CORONERS ACT, 2003

SOUTH  *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 1st, 2nd, 3rd, 4th, 8th, 10th, 11th and 30th days of November and the 17th, 20th and 21st days of December 2021, the 12 day of January, the 7th, 28th, 29th and 30th days of March, the 14th day of April and the 31st of May 2022 and the 6th day of April 2023, by the Coroner's Court of the said State, constituted of David Richard Latimer Whittle, State Coroner, *into the death of Zhane Andrew Keith Chilcott.*

The Court finds that Zhane Andrew Keith Chilcott aged 13 years, late of 94 Marston Drive, Morphett Vale, South Australia died at Morphett Vale, South Australia on the 12 day of July 2016 as a result of hanging. The Court finds that the circumstances of his death were as follows:

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'*Zhane was, by all accounts, a very caring and extremely likeable young man who had a big impact on those who knew him. He was described as having a 'wonderful sense of humour', having 'lots of character', being 'warm and kind' and 'a very charismatic boy who could lift your mood with a smile.*'[1]

1. Introduction and cause of death

1.1. Zhane Andrew Keith Chilcott was born on 20 June 2003. Zhane was the biological child of Mr Keith Ronald Chilcott-Sing Poo and Ms Ursula Marie Stier. Ms Stier identifies as Aboriginal, and Mr Chilcott-Sing Poo identifies as being of Aboriginal and Malaysian descent.

1.2. Ms Stier and Mr Chilcott-Sing Poo had four older children together[2] but separated around the time Zhane was born.[3]

1.3. Zhane was a brother to Graham, Adrian, Tanisha and Nikita and a half-brother to Leigh Stier.

1.4. Zhane entered state care as an infant at 10 months of age and at the time of his death was to remain under guardianship of the Minister until 18 years of age. Between entering care in April 2004 and his death, he had 18 different placements in varied locations within South Australia.

1.5. Zhane had resided in the Morphett Vale Community Unit (MVCU) - a Department[4] residential care facility - since November 2015, with eight other teenaged males who were also under guardianship of the Minister.

1.6. Zhane loved football, cooking, Lego and his teddy bears. He wanted to join the Army when he was older.[5] Zhane had just turned 13 years of age when he took his life at the MVCU on 12 July 2016.

1.7. Zhane's cause of death was hanging.[6]

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[1] Exhibit C43, Independent Review by Anne Nicolaou, page 3
[2] Graham Chilcott (DOB 13/04/1998), Adrian Chilcott (DOB 20/04/2000), Tanisha Chilcott (DOB 29/03/2001), and Nikita Chilcott (DOB 01/03/2002) - Ms Stier is also the mother of Leigh Stier (DOB 13/02/1996)
[3] Exhibit C41, Annexure SM1 'Interagency Review', page 26 (Attachment 1, Genogram)
[4] References in this finding to the Department are to the Department for Child Protection or its predecessor, Families SA
[5] Exhibit C67
[6] Exhibit C2

1.8. The death of one so young is always a tragedy and Zhane's death was particularly so for his family, for Stephen Rimes who Zhane considered to be his 'forever father', and for all those who were involved in Zhane's care.

2. The events of 12 July 2016, the day of Zhane's death

2.1. In July 2016 Zhane was in Year 7 at Hackham West Primary. On 12 July, during school holidays, Zhane and another MVCU resident were taken to Inflatable World during the day. Due to some bad behaviour, including aggression and failure to follow instructions, staff imposed a consequence of an early bedtime for Zhane, being the non-holiday time of 8:30pm with lights out at 9:30pm.

2.2. After Inflatable World, Zhane spent most of the afternoon at the MVCU playing Xbox, and in the evening he spent some time playing outside. At about 7:15pm he asked to call his mother.

2.3. Contact with his birth mother had only been reinitiated some days before, when she sent him (via his caseworker) a package with a letter and a mobile phone. Prior to 12 July 2016 he had made three calls to his mother from this phone.

2.4. Staff attempted to call his mother at about 7:15pm on the evening of 12 July 2016 but the call went unanswered. Zhane went back outside for some time, then went inside, had some dessert and watched TV.

2.5. At approximately 8:30pm Zhane asked to call his mother again. When he was denied the call, as it was his bedtime, he became upset, arguing and being physically aggressive with staff.

2.6. He was physically removed from a couch by two MVCU workers and taken to his room. In the course of being moved to his room Zhane slipped and fell, and the two workers then held his wrists onto the ground for some time so that he could not hit them. The appropriateness of the physical restraint used on Zhane on this evening was not specifically examined during the inquest, and on the basis of child and adolescent psychiatrist Dr Julie Nadine Caunt's assessment of this that '*from the accounts of staff, it seems as though they felt that physical intervention was the appropriate course of action to contain Zhane's behaviour and their accounts do not suggest excessive*

force',[7] I make no criticisms of those involved in these interactions with Zhane on this evening.

2.7. Throughout this episode and while being restrained by his wrists, Zhane was screaming that he wanted to call his mother, and said words to the effect of:

> 'It's all your fault I am not with my mum. Families SA took us kids away from her.' [8]

2.8. Zhane calmed down and eventually asked for some paper and pencils, which he was given. By about 9:15pm Zhane was calm and reportedly showing remorse over the incident.

2.9. Zhane was last seen alive at about 9:50pm when he came out for some water. By 10:20pm when a night shift staff member commenced his shift and conducted a room check on Zhane, he was hanging in his wardrobe by an electrical cord from the TV in his room.[9] Other staff members were alerted, Zhane was cut down and emergency services were contacted. CPR was attempted, but Zhane was deceased.

2.10. A handwritten note was located on Zhane's bed. The note read:

> 'I don't want to be in care. I want to be with you, mum. I always thought of what it would be like if I lived with you and my sisters, always there when I wake up and to say, 'Good morning, mum' and 'Goodnight, mum'. My mum, it's not your fault I did this, it's my choice. You will always be in my heart. I love you, and goodbye.'[10]

2.11. A review conducted jointly by the Department and SA Health post Zhane's death concluded that it was not certain whether Zhane's death was suicide or accidental, given that on two previous occasions he had choked himself without apparent suicidal intent.

2.12. I do not agree with that assessment. I find that Zhane wrote his note shortly before he intentionally suspended himself from his bedroom wardrobe railing by his neck, using an electrical cord he obtained from within his room, intending to end his own life.

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[7] Exhibit C47, page 34
[8] Exhibit C24
[9] Exhibit C23
[10] Exhibit C18a, page 9

3. Issues examined at inquest

3.1. An inquest was held to ascertain the cause and circumstances of Zhane's death.[11]

3.2. The Coroners Court may add to its findings any recommendations that might prevent, or reduce the likelihood of, a recurrence of a similar event. It may also make a recommendation relating to matters arising from the inquest, including, relevantly in this case, the quality of care, treatment and supervision of Zhane prior to his death.[12]

3.3. One of the circumstances of Zhane's death was that he was under guardianship of the Minister[13] pursuant to orders of the Youth Court made under the *Children's Protection Act 1993*. That Act was repealed (in relevant part) on 19 December 2017 and replaced by the *Children and Young People (Safety) Act 2017*, which introduced 'guardianship of the Chief Executive (of the Department for Child Protection)' in place of 'guardianship of the Minister'. Children and young people under previous orders for 'guardianship of the Minister' were thereafter taken to be under guardianship of the Chief Executive.[14] Throughout this Finding, where I use the term 'guardianship of the Minister', it shall also be taken to be a reference to guardianship of the Chief Executive.

3.4. Zhane entered state care as an infant. He was the subject of at least five child protection notifications between September 2003 and March 2004. The first intake related to Zhane (then aged three months) and his siblings being left home alone. SA Police attended the home, finding the children alone, and reported that the children and the home environment appeared neglected. Upon investigation by the Department, abuse and/or neglect were not confirmed. Six months later, similar concerns were reported and upon investigation the children were removed under Section 16 of the Children's Protection Act 1993 (SA) due to ongoing neglect. Following two 12-month orders in June 2004 and April 2005, Zhane was eventually placed under a long-term Care and Protection Order on 26 June 2006 having just turned three years of age.

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[11] Section 13, Coroners Act 2003

[12] Section 25, Coroners Act 2003

[13] The title of the responsible Minister changed from time to time. When Zhane was first placed under the guardianship of the Minister in 2004, the Minister responsible for the administration of the Children's Protection Act 1993 was the Minister for Families and Communities. In 2011 the Minister for Education and Child Development became the Minister responsible for the administration of the Children's Protection Act 1993. At the time of his death in 2016, Zhane was under guardianship of the then Minister for Education and Child Development.

[14] Pursuant to section 24, Children's Protection Law Reform (Transitional Arrangements and Related Amendments) Act 2017

3.5. In the report following the Child Protection Systems Royal Commission, 'The Life They Deserve', Commissioner Nyland made the following poignant observation:

> '*When the state obtains a long-term order taking a child into care it assumes the heavy burden of providing for the physical, emotional, psychological and developmental safety of that child over possibly many years. Children raised in these circumstances have a right to expect a high quality of care, including priority access to health and educational services, and a high level of attention to, and investment in, helping them to recover from the experiences that brought them into care. Families SA, the agency reporting to the Minister, is responsible for looking after these children and young people. It must meet their needs for a high standard of care and endeavour to ensure they benefit from a supportive environment and expert therapeutic support.*' [15]

3.6. This inquest examined Zhane's experience as a child under guardianship of the Minister for a period of almost 13 years, and the contribution of his experiences towards his untimely death by suicide

3.7. Four main periods of Zhane's life were examined: his time in a family-based placement with LB,[16] his many years in commercial care, his time in a family-based placement with Mr Stephen Rimes, and his time living in the MVCU in the months leading up to his death.

3.8. The examination of these periods of Zhane's life leads me to the conclusion that the Department failed - a number of times, in a number of ways, and over a number of years - to meet Zhane's needs for a high standard of care, a supportive environment and expert therapeutic support. I set out in this Finding my reasons for coming to this conclusion.

3.9. In discussing what I consider to be failings on the part of the Department, I do not overlook the efforts of those within the Department who advocated regularly for Zhane and showed immense dedication to his wellbeing. The evidence before me made plain that during his many years in state care there were many within his care teams who were fond of Zhane, who wanted the best for Zhane, and who did their best for Zhane. I acknowledge the impact that Zhane's death has had on many of those individuals.

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[15] The Life They Deserve – Child Protection Systems Royal Commission Report, The Hon Margaret Nyland AM, Commissioner, page 239

[16] Name suppressed

3.10. I also recognise that Zhane had experienced significant trauma as an infant, before he entered the care system. Dr Caunt gave evidence that the first two years of life are the strongest indicators '*for the outcomes for suicide in all mental health issues, it is one of the strongest predictors … that is our capacity to emotionally regulate*.'[17] However, Dr Caunt also gave evidence that the impact of those two years can be:

> '… moderated later on, but that that's a crucial point in our development, and just like any other development thing we missed out in our development it can be caught up with, and that's a very important first stage.' [18]

4. Changes following the Child Protection Systems Royal Commission

4.1. At the time with which this inquest is concerned, the Children's Protection Act 1993 was the legislation governing the care and protection of children in this State. Families SA (FSA) was the Department charged with delivering that care and protection.

4.2. 'The Life They Deserve' was published on 5 August 2016, less than a month after Zhane's death. It is an uncomfortable fact that at the time the Royal Commission was being conducted, Zhane was languishing in state care.

4.3. The report and its 260 recommendations set into motion a number of significant changes in child protection in South Australia. One of the most significant was that Families SA ceased to exist on 1 November 2016 and the new, stand-alone Department for Child Protection was created. The following year, the Children's Protection Act 1993 was superseded by the Children and Young People (Safety) Act 2017.

4.4. The Department has accepted or accepted in principle all but four of those recommendations. It has been submitted by Senior Counsel for the Department for Child Protection that it is now a very different place, with a very different culture and operates very differently to FSA.

4.5. It is not possible to say whether, if the changes that have resulted from the Royal Commission recommendations were in place in July 2016 or earlier, the tragic outcome of Zhane's death may have been avoided.

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[17] Transcript, page 778
[18] Transcript, page 778

5. Other reviews into the circumstances of Zhane's death

5.1. As well as 'The Life They Deserve', which analysed many of the issues facing children under guardianship of the Minister generally, after Zhane's death there were two other reviews conducted into circumstances surrounding his experiences under guardianship of the Minister.

5.2. The 'Interagency Review' was an 'adverse events review' and involved two agencies, the Department and SA Health. The purpose of the Interagency Review was to examine broad changes that could be made to the system for children and young people, particularly in residential care who had an experience of abuse in care.[19] The Interagency Review also made a number of recommendations, and I am told the Department has also acted on a number of those recommendations.

5.3. There was also a review undertaken by child protection consultant Ms Anne Nicolaou. Ms Nicolaou's review was commissioned by the then Chief Executive of the Department for Child Protection, Ms Cathy Taylor, in October 2017. The focus of this review was on the breakdown of Zhane's placement with Stephen Rimes. Ms Taylor's evidence was that she commissioned this review for a human resources purpose.

5.4. Each of these reviews was the subject of extensive evidence at this inquest. As with 'The Life They Deserve' report, although I cannot conclude whether the implementation of recommendations arising out of each of these reviews may have changed the outcome for Zhane, I recognise that these reviews represented a significant undertaking by the Department to analyse what led to this dire outcome for Zhane, motivated by a desire to prevent other children from suffering in some of the ways Zhane suffered. These reviews have been of significant assistance in this matter.

6. Witnesses and legal representatives

6.1. In addition to the many affidavits of witnesses to which I had regard, I heard oral evidence during the inquest from fourteen witnesses.

6.2. Ms Kara Savilla is a qualified psychologist who was formerly employed as a psychologist within the Department. She was sporadically engaged with Zhane and his care team from 2006 until shortly before his death.

[19] Transcript, page 295

6.3. At the time the inquest was heard, Ms Cathy Taylor was the Chief Executive of the Department. She was appointed to the role in October 2016 following a recommendation in 'The Life They Deserve'.

6.4. Ms Susan Macdonald is an Executive Director of the Department and was also employed within the Department at the time of Zhane's death. Ms Macdonald was responsible for coordinating the Interagency Review.

6.5. Dr Katy Osborne is a general medical practitioner with whom Zhane had a consultation two months prior to his death. Dr Osborne obtained her medical degree in the United Kingdom in 1999 and moved to Australia in 2015.

6.6. Dr Nadine Caunt is a child and adolescent psychiatrist who practises in Western Australia. She was engaged by the Coroners Court as an independent expert and provided a report for the purposes of the inquest following her review of the documentary evidence.

6.7. Dr Mohammad Usman is the Clinical Director of the Child and Adolescent Mental Health Service, which is provided through the Women's and Children's Health Network across South Australia.

6.8. Mr Stephen Rimes was a foster carer with Life Without Barriers (LWB) and cared for Zhane at his home in Caltowie between April 2014 and July 2015.

6.9. Ms Michelle Hopkins was employed as an Advocate at the Office of the Guardian for Children and Young People. She visited Zhane at the MVCU on 16 February 2016 and conversed with him on the telephone in May and June of 2016.

6.10. Ms Joanne Perry was employed as a Senior Youth Worker at the MVCU in the months leading up to and at the time of Zhane's death.

6.11. Mr Steven Weinert was employed as a Child Support Worker at the MVCU in the months leading up to and at the time of Zhane's death.

6.12. Ms Dianne Longman is a qualified social worker and was the Supervisor of the Port Pirie office of the Department in the months leading up to and at the time of Zhane's death. She was the supervisor of Zhane's case worker Mr Brian Verran.

6.13. Ms Janine Platt was the Supervisor of the Placement Services Unit (PSU) of the Department in 2016. The PSU was a state-wide service consisting of five social

workers and senior social workers. The role of the PSU was to receive all of the placement requests for the State in regard to children requiring respite or some form of alternative care.

6.14. Mr Martin Hinton QC is the Director of Public Prosecutions (SA). He gave evidence, based on his review of the relevant files, about the Witness Assistance Service (WAS) of the Office of the Director of Public Prosecutions, including the services it provides to alleged victims as a matter progresses through the court system, and what involvement the WAS had with Zhane.

6.15. Ms April Lawrie is the Commissioner for Aboriginal Children and Young People in South Australia.

6.16. With the leave of the Court, the following counsel appeared to represent witnesses and interested parties:

- Ms Bowering appeared with Mr Charles for the biological family of Zhane Chilcott;
- Mr Robertson SC appeared with Ms Gavranich for the Department for Child Protection, the Women's and Children's Health Network, Ms Taylor, Ms McDonald, Ms Savilla, Dr Usman, Ms Longman, Ms Platt, Ms Perry and Mr Weinert. They also represented Mr Brett Vayro and Mr Etienne Scheepers, who did not give evidence in person;
- Ms Cliff appeared for Dr Osborne;
- Mr Homburg appeared for Life Without Barriers.

6.17. Following the conclusion of the evidence in the inquest I received comprehensive and helpful written submissions from all counsel. The submissions of Mr Robertson SC and Ms Gavranich were identified as submissions on behalf of the 'Child Protection Respondents'. Where it is appropriate to identify their clients collectively, I have chosen to refer to them as the Government Agencies and Witnesses, to properly reflect that an inquest is not an adversarial proceeding with an applicant and respondent but, rather, is an inquiry by the Coroners Court directed towards determining the cause and circumstances of a death.

6.18. I turn now to consideration of Zhane's experiences under guardianship of the Minister from just 10 months of age.

7. Placement with LB

7.1. For the first nine months he was under the guardianship of the Minster, Zhane resided with AC and RR.[20] In March 2005, at the age of 22 months, he entered what was to become his longest family-based placement, with LB. This continued for more than six years, until he was almost nine.

7.2. LB was the daughter-in-law of AC and had known Zhane from the time he entered AC's care.

7.3. Sometime in mid-2004, LB undertook the carer screening process to become a foster carer. This process noted the active involvement of her former partner PC in parenting the biological children of the family and occasionally staying over, despite the couple having separated in 1996.

7.4. On 20 September 2004, LB registered as a Family Based Carer to provide emergency care, and long-term and respite care.

7.5. On 14 March 2005 Zhane was placed in the care of LB, through Aboriginal Family Support Services (AFSS).[21] LB's ex-partner PC was Aboriginal and although he did not reside in the home, he visited regularly, and this was thought to afford Zhane some connection to his Aboriginal culture.

7.6. Four days prior to Zhane being placed with LB, a child protection notification had been raised regarding LB possibly physically abusing her biological son.[22] This was dealt with by way of invitation to a family meeting. When Families SA properly declined to disclose to LB details of the report and the identity of the notifier, LB did not attend, and the outcome was recorded as '*family meeting not attended*'.[23]

7.7. This notification should have caused FSA to have at least had some level of concern about LB's ability to care for a child, and especially a vulnerable child like Zhane. There was an opportunity for FSA to more closely scrutinise LB and her parenting practices before Zhane was placed. The Department, through Ms Sue Macdonald, has

[20] Names suppressed
[21] Exhibit C9, Appendix C
[22] Exhibit C25, pages 11-12
[23] Exhibit C25, page 12

conceded that this was an error, and that FSA should have conducted further assessment of LB's ability to engage with FSA and attend to the needs of children.[24]

7.8. In light of the allegations made by her son in the days leading up to Zhane's placement, I find that Zhane should not have been placed with LB without further scrutiny.

