent complexity of the ultimate question of whether Heidi Singh's death was a preventable death. There is no simple answer. On the whole of the evidence and in light of Heidi's complex history, **I find it is not possible to conclude with any certainty whether Heidi's death was a preventable death**.

16.18. Was Heidi Singh's death the result of suicide or misadventure?

16.19. I should state at the outset that during this inquest an article which appeared on the ABC News website referred to the *suicide* of a 14-year-old girl.[385] That is an example of inaccurate media reporting. The question of whether the death was a suicide is for this Court to determine.

[385] Refer transcript, page 2006

16.20. This question is also a complex one. It is undisputed that Heidi had an interest in trains. She often went to the railway line and she had engaged in risky behaviour by 'playing chicken' on the tracks. It is also undisputed that, whilst in the care of Mrs Flink, Heidi had asked on more than once occasion what would happen if a train hit you, or words to that effect. Heidi also had a history of hospital admissions for self-harming and suicidal ideation, and she had been assessed as being at chronic risk of suicide. On the face of it, these matters would point towards her actions on 21 August 2014 being a suicide.

16.21. On the other hand, as pointed out by Dr Hooper, trains and risk-taking behaviour at train stations were not the sole or pervasive object that Heidi used when she was distressed. Heidi had taken overdoses of prescription medication, she engaged in head banging and had made threats of harm involving knives. On one occasion, it was reported that Heidi drank nail polish remover and Windex.[386] The evidence also established that, from a young age, Heidi had a strong affinity with heights, she was impulsive and showed no sense of danger.[387]

16.22. In resolving this difficult question, I have been assisted in particular by the evidence of Dr Hooper and Dr Caunt. The effect of Dr Caunt's evidence was that Heidi's developmental issues, her history of impulsive behaviour without regard to risks, along with her mental state on the evening of 21 August 2014, make it hard to conclude that on 21 August 2014 she made the connection between the pylon and the danger of electricity or that she acted with pre-mediation.[388] I agree.

16.23. Having considered the whole of the evidence, **I find** that when Heidi ran away from the placement on the evening of 21 August 2014, she was in a distressed and disassociated state. **I find** that Heidi ran to the railway line and, as she had done on so many previous occasions, she climbed to a high place for self-comfort. The other alternatives are that Heidi climbed the pole intending to jump to her death, or climbed it knowing that the pole was electrified. I consider both scenarios are implausible. **In the circumstances, I find that the cause of death by electrocution was accidental and that Heidi died as a result of misadventure**.

[386] See statement of Dr Hooper at pages 19-20
[387] See statement of Dr Hooper at pages 19-20
[388] Transcript, page 1473

17. Summary of Key findings

17.1. I do not intend to repeat all findings I have made throughout this inquest finding.[389] The **key findings** are as follows.

17.2. **I find** that CAMHS provided an inadequate level of service.

17.2.1. The so-called multidisciplinary team within the CAMHS Aboriginal Service was multi-disciplinary in name only.

17.2.2. CAMHS social worker, Ms Helen Wyld, essentially operated as a sole practitioner without supervision and oversight by a clinician such as consultant psychiatrist, Dr Hooper.

17.2.3. Ms Wyld continued to act as Heidi's sole therapist for an unduly long period of time. Undue reliance was placed on her own skills and therapies and insufficient weight on information that pointed to the need, at least by 2013, for a transfer of primary care to a psychologist and/or psychiatrist.

17.2.4. A comprehensive psychiatric and psychological assessment should have been undertaken at an early stage and Heidi's case ought to have been subject to psychiatric oversight by a suitably qualified clinician such as Dr Hooper.

17.2.5. A prolonged admission to the WCH Boylan Ward for a minimum of seven days for observation (as suggested by Dr Ford) and careful assessment was warranted. It would have provided an opportunity to trial medications and to develop a coordinated management and treatment plan.

17.2.6. CAMHS ought to have obtained consent from Heidi's carers to exchange information with Heidi's long-term paediatrician, Dr Lamb, and any other clinicians or health professionals who were involved in Heidi's ongoing care. The approach that was adopted by CAMHS was 'silo' driven.

[389] See pages 32-34, 38-39, 41, 49-50, 57-58, 64, 73-74, 87-88, 104-105

17.2.7. The flat CAMHS structure and the fact that Ms Wyld was expected to manage her own caseload (including complex cases such as Heidi's) without the benefit of clinician oversight, and with only periodic assistance from clinicians such as Dr Meredith and Dr Hooper, was a significant contributing factor to the deficiencies I have identified.