7.9. Zhane's first few years residing with LB were also met with inadequate scrutiny. FSA contact with Zhane was infrequent and irregular. Between 2005 and 2009 FSA conducted four home visits and contacted LB via telephone approximately ten times per year.[25] Telephone contact was usually in relation to access arrangements or financial reimbursements.[26] Based on that very limited contact, no conclusion can be drawn about the suitability of that placement in those first few years. What is clear is that during this period of time Zhane was '*relatively invisible*'[27] to the Department.

7.10. In 2008 when Zhane began pre-school, teaching staff observed social and emotional difficulties, including difficulty following and complying with instructions, leaving the classroom, taking things from other students, spitting and throwing objects, and displaying sexualised behaviours. LB stated she had not observed any of this behaviour at home.[28]

7.11. A psychological assessment took place in March 2008.[29] During that process Zhane attributed several negative emotions and experiences to LB's biological sons. Yet there was no enquiry by the Department (with Zhane or with LB) until 2010, regarding these concerns raised by Zhane about his foster brothers.[30]

7.12. In September 2010, a care concern was raised in relation to LB allegedly punching and kicking Zhane and putting pepper in his water. Also in this year, Zhane started to exhibit worrying sexual behaviours, and Child Abuse Report Line (CARL) notifications were raised regarding Zhane's sexualised behaviours in August 2010 and November 2010.[31]

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[24] Exhibit C41, paragraph 28, and Transcript, pages 310 and 344
[25] Exhibit C41, Annexure SM1 'Interagency Review', Appendix 1, Timeline 3
[26] Exhibit C41, Annexure SM1 'Interagency Review' at page 7
[27] Exhibit C41, Annexure SM1 'Interagency Review' at page 11
[28] Exhibit C41, Annexure SM1 'Interagency Review' at page 7
[29] Exhibit C10
[30] Exhibit C41, Annexure SM1 'Interagency Review' at page 7
[31] Exhibit C29f, page 331

7.13. Despite the concerns raised by the 2008 psychological assessment, and emerging concerning behaviours between 2008 and 2011, the Department only conducted three home visits to LB and contacted her via telephone approximately six times per year throughout 2008 to 2011.[32] That was despite the introduction of the 2008 Standards of Alternative Care which dictated the frequency of contact by the Department should have been once per month. Contact was typically in relation to respite arrangements.[33] Quite simply, the Department failed to have proper oversight of Zhane while he was living with LB.

7.14. In her summary of Zhane's placement with LB, Dr Caunt wrote:

> 'There were concerns about the capacity of [LB] to provide a developmentally attuned environment from the time Zhane commenced school. Initially the challenging behaviours were conceptualised as arising from his earliest years of development, that is, prior to being in [LB's] care. As his behaviour became more disruptive, aggressive and sexually inappropriate there were evolving concerns about the foster care.'

Dr Caunt went on to say:

> 'The delays in provision of interventions aimed at improving parenting and gaining therapeutic relationship for Zhane were concerning given the degree of behavioural disturbance.' [34]

7.15. A note from a meeting between Child Protection Services (CPS) and Department psychologists in November 2010[35] details concerning sexualised behaviours which Zhane was demonstrating. The case notes state:

> 'Issue (is) complicated by FSA's lack of knowledge of the carer and the family home circumstances'. It goes on to say that 'sexualised behaviours could be accounted for by Zhane being exposed to adult magazines or movies or adult sexual behaviours (observed or perpetrated).' [36]

The meeting note states:

> 'Meeting participants agreed that Zhane needs to be assessed/interviewed.'

However, several interview options were seemingly discounted at that meeting.[37] Dr Caunt opined it was dismaying that the options for assessment of Zhane were

[32] Exhibit C41, Annexure SM1 'Interagency Review', Appendix 1, Timeline 3
[33] Exhibit C41, Annexure SM1 'Interagency Review', page 7
[34] Exhibit C47, page 23
[35] Exhibit C26a, pages 448-449 (chronology document 52)
[36] Exhibit C26a, pages 448-449 (chronology document 52)
[37] Exhibit C26a, pages 448-449 (chronology document 52)

discounted for reasons including likely disagreement regarding forensic interview by police as there was no 'actual disclosure', the expectation that a CPS interview would not be prioritised, and the absence on leave of a worker from Child and Adolescent Mental Health Services (CAMHS) Sexualised Behaviours Program.[38] Ms Sue Macdonald agreed with Dr Caunt's opinion that it was dismaying that options for assessment were all discounted at this time.[39] I also agree.

7.16. In a December 2010 report by FSA Psychological Services psychologist Rachel Whenan and trainee psychologist Vanessa Launer,[40] a number of recommendations were made including that Zhane undergo further assessment to establish possible reasons for his sexualised behaviours, and that Zhane receive support from an appropriate agency, for example CAMHS, in order to further assess and attend to the issues underlying Zhane's behavioural and emotional functioning. Dr Caunt opined that:

> 'The recommendations in the Launer and Whenan psychological report are reasonable and could have formed a basis for articulated direction, goals and timeframes for reassessment. There were significant delays in the report being available and in effecting aspects of the plan.' [41]

According to the Interagency Review:

> 'The above recommendations if carried out would have been protective factors for [Zhane's] safety and wellbeing. However, there were four different primary assigned case managers over 16 months around this period and the recommendations were not adequately carried out. This point highlighted the importance for consistency of case management for children in long-term care.'[42]

7.17. Despite these concerns discussed in the November 2010 meeting, and the psychological report from December 2010, Zhane remained in LB's care until June 2011 without any proper investigation of his sexualised behaviours or pursuit of the recommendations made in the December 2010 psychological report. I consider that the failure to properly investigate these concerns was a significant failure of the Department's duty of care towards Zhane.

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[38] Exhibit C47, page 22
[39] Transcript, page 311
[40] Exhibit C29f pages 260-283 (chronology document 54)
[41] Exhibit C47, page 24
[42] Exhibit C41, Annexure SM1 'Interagency Review', page 9

7.18. In May of 2011 the relationship between the Department, AFSS and LB began to deteriorate due to LB's requests for frequent respite care for Zhane, as well as LB's refusal for her daughter and a male visitor who was frequenting the home to undergo police checks, as household members of a child under the guardianship of the Minister.[43] On 8 June 2011 the placement was suddenly terminated by LB, who did not request any further contact with Zhane.[44]

7.19. The Department has conceded that there was not sufficient engagement between FSA and LB and that FSA's overview of LB and ongoing assessment and monitoring of Zhane during the placement did not meet its own minimum standards. It has accepted, and I find, that the lack of oversight exposed Zhane to risks that he should not have been exposed to, including the potential for abuse.[45]

7.20. Whilst the inquest heard evidence of allegations Zhane subsequently made against LB of physical and sexual abuse,[46] LB was never tried in a criminal court in relation to these offences, as a trial was due to commence in August 2016, and Zhane died before that trial. I make no finding as to the allegations made by Zhane against LB.

7.21. It was clear in the years following his placement with LB that Zhane did not look back fondly on this period of his life. This placement seemingly had a lasting, negative impact on Zhane.

8. Commercial care - 2011 to 2013

8.1. Once Zhane's placement with LB officially ended in May 2011, Zhane resided in commercial care between June 2011 and February 2013.[47]

8.2. The disadvantages of commercial care for young children are significant. The Interagency Review states:

> 'The deficits of commercial care are widely understood in the child protection sector. This includes (but is not limited to): an environment that is developmentally inappropriate for most children where their sense of certainty and self-worth is undermined; and generates

[43] Exhibit C41, Annexure SM1 'Interagency Review', page 10
[44] Exhibit C29o, page 53 (chronology document 130)
[45] Government Agencies and Witnesses Closing submissions paragraphs 90-91
[46] See Exhibit C19f, Exhibit C9, Appendix B, Exhibit C26h, pages 1522-1523 & 2078
[47] Exhibit C9, Appendix C

> a high level of anxiety for children due to the unpredictable nature of who will be caring for them and when.' [48]

Commercial care was described in 'The Life They Deserve' as '*developmentally inappropriate for most children, and a poor substitute for the care provided in a loving home*'.[49]

8.3. In addition to the general deficiencies of a commercial care environment for a young child, Zhane's time in commercial care was marked with significant difficulties. In 2012, four care concern referrals were raised.[50] The Child Protection Service was critical of the commercial carers' commitment in ensuring Zhane attended his therapy appointments and many of these were missed.[51] A letter from Deborah Clark, CPS therapist dated 5 October 2012 states the following concerns:

> 'I am writing as Zhane's therapist at the Child Protection Service to express my very serious concerns about Zhane's current placement and its effects on both Zhane and the staff attempting to care for him.
>
> …
>
> Unfortunately, Zhane's level of trauma and the consequent severity of his emotional and behavioural disturbances prevent most staff from achieving a sufficiently deep bond with Zhane and sufficient authority in his eyes to be able to have any real control over his behaviour.
>
> As a consequence, Zhane is in a near constant state of high arousal and fear and this is expressed in violence towards carers, verbal abuse of carers and ongoing destructive and dangerous behaviour.
>
> …
>
> This is replicating the worst possible family situation for a child: one in which they are both frightened of carers and frightening to carers.
>
> As a result of such difficulties, with the best will in the world, it is almost impossible for the care agency to maintain staffing at Zhane's home, much less provide him with the relationships, the predictability and the consistent approach that he requires if he is not to continue to deteriorate.
>
> …
>
> He continues to lose carers with whom he has formed a relationship, reinforcing his most basic and damaging beliefs about himself (that he is bad and unlovable and will always be rejected).

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[48] Exhibit C41, Annexure SM1 'Interagency Review', page 13
[49] 'The Life They Deserve', page xxvi
[50] Exhibit C41, Annexure SM1 'Interagency Review', page 13
[51] Exhibit C41, Annexure SM1 'Interagency Review', page 13

> He continues to experience the adult world as a place which cannot assist him to manage his feelings and behaviours and where he can get what he thinks he wants by abuse and violence. He experiences very little sense of safety and emotional containment.
>
> …
>
> While Zhane is in such a chaotic and difficult living situation, little progress can be expected in therapy as he is far too anxious and disorganised to be able to tolerate discussion of emotional material or to be able to reflect sufficiently on what is happening for him.' [52]

8.4. The Interagency Review also states that although:

> '… care techniques were communicated to the carers, not all of them managed to implement the strategies provided. This was believed to be because they were not trained in trauma-informed care. This resulted in [Zhane] reacting adversely to some of their traditional behaviour management styles, and many subsequent (sometimes daily) critical incident reports where [Zhane] was heightened for long periods of time which resulted in him acting out aggressively towards the carers.' [53]

8.5. The Interagency Review concluded that the commercial care environment for Zhane was a highly inappropriate one and Dr Caunt agreed with that opinion.[54] I so find.

8.6. I am informed that the Department's contracts for provision of commercial care expired on 9 October 2020, responding in full to recommendation 128 of 'The Life They Deserve', which was to phase out the use of commercial care as a placement option except in genuine short-term emergencies. As of 30 June 2021, there were no children residing in commercial care placements.

9. Family-based placement through Key Assets – February 2013 to November 2013

9.1. In February 2013 Zhane was placed with a family through foster care provider, Key Assets.

9.2. Prior to the commencement of that placement, concerns were raised by a Department clinical psychologist about the short timeframe for transition. An email from a clinical psychologist dated 14 January 2013 stated:

> 'I am concerned that if we do not allow adequate time to prepare [Zhane] and his prospective carers (and the foster siblings) for this significant change then we could jeopardise the success of this placement. A further placement breakdown will have serious ramifications for [Zhane's] wellbeing. It would compound his already entrenched negative template of himself as unlovable and bad and would likely result in significant

[52] Exhibit C29s pages 446-447
[53] Exhibit C41, Annexure SM1 'Interagency Review', page 13
[54] Transcript, page 54

> regressions in his functioning, like escalations in his aggression, property damage, absconding, soiling and smearing, and would place him at increased risk of mental health and relationship difficulties, and offending behaviour.' [55]

She goes on to conclude:

> 'With all of this in mind, I believe that it is in [Zhane's] best interests to extend his NBH placement by 3 to 6 months to allow for a well-planned and supported transition.'[56]

It appears this clinical recommendation was not heeded, and Zhane was placed into the family's care on 15 February 2013.[57]

9.3. By the time of Zhane's Guardianship Annual Review on 11 July 2013, concerns were identified about Zhane's placement with this family. It was observed that since being with this family, Zhane's behaviours and anxiety had increased. Soiling increased to nearly daily, and the carers were placing him in pull-ups. It was noted Zhane was regressing in this placement.[58]

9.4. In an internal memorandum dated June 2013 from a social worker and the worker's supervisor to the Acting Executive Director of FSA at the time, the social worker is highly critical of the placement of Zhane with this family. This memo states:

> 'The decline in placement is not due to Zhane as he is a manageable child, it is about the carer's capacity to provide the attention and support to Zhane that he requires. Matching of Zhane to this foster family was not an accurate or appropriate process. The carers are untrained and unprepared for placement. Concerns were noted from day one regarding this placement.' [59]

The overall assessment in this memo was that:

> 'Families SA will need to end the placement urgently taking the blame for placing Zhane there and helping to avoid another major rejection.'

9.5. This plea for urgent action failed and the Acting Executive Director noted on the memo that there was no due process or procedural fairness afforded to the carers. Zhane then remained in their care until, on 1 October 2013, the carers gave 30 days' notice that they could no longer continue caring for Zhane, who left their care on 19 November 2013.[60]

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[55] Exhibit C28a, pages 199-200
[56] Exhibit C28a, pages 199-200
[57] Exhibit C28a, page 189 and Exhibit C9, Appendix C
[58] Exhibit C29o, page 53
[59] Exhibit C29o, page 53
[60] Exhibit C9, Appendix A

9.6. The matching process and transition phase for this placement, and the reason for its breakdown, was not explored in detail in this inquest, nor was it considered by the Interagency Review.[61] However, the evidence indicates that there were concerns noted about this placement from day one and this culminated in yet another placement breakdown for Zhane.

9.7. The significance of this placement breakdown for Zhane was explained by Department psychologist Ms Savilla in an email (referring to a later impending placement breakdown) where she stated:

> 'It is important to note that each of these placement changes represents a significant experience of loss for Zhane. He lost his mother at a critical age of attachment development; he lost [LB] who, despite the abuse, had for several years been his 'family'; he lost multiple IEA carers with whom he had managed to forge some sense of relationship; and he lost [Key Assets Carers] who had promised to be his "forever family".
>
> Each of these losses has reinforced Zhane's view of himself that he is unlovable and unworthy of care. It has also reinforced his view that relationships are fleeting and cannot be relied upon, which understanding has had devastating effects on Zhane's capacity to trust his adult caregivers.' [62]

9.8. Following the breakdown of this placement, Zhane was placed back into commercial care from November 2013 to February 2014 and was then placed into residential care from February 2014 until April 2014.[63]

10. Placement with Stephen Rimes

10.1. In April 2014 Zhane was placed with Mr Stephen Rimes who was a registered foster carer with Life Without Barriers (LWB), a national not-for-profit organisation providing services in aged care, disability, mental health, refugee services, homelessness and foster care sectors.

10.2. LWB was contracted to provide specialist foster care services. Specifically, the Service Agreement between the Minister for Education and Child Development and LWB for a three-year period between 1 July 2013 and 30 June 2016 required LWB to provide:

> 'Individualised care and a supportive, stable and nurturing placement for 93 children and young people under the Guardianship or Custody of the Minister between the ages of 5 and 17 years, who have significant or extreme care needs and behaviours.'

[61] Evidence of Sue McDonald Transcript, pages 315-317
[62] Exhibit C26p, pages 844-947 (chronology document 161)
[63] Exhibit C9, Appendix A

The placements were 'long-term out of home care placements'. The Service Agreement identified the 'target group' as:

> 'Children and young people assessed at a Level 3 or 4 of the Families SA Complexity Assessment Tool (CAT).'

10.3. Mr Rimes had a long history of providing foster care services for LWB dating back to July 2002. His history included three long-term placements before Zhane. He was registered under the *Family and Community Services Act 1972* (SA) to provide care to two children.

10.4. Ms Savilla was consulted prior to Zhane's transition into Mr Rimes' care, and was clear in her evidence about her views on Mr Rimes' suitability as a carer for Zhane:

> 'When I met with Mr Rimes - with Steve - he was very receptive to hearing about Zhane's experiences; what we were able to share with him. He, in turn shared that he had already cared for children from similar backgrounds with similar challenges. He was not unfamiliar, he said, with caring for adolescent boys who had challenging behaviours and I believe was still in touch with some of those children that he'd cared for. He was just a very empathic man, I felt. When I spoke about what I believed was therapeutic care for Zhane, Steve could almost predict what it was that I was going to say, in terms of "exactly, he's had these experiences, we need to be providing this level of care to him". The psychoeducation session went beautifully well, he was very receptive to all of that information, showed empathy for Zhane, and at that time he seemed to be wanting to put Zhane's interests first. So yes, he seemed like a very receptive, very empathic, very warm, very nurturing kind of person, and I felt able to provide therapeutic care.' [64]

10.5. Zhane's placement with Mr Rimes was initially due to commence on Friday 28 March 2014. However, shortly prior to the commencement, Mr Rimes indicated that he was not willing to proceed because the carer payment was insufficient. Mr Rimes was advised that he would be contracted at approximately $65,000 per year for Zhane's placement,[65] having been previously contracted at approximately $85,000.[66]

10.6. The reason for this reduction was that over the years Mr Rimes had been a foster carer, the reimbursements available to foster carers had changed as follows:[67]

10.6.1. In 2001, the DCP introduced the Individual Packages of Care (IPC) service model which was allocated through a preferred provider panel. The model

[64] Transcript, pages 75-76
[65] Exhibits C40 & C41, Annexure SM1 'Interagency Review', page 14
[66] Exhibit C41, Annexure SM1 'Interagency Review', page 14
[67] Exhibit C41, Annexure SM1 'Interagency Review', page 14

provided family-based care with approved foster carers and the initial financial cap for each service was $60,000.

10.6.2. In 2005, the IPC model was expanded to include three levels of complexity based on Level of Care (LOC) rating with cost bands being '<$65k, <$75k and <$90k'.

10.6.3. In 2008, the IPC program was converted to the Specialised Placement and Support Program (SPSP). The SPSP model provided for three defined levels of care:

1) 'Level 1: Specialist Foster Care $85k - $120k;
2) Level 2: Adolescent carer with youth worker support $120k - $200k;
3) Level 3: Youth worker or hybrid youth worker/adolescent carer model $200k - $400k'.

10.6.4. In 2012, it was decided that the SPSP be wound down by 30 June 2013. In February 2013, the Specialised Residential Care model was approved as an alternative. Unlike the SPSP model where the carer payment was determined by the complexity of the care needs of an individual child, the Specialised Residual Care model provided for block funding payable to LWB quarterly in advance.

10.7. Mr Rimes considered himself to be a professional carer. The SPSP funding model had afforded Mr Rimes the financial means to meet his broader financial commitments which included a mortgage and other loans and the running costs associated with his home, as well as to provide for the maintenance and needs of children in his care. In contrast the Department specified – and consequently LWB also considered – that the purpose of the funding to be in the nature of financial assistance to help carers meet the costs associated with caring for children and young people.

10.8. Mr Rimes explained his stance in an email sent on 31 March 2014. He expressed regret for what had occurred with the placement initially being delayed and conveyed his desire to continue in his role as a carer. He stated:

> 'Zhane is the 1st placement under the new guidelines, I now understand what it is and will not knowingly ask for something that is not available. I ask you to please consider placing

> Zhane with myself and my family, I will live on bread and water if needed and if possible, look for part-time employment to coincide with Zhane's time in school.' [68]

10.9. Discussions and negotiations between Mr Rimes, LWB and Department staff followed, culminating in a face-to-face meeting on 16 April 2014 during which Mr Rimes confirmed that he now understood the new funding arrangements. The placement was allowed to proceed despite both LWB and the Department being aware of Mr Rimes' expressed concerns about the financial aspects of the placement. Zhane's placement with Mr Rimes commenced on 16 April 2014.

10.10. At the time, Mr Rimes was a single parent living on a property at Caltowie in South Australia. His son Jordan, then aged 20, was also residing with him. His two older sons, Brandon and Luke, did not live with Mr Rimes during Zhane's placement.[69]

10.11. Zhane settled into this placement exceptionally well on all accounts. According to Anne Nicolaou's report:

> 'He spontaneously began calling Mr Rimes 'Dad', he was able to increase his school attendance from 2 hours per day with the support of a School Services Officer to full time without SSO support, he was developing friendships at school, and his behaviour at school dramatically improved, such that Zhane could manage his feelings and deal with conflict and aggression.'[70]

Zhane spent time with Mr Rimes' son Brandon as a formal respite arrangement.[71] Mr Rimes engaged Zhane in cultural events and facilitated contact between Zhane and his biological sisters.

10.12. Dr Caunt describes Zhane's time with Stephen Rimes as '*the period of most emotional and behavioural stability*'.[72]

10.13. A case plan developed for Zhane in August 2014 states:

> 'The placement is providing stability and a sense of belonging for Zhane and an opportunity to prosper. Zhane is making significant progress in all life domains suggesting that all his needs are being supported.' [73]

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[68] Exhibit C26h, page 1303
[69] Transcript, page 182
[70] Exhibit C43, page 5
[71] Transcript, page 196
[72] Exhibit C47, page 5
[73] Exhibit C29t, page 149 (chronology document 158)

By October 2014 Zhane was attending school full-time in a mainstream class, a marked improvement from the fact that he had previously only been attending a few hours a week. He no longer needed SSO support.[74]

10.14. In December 2014 when Zhane's case was transferred to Port Pire, the outgoing case manager disseminated an internal memorandum to internal and external staff involved with Zhane at the time, detailing that Zhane had made the following developments since entering the placement:

1) CAT score reassessed from a Level 3 to a Level 1 (the lowest level of need);

2) School attendance increased from two hours/day with the support of a Student Support Officer (SSO) to full-time without an SSO; he had developed friendships at school; and was demonstrating his ability to manage his feelings and resolve conflict safely;

3) His prescription for pericyazine (an antipsychotic) had ceased, and he was sleeping well through the night;

4) He had disclosed horrific experiences of abuse and neglect to Mr Rimes about his previous foster placement with [LB];

5) He was more able to follow instructions and was visibly happier.[75]

10.15. Zhane's incoming case manager in the Port Pirie Office, Mr Brian Verran, provided in his statement details Zhane provided him about his time with Mr Rimes:

> 'Zhane informed me that he enjoyed attending Gladstone High School and that he had made some friends there. Zhane informed me that he was mentored on weekends by Steve's son Brandon and he would stay overnight and either go on picnics or went for drives depending on the weather. Zhane said that he liked Steve's cooking but also said at times the presentation was not the best, but it tasted great. Zhane said he enjoyed living in the country as opposed to the pace of city life.' [76]

10.16. However, Mr Rimes' financial situation began to deteriorate while Zhane was in his care, as he struggled to adjust to the significantly lower carer payments. As summarised in Ms Nicolaou's report:

> 'He had set his life up on the original LWB package rate, with a mortgage on his home and additional loans and credit cards to do renovations on the house. He initially had a

[74] Exhibit C29p, pages 2-8 (chronology document 160)
[75] Exhibit C28e, page 146
[76] Exhibit C21, page 2

> small car, but then purchased a larger four-wheel drive, which he used for school runs and country trips with Zhane. He could not maintain his financial commitments on the reduced subsidy and began to get into arrears on his mortgage.' [77]

As stated by Ms Nicolaou:

> 'A key point in this situation is that Mr Rimes was a specialist carer on a semi-professionalised arrangement for a lengthy period of time and had therefore come to think that such arrangements would continue into the future. He had established a modest life with a mortgaged house that he did some renovations on and bought a four-wheel drive. Pretty ordinary really, and well within the average lifestyle of middle Australia. The Department set up these arrangements, and then took them away, and not surprisingly Mr Rimes found it very difficult to adjust to a $20,000 per year drop in income to meet his financial commitments.' [78]

10.17. Mr Rimes gave evidence that he was told a second child would be placed in his care within three months of Zhane commencing his placement,[79] assuming Zhane settled in. This would have alleviated the financial pressure caused by the reduced payments for one child. Mr Rimes was approved by LWB to have two children in his care.[80] An email from LWB refers to a discussion with Mr Rimes some time prior to Zhane being placed, stating:

> 'There was a discussion that he was open to having a sibling group or two children placed as it would effectively mean he could maintain the circumstances in which he had been living for the past 13 years.' [81]

This email goes on to state:

> 'As you know, Zhane was placed first and there was an expectation that [K] may be a suitable second placement, such that Steve was of the view that this would happen.'

There is also an email from Jane Longbottom, then Director of LWB which states:

> 'Just prior to the current placement with Zhane commencing (approximately 1 week from memory), Steve announced that he would not proceed with the placement as the reimbursement was insufficient … In the end, a pragmatic solution was found which involved increasing the travel allowance and the likelihood that a second placement would be pursued.' [82]

10.18. I accept, based on the evidence of Mr Rimes and these emails, that Mr Rimes took Zhane into his care with an expectation that any financial pressure he may experience

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[77] Exhibit C43, page 14
[78] Exhibit C43, page 32
[79] Transcript, pages 228-229
[80] Exhibit C33, page 403
[81] Exhibit C26p, page 996 (chronology doc 161 b)
[82] Exhibit C39, page 52

due to receiving a lower carer reimbursement than he was accustomed to would be alleviated by the placement of a second child within a few months of Zhane being placed.

10.19. Mr Rimes had no prior history of having two foster children in his care at the same time. In a further request from the Department to LWB for family-based care starting 11 February 2014,[83] the Department indicated that it was now appropriate to place Zhane with other children, but not children younger than Zhane.[84]

10.20. The LWB Placement Matching and Planning Group met on 12 February 2014. Potential matches for Mr Rimes were discussed. The minutes of the meeting record a plan to match Zhane with Mr Rimes, and after about three months look at whether Mr Rimes was a suitable match for another particular child. The Planning Group expressed reservations about the placement of a second child with Zhane.[85] The minutes of a subsequent LWB Placement Matching and Planning Group on 19 February 2014 express similar reservations.[86]

10.21. By email sent on 22 October 2014, a senior Department social worker, Ms Eberhard, conveyed the Department's view of Mr Rimes' request for a second placement to LWB. In summary, the Department was happy for LWB to begin the matching process for another child to be placed in Mr Rimes' care if considered appropriate. Ms Eberhard also inquired whether LWB was able to explore financially supporting Mr Rimes until another child was placed in his care.[87]

10.22. By email sent on 10 November 2014, Ms Eberhard advised Ms Roden that she had informed 'placement services' of Mr Rimes' request for a younger child to be placed in his care so that Zhane could fill the role of an older brother. Ms Eberhard stated that she was happy for LWB to share profiles of children with Mr Rimes and that if Mr Rimes felt comfortable about any profiles to then inform FSA to consider.[88] In about December 2014, a potential match was identified for a second placement into Mr Rimes' care. The potential match was a seven-year-old boy [KH] who was living in Port Lincoln.

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[83] Exhibit C33, page 37
[84] Exhibit C33, page 41
[85] Exhibit C33, page 258
[86] Exhibit C33, page 267
[87] Exhibit C33, pages 363-364
[88] Exhibit C33, page 383

10.23. The prospect of placing [KH] with Zhane and Mr Rimes appeared promising. However, the placement process for [KH] came to a halt following consideration of a report from CAMHS dated 5 January 2015. The authors of the report opined:

> 'CAMHS feels that cohabitation of these children is not suitable given their commonality of issues. CAMHS feels progressing with the placement may prove detrimental to their individual progress.' [89]

10.24. This report was considered by the LWB Placement Matching and Planning Group on 7 January 2015. A decision was made that in view of the report, the contemplated match should not proceed. Mr Rimes was informed of the decision on the same day.[90]

10.25. Mr Rimes' evidence was that while caring for Zhane and awaiting the placement of a second child to alleviate the financial pressure, his financial situation continued to deteriorate. He explained '*that whole year I waited I was borrowing money basically every week to pay bills*'.[91]

10.26. Whilst the Volunteer Foster Carer Agreement that Mr Rimes and LWB signed in relation to Mr Rimes' care of Zhane did not expressly prohibit Mr Rimes from taking up employment, a combination of Mr Rimes' care obligations towards Zhane, together with the limited employment opportunities available in the area where Mr Rimes lived, rendered it impracticable for Mr Rimes to pursue employment.

10.27. Mr Rimes consistently advised LWB and the Department that his financial circumstances were deteriorating, and a time was coming where he may no longer be able to afford to care for Zhane. The first indication of Mr Rimes' resignation was contained in his email to Jane Eberhard (copied to Ms Roden) sent on 10 September 2014.[92] Mr Rimes reiterated the same sentiment following the decision made on 7 January 2015 not to place KH with Zhane.[93] On 3 February 2015 Mr Rimes spoke to Sue Roden. He told Ms Roden that if he was not to be given another placement because of the CAMHS report, he was going to resign.[94]

10.28. Mr Rimes' evidence was that by mid-2015 his financial situation was such that he had to sell his house to alleviate some financial pressure. He sent a letter of resignation to

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[89] Exhibit C33, page 430
[90] Exhibit C33, pages 443-445
[91] Transcript, page 187
[92] Exhibit C33, page 342
[93] Exhibit C33, page 445
[94] Ibid, page 46

LWB on 27 May 2015[95] after months of clear messaging that he required further financial support to continue caring for Zhane. He sold his home and was moving in with his son, who did not have room for Mr Rimes, Jordan and Zhane. The placement had to end unless Mr Rimes' payments could be increased to assist him in finding appropriate accommodation for the three of them.

10.29. A number of people advocated strongly for the placement to be maintained. Ms Savilla emailed her managers at the Department. Her compelling email strongly expressed her view:

> 'Overall, it is my clinical opinion that transitioning Zhane out of Steve's care will constitute a traumatic experience from which there is little hope of recovery. Zhane's placement with Steve is in my view his last option. No other placement has been or would likely be as successful as the placement with Steve has been.' [96]

She also made the following convincing point:

> 'If the only barrier to this placement continuing is financial, and if we know that supporting Steve financially will cost less than placing Zhane in rotational care, I struggle to understand why we would not support the placement when we also know it is Zhane's best interests.'

10.30. Dr Caunt was of the opinion that '*more weight should have been given to [Savilla's] opinion*'[97] and that the placement with Mr Rimes was the only placement secure enough for Zhane to receive more challenging individual therapeutic intervention.[98]

10.31. Gladstone Primary Principal Matt Delaney also sent an email advocating for the placement to be maintained. He pointed out the significant progress that Zhane had made in the care of Mr Rimes and as a student at Gladstone Primary School. He referred to Zhane as '*the exception to the rule*' who was '*improving despite his past*' and stated that '*it would be a disgrace for this placement to be discarded due to money*'.[99]

10.32. According to Ms Nicolaou's report, '*SAPOL also advocated, as the loss of Zhane's placement would also severely compromise his ability to give evidence against [LB] in a forthcoming trial*'.

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[95] Exhibit C39, page 146
[96] Exhibit C26p, pages 844-847 (chronology document 161a)
[97] Transcript, page 807
[98] Exhibit C47, page 18; Transcript, pages 805, 520-521
[99] Exhibit C26m

10.33. The evidence suggests that there were various avenues – other than just the placement of a second child - available to the Department to financially support the continuation of Zhane's placement.

10.34. I heard evidence from Ms Macdonald and Ms Taylor that there was discretionary funding available to the Department that could have been used to come to a financial arrangement that was more suitable from Mr Rimes' perspective. Ms Macdonald stated in her affidavit that:

> 'Such an approach would have acknowledged Mr Rimes' need for additional funding was finite and was likely only required until Zhane was able to manage the placement of another child with Mr Rimes.' [100]

Contracts and Licensing in the Department also advised Ms Nicolaou that, if a compelling case was made with a strong rationale, a variation to contract could be made in the interests of the child in the placement. An application for this could be made and it would be submitted for approval to either the Chief Executive or the Minister.[101]

10.35. Another alternative was a variation of the contract between LWB and the Department, whereby LWB placed 92 children instead of 93 over the course of the contract and sacrificed that 93rd placement so that payment could be used for Mr Rimes and Zhane. Ms Taylor agreed that this could have been a practical solution and that the contract could have been varied to make provision to support this placement to the financial extent required by Mr Rimes.[102]

10.36. I find that there were a number of avenues by which the Department could have financially supported the placement of Zhane with Mr Rimes. And yet, despite the strong advocacy from those who knew Zhane best and who recognised the progress that he had made in Mr Rimes' care, as well as those with clinical expertise, the Department chose not to exercise any of these options to offer Mr Rimes additional financial support. As a result, Mr Rimes relinquished care of Zhane on 26 June 2015.

[100] Exhibit C41, paragraph 66
[101] Exhibit C43, page 32
[102] Transcript, pages 456-457

10.37. The sequence of events that led to Mr Rimes relinquishing care of Zhane on 26 June 2015 was as follows:

10.37.1. Mr Rimes wrote his email of resignation on 27 May 2015.[103]

10.37.2. On 28 May 2015 Jane Longbottom received an email sent by Anya Fiedler of LWB summarising Zhane's placement with Mr Rimes, the steps taken to identify a suitable second placement for Mr Rimes, details of some of the communications Mr Rimes had with FSA and LWB concerning a second placement, details of Mr Rimes' previous threats to terminate the placement, his deteriorating financial position and that Mr Rimes had been offered financial counselling. The email also referred to a telephone conversation Ms Fiedler had with Roger McCarron of the Department during which Mr McCarron expressed the urgency to identify a suitable second placement for Mr Rimes.[104]

10.37.3. On 29 May 2015 Jane Longbottom received an email from Roger McCarron forwarding Mr Rimes' email of the previous day.

10.37.4. On 2 June 2015 Ms Longbottom received an email from Jean Bacon, the Manager Port Pirie and Kadina Office of Families SA, proposing a teleconference to discuss Zhane's placement.[105] It is apparent from subsequent emails that this meeting occurred and that minutes of the meeting were taken and circulated.[106] Those minutes have not been produced as part of this inquest.

10.37.5. On 3 June 2015 Ms Longbottom sent an email to Ms Sharon Ryan who was the Assistant Director Country Care and Protection with the Department.[107] This email followed a discussion Ms Longbottom had with Mr Rimes the same day. The email describes four options that Ms Longbottom discussed with Mr Rimes. This email was copied to Mr Rimes. He expressed his agreement with its contents.[108]

[103] Exhibit C39, page 146
[104] Exhibit C39, pages 22-40
[105] Exhibit C39, pages 119-120
[106] Exhibit C39, page 119
[107] (Chronology documents 161b)
[108] (Chronology documents 161b)

10.37.6. On 11 June 2015 there was a case conference between Anya Fiedler, Sharon Ryan and Caroline Keogh.

10.37.7. On 15 June 2015, Ms Keogh, the then FSA Acting Director, Country Care and Protection Services, wrote a memo to Ms Hemphill, then Executive Director, Country and Statewide. In that memo Ms Keogh recommends '*No further financial assistance be provided to Mr Rimes*'.[109]

10.37.8. On Monday 15 June 2015, Mr Rimes informed the Department that the date for Zhane being rehoused or moving out had to be 25 June 2015.[110]

10.37.9. On 16 June 2015, Ms Keogh wrote Ms Hemphill an email in which she stated:

> 'I very (x100) reluctantly suggest that, failing any alternate family-based placement being found … LWB assist him to locate suitable rental accommodation in Port Pirie – he be responsible for paying rent and utilities and food and all reasonable costs associated with caring for Zhane. He continue to receive the current carer subsidy and carer allowance plus 25% loading.' [111]

10.37.10. On Friday 19 June 2015, Ms Longbottom, then Director of LWB, advised Ms Sharon Ryan and Ms Caroline Keogh that she would be asking for an emergency meeting with Mr Etienne Scheepers (then the Deputy Chief Executive of the Department) on Monday to try for an eleventh-hour solution.[112] There is no evidence of whether that meeting occurred.

10.37.11. There is no evidence of what transpired between Friday 19 June and Monday 22 June 2015.

10.37.12. On Monday 22 June 2015, someone at the Department authorised Ms Longbottom to offer Mr Rimes double the carer payment on the condition that:

1) Zhane stays at his current primary school;

2) He is reassessed within three months regarding suitability for a second placement;

[109] Exhibit C55, JLL3
[110] Exhibit C39, page 127
[111] Exhibit C55, JLL4
[112] Exhibit C39, page 129

3) Once resettled, a fulsome Carer Review would be conducted;

4) The Department would pay $650 per week until such time as a second placement is a reality, including if it never is.[113]

10.37.13. That proposal was presented to Mr Rimes on 23 June 2015 and Mr Rimes agreed with that proposal.[114] Mr Rimes indicated he was, at the time of being advised of this, '*So relieved that I wasn't going to lose Zhane*'.[115]

10.37.14. On 24 June 2015, Ms Longbottom was in Sydney for a conference. She recalls stepping out of the conference on several occasions to have telephone conversations relating to Zhane's placement with Ms Pam Hemphill and, she believes, Ms Sharon Ryan. She cannot recall the details of those conversations.

10.37.15. On Friday 26 June 2015 Mr Rimes was advised by Ms Longbottom that this offer was no longer on the table and that the alternative proposition was that the Department would put Mr Rimes and Zhane in a serviced apartment for a week and fast track the assessment of suitability of Mr Rimes and Zhane for a second placement.[116] Ms Longbottom advised Mr Rimes of this based on a discussion she had that day with Ms Sharon Ryan.[117] It is unclear on the evidence who authorised Ms Longbottom to make that offer to Mr Rimes, and who subsequently retracted that offer and why.

10.37.16. Mr Rimes was unhappy that the offer for double carer payments was retracted. He gave evidence that after being advised that the carer payment would be doubled:

> 'I'd already arranged to rent one that's big enough for Jordan, Zhane and myself. And then I got a phone call saying it wasn't going to happen.' [118]

Mr Rimes refused to work with LWB and the Department beyond that date.