17.3. **I find** that Heidi did not receive an adequate level of care and protection whilst in the interim custody of and under the guardianship of the Minister.

17.3.1. A severe shortage of foster carers in South Australia resulted in Heidi Singh being placed in Emergency Care.

17.3.2. It was a form of care which could not meet Heidi's complex needs.

17.3.3. The carers who were contracted to provide care by Families SA did not have an adequate level of training, skills or experience to manage a child with such complex needs.

17.3.4. The Families SA departmental consultant psychologist did not have the confidence and/or experience to provide direction on a case of this complexity. The short-term harm minimisation strategies that were provided by Ms Hayter (to assist the HenderCare carers) were sound in principle but they could not address the glaring problem, namely, the inherent unsuitability of Emergency Care for Heidi Singh and the inability of Families SA to provide a suitable alternative.

17.3.5. The Psychological Services Division should have independently assessed the 'therapy' that was being provided by CAMHS social worker, Ms Wyld, and, if necessary, recommended a different approach. A fresh baseline psychological assessment should also have been undertaken. Neither of these steps were taken.

17.3.6. In terms of familial connections, Families SA had no dedicated unit for investigating potential kinship connections (as identified by the Kinship Care Team). Nor did it have any separate unit which focused on investigating

Aboriginal kinship connections. Given the fundamental importance of the Aboriginal Child Placement Principle **I find** that was a significant failing in the governance structure of Families SA.

17.3.7. The critical task of identifying kinship networks was relegated to busy Families SA social workers who were juggling large caseloads and other competing demands on their time.

17.3.8. Heidi's potential links with the Varcoe family, the possibility that Alex Varcoe was her biological father and her potential family ties with the Ngarrindjeri Peoples of South Australia on her mother's side were never investigated.

17.3.9. On 21 July 2014, Families SA ought to have made an urgent application to the Youth Court to re-open the case, rescind the guardianship order and adjourn the matter pending an investigation into Heidi's familial connections with the Ngarrindjeri Peoples.

17.3.10. Families SA social worker, Ms Gabriella Frangiosa, warned departmental executives in writing, on two occasions, that Heidi **was not safe at the emergency placement**. The second warning occurred only **three days before Heidi's death** (18 August 2014). The warnings fell on deaf ears.

17.3.11. Those who were primarily responsible for Heidi's day to day care were left with no option but to manage, as best they could, in a setting that was neither stable nor suited to meet the complex needs of this child.

17.3.12. There was an air of resignation within Families SA about the inability of the department to provide any suitable alternative.

17.3.13. In short, ***Families SA was unable to provide safe and stable accommodation and/or therapeutic care to a vulnerable 14-year-old Aboriginal child who was under the guardianship of the Minister at the time of her death*.**

17.4. In relation to Heidi's medical management by clinicians and other health professionals, **I make the following findings**:

17.4.1. There is no basis to criticise the care provided by paediatrician, Dr Christopher Lamb.

17.4.2. There is no basis to criticise Dr Hooper's medical management of Heidi, particularly in light of the flawed CAMHS structure within which he operated.

17.4.3. There is no basis to criticise the medical assessments conducted by Dr Batterham.

17.4.4. In relation to the multiple hospital presentations, it is artificial to isolate and criticise the decision of any single clinician, nurse and/or other health professional at one narrow point in time. Such professionals are required to operate in busy EDs and, in this case, they were required to manage acute crises without the assistance of a clearly articulated crisis/safety management plan. **I find** no basis to criticise the medical assessments of Heidi on these occasions and/or any decisions that were made to discharge Heidi into the care of her various carers, including HenderCare.

17.4.5. There is no basis to criticise the mental health assessments conducted by Ms Bailey or her recommendation on 20 August 2014 for Heidi's discharge into the care of HenderCare.

17.5. In relation to HenderCare **I make the following findings**:

17.5.1. **I find** no basis to criticise any individual HenderCare carer. They acted diligently, in good faith and to the best of their ability in difficult circumstances.

17.5.2. The communication protocols adopted by HenderCare did not promote efficient and formalised communication and lacked mechanisms to ensure that information and directions were fully understood and consistently applied by the carers.

17.6. In relation to the **establishment of a secure therapeutic facility in South Australia** I find myself in disagreement with the recommendation of the Nyland Royal Commission to establish such a facility in South Australia. I am not persuaded that this is the best way forward to address the needs of behaviourally disordered adolescents including those who are under the guardianship of the Minister.