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[113] Exhibit C39, page 138 and Exhibit C55

[114] Exhibit C39, pages 131 and 138; See also Exhibit C26m - an email from Ms Longbottom to Mr Rimes dated 26 June 2015 stating, 'as soon as we get the written confirmation from Department we will start paying the extra $650 a week, so I hope that means it will be from next week'

[115] Transcript, page 211

[116] Exhibit C44, paragraph 40 and Exhibit C55, JLL5

[117] Exhibit C26m, page 71

[118] Transcript, page 208

10.37.17. On 26 June 2015 Mr Rimes attended the Port Pirie DCP office to relinquish care of Zhane.[119]

10.37.18. On Wednesday 1 July 2015, LWB formally accepted Mr Rimes' resignation.[120]

10.38. Though the thorough report of Ms Anne Nicolaou into the events that led to Mr Rimes relinquishing care of Zhane concluded that the final decision not to offer Mr Rimes the financial assistance he required was made by Ms Keogh and endorsed by Mr Scheepers, there is insufficient evidence before me to make that finding. It appears that Ms Nicolaou did not have the benefit of information provided by Ms Longbottom in her affidavit when she reached her conclusion. Ms Nicolaou's report also suggested she did not speak to Ms Sharon Ryan as part of her investigation; Ms Longbottom's affidavit suggested Ms Ryan was intimately involved with this decision-making process.

10.39. Mr Scheepers states[121] that that he did not recall making the decision not to extend financial support for the continuation of Zhane's placement with Stephen Rimes. His stated best recollection is that he did not make the decision. He does not believe he received any kind of briefing note or memo about the decision or decision options. He has a limited recollection of an informal discussion he had with Ms Caroline Keogh, as the Acting Director of Country Care and Protection Services (in June 2015), on the topic of Zhane's placement with Mr Rimes. He said his impression and understanding of the circumstances of the conversation was that Ms Keogh was running her view, and the conclusion she had formed, past him to gauge what he thought. As far as he recalled, it was an informal discussion between two professionals. He did not believe at that time, nor does he believe now, that he was being asked to make, let alone that he was making, a decision whether or not Zhane's placement was to continue with Mr Rimes. He said he had no reason to disagree with the conclusion that Ms Keogh had reached based on the oral information she provided to him. He said Ms Keogh did not ask him to investigate the matter further, or to consider any further information.

[119] Exhibit C41, Annexure SM1 'Interagency Review', page 14
[120] Exhibit C39, page 145
[121] Exhibit C71

10.40. No statement was obtained from Ms Keogh as to her involvement in this decision-making process and she was not required to attend to give evidence at the inquest.

10.41. On the available evidence I cannot find who decided not to proceed with the offer of double carer payments for Mr Rimes, although I do find that it was someone within the Department executive. I also find that the decision-making process regarding this decision is not properly documented, and I concur with Ms Nicolaou's view that '*for such a major stakes decision this is clearly unacceptable*'.[122]

10.42. I also find that the Department should have financially supported Mr Rimes to the extent he required in order to continue caring for Zhane. As stated by Ms Nicolaou:

> 'The placement should have been maintained because a critically vulnerable boy needed it; it offered him a real chance of survival, stability, belonging, healing, and reconnection with his family, community and culture.' [123]

The Department has conceded that the decision to end the placement with Mr Rimes, in particular by not locating additional funding to support its continuation, was the wrong decision. Ms Taylor '*absolutely*' agreed that the decision not to support the continuation of Zhane's placement with Mr Rimes was flawed and not defensible and I find accordingly.[124]

10.43. The breakdown of this placement was catastrophic for Zhane. As explained by Ms Nicolaou, '*as predicted by those who knew Zhane well, Zhane's functioning rapidly deteriorated and his trauma symptoms escalated*'.[125] Ms Tammy Brookes, the Principal Aboriginal Consultant, described to Ms Nicolaou that she saw Zhane when he had been in Mr Rimes' care for a period and when she saw him he was a young man. When she saw Zhane again after he had left the placement, he was half the person he was before.[126] In the months following the breakdown of this placement, Zhane described Mr Rimes to a psychologist as:

> 'Awesome. Funny and relaxed and chilled out, cool kind of guy and the only 'parent' who has treated me right.'[127]

[122] Exhibit C43, page 29
[123] Exhibit C43, page 31
[124] Transcript, page 443
[125] Exhibit C43, page 37
[126] Exhibit C43, page 12
[127] Exhibit C67

10.44. I cannot conclusively state whether the decision to continue the placement with Mr Rimes would have prevented Zhane's death.[128] However, Dr Caunt's report states that:

> 'The placement with Mr Rimes led to significant improvement that suggested that Zhane had the capacity to make gains in the right context. More vigorous attempts to maintain the placement with Mr Rimes may have influenced the outcome'.

Ms Anne Nicolaou concluded that:

> 'It is probable that had the placement been maintained and successfully sustained, Zhane would have continued to stabilise, continue a healing process, make progress in his development, and reconnect with his family and community.' [129]

Therefore, whilst I cannot positively find that the decision to continue the placement with Mr Rimes would necessarily have prevented Zhane's eventual death, it is open to me to find that had this placement been maintained, Zhane's death in 2016 was likely to have been prevented, and I so find.

10.45. Dr Caunt stated the following about the impact the breakdown of this placement would have had on Zhane:

> 'So it seemed from all reports from the statements people made about him is that Zhane had a lot of hope for that relationship to be a long-term relationship. He'd called him his dad, he was appropriately seeking his support in very stressful times while he was giving police statements and things like that. So for a young person to have that degree of hope and for then to be disappointed is again dismaying, isn't it. It's like he had this relationship that was working for him and this was leading to positive gains in school and for him personally and then that ended. Again, it would be difficult despite what was being said for him to not again experience that as a rejection. And in some ways reflective on him as a person.' [130]

10.46. I also find that following the breakdown of this placement, the Department failed to facilitate a continuing relationship between Mr Rimes and Zhane. Mr Rimes was clear his intention was to continue contact with Zhane. He passed on contact details and offered to provide respite care.[131] It is clear Zhane wished for that relationship to continue. Shortly after he left the placement, he asked his social worker to forward '*Dad*' (Mr Rimes) a copy of his school report.[132] On 6 November 2015 an email was sent from Ms Jane Eberhard to Mr Verran in which she stated '*Zhane has asked to have*

[128] Government Agencies and Witnesses Closing submissions paragraph 139
[129] Exhibit C43, page 37
[130] Transcript, pages 510-511
[131] Transcript, page 213
[132] Exhibit C21, page 7

contact with his biological mother and siblings. Zhane had also asked to have some contact with 'Dad' - Steve Rimes, and said he misses him'[133] and on 14 December 2015 when Mr Verran visited Zhane at the MVCU, he asked Mr Verran to speak to '*Dad*' (Mr Rimes).[134] Mr Weinert, MVCU child support worker, gave evidence that during his time at MVCU Zhane mentioned Mr Rimes '*quite often, quite fondly. That he wanted to still be there*'.[135]

10.47. Yet Zhane was not granted any opportunities to contact Mr Rimes, despite his expressed wishes to many in the Department. Ms Nicolaou postulated in her report that:

> 'DCP acted to prevent Zhane from having an ongoing relationship with Mr Rimes after the placement ended, against the stated wishes of both Zhane and Mr Rimes, and the best practice expectation. This was likely done out of ignorance of why it mattered so much, loss of focus once the crisis had passed, arrogance that workers who had little to no knowledge of Zhane and how he had been so well cared for could speak on behalf of Mr Rimes, and likely out of a need to punish Mr Rimes for his non-compliant behaviour. This further compounded the harm to Zhane.' [136]

10.48. Though the reason why the Department failed to facilitate a meaningful continuing relationship between Mr Rimes and Zhane is unclear on the evidence before me, I find that this failure did exacerbate the mental harm caused to Zhane by the breakdown of this placement. The impact of failure to continue contact with Mr Rimes was also detailed by Dr Caunt, who stated:

> '… he had then only his imagination of what had occurred, that he had put a lot of promise and hope into this relationship and there'd been a promise of ongoing contact that it wasn't - that Mr Rimes had stated that it wasn't his fault and there was a promise of some ongoing relationship that didn't eventuate, so that would have been very disappointing to him and he would have been left only with his imagination about why that had occurred and it was likely, given the context of the rest of his development, that he would feel blamed for that.' [137]

10.49. Following the breakdown of his placement with Mr Rimes, Zhane had a short placement with another LWB carer based in Port Pirie which lasted less than one month

[133] Exhibit C26i, page 467
[134] Exhibit C21, page 10
[135] Transcript, page 1196
[136] Exhibit C43, page 25
[137] Transcript, page 552

and broke down on 17 July 2015 after the carer reported she could not manage Zhane's heightened behaviours.[138]

10.50. Zhane went into Interim Emergency Care from 17 July 2015 until he was transferred into a Helping Young People Achieve (HYPA) placement in Adelaide on 27 July 2015. The approval for Interim Emergency Care for one month from 17 July 2015 to 16 August 2015 was a total of $51,549,75.[139] This was two and a half times as much in a single month as Mr Rimes was seeking over the course of one year and emphasises the abject futility of the Department's failure to supplement Mr Rimes' remuneration to retain him as Zhane's carer.

11. Residential care

11.1. In July 2015 Zhane was relocated back to Adelaide and went into residential care. Ms Kara Savilla gave the following evidence about the impact that being placed back into residential care in 2015 would have had on Zhane:

> '… I think Zhane's transition back to rotational care, from a psychological perspective, I think would have been very damaging in terms of that sense of self. I think it would have been further confirmation that he was unlovable, that the world was not a safe or consistent place for him and that he couldn't rely on adults to give him consistent care. I remember, it was just probably at the time when we learned that there was something amiss in the contract with Steve, and I remember reading somewhere in my notes that Zhane had said "Every time something good happens to me it gets all messed up". Something to that effect. So I think this was confirmation for him again that he wasn't deserving of good things. Good things never lasted for him, and the impact that that would have had on the way he viewed his future would have been devastating for him, to not be able to believe that you can be properly cared for or put trust in your carers I think would have been very difficult for him to be living with.' [140]

11.2. Ms Savilla also gave evidence that she was frustrated that she was not informed or involved in the process of relocating Zhane back to Adelaide and into residential care. She explained:

> 'I would have really welcomed some early conversation about how the transition was going to proceed. You know, did Zhane know what that house looked like, did he know who the carers were going to be, did he have any questions about it, were they setting up a room for him with his things. I would have wanted the carers there to know what some of his triggers were. Little things, like he didn't like certain people preparing his food for him. They needed to know about this, because those are the things that for Zhane were

[138] Exhibit C26m (chronology document 172)
[139] Exhibit C26k, pages 199-201 (chronology document 174)
[140] Transcript, pages 92-93

> really important and had they known about some of his triggers, had they known the kind of care environment that really worked for him, the style of therapeutic care that I had found worked with him. I mean, I don't know how they approach their caregiving, but it could have been approached slightly differently. So I would have liked to be very much involved in helping Zhane learn about the new placement, in helping the new placement learn about Zhane and sharing with them what I knew about therapeutic care for Zhane.' [141]

11.3. Zhane spent four months cycling between HYPA houses at Mawson Lakes and Golden Grove.[142] An email from a Department supervisor about this placement, prior to Zhane commencing there, noted that this was considered to be a therapeutic placement, that a detailed matching process had taken place to ensure Zhane would fit in the placement along with the other residents there, and that this was to be a long-term placement until Zhane turned 18.[143]

11.4. However, despite the optimism, between 14 September and 30 October 2015 Zhane had six moves between HYPA accommodation houses between Mawson Lakes and Golden Grove due to staffing difficulties.[144] According to Zhane's then case manager Mr Brian Verran: '*This proved to be very detrimental for Zhane and there was deterioration in his behaviours and actions*'. Zhane exhibited a number of concerning behaviours during this placement including being reported as a missing person on a number of occasions and committing property damage.[145]

11.5. There were concerns about the care being provided to Zhane in these placements. One document notes:

> 'After hours staff appear to be ill-equipped to deal with situations that can arise in group homes. Staff have not received appropriate training to deal with the varied needs of these young people.' [146]

There were also two care concerns raised about workers in these HYPA placements.[147]

11.6. On 23 November 2015 there was an incident in which Zhane put large holes in his bedroom wall, was physically aggressive towards carers punching and kicking them, spitting at carers, breaking items and throwing paint everywhere, and placing handprints on a car using paint. Police were contacted and Zhane was arrested and

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[141] Transcript, pages 94-95
[142] Exhibit C41, Annexure SM1 'Interagency Review', page 21
[143] Exhibit C26m, page 147
[144] Exhibit C2, page 7
[145] See Exhibit C19 (chronology document 175, 176, 179, and 233)
[146] Exhibit C26l, page 465
[147] Exhibit C70

taken to the Adelaide Youth Training Centre at Cavan, where he spent one night.[148] Zhane's HYPA placement was terminated on 24 November 2015.[149] The termination email from a HYPA psychologist acknowledged, '*Recent unsettledness within HYPA Homes has likely contributed to Zhane's sense of security of placement*'.[150] Following his court hearing on 24 November 2015 Zhane was released and taken to his next, and what became his final, placement at the Morphett Vale Community Unit (MVCU).[151]

12. Morphett Vale Community Unit

12.1. Zhane was placed into the MVCU, a Department residential care facility:

> '…with seven other males with oppositionality, emotional reactivity, impulsivity, behavioural deficits, verbal abuse of staff, running away and involvement with the court systems, and there was at least one resident with deliberate self-harm.' [152]

12.2. The evidence before me suggests that the MVCU was an inappropriate placement for Zhane from the outset. Ms Savilla stated, '*It certainly wouldn't have been the best living environment for him at the time, no*'.[153] Following a visit to MVCU, Ms Savilla wrote an email to Mr Verran:

> 'It's very clear that Zhane has not coped well with the placement breakdown with Steve and is struggling in residential care. This isn't surprising given that Zhane has never been recommended for placement with other children (particularly not other children with [child protection] histories) and that he requires 1:1 care to enable him to have consistent co-regulation from a trusted primary caregiver – without that Zhane struggles to regulate his emotions and behaviours, and these behaviours of concern (aggression, soiling, anxieties about food provision, verbal abuse etc start to emerge.' [154]

She refers in this email to MVCU being '*quite a chaotic and emotionally (and sometimes physically) unsafe place for Zhane*'.[155]

12.3. Dr Caunt was also of the view that the MVCU was not an appropriate placement for Zhane[156] and elaborated on her concerns:

> 'I understand that there may not have been other options but I think larger units for particularly young adolescents, which he was - I think when he went there he was only 12, possibly just turned 13 - for younger adolescents, the sort of age range from 10-17 is quite

[148] Exhibit C26l, page 573
[149] Exhibit C26l, page 579
[150] Exhibit C26l, page 579
[151] Exhibit C26l, page 595
[152] Exhibit C47, page 5
[153] Transcript, page 102
[154] Exhibit C29n, pages 145-146
[155] Exhibit C29n, pages 145-146
[156] Transcript, page 514

> a huge age range from the point of view of development. One of the difficulties is that up until that point it didn't appear that Zhane had offending behaviours, for instance, and that there is a contagion in those environments that's both about the behaviours but also about the dysregulation. So if you are unable to manage yourself and you are in an environment where people are frightening, scary, angry, that that increases your stress levels, which then he seems to act out through behaviours, but we don't really know what was happening in his emotional life because there is no record of that in his notes. Really, we can only ascertain that emotionally he was quite distressed as well and that some of the incidents where he would self-harm were also around conflicts. Obviously he was sensitive to conflict, so arguments with other residents and with staff, he was quite sensitive to those things, so they would increase his emotional lability. So it was a difficult place for him to be.' [157]

12.4. Not only was MVCU an inappropriate living environment for Zhane, it was also his 18th placement during his time under the guardianship of the Minister. According to Dr Caunt, '*It is startling that this boy had over 18 placements and few that could be measured in more than months*'.[158]

12.5. The evidence before me is clear that Zhane was unhappy in this placement and became increasingly so as time went on. On 9 February 2016, when Zhane had resided at MVCU for just shy of three months, he completed a Viewpoint Survey. Dianne Longman gave evidence that:

> 'The purpose of the viewpoint is to ascertain the child's view whilst they're in their current placement just to ensure that we are meeting their needs and the best service delivery that we can afford them whilst in care.'[159]

Although he stated he felt '*completely*' settled at MVCU and made positive remarks about the carers and feeling safe at the time of completion, he also noted he did not like being restrained, he felt like people did not listen to him very often, and he would rather be with his Mum and sister than in Adelaide.[160]

12.6. I also heard evidence from Ms Michelle Hopkins, who in 2016 was an Advocate at the Office of the Guardian for Children and Young People and visited Zhane at the MVCU on 16 February 2016. Ms Hopkins gave evidence that '*Zhane expressed that this was one of the worst placements he'd been in and that he felt it was for the naughty kids*'.[161]

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[157] Transcript, page 514
[158] Exhibit C47, page 36
[159] Transcript, page 925
[160] Exhibit C26n, page 119
[161] Transcript, page 741

12.7. By May 2016 Zhane's unhappiness in the placement reached a point where there was an incident at school on 10 May 2016 where he threatened to kill himself if he was returned to the unit.[162] According to the notation by Ms Dianne Longman in the C3MS record of this event:

> 'Zhane wants to be placed in another placement as his carers and children in the unit are annoying him. When further questioned Zhane was unable to articulate what and how this was occurring.'

13. Self-harm behaviours

13.1. I turn now to a consideration of Zhane's self-harm behaviours in the years, months, weeks and days leading up to his death.

13.2. The documentation before me contains some mentions of self-harm behaviours from as early as 2011. On a 27 July 2011 CAMHS care plan review there is record of minor self-harm, fleeting suicidal ideation and low lethality impulsive suicidal acts that are not more extensively documented.[163] Later in 2011 and 2012 there were critical incident reports (CIR) and carer reports to the FSA psychologist during meetings that Zhane demonstrated suicidal behaviours including wanting to self-punish after misbehaviour, banging his head, scratching himself and attempting to choke himself with a shoe lace when highly dysregulated. In February 2012 he stated that he wanted to kill himself. In June 2012 he said that he wished someone would kill him after an incident of uncontrollable behaviour in which he expressed negative views about himself and his life. During a critical incident he attempted to choke himself with cords and by putting objects in his mouth. In June 2014 Zhane disclosed that he sometimes choked himself while he was in the shower.[164] A Safety and Risk Management Plan for Zhane developed on 16 November 2015[165] notes concerns of '*biting batteries, wrapping glad wrap around face, accessing kitchen washing detergent and threatening to drink it*'. The risk likelihood is noted as a C4, which means '*likely sometimes, with extreme consequences*'.

13.3. It appears that Zhane's self-harm escalated during his last few months at the MVCU. In May 2016 there are a number of specifically recorded incidents including cutting

[162] Exhibit C26o, page 449
[163] C26b C3MS 2011, pages 289-296
[164] Interagency Review
[165] Exhibit C26i, page 545

wrists with mug,[166] and threatening to self-harm at school.[167] Weekly Update Sheets note other incidents including on 9 May 2016 '*Zhane handed staff a serrated metal object, he had superficial scratches on his arm and wouldn't say why they were there but appeared disappointed in himself*'.[168] On 10 May 2016 staff found a plastic bag with pieces of broken mug in Zhane's room. He told carers he would only use a broken mug to self-harm.[169] Mr Verran wrote in the last CAT completed for Zhane in June 2016:

> 'Zhane was self-harming when he first arrived at the Morphett Vale Community Unit, this included cutting his hands/wrists, this has not been evident in recent times'.

Yet there is no independent record of cutting prior to May 2016, by which time he had been at the MVCU for some six months.