17.7. There is an urgent need to fund and develop **a new Therapeutic Model of Care** in South Australia with immediate focus on the needs of children who are in the interim care or guardianship of the Minister.

17.8. In the meantime, Families SA must develop the capacity to provide skilled carers and skilled therapeutic support for children who remain in commercial care arrangements.

17.9. In relation to the Heidi's conduct on 21 August 2014 **I make the following findings**:

17.9.1. On 21 August 2014 Heidi ran from the placement in a distressed and dissociated state. She climbed an electrified pole at a nearby railway station.

17.9.2. **I find** that Heidi's death was not a suicide. The death by electrocution was accidental and a result of misadventure.

17.9.3. **I find** it is not possible to conclude with any level of certainty whether Heidi's death was a preventable death.

18. Recommendations

18.1. Pursuant to section 25(2) of the Coroner's Act 2003 my primary task is to make factual findings and, if appropriate, to make recommendations that, in the opinion of the Court, might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the inquest. Commentary is necessarily limited. However, in the case of Heidi Singh, I feel compelled to repeat that ***the primary agency charged with responsibility for child protection in South Australia was unable to provide a safe and stable placement to a traumatised and vulnerable 14-year-old Aboriginal girl who was under the guardianship of the Minister. Nor was it able to deliver the skilled care and therapeutic support that she needed.***

18.2. In 2016, the Nyland Royal Commission pointed *to under-investment over many years as a key factor that has hindered service provision in the area of child protection.* The system itself was described as based on 'an outdated model'. A key observation made by the Royal Commission was the 'yawning gap' between policy requirements and the day-to-day practice in many areas, along with the lack of investment in growing the knowledge base of the workforce tasked with managing this complex work.

18.3. There is no doubt there is serious competition for scarce financial resources in this sector. That said, there must be a better way and, dare I suggest, possibly a cheaper way to manage the needs of such children. I suspect that the answer lies in a wholescale paradigm shift, the abandonment of outdated models of care, early intervention programs and a significant financial investment in a new Therapeutic Model of Care.

18.4. I make the following **recommendations** directed to the Attorney-General, the Minister for Child Protection, the Minister for Health and Wellbeing, the Minister for Human Services and the Minister for Education:

18.4.1. I **recommend** that a sum of money be quarantined to develop a new Therapeutic Care Model in South Australia to be applied in the first instance in respect of children who are under the interim care and/or guardianship of the Minister.

18.4.2. I **recommend** that a parallel assessment be undertaken by a health economist as to potential health cost savings of a new model of care.

18.4.3. I repeat the **recommendations** made by the former State Coroner Mark Johns and Deputy State Coroner Anthony Schapel in 2014 calling for a substantial increase in the number of child and adolescent psychiatrists within CAMHS.

18.4.4. With the exception of the recommendation directed at the establishment of a secure care facility in South Australia, I **recommend** full implementation of the recommendations made by the Nyland Royal Commission which pertain to matters relating to this inquest and, in particular, those directed at Kinship Care and promotion of the Aboriginal Child Placement Principle, phasing out the use of commercial carers in any rotational care arrangement except in genuine short-term emergencies, ongoing professional development of child

and youth support workers, the establishment of a centralised CAMHS triage services.

18.4.5. In particular, I recommend urgent implementation of the Therapeutic Needs Assessment Panel along with the recruitment of new foster carers and therapeutic foster carers.

Key Words: Families SA; Guardianship of the Minister; CAMHS; Child Protection;

In witness whereof the said Coroner has hereunto set and subscribed her hand and Seal the 14th day of November 2019.

Deputy State Coroner

inquest Number 6/2017 (1447/2014)