13.4. Focussing on the communication of these incidents of 5 May and 10 May 2016 to Zhane's wider care team, it is evident from records that both of these incidents were reported to staff of MVCU and the Department, including Ms Longman, Mr Verran and Mr Weinert. They were recorded in the weekly update sheets (which were summarised from the logbooks maintained by MVCU). Ms Macdonald said that it was her expectation that both the supervisor and manager, as well as senior youth workers and case workers, of the MVCU would review and discuss the weekly update sheets.

13.5. Of note, however, there were no critical incident reports logged in relation to any self-harm acts or threats by Zhane, including either the 5 May or the 10 May 2016 incidents.[170] Ms Macdonald's evidence was that the two incidents may have met the technical definition of a critical incident under the policy as it stood at the time. However, she emphasised the need for professional judgement as to whether something was a critical incident or not. It seemed there was a difference in professional judgement about what was or was not to be categorised as a critical incident - Mr Steven Weinert stated that he '*suspected*' the incident at MVCU on 5 May 2016 where Zhane cut his wrists with a mug was sufficient to be a critical incident[171] and Ms Jo Perry stated she believed that should have been reported as a critical incident.[172] Ms McDonald

[166] Exhibit C26o page 440
[167] Exhibit C26o, page 447
[168] Exhibit C26o, page 461
[169] Exhibit C26o, page 462
[170] Exhibit C7, page 6
[171] Transcript, page 1115
[172] Transcript, page 1076

agreed the incident at the school on 10 May 2016 met the definition of a critical incident and therefore the expectation in accordance with the policy at the time was that it would be logged as a critical incident[173] and yet, it was not logged as such by anyone.

13.6. The report of an incident as 'critical' would have caused the report to follow a communication pathway intended to bring the incident to the attention of important people in the management of Zhane's care. Counsel for the Government Agencies and Witnesses have submitted that that occurred here in any event; the most important people for Zhane were aware of the incidents. Zhane's case worker was aware of the incidents and, as Ms Macdonald suggested, they are the key person.

13.7. Ms Macdonald conceded that logging an incident as a critical incident would make more people aware of the incident[174] and thus the failure to log either of these events as critical incidents was a missed opportunity to bring Zhane's acts and/or threats of self-harm to the attention of a wider audience. Perhaps Mr Verran as the 'key person' was aware, but any response by Mr Verran was not proportionate to the escalating risk. Perhaps if a wider audience was made aware of these incidents, someone other than Mr Verran would have turned their mind to whether the response was adequate in the face of the escalating self-harm threats. One can only speculate about whether, had Zhane's self-harm behaviours been monitored or investigated more closely following these incidents in May 2016, his death in July 2016 may have been prevented – but clearly there was a missed opportunity to further assess this self-harm behaviour, and that was something that needed to happen for Zhane's safety.

13.8. Zhane's self-harm behaviours warranted closer monitoring and further investigation by a professional and those that were aware of these behaviours failed to ensure an appropriate or rapid response to his self-harm behaviours and threats in May 2016. Dr Usman, the Clinical Director of CAMHS, was of that view that there was insufficient clinical assessment of Zhane's self-harm behaviours, and I so find.[175]

13.9. I find that following these incidents in May 2016 there was an urgent need for a thorough assessment of Zhane's mental state by a professional, provided with all of the relevant information.

[173] Transcript, page 1449
[174] Transcript, page 1497
[175] Transcript, page 725

14. Dr Katy Osborne

14.1. Shortly after these two self-harm incidents in May 2016, Zhane was taken for a consultation with general practitioner Dr Katy Osborne.

14.2. Prior to a consultation in May 2016, Dr Osborne had consulted with Zhane on one occasion in December 2015 in relation to a rash.

14.3. Zhane was next taken for a consultation with Dr Osborne on 18 May 2016 for a mental health plan and referral to the school psychologist. Dr Osborne said she was told there had been superficial cutting in recent weeks.[176] Dr Osborne viewed Zhane's arm and was unable to see any scarring.[177] She was not told he had threatened to kill himself if he was returned to the MVCU.[178] She said the purpose of the appointment was about behavioural issues at school.

14.4. Dr Osborne's evidence was that she was given extremely limited information. Her evidence was that she was told that:

> 'Zhane had been getting into increased trouble at school and in the Families SA care environment he was having anger management issues with certain children and matters were escalating and the staff at the school were finding it increasingly difficult to manage his behaviours, so the school wanted supports around anger management and dealing with Zhane's emotions.' [179]

14.5. Dr Osborne said the purpose of the appointment was to get a mental health treatment plan and a referral to the school psychologist. Dr Osborne noted on this mental health treatment plan that she asked Zhane direct questions about plans of ending his life, he said no, and there did not seem to be any evidence to the contrary.[180] She stated:

> 'I can't stress enough that this was not a suicidal - I wasn't being presented with a suicidal 12-year-old who was making remarks about wanting to kill himself and was doing self-harm behaviours that were deep cutting with suicidal intent, he was brought in for in-school psychology for behavioural issues, that was how he was presented to me.' [181]

14.6. She was told that there were lots of historic issues relating to trauma and abuse from family and foster family, from the carer and there was no embellishment of that

[176] Transcript, page 143
[177] Transcript, page 143
[178] Transcript, page 157
[179] Transcript, page 139
[180] Transcript, page 153
[181] Transcript, page 173

information.[182] It was Dr Osborne's view that it was not appropriate to question Zhane about these matters during this appointment.

14.7. On the basis of the information with which was she presented, Dr Osborne completed a mental health plan and a referral to the in-school psychologist. She conceded she should have detailed the superficial cutting on the referral,[183] although given what subsequently transpired with this paperwork, which I will address later in this finding, it is unlikely the inclusion of this information would have had any impact on how Zhane's matter progressed with in-school psychology.

14.8. This appointment was an opportunity for a general practitioner to consider what urgent mental health assessment and/or intervention Zhane may have required. Yet Dr Osborne was not given all of the relevant information to properly consider that. According to Dr Caunt:

> 'The longitudinal picture of his self-harm doesn't seem to be captured in the documentation of people who were assessing him for self-harm risk at the time.'[184]

Dr Caunt also concluded that:

> 'The risk assessment by the general practitioner was limited by lack of information and verbal interaction with Zhane, so likely inadequate.' [185]

14.9. Dr Osborne's involvement was limited by the lack of information provided to her. The person accompanying Zhane to this appointment for a mental health plan should have been properly informed of Zhane's self-harm acts and threats from recent weeks and should have properly informed Dr Osborne of this information. Dr Osborne stated:

> 'If he presented, if they kind of brought him in saying "Look, we're really concerned. He's got active suicidal thoughts, or the behaviours occurred that way" we would have done a referral to CAMHS which we would have faxed through and depending on your level of concern we may have followed it up with a phone call. We definitely wouldn't have just given it to the accompanying carer to pass on and follow up that way. It would have been faxed and a phone call to follow up at that point.' [186]

[182] Transcript, page 140
[183] Transcript, page 145
[184] Transcript, page 527
[185] Exhibit C47, page 35
[186] Transcript, page 149

She also stated that if suicide had been the concern at the time:

> 'I wouldn't have felt that, you know, six sessions with an in-school psychologist would've been the most appropriate form of support.' [187]

14.10. I find that Dr Osborne's treatment of Zhane during this appointment was appropriate based on the information with which she was presented. However, I also find that Dr Osborne was not provided with crucial information about Zhane's mental state at the time she was asked, by the guardian accompanying Zhane to this appointment, to complete this psychology referral and mental health plan.

14.11. I have not heard evidence from the individual that took Zhane to that appointment as to why that information was not given to Dr Osborne. It has been difficult to identify who that individual was. Counsel Assisting has submitted that I can be satisfied on the balance of probabilities that that individual was Brett Vayro, based on: the fact that Dr Osborne's evidence that it was an adult male who was accompanying Zhane at the appointment,[188] the time of the appointment being 10:32am;[189] the MVCU rosters for this date[190] which reveals the only males working that shift were Shane Sterzl, who was rostered on as an OPS4 Supervisor, and Brett Vayro; the fact that Mr Shane Sterzl's affidavit stated that it would be rare for a supervisor to take a child to an appointment;[191] and the statement of Mr Brett Vayro that it would usually be the case that a worker from the MVCU would take children to appointments, and that he recalls taking Zhane to some medical appointments.[192] However, Counsel for the Government Agencies and Witnesses have pointed out that although Dr Osborne recalled an adult carer from FSA, she did not say how she was aware that the person was from FSA, nor was she asked. She was not asked to identify the male from a photograph, and she said she has no memory in any case of who he was or what he looked like.

14.12. Mr Brett Vayro does not recall taking Zhane to this appointment.[193] So even if it was Mr Vayro who took Zhane to this appointment, I have no explanation for Dr Osborne not being told of Zhane's threat to kill himself if he was returned to the MVCU. It might be that the individual was not aware of that incident at the time of the

[187] Transcript, page 154
[188] Exhibits C38 and C38a
[189] Exhibit C34, page 2
[190] Exhibit C69
[191] Exhibit C65, page 4
[192] Exhibit C22a
[193] Exhibit C22a

appointment, or he was aware but did not mention it to Dr Osborne. In the circumstances I am unable to make a finding about whom it was who accompanied Zhane to this appointment, what information that person had at the time of the appointment, and why particular information was not given to Dr Osborne.

14.13. Whoever it was and whatever the reason, it was unsatisfactory that Zhane was taken to this appointment by a person who did not provide Dr Osborne with important information about his recent self-harm acts and threats. Dr Osborne was the last medical professional to properly turn her mind to Zhane's mental state, and yet her consultation was limited by a crucial lack of information about his recent behaviours.

14.14. Counsel for the Government Agencies and Witnesses have submitted that nothing additional was likely to have flowed from the provision of this additional information about Zhane's threat to end his life if he was returned to the MVCU. However, Dr Osborne's evidence was that she would have accelerated the referral to CAMHS. I will address later in this finding why a CAMHS referral was urgent by this time, and why a CAMHS referral was not actioned before Zhane's death. To the extent that this appointment with Dr Osborne was a missed opportunity to have a CAMHS referral for Zhane accelerated in May 2016, I find that this appointment with Dr Katy Osborne was a significant missed opportunity to get Zhane the mental health support he so urgently needed at the time. The cause of that missed opportunity was the failure of the Department to ensure that the guardian accompanying Zhane to this appointment was equipped with all of the important information a general practitioner would require when completing a mental health plan and passed all of that important information on to the assessing general practitioner.

15. <u>In-school psychologist</u>

15.1. Ms Patricia Mahoney was the clinical psychologist with In-School Psychology Child and Adolescent Services (In-School Psychology) who worked at Hackham West in 2016.[194] In-School Psychology received a referral for Zhane on 30 May 2016[195] which included the mental health plan prepared by Dr Osborne. That referral was signed on 12 May 2016 by Ms Jo Harvey, and on 18 May 2016 by Brian Verran.

[194] Exhibit C52
[195] Exhibit C52, Annexure A

15.2. Ms Mahoney had a conversation with Mr Verran on 7 June 2016. In that phone call Mr Verran mentioned he had also submitted a referral to CAMHS the previous day. Ms Mahoney says she informed Mr Verran that if he had made a referral to CAMHS and the In-School Psychologists, then a decision would need to be made as to which referral pathway they wished to pursue for Zhane.[196]

15.3. Ms Mahoney attempted to follow this up on 7 June 2016, 28 June 2017 and 7 July 2016.[197] On 7 July 2016 Mr Verran informed Ms Mahoney that he still had not spoken to his supervisor Ms Dianne Longman about which pathway of service they wanted for Zhane. Ms Mahoney sent an email to Mr Verran and Ms Longman, and copied in Ms Jo Harvey, on that day.[198] Ms Mahoney wrote:

> 'My understanding is that Zhane's trauma history is longstanding and complex, and that he has been without therapeutic intervention since his transfer to the metropolitan area six months ago. I would have been happy to commence working with Zhane in June but thought clarification from the appropriate delegated authority in Families SA would be appropriate before meeting with him. I would very much appreciate contact from you regarding whether or not you would like me to start work with Zhane.' [199]

She received no response to that email.

15.4. Later that day Ms Mahoney emailed her manager to update him on the situation with Zhane's referral. He replied the following day, 8 July 2016, writing:

> 'The situation with Zhane is intolerable but we have all done what we can and maybe someone 'up the ladder' will allow him to get the help he needs.' [200]

On 14 July 2016 Ms Longman contacted Ms Mahoney to advise that Zhane had died.

15.5. The In-School Psychology service, and in particular Ms Mahoney, did their best to provide assistance to Zhane. Ms Mahoney was willing to work with Zhane from June. She followed up this referral on a number of occasions. Her efforts were frustrated by a lack of communication from the Department, namely Mr Verran and Ms Longman. Ms Mahoney wrote in an email to colleagues post Zhane's death:

> 'I do not know if therapy would have prevented his death, but I do know the system let him down.'[201]

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[196] Exhibit C52
[197] Exhibit C52
[198] Exhibit C52, Annexure C
[199] Exhibit C52, Annexure F
[200] Exhibit C52, Annexure G
[201] Exhibit C52, Annexure F

Ms Mahoney was very proactive in liaising with the Department to try and progress therapy for Zhane – whether it be CAMHS or In-School Psychology - yet through the inaction of those charged with protecting him, Zhane did not receive the benefit of any therapy in the months leading up to his death.

16. CAMHS involvement

16.1. CAMHS is part of SA Health's Women's and Children's Health Network. Between 2011 and 2016 there were multiple episodes of care for Zhane created by various CAMHS teams.[202] The role of CAMHS was to provide mental health assessment and therapeutic input directly to Zhane, as well as his carers. The aim was to improve Zhane's placement, enhance his mental health and reduce any problematic behaviours.[203]

16.2. Dr Mohammed Usman, currently Divisional Director with CAMHS, reviewed CAMHS' involvement with Zhane's care and identified what he considered to be two gaps. First, there was a degree of confusion as to who was leading Zhane's case. This arose from the multiple therapists/agencies involved with Zhane, the complexity of Zhane's case, and the failure to identify with precision who was leading the therapeutic roles. Dr Usman accepted that the leadership roles should have been clarified. Secondly, Zhane had multiple involvements with different parts of CAMHS. This had the effect that some information was not transferred clearly within CAMHS. Dr Usman opined that this was most likely due to the systems used at that time.

16.3. One particular question that arose was why Zhane had no involvement with CAMHS between the time he left Mr Rimes' care and his death. On 3 August 2015, the Port Pirie CAMHS' therapist emailed the DCP case manager and noted that once the move to Adelaide was confirmed, '*it would be an appropriate time to close CAMHS episode and allow Zhane time to transition and adjust to new placement*'.[204] However, Dr Caunt's evidence was that an assessment of Zhane's mental health needs was probably urgent as soon as he left Mr Rimes' care.[205] There was no attempt to re-engage

[202] Exhibit C48, page 14
[203] Exhibit C48
[204] Exhibit C48, paragraph 4, and Exhibit C27a, pages 236-238
[205] Transcript, page 538

CAMHS until April 2016 by which time, according to Dr Usman, there was an urgent need for Zhane to have CAMHS' assistance.[206]

16.4. On 21 April 2016, Mr Brian Verran contacted CAMHS in relation to making a referral and was sent the CAMHS' referral paperwork.[207] On 11 May 2016 Mr Verran sent the paperwork to CAMHS. CAMHS responded saying more information was required.[208] Dr Usman's evidence was that CAMHS should have accepted the referral as it was.[209] On 25 May 2016 CAMHS followed up with Mr Verran about the returning of the paperwork with the additional information they said they required.[210] On 25 May 2016 Mr Verran emailed the paperwork to the incorrect email address (another government employee by the same name, who did not work for CAMHS). On 21 June 2016 Mr Verran emailed the incorrect person again asking for an update.[211] On 8 July 2016 Mr Verran contacted CAMHS about the referral and then subsequently emailed the paperwork again.[212] The referral was accepted on this day. Various people involved in this referral went on leave for a number of days, with an email stating '*I will be back on Wednesday and will have a further read through the documents at that time*'.[213] Zhane died on Tuesday.

16.5. Not only was the referral process unnecessarily delayed,[214] but the referral paperwork itself did not accurately reflect Zhane's needs at that time,[215] as it did not mention Zhane's recent acts and threats of self-harm.[216] Dr Usman's evidence was that previous history of self-harm should have been included on this referral and the fact that he threatened to kill himself in the residential facility should have been included.[217] He explained:

> 'That would certainly have made us aware of the risk issues, and that would have, in all respects could have, been actioned earlier on.' [218]

[206] Transcript, page 712
[207] Exhibit C29v, pages 28 and 30
[208] Exhibit C29v, pages 42-48
[209] Transcript, page 709
[210] Exhibit C29v, page 48
[211] Exhibit C26o, page 572
[212] Exhibit C29v, page 54 and Exhibit C26o, page 615
[213] Exhibit C29v, page 58
[214] Transcript, page 711
[215] Transcript, page 713
[216] Exhibit C29v, pages 60-63
[217] Transcript, page 714
[218] Transcript, page 714

He went on to say:

> 'If there is information in front of mind which says somebody is going to self-harm or has self-harmed, then there would have been an immediate crisis plan we could have delivered and offered that back to the referee, and then there should have been some plans followed up Monday.' [219]

16.6. Whilst I cannot conclude that CAMHS' intervention after Zhane's removal from Mr Rimes and in the months leading up to his death would have prevented his death,[220] it was a significant missed opportunity to reduce the chance of death by suicide. According to Dr Caunt's report:

> 'Access to a trained mental health professional could have facilitated a comprehensive risk assessment, identified any remediable contributing factors and resulted in development of a safety plan. The process may have identified times of greater risk and assisted Zhane and the carers managing times of heightened affect and impulsivity. It also might have identified ways that Zhane could have communicated any suicidal ideas or intent and seek help.' [221]

16.7. I was also told by Dr Usman that Zhane was never referred to the Complex Care Review Committee. This Committee comprises senior clinicians within CAMHS and serves as an escalation pathway for complex patients where multiple systems interact with each other.[222] Any clinician in CAMHS could have referred Zhane to the Complex Care Review Committee between 2009 and 2016.[223] Yet Zhane was not referred to the Complex Care Review Committee at any time in his life. Dr Usman was of the opinion that Zhane should have been referred to the Complex Care Review Committee[224] and that he suffered a disadvantage by his case not being referred.[225] Dr Usman was not aware of why Zhane was never referred to the Complex Care Review Committee.[226] Dr Usman explained the role the Complex Care Review Committee might have taken:

> 'I would have expected the Complex Care Review would have had to been able to say "Look, we need a clear lead in this case, and who is doing what?" And that would have been the Complex Care - if it hasn't been identified before then the Complex Care Review Committee should have been able to identify that, that's the systemic work they always do.' [227]

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[219] Transcript, page 714
[220] Exhibit C47, page 35
[221] Exhibit C47, page 35
[222] Exhibit C48, paragraph 54.10
[223] Transcript, page 722
[224] Transcript, page 722
[225] Transcript, page 723
[226] Transcript, page 722
[227] Transcript, page 730

On that basis I find that the Complex Care Review Committee may have offered some benefit to Zhane, yet for reasons unknown, no one involved in his care ever referred him to this Committee. I find that Zhane should have been referred to the Complex Care Review Committee and suffered a disadvantage by the fact that his case was not so referred.

16.8. Dr Usman gave extensive evidence in relation to the structural changes of CAMHS since the time of Zhane's death. Of particular relevance is that the lead clinician allocated to a particular case is now clearly identified. The lead clinician makes the decisions that direct the trajectory of the case. Further, there are now a number of escalation pathways. This means that as the complexity of a patient's case increases, CAMHS has the means and a range of processes for escalating CAMHS' involvement. These pathways are now clearly set out in written policies and operational guidelines. The pathways provide for multidisciplinary responses (if that is required), case conferences and Complex Care Review Committee meetings. Among other things, the Committee provides input into what changes are required and make recommendations to address the case needs of these children.[228]

16.9. Another important change is that an episode of care is not treated as closed until responsibility for the individual's care is in fact transferred to another provider. In other words, CAMHS' staff must follow up to ensure that care is being provided until a handover of the case to another provider actually occurs. The transfer between teams in CAMHS flows easily. These safeguards and directives are all set out in the CAMHS' operational guidelines. Further, Dr Usman's evidence was that interaction between the Department and CAMHS has vastly improved. CAMHS has been undergoing change since around 2014, in parallel to changes occurring within the Department. There have been multiple conversations between the two agencies. Of note, these conversations have led to the secondment of a child psychiatrist from CAMHS for the Department. In addition, there are now at least two layers of teams; one of these is the Guardianship Team, which is specifically focused upon children under care, another is the Interagency Therapeutic Needs Panel, which arose out of the Child Protection Systems Royal Commission.[28]

[228] Transcript, page 626

17. Stressors proximate to Zhane's death

17.1. In the three-month period leading up to his death, Zhane was experiencing a number of significant life stressors.

17.2. Zhane was due to give evidence as an alleged victim at a trial against LB on 29 August 2016. Dr Caunt raised concerns about a lack of support for Zhane through the court process,[229] stating that Zhane needed someone who was trauma informed to get involved as early as possible before the court case, to develop a relationship with him, be with him and support him through the process. I heard evidence from Mr Hinton KC, the Director of Public Prosecutions (the Director), about the Witness Assistance Service (WAS) and the involvement of that service with Zhane. He had reviewed the WAS file and the prosecution brief in relation to LB. The Director gave evidence that the role of WAS is '*to assist us to assist the witness to give their best possible evidence so that we can get the best possible outcome in a prosecution*'.[230] The Director was asked about Dr Caunt's statement that Zhane needed somebody who was trauma informed to get involved as early as possible to develop a relationship with him. The Director was clear that that was not, and is not, the role of WAS.[231] The Director said there is no evidence that a social work assessment was done by WAS in relation to Zhane but went on to state in '*…Zhane's position, we would have assumed, by virtue of the nature of the people who were responsible for his care, that all those sorts of things, as part of their duties, are ordinarily done*.'[232] He said the WAS did not have any information about what support structures Zhane did have in place, but that they would have operated on the basis of assumption.[233] The WAS file[234] indicates that the WAS officer was making contact with Mr Verran, offering to answer questions and provide further information and to take Zhane on a court tour. It appears these offers were not taken up by Mr Verran.[235] In my view, it was the role of the Department, as Zhane's legal guardian, to ensure he had appropriate support structures in place throughout the process of giving evidence as an alleged victim in a trial. This did not occur.

[229] Transcript, pages 535-536
[230] Transcript, page 1042
[231] Transcript, page 1036
[232] Transcript, page 1031
[233] Transcript, page 1031
[234] Exhibit C54
[235] Exhibit C54, pages 39, 43 and 45

17.3. Another stressor in Zhane's life in the lead up to his death was his status as a person under the guardianship of the Minister until the age of 18 years. I accept, based on the evidence I have heard, that sometime between his conversation with Ms Michelle Hopkins on 11 May 2016 and 29 June 2016, Zhane formed the belief that he was going to be staying in the MVCU until he was 18 years of age. Ms Michelle Hopkins' evidence was, based on the conversation she had with him on 29 June 2016:

> 'I think he was pretty resolute that he was going to be stuck there forever. He was very upset, like, he was, as I said, very desolate, very sad, when he was talking about that.'[236]

The timing of Zhane forming this view coincides with an email sent by Ms Dianne Longman on 1 June 2016, following an enquiry from Ms Hopkins, in which Ms Longman stated:

> 'Zhane is currently placed in Morphett Vale Units – Residential Care. It is anticipated that he will remain in this placement until he attains the age of 18 years old. There are no plans for reunification.'[237]

Ms Longman gave evidence that she would expect that Mr Brian Verran – who was also copied into this email - would interpret that email as confirming that Zhane was to remain in the MVCU until he was 18 and that he would tell Zhane it is anticipated he would stay in the unit forever.[238] Based on that information which was conveyed by Ms Longman to Mr Verran and Ms Hopkins, and Ms Longman's understanding that Mr Verran would convey that to Zhane, and Ms Hopkins' evidence that between her conversation on 11 May 2016 and the conversation on 29 June 2016 with Zhane it appeared that Zhane had been given further information about his situation,[239] I am satisfied on the balance of probabilities that someone within the Department advised Zhane in June of 2016 that it was anticipated that he would remain in the MVCU until he was 18 years old.

17.4. Though various witnesses from the Department maintained there was no plan for Zhane to stay in the MVCU until he was 18, it seems the understanding was that that would be the case. Ms Longman clearly understood that was the case when she sent the email on 1 June 2016, though she could not recall in her oral evidence the basis upon which

[236] Transcript, page 768
[237] Exhibit C49, Annexure E
[238] Transcript, page 961
[239] Transcript, page 761

she did so. Dr Caunt was asked about the impact it may have had on Zhane receiving information about remaining in the MVCU until he was 18 in June 2016 and responded:

> 'I'm not sure if he would have felt secure in that unit or secure in his relationships to receive that information other than in a way that would cause him some anxiety, or quite a lot of anxiety.'[240]

Zhane's suicide note points to his desire to not be in care as a significant stressor on the night of his death.[241] I am satisfied that at the time of his death Zhane was distressed by his belief he was going to stay in the MVCU until he was 18 years of age, a belief he formed based on information provided to him by someone within the Department in June 2016, the month before his death.

17.5. Another stressor in Zhane's life in the lead up to his death was the resumption of contact with his birth mother, with whom he had had no contact or relationship since he was an infant. Though there was some suggestion throughout the notes that Zhane may have had prior telephone contact with his mother during visits with his sisters, his first real contact with his mother was via a mobile phone sent to him by his mother in July 2016.[242] According to the MVCU weekly summary sheet, the first call between Zhane and his mother on that mobile phone, on 9 July 2016, '*went well and he was excited*.'[243] However, Ms Sue McDonald concluded that '*the beginning contact Zhane had with his mother shortly before his death was not adequately supported, given his extreme vulnerability*.'[244]

17.6. At the time of his death, Zhane's key worker, Mr Brett Vayro, was on leave.[245] Dr Caunt was of the view that this could have placed extra stress on Zhane stating:

> 'In a circumstance where he didn't have too many other people who may have had a mind for him or he felt was his special person, the fact that his key worker wasn't there, was somebody that he at times of stress might seek to talk to about things that are worrying him, he would have been not left with an option of that person because I think the key worker - for most young people that's the case, they usually have either a key worker or someone within the residence but this key worker I think had a relationship with him that may have had, within the matrix of people that could contain him, be someone that was absent and that was experienced with him, as a loss of whatever small amount of containment he did have in his context. Young people can be very sensitive to the loss of these things. For instance, a young person can become suicidal at the loss of a pet or

[240] Transcript, page 831
[241] Exhibit C19e
[242] Exhibit C26o, pages 614, 616, 624 & 625
[243] Exhibit C26o, page 625
[244] Exhibit C43, page 25
[245] Exhibit C22, page 5

> something like that, so it might not seem an important relationship to us but when I'm thinking about him, it possibly could be an important relationship.'[246]

Zhane had a history of distress when one of his carers was absent. It is noted in a HYPA psychological report:

> 'It is known that he experienced distress when one of his carers was sick or if there was a change in his carer roster.' [247]

17.7. Other proximate stressors referred to by Dr Caunt include commencing high school, a transition he reported that he did not feel ready for, sexual behaviour between Zhane and another MVCU resident, a pending court matter in which he was accused, a minor head injury at a football match, and the anniversary of the breakdown of his placement with Mr Rimes.[248] It was also postulated that Zhane may have become aware and distressed by the death of his former mentor, Stephen Rimes' son Brandon, who died by suicide in December 2015. Though it is not known if Zhane was aware of this fact, according to Ms Nicolaou's report, '*suspicions linger that Zhane may have heard about it via social media or other social connections*'.[249] Mr Rimes had a conversation with one of Zhane's sister's about Brandon's death, and Mr Rimes said he thought Zhane found out, although he was not 100% sure.[250] There was information about Brandon's death on Facebook although Mr Rimes was not sure if there was any detail on Facebook about how Brandon died.[251]

17.8. I conclude that at the time of his death, Zhane had a number of proximate stressors which he was attempting to deal with without any therapeutic support, with a case worker who was physically distanced (situated in Port Pirie), and in a living environment which was inappropriate for him and his needs. These events were occurring in Zhane's life against a background of him having what Dr Caunt described as:

> 'A complex neurodevelopmental disorder with contributions as a result of intrauterine exposure to toxins and early life trauma, and ongoing neurodevelopmental impacts of attachment-based trauma.'

[246] Transcript, pages 534-535
[247] Exhibit C67
[248] Exhibit C47, page 2
[249] Exhibit C43, page 7
[250] Transcript, page 215
[251] Transcript, page 216

Dr Caunt noted that without the benefit of having met with Zhane or examined him herself, it was difficult to make any more precise diagnosis, but that he certainly had an adjustment disturbance.[252]

17.9. Unfortunately, while there is one logbook from MVCU before the Court covering 3 July 2016 until the date of Zhane's death, no logbooks from the MVCU for the rest of Zhane's time there (November 2015 - July 2016) have been produced despite requests from this Court. I am satisfied based on affidavits received that these logbooks were not seized by SAPOL, in the conduct of a coronial investigation, or SafeWork during their investigations. The Department has detailed the usual process in relation to the storage of these logbooks and the extensive, but ultimately unsuccessful, searches which have been undertaken for them. The absence in evidence of these logbooks has deprived this Court of the opportunity to closely scrutinise the written records of the last few weeks and months of Zhane's life.

18. Contact and connection with biological family

18.1. The Interagency Review, Appendix 1, Timeline 2 is a timeline of family contact between Zhane and his biological family.

18.2. The timeline shows that Zhane's mother was engaged with the AFSS in 2008 and requested contact with Zhane. She was told to contact the Department. There was then a large gap in contact between the Department and Zhane's biological parents from 7 May 2008 to 27 June 2012. In June 2012 it was suggested by the Department over the telephone to Zhane's mother that she write to him. Over the next two years, minimal efforts were made by the Department to contact Zhane's mother regarding Zhane, despite the fact that during this time some of Zhane's other siblings were being reunified with their mother.

18.3. In 2014, following a Department visit to Zhane's mother, it was noted that she demonstrated a commitment to reconnecting with Zhane and that at that time she was caring for two of her children and meeting their needs.[253] Despite his mother's progress and her desire to reconnect with Zhane, the Department did not take any affirmative action at the time to reconnect Zhane to his mother.

[252] Transcript, page 557
[253] Exhibit C26i, page 459

18.4. In relation to contact between Zhane and his biological father, the Department has accepted that not enough was done to get Zhane back in touch with his father,[254] an assertion with which I agree. Of particular significance is that Mr Chilcott-Sing Poo was not informed that Zhane was moved to the MVCU, or back to Adelaide generally. The Department was aware that Mr Chilcott-Sing Poo was residing in Adelaide from at least September 2015 when they hand-delivered a letter to him.[255] It was in 2015 that Zhane started to ask more about his father, and Mr Verran wrote to Mr Chilcott-Sing Poo to request a photograph. A more proactive attempt to connect Zhane with his father should have been made at this time.

18.5. Dr Caunt gave evidence that a documented family plan was important in a situation like Zhane's so it '*didn't fall out of the mind*',[256] yet she saw no evidence of a documented family plan at all in the records. The type of information that Dr Caunt would expect in such a plan would be the historical context of what had happened regarding contact with the family, attempts to contact the family, the views of the young person, the plan about family contact and who was responsible for undertaking specific actions and follow ups.[257] Dr Caunt's evidence was that it was not clear from the documentation who had the role to even consider Zhane's contact with his family, and that was concerning in itself.[258]

18.6. The failure to facilitate adequate contact with his biological family left Zhane in a situation where he had little idea about where he had come from or to whom he belonged. Ms Nicolaou concluded in her report:

> 'Zhane's need for contact with his family was seriously neglected by DCP over many years and he had very little knowledge of his family and culture. He belonged to nobody and nowhere, with catastrophic results.' [259]

Zhane's lack of knowledge of his biological family is evident in a 2015 psychology report which states:

> 'Zhane couldn't tell me anything about his biological parents aside from "I haven't seen them since I was a baby, I don't even know them". Zhane was unable to tell me his birth father's first name.' [260]

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[254] Transcript, pages 339 & 341
[255] Exhibit C22c (2), pages 137-141
[256] Transcript, page 800
[257] Transcript, page 802
[258] Transcript, page 800
[259] Exhibit C43, page 25
[260] Exhibit C67

18.7. Zhane's Viewpoint Survey from February 2016 indicates his extreme dissatisfaction with the amount of contact he had with his biological family.[261] In this survey he indicated that he gets to visit his family less than he wants, gets to talk to his family less than he wants, gets to write to his family less than he wants, and that he:

> '… would like to visit my Mom and my sisters I'd rather go up there than stay in Adelaide :(' [262]

Despite his extreme dissatisfaction being voiced to the Department at that time, the Department continued to fail to facilitate regular and meaningful contact between Zhane and his biological family.

18.8. Ms Michelle Hopkins also detailed in her evidence how lack of family contact was a prominent issue in Zhane's mind during a conversation she had with him in May 2016, less than eight weeks before his death. Her evidence on this topic was as follows:

> 'A. He kept coming back to the subject of contact with his mother and then I would ask him, "So how have things been going at school?" And that's when he outlined the other issues he had at school and then I said, "Well, how about Scouts, how's Scouts been going?" and then he said "I'm not going to Scouts anymore. I'm too old for it. I don't like it anymore", and he just - I kept trying to change the subject a little bit because I was clear on where he was going, but he kept wanting to say that he was missing his mum and it was upsetting him and there was supposed to be contact with his family coming up but it kept getting cancelled and the dates kept getting changed and he didn't have confidence it would happen and –
>
> Q. You have probably just answered my question there, but you have said "He did not think that this was going to take place in regards to visits". What did he say about thinking that a planned visit wasn't going to take place.
>
> A. Yeah, as I said, he said that in the past, he had been disappointed a number of times because the dates would get pushed out or the visits would be cancelled.
>
> Q. Did he say why or what his understanding was of why dates were being pushed out or visits were being cancelled.
>
> A. He blamed the department, Families SA, but all young people tend to do that, so I wasn't really sure of the reason why, but he obviously felt it was Families SA that were doing that.'[263]

[261] Exhibit C26n, page 119
[262] Exhibit C26n, page 121
[263] Transcript, page 752

18.9. I find that the Department failed to connect or keep Zhane sufficiently connected with his biological family, throughout the entirety of his life under the Guardianship of the Minister, and that this had had a deleterious effect on Zhane.

19. Connection with Aboriginal culture

19.1. The failure to facilitate meaningful family contact between Zhane and his biological family was not only distressing from Zhane's perspective but was also a breach of the Department's obligations in accordance with the 'Aboriginal and Torres Strait Islander Child Placement Principle' (the ATSICPP).

19.2. The ATSICPP aims to keep children connected to their families, communities, cultures and country, and to ensure the participation of Aboriginal and Torres Strait Islander people in decisions about their children's care and protection. The onus was on the Department to ensure that the ATSICPP was complied with and to continue to make active efforts to connect Zhane to family and community.[264]

19.3. It was recognised as early as 2010 as part of a psychological assessment[265] that connection to community and family needed to be improved for Zhane. The report following this assessment included recommendations that Zhane should resume regular contact with his siblings and be provided with accurate information regarding his parents and siblings through the development of a detailed genogram and life story book, and that Zhane receive ongoing narrative regarding his cultural identity, such as who he is and where he belongs and be provided with opportunities to participate in relevant cultural events as well as mentoring by a Ngarrindjeri elder. However, the Department did not follow through on these recommendations.

19.4. The implications of the failure to have regard to this principle were enunciated in the affidavits of Ms April Lawrie, Commissioner for Aboriginal Children and Young People, where she stated:

> 'In Zhane's case there was no plan for family contact and no consideration of reunification after it was considered very early in his life. Had there been some proper attempt to apply the placement hierarchy and use the RATSIO[266] in the search for family and community, then at the very least proper contact with family, community and culture may have been re-established. Zhane's voice, pleading for reconnection, may have been heard and saved

[264] Exhibit C66, paragraph 82
[265] Exhibit C29f, page 260 and Exhibit C29g, page 167
[266] Registered Aboriginal and Torres Strait Islander Organisation

> him from feeling cut loose in a world where no-one cared for him and where he felt that the adults surrounding him were actively working against his wishes. In these circumstances, the proper application of the ATSICPP could have been a lifeline that may have seen him having regular contact with at least his mother and his siblings and could potentially have yielded a placement with family and community or even reunification with his mother. However, at that stage not only was the ATSICPP totally ignored, but it was weak in structure and lacking the vital connection to family and community.' [267]

19.5. The 2016 Guardianship Annual Review[268] mentions the following areas requiring intervention:

(a) Case worker in partnership with AFP to explore Aboriginal connections on both sides;

(b) AFP to make contact with AFSS to explore family's cultural background;

(c) Follow up Aboriginal Life Story Book;

(d) Case worker to ensure C3MS is accurately reflecting his Aboriginality and Malaysian heritage.

The fact that these areas required intervention in 2016 reflected the fact that they had been neglected until that time, despite Zhane having been under the guardianship of the Minister for almost 13 years. There is also no evidence any of these things were actioned following the 2016 Guardianship Annual Review.

19.6. Ms Michelle Hopkins' evidence about the lack of connection to culture within the MVCU was insightful. Her perspective is that of a Kamilaroi[269] woman whose own Aboriginality is of particular importance to her. She noted there were a number of Aboriginal residents at the MVCU, but when she looked around the MVCU, cultural items were stark in their absence. She said a number of residents had raised the lack of cultural features with her as a concern. Her evidence was that having a strong cultural identity herself she recognised the importance of it and especially for young people like Zhane.[270] She said Zhane told her '*he was missing his connection with culture*'.[271]

19.7. In Zhane's Viewpoint Survey[272] he answered '*no*' to a question about whether he was helped to follow his beliefs and customs and the viewpoint indicates that he is 33.25%

[267] Exhibit C66, paragraphs 201-202
[268] Exhibit C26n, page 204, paragraph 212
[269] There are several accepted spellings. This is Ms Hopkins' preference.
[270] Transcript, page 742
[271] Transcript, page 737
[272] C26n, question 30

satisfied with his sense of community.[273] However, despite this low level of satisfaction, there was no plan in place to address it.