APPENDIX A

Date	Event	Reference
24/06/00	**Heidi is born at RAH** Heidi is placed into the informal care of Lyn & Wolter Flink	C26, pages 97, 317-350
31/10/06	Dr Dowell (GP) refers Heidi to Dr Christopher Lamb (paediatrician) to assess school issues, anxiety, absconding and behavioural problems	C28, page 158
18/01/07	Dr Lamb's first consultation with Heidi aged 6½ years	C27, page 85 C24, page 275
25/12/08	**Wolter Flink dies** Lyn Flink assumes sole care of Heidi aged 8 years	
22/08/11	CAMHS-Ngartunna Patpangga Service (CAMHS Aboriginal Service) accepts a referral from Mrs Flink	C21e, page 42
01/09/11	**Heidi and Lyn Flink commence regular sessions with CAMHS social worker, Ms Helen Wyld**	
01/10/11	Heidi spends time with her biological mother and is reported to experience anxiety leading to ED presentation at the Women's and Children's Hospital ('WCH')	C26, page 286
On or about 27/11/11	**Heidi's biological mother dies of a drug overdose**	C21e, page 25
29/10/12	First appointment with CAMHS psychiatrist, Dr Ken Hooper	
07/04/13	**Lyn Flink dies**. Heidi is aged 12 years (almost 13 years). Alina Flink assumes informal care of Heidi with the knowledge of Families SA	
08/04/13	Heidi is taken to the ED of WCH after a violent outburst at school with reports of aggression towards other students and threatened self-harm with scissors	C26, page 18 C21e, page 43
09/04/13	CAMHS psychiatrist, Dr Hooper, conducts first review on referral from Ms Wyld	C25, page 58
06/06/13	Heidi absconds. Missing Person Report filed. Heidi is returned by police at 2am with reports that she is hearing voices and talking of self-harm	
06/06/13	CAMHS psychiatrist, Dr Hooper, conducts second review on referral from Ms Wyld	

Date	Event	Reference
10/06/13-11/06/13	Heidi is taken to the ED of the Flinders Medical Centre ('FMC') after unusual behaviour in an IGA supermarket. A mental state examination is conducted by psychiatrist, Dr Batterham. Heidi is deemed safe for discharge to care of Alina Flink however Dr Batterham opines she 'will remain at chronic risk of emotional outbursts and suicidal ideation…' Discharged to carer Alina Flink	C24, pages 112-113Transcript, pages 304-307, 361-365, 395
11/06/13	Heidi is taken to the ED of WCH and admitted overnight after an aggressive outburst Discharged to carer Alina Flink	C26, pages 250, 260, 284 C22d, pages 44, 46, 56
20/07/13	Heidi is taken to the ED of the WCH after banging her head against a wall. Discharged to carer Alina Flink	C26, page 26 C28, page75
19/08/13	Heidi is located by police at a bus stop self-harming by scratching wrist and hallucinations. She is taken to the ED of the WCH and subsequently discharged to carer Alina Flink	C26, page34 C28, page73
20/08/13	Heidi is D of the WCH and subsequently discharged to carer Alina Flink	C26, page p36 C21e, page 43
26/08/13-29/08/13	Heidi has a three day planned admission to WCH Boylan Ward. Discharged to carer Alina Flink	C26, page193
04/09/13	CAMHS psychiatrist, Dr Hooper, conducts third review on referral from Ms Wyld	C26, pages 77,80 C28, page72.
18/09/13	Heidi is located by police on roadside cutting arm with a knife on a background of reports of frequent head butting on a wall. Taken to the ED of the WCH and subsequently discharged to carer Alina Flink	C26, page 41
22/09/13-23/09/13	Heidi is presented to the ED of the WCH and admitted overnight with suspected quetiapine overdose. Discharged to carer Alina Flink	C26, pages 56, 142, 144, 151, 155, 159 C22d, page 105
23/09/13	Heidi is presented to the ED of the WCH after an altercation with a child. Subsequently discharged to carer Alina Flink	C21e, page 43
03/10/13-04/10/13	Heidi is presented to the ED of the WCH and admitted overnight after alleged assault of another student, absconding to a train station, standing behind a truck and threatening suicide. Transferred to Boylan Ward **Alina Flink declines to receive Heidi back into her care**	C21e, pages 43-44 C28, page 65 C26 pages 102, 106, 113-4, 122, 135-141