19.8. I find that the Department failed to apply the ATSICPP by neglecting to facilitate regular and meaningful contact between Zhane and his biological family, and failing to keep Zhane connected to his family, community, and culture. Ms Nicolaou expressed that Zhane was an Aboriginal child who was entirely disconnected from his family since he was a baby, despite the Department having a proactive obligation to maintain his connection and relationship with his family and culture.[274] I agree.

20. Placement decisions

20.1. There was also an onus on the Department to ensure that the ATSICPP was complied with in relation to each of Zhane's placements.[275] The Department should have consulted with a RATSIO[276] whenever a new placement was in contemplation for Zhane.[277] According to Ms Lawrie, Zhane's placements following his placement with Mr Rimes show an almost total disregard for the ATSICPP. Ms Macdonald's evidence was that '*... my review of Zhane's case would suggest that there wasn't high regard given to the Aboriginal Child Placement Principle*'[278] and she also agreed that there is no evidence of attempts later on in his life to adhere to the principle.[279]

20.2. Coupled with the failure to comply with the ATSICPP in relation to each of Zhane's placement decisions, was a lack of exploration of kinship placement options for Zhane throughout his life. According to the affidavit of Ms Lawrie:

> 'Looking at the genogram[280] for Zhane there is no information about his father's family, but on his mother's side there are tantalising clues as to where his extended family and kin may be. He identified as Ngarrindjeri. I can see that he is also connected to Coulthards, Adnyamathanha people. Both are strong First Nations peoples who are holders of native title and who have deep, continuing, and extensive connections to their Country in the lakes and Coorong and Flinders Ranges, respectively. I do not know who prepared the genogram, but I do know that it was not a person with deep cultural knowledge, nor was this knowledge pursued at any later time to help guide the application of the ATSICPP at

[273] Transcript, page 933
[274] Exhibit C43, page 33
[275] Exhibit C66, paragraph 82
[276] At the time, AFSS was the only RATSIO
[277] Exhibit C66
[278] Transcript, page 32
[279] Transcript, page 326
[280] Exhibit C44, Annexure CT1, page 26

> all future placement decisions. It is not even clear if the genogram is tracking both Aboriginal and non-Aboriginal kin.'

The implication of this according to Ms Lawrie was that:

> 'DCP failed to explore all placement options in accordance with the ATSICPP due to an incomplete genogram and a lack of information about other individuals within Zhane's Aboriginal family and community in accordance with Aboriginal law, custom and practice.'[281]

20.3. Ms Macdonald gave evidence that there is nothing on C3MS or the contact files that suggests that Zhane's extended family were considered as placement options.[282] Furthermore, the 2016 Guardianship Annual Review contains an action of '*Referral to kinship for scoping*' yet there is no evidence this occurred, which begs the question why this did not happen much earlier for Zhane.

20.4. The oral evidence about placement decisions for Zhane focused particularly on the placement decisions in 2015 and 2016. I heard oral evidence from Ms Janine Platt who was the Supervisor of the Placement Services Unit (PSU) in 2016. At that time the PSU was a state-wide service consisting of five social workers and senior social workers. The role of the PSU was to receive all of the placement requests for the State in regard to children requiring respite or some form of alternative care.[283]

20.5. Ms Platt explained that upon receiving a placement request from a worker the PSU would send out a request to outside agencies or within the Department for appropriate placements to be identified. The case worker, not the PSU, would make the final decision as to placement of a child with any of the identified options.[284]

20.6. Once a placement is secured that is in the best interests of the child, the PSU's role would cease. However, if the circumstances of a child were to change and their placement was no longer considered to be in their best interests, then the PSU could be re-engaged through a new placement request.[285]

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[281] Exhibit C66, paragraph 216
[282] Transcript, page 327
[283] Transcript, page 1207
[284] Transcript, page 1374
[285] Transcript, page 1212

20.7. Zhane was placed in MVCU in November 2015. A PSU request for an alternative placement was next generated in March 2016.[286] Ms Platt gave evidence that she would have expected one to be submitted at an earlier time.[287]

20.8. The PSU request generated in March 2016 contained significantly out of date information.[288] This was caused by the use of a 'cloning' tool, which effectively cloned information from Zhane's previous PSU request onto this new request, disregarding the fact that the information being cloned was, by that time, significantly out of date.

20.9. The only action PSU took in relation to Zhane in 2016 was to send out this one placement request, containing outdated information, to three agencies.[289] One agency requested further information and there is no evidence to suggest that was responded to.[290] Ms Platt gave evidence she would expect the placement request to have been updated in June 2016, but that was not done.[291]

20.10. Counsel for the Government Agencies and Witnesses submitted that I should find the Department continued to scope for alternative placements for Zhane while he was at the MVCU and that the PSU referral for Zhane was current and active up until his death.

20.11. I cannot conclude how long the March 2016 placement request was active. It was withdrawn at some time between its creation and the production of this document for the inquest.[292] Despite initially suggesting that the placement request was not withdrawn until after Zhane's death, Ms Platt later conceded there was no basis upon which any conclusion could be made about when that placement request was withdrawn.[293] There is no evidence upon which I can make a finding that there was an active placement request at the time of Zhane's death.

20.12. Though witnesses spoke of the fact that the Department was '*continuing to scope*'[294] for an alternative placement for Zhane, Ms Platt agreed with the proposition put by Counsel Assisting that if PSU was in fact continuing to scope for an alternative placement for Zhane, there would be more notes and attachments recorded against this placement

[286] Exhibit C26n, page 231
[287] Transcript, page 1349
[288] Transcript, pages 1278, 1307 & 1347
[289] Transcript, page 1310
[290] Exhibit C58, Tab 6C, page 4 and Transcript, pages 1247-1248
[291] Transcript, pages 136-137
[292] Exhibit C26n, page 231
[293] Transcript, pages 1240-1241
[294] Transcript, page 1372

request.[295] On the contrary, there is no evidence that PSU were continuing to scope for alternative placement for Zhane, or if so, what that scoping entailed.

20.13. Ms Platt gave evidence to the effect that a decision was made that Zhane would be better off remaining in MVCU rather than being placed into a general foster case placement while awaiting a therapeutic placement. She stated:

> 'So my understanding from the complexities of Zhane and that one of the things that is really important for our children and young people is to have the least placement moves as possible, and that we know that at times with our general fosters, with children with complexities such as Zhane had, that they can struggle and that they at times can experience placement breakdowns. And so that's why the focus of placement services was towards having a therapeutic placement for Zhane, so that his care needs could have been met and the carer would have been supported at a higher level.' [296]

20.14. No decision that Zhane would be better off remaining in MVCU, a non-therapeutic residential care facility, rather than a general foster care family placement, is documented in the evidence before the Court. I have no evidence about who, if anyone, made such a decision or why that decision was made. However, it appears to contradict the recommendation of Ms Savilla in an email of February 2016 following her visit to the MVCU that:

> 'The only other recommendation that I would have at the time is to find Zhane a family-based placement as a matter of urgency.' [297]

20.15. I do find that by mid-2016, prior to Zhane's death, there was a general perception within the Department that an alternative placement was unlikely to be found for Zhane and that he was to remain in the MVCU for a significant period of time. I make this finding based on the email sent by Ms Dianne Longman in June 2016 stating, '*it is anticipated that Zhane will remain in the MVCU until he attains the age of 18 years*',[298] and the statement of Ms Sue McDonald in her affidavit that:

> 'Although it was hoped that a further family-based placement could be found for Zhane, it became clear in early 2016 that Zhane was likely to remain at the MCVU for a considerable period.' [299]

[295] Transcript, page 1310
[296] Transcript, page 1346
[297] Exhibit C29n, pages 145-146
[298] Exhibit C49, Annexure E
[299] Exhibit C41, page 11

21. Case management concerns – 2015 and 2016

21.1. Mr Brian Verran was Zhane's case manager[300] from December 2014 until his death in July 2016. Mr Verran died shortly before this inquest commenced but prior to his death he provided an affidavit, which was tendered.[301]

21.2. According to Dr Caunt, by the time of Zhane's death:

> 'There was miscommunication and case management may have drifted such that Zhane's needs were not being addressed in a timely manner.' [302]

21.3. There were a number of concerning aspects of Zhane's case management in the period from 2015 to 2016.

21.4. Guardianship Annual Reviews

21.5. According to section 52 of the Children's Protection Act, the Minister was obliged to annually review the circumstances of children and young people on long-term orders. The review had to be carried out by a panel appointed by the Minister and the panel was to produce its conclusions in writing. According to 'The Life They Deserve', '*The obligation in section 52 is key to ensuring that planning for children is regularly scrutinised and updated*'.

21.6. 'The Life They Deserve' indicates that for the 2014-15 financial year 2100 children were entitled to an annual review. Eighty-three per cent, or 1740 children, were reviewed. However, it meant that for 2014-15 there were still 360 children in care who were not reviewed in accordance with the requirements of the legislation. It seems that Zhane fell within that group of 360 children in care whose circumstances were not reviewed in 2015 in accordance with the requirements of the legislation. There is a Guardianship Annual Review dated October 2014,[303] so the next review should have been done in approximately October 2015, shortly after Zhane left Mr Rimes' care. Ms Longman gave evidence that a Guardianship Annual Review should be located in what she referred to as the '85' file which was also referred to as a Contact File.[304] Each of Zhane's Contact 85 Files is before this Court and does not contain a Guardianship Annual Review from 2015. There is no evidence that a Guardianship Annual Review

[300] The terms case worker, case manager and social worker were used interchangeably at the Inquest
[301] Exhibit C21
[302] Exhibit C47, page 7
[303] Exhibit C29p, pages 2-8 (chronology document 160)
[304] Transcript, pages 903-905

was completed for Zhane in 2015. I find that there was no Guardianship Annual Review completed for Zhane in 2015, in clear breach of the legislative requirement. Given this was the year of the placement breakdown with Mr Rimes, failure to do a review in this year was a significant oversight.

21.7. Although there was a Guardianship Annual Review completed for Zhane in 2016,[305] there is no evidence he was consulted throughout this process at all. The heading '1. Participative Case Planning and Decision Making' asks questions including whether the child has been provided with opportunities to have their opinions, thoughts and views heard and recorded, and whether the child has been provided with opportunities to participate in case planning and decision making. None of these questions is answered in Zhane's 2016 Annual Review.

21.8. Zhane's 2016 Guardianship Annual Review resulted in a number of matters being identified for action to be taken. The proposed actions were undertaken either not in a timely fashion, or not at all. I refer in particular to the following actions:

- <u>*CAT to be done*</u>: Zhane's CAT (Complexity Assessment Tool) was out of date for approximately eight months between October 2015 and June 2015.[306] When PSU generated a placement request in March 2016 it was already five months out of date. Once the CAT was updated in June 2016, four months after it was listed as an action to be undertaken following Zhane's 2016 Guardianship Annual Review, it contained information that did not accurately reflect Zhane's situation. For example, it stated, '*Zhane was self-harming when he first came to the unit, that has not existed in recent times*'. That clearly conflicts with records of self-harm from May 2016. Secondly, the CAT from June 2016 states that Zhane continued to receive support from CAMHS OT Emma Young for sensory processing issues. Zhane had not seen Emma Young since June 2015 and that had not been the focus of her involvement.[307] As Dr Caunt observed, inaccuracies in documents have the potential to cause confusion.[308] The inaccurate information in the CAT is a poor reflection of Zhane's care team's understanding of his circumstances at the time.
- <u>*Requires case worker to be based near him*</u> – this was still not actioned at the time of Zhane's death. Despite Zhane relocating to Adelaide in 2015, his case remained

[305] Exhibit C26n, pages 204 onwards
[306] Transcript, page 1336 and Exhibit C58a
[307] Exhibit C47, page 7
[308] Exhibit C47, page 7

with the DCP Port Pirie office for case management until the time of his death. I have heard no oral evidence about why Zhane's case was not transferred to an Adelaide office for case management. The Interagency Review states:

> 'The DCP case manager could not recall the particular details regarding why the case had not been transferred in 2016. It was discussed that case transfer from country offices to the metropolitan area is difficult due to the receiving officer workload pressures.'[309]

An obvious unsatisfactory consequence of Zhane's case remaining with the Port Pirie DCP office for management was the lack of face to face contact that Zhane had with his case manager throughout late 2015 and 2016. In the 12 months prior to Zhane's death, Mr Verran had only seen him five times when the expected minimum would be once per month[310] in accordance with the 2008 Standards of Alternative Care. The Port Pirie office did not utilise the Country Case Management Team who may have been able to undertake the task of visiting Zhane face-to-face once a month while he was in the MVCU.[311] One of the visits Mr Verran did make to the MVCU was in February 2016 and attention must be drawn to Mr Verran's account of this visit:

> '[Supervisor][312] asked where Zhane would rather be, at the unit or with a family, Zhane immediately said "with a family". [Supervisor] commented that he would need to be demonstrating better behaviours because families consider all aspects of children before agreeing to take them into care. [Supervisor] asked why he had been so good when he was with Steve. Zhane spoke about being with Steve and being part of a family, he said that Steve cared for him more than unit staff that was "only on shift".' [313]

In my opinion Zhane is likely to have perceived that he was being blamed for the fact he was not able to be placed with a family. This is likely to have had a negative impact on him.

- *PSU referral for family-based placement to occur* – this is contrary to Ms Platt's evidence that only therapeutic placements were to be considered for Zhane at this time. There was no PSU referral in 2016 for a family-based placement;

[309] Exhibit C41, Annexure SM1 'Interagency Review', page 40
[310] Exhibit C47, page 7
[311] Exhibit C41, Annexure SM1 'Interagency Review', page 21
[312] The Supervisor was Ms Cheryl Yeates who died some time prior to this inquest
[313] Exhibit C21

- *Referral to kinship for scoping* – there is no evidence this occurred, and it also begs the question why this did not happen much earlier for Zhane;
- *Follow up Aboriginal life story book* – again, this begs the question why this was being followed up when he was thirteen years of age, and not at a much earlier time. There is also no evidence this was actioned before his death.

21.9. 2016 Solution Based Casework (SBC) case plan

21.10. According to 'The Life They Deserve', case planning is an integral part of the broader service delivery approach of case management for each child or young person. Case planning is '*the process which provides the framework for making decisions about a child/young person in order to achieve identified outcomes*'. This critical activity is based on an assessment of the child's needs and establishes a guide for the tasks and activities of all parties involved in the child's care. The case manager takes a leadership role in this process.

21.11. Quality standard 2.6 of the 2008 Standards for Alternative Care required that every child in care have a case plan that is developed, monitored and reviewed every six months. A case plan document should record the aims and outcomes of the case planning process, list the activities and services that will be required to achieve those goals, and describe how and when those services will be delivered. It is a formal record which provides transparency of action for all parties who retain a legitimate interest in the child's wellbeing. The planning process also allows a child or young person to contribute their goals, aspirations and intentions in the short and long term, and to record how these contributions have been taken into account in planning.

21.12. There is an unsigned SBC case plan for Zhane which Ms Dianne Longman agreed must have been completed after 11 May 2016.[314] Ms Longman explained:

> 'Part of our legislation to have a case plan in place for our children whilst in care so that we can monitor their life domains and to ensure that they're getting the best service provision whilst in care.' [315]

She gave evidence this should usually happen within six months of the Guardianship Annual Review.[316]

[314] Transcript, page 925
[315] Transcript, page 896
[316] Transcript, page 923

21.13. The unsigned SBC case plan prepared after 11 May 2016 states:

> 'In Zane's (sic) view point it indicates that he is happy with his current accommodation and he is indicating that he'd get on well with the workers.' [317]

That is referring to his Viewpoint from February 2016, and completely disregards the threat to kill himself if returned to the MVCU that he made on 10 May 2016. Dr Caunt observed that the:

> 'Lack of an adequate and up to date case plan suggests the engagement between Zhane and the caseworker was not sufficiently active and purposeful.' [318]

21.14. As noted in 'The Life They Deserve':

> 'The existence of a good quality case plan reflects a relationship between a child or young person and their worker which is current, active and purposeful, and reveals a level of attention to, and engagement with, the young person concerned. It also provides a measure against which to track progress and assess the utility of services provided to a child or young person. Without a formal case plan, there is a risk that the needs of a child will be neglected, and their case left to drift.'

21.15. I find that this unsigned 2016 SBC case plan - and the absence of a signed one - reflects how out of touch Zhane's care team was with his needs in the months leading up to his death, and that his needs were being neglected and his case left to drift.

21.16. An analysis of these abovementioned documents leads me to the conclusion that by 2016 case management had in fact drifted such that Zhane's needs were not being addressed in a timely manner.

22. Findings in summary

22.1. Zhane's cause of death was hanging.[319]

22.2. As to the circumstances of Zhane's death, I make the following findings:

22.2.1. Zhane should not have been placed with LB in light of allegations made against her by her biological son in the days leading up to Zhane's placement, without further scrutiny of those allegations.

[317] Exhibit C29v, page 100
[318] Exhibit C47, page 7
[319] Exhibit C2

22.2.2. There was insufficient engagement between the Department and LB during Zhane's placement with LB.

22.2.3. The lack of oversight exposed Zhane to risks that he should not have been exposed to, including the potential for abuse.

22.2.4. The commercial care environment for Zhane was a highly inappropriate one.

22.2.5. Mr Rimes took Zhane into his care in the expectation that any financial pressure he may experience due to receiving a lower carer reimbursement than he was accustomed to, would be alleviated by the placement of a second child within a few months of Zhane being placed.

22.2.6. Zhane's placement with Mr Rimes was the period of greatest stability in his entire life. He was happy and thrived in this placement.

22.2.7. There were options available to the Department to financially support the continuation of Zhane's placement with Mr Rimes.

22.2.8. The Department chose not to exercise any of those options to ensure Zhane could remain in that placement with Mr Rimes.

22.2.9. The breakdown of this placement was catastrophic for Zhane.

22.2.10. The Department failed to facilitate a meaningful relationship between Zhane and Mr Rimes following Zhane leaving Mr Rimes' care.

22.2.11. The MVCU was an inappropriate placement for Zhane, and he became increasingly unhappy in this placement.

22.2.12. On 10 May 2016 Zhane threatened to kill himself if he was returned to the MVCU.

22.2.13. By this time there was an urgent need for a thorough assessment of Zhane's mental state by a professional equipped with all of the relevant information.

22.2.14. The only assessment of the state of his mental health by a qualified professional after this threat to end his life on 10 May 2016, was by Dr Katy Osborne on 16 May 2016. She was not told that Zhane had threatened to end his life. Dr Osborne's consultation was limited by the lack of information provided to her by the guardian accompanying Zhane to that appointment.

22.2.15. Zhane should have been under CAMHS' care by May 2016.

22.2.16. By mid-2016, prior to Zhane's death, there was a general perception within the Department that an alternative placement was unlikely to be found for Zhane and that he was to remain in the MVCU for a significant period of time.

22.2.17. Someone within the Department advised Zhane in June 2016 that it was anticipated that he would remain in the MVCU until he was 18 years old.

22.2.18. By 2016 case management had drifted such that Zhane's needs were not being addressed in a timely manner.

22.2.19. Zhane had a number of stressors in his life in the months leading up to his death.

22.2.20. The Department failed to apply the ATSICPP by neglecting to facilitate regular and meaningful contact between Zhane and his biological family, and failing to keep Zhane connected to his family, community, and culture.

23. Was Zhane's death preventable?

23.1. The circumstances of Zhane's death are complex and multifactorial. The question of preventability of his death is therefore a complicated one.

23.2. Dr Caunt stated in her report:

> 'There is debate about whether suicide is ultimately preventable. That being so, there were a number of missed opportunities to moderate the chances of death by suicide that extend back to his early life.'[320]

Dr Caunt elaborated on some of these missed opportunities in her oral evidence:

a) A missed opportunity for some early intervention and early interventions with his family or improvements in his family context before he went into care;[321]

b) A missed opportunity for quicker stabilisation of his care once he was in care and then being placed into a nurturing foster environment with foster or adoptive carers, so family-based placement;[322]

[320] Exhibit C47, page 36
[321] Transcript, page 559
[322] Transcript, page 559

c) Multiple missed opportunities associated with the trauma of repeated losses and attachment traumas related to multiple placements. As to this, Dr Caunt elaborated that:

> 'The missed opportunities sort of compound on each other and there are probably more than just five and so I'm trying to collapse some down. The repeated multiple placements - so once a placement, you know, the longest placement that he had, dissolved to be quickly put back in another nurturing foster environment, that opportunity was lost as well and that resulted in multiple placements and the more placements the more impact on, you know, the more attachment trauma that he suffered and so you know like that collapses down into one but it's multiple missed opportunities where there's more placements.'[323]

d) There were multiple missed opportunities where he could have had involvement with a skilled multidisciplinary team that completed strength and needs based assessments on which a comprehensive plan and targeted plan could have occurred;[324]

e) In regard to psychiatric treatment:

> 'In the closer period to his death, there were a number of missed opportunities to get involved earlier with him to be able to have a comprehensive plan to address any risk factors within the context that he found himself.'[325]

23.3. An analysis of those missed opportunities does not lead with certainty to the conclusion that Zhane's death by suicide was preventable. I do find, however, that there were a number of missed opportunities in Zhane's case to moderate the chances of death by suicide which, if taken up, may well have prevented his death in July 2016.

23.4. Of course, those factors elaborated upon by Dr Caunt during her evidence were but a broad summary of opportunities to moderate Zhane's risk of suicide. This inquest has identified many specific failings in the provision to Zhane of state care. In my opinion, the cumulative effect of all those failings was to increase his risk of suicide. Had those failings not occurred, it can only be said that the risk of Zhane taking his own life must have been reduced.

[323] Transcript, page 775
[324] Transcript, page 775
[325] Transcript, page 559

24. Recommendations

24.1. Pursuant to Section 25(2) of the Coroners Act 2003 I am empowered 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.

24.2. I intend to make a number of recommendations, directed to the Minister for Child Protection, the Chief Executive of the Department for Child Protection, and the Chief Executive of the Women's and Children's Health Network, as the case requires.

24.3. Ms Macdonald described in her affidavit and in her oral evidence a number of measures that have been implemented since the events with which this inquest is concerned, many of which arose out of the recommendations of 'The Life They Deserve' and the Interagency Review into Zhane's death. Although many of those changes may have had a bearing on Zhane's experiences under guardianship of the Minister, a full analysis of the impact of these measures was beyond the identified scope of this inquest. However, this inquest highlighted a number of areas of concern which, in my view, require further recommendations to be made.

24.4. Counsel Assisting in her written submissions has pointed to the statement in the Interagency Review:

> 'Zhane did not have an overt self-harm history and he had not disclosed thoughts of self-harm or suicide. Upon review the only incidents of self-harm were (1) in June 2014 Zhane disclosed that he sometimes choked himself while he was in the shower and (2) In May 2016 there was an incident where he had small cuts on his arm.'

This conclusion of the Interagency Review is factually incorrect. Zhane said that he would kill himself if he was returned to the MVCU. There were numerous other mentions of self-harm throughout Zhane's life. Counsel Assisting has submitted that a conclusion that can be drawn from this inaccurate assessment of Zhane's self-harm history in the Interagency Review, is that it is difficult to ascertain a child's self-harm history from Department documents. There is no single source of information about a child's self-harm risk or behaviours.[326] If these agencies, collaboratively undertaking a root cause analysis type review, somehow managed to not reveal the complete picture

[326] Transcript, pages 1474-1475

of Zhane's self-harm history throughout his life, it must be difficult for anybody within the Department trying to ascertain such information to do so. Counsel Assisting urged me to recommend that a risk register be established which records all acts or threats of self-harm by a child under the guardianship of the Chief Executive.

24.5. Counsel for the Government Agencies and Witnesses submitted that a risk register reviewed in isolation of a deep understanding of the child's personal circumstances is unlikely to be effective, as acts of self-harm or threats of self-harm need to be assessed and understood by the care team closest to the child in the context of the individual child's circumstances. Further, children and young people may have varying difficulties arising from their complex trauma experience – such as significant offending behaviours, drug or alcohol misuse or eating disorders. Self-harming is not the only presentation of a child's trauma experience.

24.6. Nevertheless, it was clear to me that no person involved in Zhane's care, not even those who had or should have had 'a deep understanding of the child's personal circumstances', had a complete picture of his self-harm behaviours and how they had developed over time. The evidence does not suggest that in this regard Zhane's case was an isolated one. I intend to make a recommendation accordingly.

24.7. Accordingly, I recommend that a risk register be established which records all acts or threats of self-harm by a child under the guardianship of the Chief Executive. There should be appropriate information sharing arrangements in place in relation to this risk register for all agencies that may deal with a child under the guardianship of the Minister including DCP, CAMHS, CPS, DECD and SAPOL. The risk register in relation to each child should be reviewed at regular intervals by an appropriately qualified professional with the ability to assess when a child may require closer assessment of suicidality and/or more intensive therapeutic treatment.

24.8. I was not told, and neither was I able to determine, why Zhane was not referred to the CAMHS Complex Care Review Committee. I recommend that CAMHS should review its policies and training regarding referrals, against the background of Zhane having not been referred, to ensure that cases requiring review are not missed.

24.9. Ms Macdonald noted in her affidavit:

> 'The absence of a well-resourced, dedicated and specialist CAMHS service for children in care presents huge challenges for young people in circumstances similar to Zhane's.' [327]

Dr Usman's evidence was that while there is a dedicated and specialist CAMHS service for children in care, it is not well-resourced.[328] I recommend that a review be undertaken of services available through CAMHS to children in state care, that the adequacy or otherwise of those services be assessed and that the necessary funding to enable provision of adequate services be determined. Whilst the allocation of financial resources to any service is a matter for government, I intend that adoption of this recommendation will facilitate future scrutiny of the adequacy of CAMHS funding.

24.10. The Department needs to increase the number of family-based foster carers. As of June 2021, 14.1% of all children in care in South Australia were in non-family-based placements. 85.9% of children in care in SA as of June 2021 were in family-based placements, whereas the national average sits at 92%.[329] To assist in increasing the number of family-based foster carers, the payment provided to these carers should be reconsidered, with close consideration given to the payment provided to therapeutic family-based carers such as Mr Rimes. Mr Rimes gave evidence of the difficulties of having employment while being a therapeutic carer.[330] There was evidence that the payment for carers is a reimbursement, not a wage[331] but if those carers cannot earn a wage at the same time, due to onerous responsibilities of providing therapeutic care, then they need to be provided with more than just a reimbursement. Through Senior Counsel, the Department advised that in December 2021, an increase was announced to the carer support payments made to all general and kinship carers, effective from 1 January 2022. Nevertheless, I recommend there be a review of the payments made to family-based foster carers with a view to increasing the availability of family-based placements for children under guardianship of the Chief Executive.

24.11. The standard of performance of some social workers involved with Zhane in 2015 and 2016 was questionable. The *Social Worker Registration Act 2021* was introduced following a recommendation made by former State Coroner Johns in the inquest into

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[327] Exhibit C41, paragraph 110
[328] Transcript, page 791
[329] Exhibit C44, paragraphs 88 and 94
[330] Transcript, page 195
[331] Exhibit C41, paragraphs 47-49

the death of Chloe Valentine.[332] Counsel Assisting has urged me to recommend that this Act be amended to include a requirement that each social worker registered under this Act and employed by the Department as a case worker for children under the guardianship of the Chief Executive, has a minimum of three of their case files relating to such children or young people audited on a yearly basis as part of a programmed performance review process. Serious concerns identified as part of this review process, in particular failures to comply with statutory obligations, should be referred to the Social Worker Registration Board for consideration of whether that person is a fit and proper person in accordance with Section 35 of the Act to be a social worker. This process may also inform whether conditions are required on a particular social worker's registration.

24.12. In response, Counsel for the Government Agencies and Witnesses submitted that all staff are already bound by the *Public Sector Act 2009* (SA) and the *Public Sector (Honesty and Accountability) Act 1995* (SA) which impose duties and provide for accountability of all public sector employees. Further, it was submitted, the Code of Ethics for the South Australian Public Sector, to which all public sector employees are bound, imposes clear professional conduct standards and disciplinary provisions. I was also told that the performance of social workers employed by the Department is assessed and monitored through continuous professional supervision, a key component of the DCP Practice Approach and the DCP Clinical Governance Framework, which also supports high quality, culturally safe practices, and enhances reflective capacity, staff wellbeing and learning. Continuing professional development and auditing and reporting programs are in place. DCP's Internal Audit and Risk team provides an assurance and consultancy service to all areas of the Department, which includes oversight, co-ordination, training, support and reporting in respect of risk management and governance in addition to the provision of internal audit, compliance reviews and fraud and corruption control strategies. The Department maintains on behalf of the Minister for Child Protection a Legislative Compliance Framework comprising a central record of all legislative obligations. I am told that the Framework is reviewed and updated annually.

24.13. The suggested recommendation would be intended to enhance the competence of social workers, some deficits in which were broadly and specifically identified during the

[332] Inquest 17/2014, Finding delivered 9 April 2015

inquest into Zhane's death. The *Social Workers Registration Act 2021* has not yet commenced operation and will commence on a date to be fixed by proclamation. The scheme of that Act requires the appointment of a Board and a Registrar and a search of publicly available information reveals that Department is in the process of recruiting a director to be responsible for the establishment, development and implementation of the scheme and that $4.7 million has been committed by the State Government over four years to fund the introduction of the scheme.[333] I have concluded that it would be premature to recommend amendments to this Act and it would be appropriate to await the implementation of the *Social Workers Registration Act 2021* and its initial period of operation, to enable its efficacy to be properly reviewed. Accordingly, I make no recommendation.

24.14. Counsel Assisting urged me to recommend that children under the guardianship of the Chief Executive should have their circumstances reviewed on a yearly basis by a psychologist, such review necessitating at least a discussion with members of the child's current care team. In some cases, a review of case notes and discussion with the care team may be sufficient, and in other cases the psychologist may require a meeting with the child. The outcome of the yearly psychological review should be documented on C3MS, distributed to the child's case manager and care team, and made available to all of those participating in the child's Guardianship Annual Review.

24.15. On behalf of the Department it was submitted that it is not in the best interests of all children under guardianship to have an annual psychological review and that what is in the child's best interests is for there to be an annual review which takes a holistic view of all of a child's life domains including disability, physical wellbeing, education and contact arrangements. It was submitted that the circumstances of children in care are reviewed regularly through case planning and annual reviews and a child's case plan must include a plan for their mental health and emotional wellbeing. Case planning and annual review processes identify where children may require therapeutic or specialist input or support. There are a number of therapeutic or specialist services and supports available to children and young people in care. As of 28 February 2022, there were 4670 children under the guardianship of the Chief Executive. The resources (both financial and human) available to provide psychological services to children in care are

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finite and most appropriately concentrated on those children and young people who have experienced trauma and who present with disabilities or other complexities.

24.16. On balance, having regard particularly to the number of children under guardianship, I conclude that the proposed recommendation would not be achievable, and I make no recommendation. In declining to make the proposed recommendation I observe that in the submissions made on its behalf, the Department appears to acknowledge the necessity to identify all those children under guardianship who require specialist therapeutic support and to provide that support.

24.17. Counsel Assisting urged me to recommend that all children under the guardianship of the Chief Executive who are alleged victims in a matter progressing through the court system, should have an appointment with a psychologist early in the process and regular psychological consultation with the same person throughout that process. Counsel for the Government Agencies and Witnesses have submitted that whether a child should receive therapeutic or specialist support at a particular point in time and the type of that support is entirely child specific. In my view, the process of giving evidence as an alleged victim in court should be recognised as an inevitably stressful situation for any child and does warrant an appointment with a psychologist early in the process, and further psychological consultation as may be advised. I recommend that the Department provide an initial psychological consultation for any child who is due to give evidence as an alleged victim, once the matter is listed for trial. The Department should inform the Witness Assistance Service at the ODPP who that psychologist is and ensure that the ODPP is properly informed about that child's circumstances and any particular concerns there may be surrounding that child giving evidence as an alleged victim.

24.18. I recommend that each child under the guardianship of the Chief Executive must have their contact with biological family considered in detail in a meaningful way at least once every 12 months. This should include a consideration of contact with all siblings and biological parents. The relevant considerations should be documented in detail each year in the child's Annual Review and saved on C3MS.

24.19. Ms April Lawrie, the Commissioner for Aboriginal Children and Young People, urged the Court to consider a number of recommendations.[334] Some of these

[334] Exhibit C66

recommendations go beyond the scope of matters considered in detail in this inquest. Fortunately, a review of the *Children and Young People (Safety) Act 2017* in accordance with Section 169 is being undertaken, and this is an appropriate forum for these recommendations to be thoroughly considered. However, a number of the recommendations urged upon me by Ms Lawrie are directly relevant to matters in this inquest and may have had an impact on Zhane's case.

24.20. I recommend:

1) A RATSIO (Recognised Aboriginal and Torres Strait Islander Organisation), as defined in, and gazetted pursuant to, subsection 12(8) of the *Children and Young People (Safety) Act (2017)* that is culturally connected to each Aboriginal child should be appointed for all such children at the point of intake into the child protection system;

2) The Department should implement a policy to ensure timely and proper consultation with a RATSIO, as required by subsection 12(3)(c) of the *Children and Young People (Safety) Act (2017)* where practicable, before all placement decisions are made;

3) In reporting the extent to which such children and young people have access to a case worker, community, relative or other person from the same Aboriginal or Torres Strait Islander community as the child or young person, in compliance with Section 156 (1)(a)(iii) of the *Children and Young People (Safety) Act (2017)*, the Department should specify the number of Aboriginal or Torres Strait Islander children who have contact with a case worker, community, relative or other person from the same Aboriginal or Torres Strait Islander community as the child or young person.

   I note that on behalf of the Department it was submitted, in effect, that this would be more readily achievable with the implementation of a new case management system, which will take several years. My view is that to properly report the extent of access as required by section 156(1)(a)(iii), the number of such children who do have access should be reported, and so I make the recommendation.

24.21. Ms Taylor provided details of the launch of a pilot program, Treatment Foster Care Oregon (TFCO), which is described as a specialised foster care program targeting

children and young people who already live in residential care, or who are at risk of entering residential care because of emotional and/or behavioural difficulties.[335] The State Government has committed $3.8 million to trial the program over two years. Carers who take part in the program will be specially trained and have access to a 24 hour, 7 days per week support line. They must not be working in any other capacity and will be reimbursed accordingly.[336] According to Ms Taylor the first young people were due to be placed in the program in December 2021 and involved 14 children aged 12 to 17 years who were in state care. According to Ms Taylor:

> 'This program is designed to provide vulnerable and complex young people the opportunity to live with a specially trained foster carer who will provide full-time one-on-one support for approximately nine months with the aim of the young person returning to a family or a stable, long-term foster carer rather than residential carer.' [337]

Ms Taylor notes that the TFCO model has operated internationally for more than 30 years and is used in Victoria, Queensland and New South Wales.

24.22. Counsel Assisting asked me to recommend an urgent review of the early findings from that pilot program in South Australia with consideration to be given to expanding that program to include placement of a larger number of children, as well as children in the younger age brackets. Greater financial investment on the part of the State Government is required to expand that trial program. Counsel for the Government Agencies and Witnesses have indicated that an evaluation of the TFCO program will be undertaken in 2023 after a full year of implementation and operation to properly inform the analysis. This satisfies me that this recommendation is not required.

24.23. Through its counsel, Life Without Barriers seeks a specific recommendation concerning information sharing between agencies and not-for-profit organisations such as LWB, observing recommendation 18 made by The Child Protection Systems Royal Commission. The Commission recommended the South Australian Government: '*Permit stakeholders such as other government agencies and not-for-profit organisations limited access to C3MS to facilitate cooperation, collaboration and transparency'*. To that end, LWB seeks a recommendation that consideration be given

[335] Exhibit C44, paragraph 99
[336] Exhibit C44, paragraph 98
[337] Exhibit C44, paragraph 99

to the introduction of an information sharing regime modelled on Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998 (NSW)*.

24.24. Counsel for the Department submitted that Section 152 of the *Children and Young People (Safety) Act (SA)* now provides for the sharing of information between certain persons and bodies, which would include the Department and LWB. This provision commenced operation on 22 October 2018 and did not exist when Zhane was in care.

24.25. This does not, however, address whether recommendation 18 of the Child Protection Systems Royal Commission has been implemented, which seems to have been at the heart of the submission of counsel for LWB. The fact that a recommendation for an information sharing regime was sought on behalf of LWB suggests – and I can make no finding to this effect – that information sharing by the Department with Life Without Barriers is not occurring to LWB's satisfaction.

24.26. The South Australian Government's responses to the recommendations of the Royal Commission were initially contained in 'Child Protection – a fresh start'[338] released in November 2017. In that document, recommendation 18 was described as 'accepted in principle' and the following commentary was provided:

> 'The South Australian Government accepts this recommendation in principle. All C3MS-related recommendations and their full acceptance are subject to the outcome of the C3MS review initiated in response to recommendation 20. Providing other government agencies and not-for-profit organisations varying levels of access to C3MS will lead to improved availability and sharing of information and therefore better outcomes for families and children receiving services from multiple partners. To define and design varying levels of access to C3MS, scoping and investigation work is required to identify key partners who would be granted access and determine the most appropriate and feasible technological solutions.' [339]

Kate Alexander, in her recent report 'Trust in Culture – a review of the child protection system in South Australia' has recorded that 'accepted in principle' in this context means that 'the government was supportive of the intent or merit of the policy underlining the recommendation but did not necessarily support the method for achieving the policy.'[340]

[338] Child Protection - A Fresh Start
[339] At page 40
[340] Trust in Culture - A Review of Child Protection in SA at page 48

24.27. More recently, in a document entitled Child Protection Systems Royal Commission 2022 recommendation status,[341] the Department ascribes recommendation 18 a 'status' of 'accepted in principle' and 'progress' is described as 'complete'.

24.28. How the current information sharing regime is working in practice was not examined in comprehensive detail during this inquest. Therefore, given that there is now a legislated information sharing regime in place, and in the absence of a detailed examination of the effectiveness of that legislated regime, I shall not make the recommendation which was sought.

24.29. However, I observe that it remains to be seen whether, and if so to what extent, LWB (and other not-for-profit providers of services to the Department) will be provided with limited access to the Department case management system (presently C3MS) to '*assist [LWB]… to perform functions related to children and young people or to manage any risk to a child or young person, or class of children or young people, that might arise in [LWB's] capacity as … provider of services*' as permitted under section 152(2) of the *Children and Young People (Safety) Act 2017*.

Key Words: Child Protection; Guardianship of the Minister; Suicide; Hanging

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 6th day of April, 2023.

State Coroner

[341] CPSRC Recommendations Status