Date	Event	Reference
04/10/13	**Alina Flink relinquishes informal care of Heidi** to family friends, Ms Malby and Mr Lane. Heidi commences living with Ms Malby and Mr Lane	
15/10/13	Families SA conduct a home visit. Message left for Catherine and/or Jason to call. Call returned with confirmation that Heidi is in their care	C22d, page 154 C22d, pages 157, 163
14/11/13	Heidi is taken to the ED of WCH after reports of banging head on a protruding nail at school, expressing suicidal ideation, reported delusions. Subsequently discharged to her new carers	C26a, pages 49, 51, 131-132 C28, page 63 C21e, page 43
19/11/13	Heidi is excluded from school for remainder of term	C 25, page 203
03/02/14	CAMHS psychiatrist, Dr Hooper, conducts fourth review on referral from Ms Wyld	C21e, page 44
31/05/14-01/06/14	Heidi is taken to FMC and admitted overnight for Tramadol toxicity. Discharged into care of new carers	C24, pages 48, 285-287 C28, page 59 C21e, page 44
03/06/14	**Ms Malby and Mr Lane relinquish care of Heidi to Families SA** **Heidi is placed in the interim custody of the Minister**	
04/06/14	**Youth Court grants Interim Investigation and Assessment order** pursuant to s20 *Childrens Protection Act, 1993 (SA)* - 7 day order to 11 June 2014	C21e, page 59 C22e, pages 87-89
11/06/14	**Youth Court grants further Investigation and Assessment order -** 42 day order to 22 July 2014	C21e page 29 C22e, page116
16/06/14	**Critical Incident Report (CIR).** Heidi is taken to the ED of the WCH after school incident, reports of hitting head with fist and wall, cutting herself, suicidal ideation. Assessed and discharged to HenderCare	C26a, pages 56-63 C22e, pages 140, 147-148
18/06/14	**Further CIR filed**	
26/06/14	Comprehensive medical assessment undertaken by FMC Child Protection Service (CPS). **CPS request urgent psychiatric assessment to be undertaken by CAMHS**	C24a, page 68
27/06/14	Heidi is presented to ED of the WCH Discharged to HenderCare	C24a

Date	Event	Reference
01/07/14	Further CIR filed	
04/07/14	**Critical Incident Report**: Heidi absconds from HenderCare. Located by police at 12:10am at Aldinga Shopping Centre and returned to the emergency placement	C21e, pages 32, 245
05/07/14	**Critical Incident Report:** Heidi absconds from HenderCare placement through bedroom window	C21e, pages 32, C22e, pages 256-257
06/07/14	**Critical Incident Report**: Heidi barricades herself in bedroom and then absconds from placement	C21e, pages 32, 261, 265
16/07/14- 21/07/14	**Critical Incident Reports (2)** Heidi is presented to the ED of the WCH and admitted for 5 nights due to quetiapine overdose. Dr Batterham is the on duty psychiatrist	C22e, pages 306, 311 C24, pages 277-278
21/07/14	Heidi is discharged into care of HenderCare **Youth Court grants Care & Protection Order. Heidi is placed into the care of the Minister until the age of 18** years (GOM 18)	C24, page10
23/07/14	**Critical Incident Reports (2).** Heidi is presented to the ED of the WCH after allegedly pushing a carer and hitting another carer across the head with a stainless steel kettle, theft of prescription medication and absconding from placement. Subsequently discharged to care of HenderCare	C26a, page 64 C28, pages 48-49
26/07/14	**Critical Incident Report.** Heidi is presented to the ED of the WCH after an angry outburst, hitting head on wall, alleged property damage, self-harm threats and attempted access to medication in a carer's bag. Subsequently discharged to care of HenderCare	C26a, pages 71-75
27/07/14- 28/07/14	**Critical Incident Report.** Heidi is presented to the ED of the WCH after an aggressive outburst and agitation along with self-harming behaviour - admitted overnight. Discharged to care of HenderCare	C26a, pages 134, 143, 149, 152, 154 C28, page 43
30/07/14	**Final review conducted by CAMHS psychiatrist, Dr Hooper**	
31/07/14	Dr Hooper provides written recommendations to Ms Wyld by e-mail about changes to Heidi's management in the emergency placement	C25, page 97
03/08/14	**Critical Incident Report.** Heidi is presented to the ED of the WCH with suicidal ideation. Subsequently discharged to care of HenderCare	C26a, pages 79, 86-87 C28, page 40

Date	Event	Reference
06/08/14	Heidi is under consideration for transfer to Onkaparinga CAMHS	C21a, page 108, 132
08/08/14	**Critical Incident Report.** Heidi absconds and is located by SAPOL with reported visual and auditory hallucinations telling her to self-harm. She is taken to the ED of the WCH and assessed by Dr Yanni. Subsequently discharged to care of HenderCare	C26a, pages 92, 116-120 C28, page 38 C26a, page 99
16/08/14	**Critical Incident Report.** Heidi is taken to the ED of the WCH. Subsequently discharged to care of HenderCare	C26a, page100
20/08/14	**Critical Incident Report.** Heidi is presented to the ED of the WCH after a fight at school. Staff report that Heidi jumped off a tree and expressed a wish to run on train tracks (train was shut down) Subsequently discharged to HenderCare	C26a, pages 104, 108
21/08/14	**Date of Heidi's death**	