RECORD OF INVESTIGATION INTO DEATH
Coroners Act 1995
Coroners Regulations 1996
Regulation 14
Form 4

These findings have been partially de-identified in relation to the name of the deceased and friends by direction of the Coroner pursuant to S.57(1)(c) of Coroners Act 1995

I, Donald John Jones, Coroner, having investigated a death of

Craig Anthony Sullivan

WITH AN INQUEST HELD AT Launceston Magistrates Court in Tasmania on the 5 – 16 September 2011; 12 – 16 December 2011; 23 – 27 January 2012; 26 – 28 March 2012.

FIND THAT:

Craig Anthony **SULLIVAN** died on or about the 25 October 2010 at the Ashley Youth Detention Centre at 4260 Meander Valley Highway, Deloraine in Tasmania.

Craig Anthony **SULLIVAN** was born in Hobart in Tasmania on the 3 October 1992 and was aged 18 year(s).

Craig Anthony **SULLIVAN** was unmarried and single, whose occupation at the date of death was unemployed.

I find that the deceased died as a result of the rupture of a left frontal cerebral abscess.

At the time of the deceased person's death he was not being treated by a medical practitioner.

CIRCUMSTANCES SURROUNDING THE DEATH: -

Throughout these findings and reasons, I will refer to the deceased as "Craig" being the name to which he was commonly referred throughout the Inquest, and the Ashley Youth Detention Centre as "AYDC".

1. On 7 October 2012 Craig was detained at the Ashley Youth Detention Centre (which I will refer to as "AYDC" throughout these findings) on remand from the

Hobart Court of Petty Sessions on various charges including stealing, breach of bail, dangerous driving, driving while disqualified, failing to stop after a crash, using an unregistered motor vehicle and using a motor vehicle without insurance. The driving and motor vehicle charges arise out of Craig's driving on 25 September 2010 which involved a crash.

2. At the time of his remand into the AYDC Craig was 18 years of age, (his birthday being 3 October 1992), however as the offences occurred whilst he was under the age of 18 years the offences were being dealt with under the provisions of the Youth Justice Act 1997.

3. On the evening of Friday 8 October 2010, Craig was assaulted by resident A.

4. Craig remained in AYDC until his death on the morning of Monday 25 October 2010 as a result of the rupture of a brain abscess.

5. Despite evidence that Craig was unwell, particularly during the weekend prior to his death, he was not referred for medical assessment and treatment.

OTHER COMMENTS:

Legislative Framework for an Inquest

6. Section 21 of Coroners Act 1995 ("the Act") invests a Coroner with jurisdiction to investigate a death if it appears that the death is or may be a reportable death.

7. A reportable death is one where, inter alia, the death occurred in Tasmania and appears to have been unexpected, unnatural, or violent, or to have resulted directly or indirectly from an accident or injury, or is the death of a person who, immediately before the death, was a person held in custody[1].

8. A person held in custody means, inter alia, a person detained in a detention centre.[2] A detention centre is a detention centre within the meaning of the Youth Justice Act 1997[3]. At the time of his death Craig was detained at AYDC which is such a centre. Furthermore, from the evidence it is clear that his death was both unexpected and unnatural. On either or both of those bases Craig's death is a reportable death. The Coroner therefore has jurisdiction to investigate the matter.

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1 Section 3 definition of "reportable death".
2 Section 3 paragraph (b)(iii) definition of "person held in custody"
3 Section 3 definition of "detention centre"

9. Section 24 of the Act states that an inquest is required where the death, or cause of death, occurred in Tasmania, or the deceased ordinarily resided in Tasmania at the time of death, or the deceased was, immediately before death, a person held in custody. On any of those bases an inquest is required.

The Matters to be addressed by a Coroner Pursuant to Section 28 of the *Coroners Act* 1995

10. Section 28 of the Act sets out the duties of the Coroner investigating a death and holding an inquest.

11. Section 28(1) of the Act deals with findings a Coroner is obliged to make where possible. They include:

    (1) the identity of the deceased,

    (2) how death occurred,

    (3) the cause of death,

    (4) when and where death occurred,

    (5) the particulars needed to register the death under the *Births Deaths and Marriages Registration Act 1999*, and

    (6) the identity of any person who contributed to the cause of death.

12. The findings should be brief and not extensive.[4]

13. Subsection 28(2) requires a Coroner, when appropriate, to make recommendations with respect to ways of preventing further deaths and on any other matter that the Coroner considers appropriate.

14. Subsection 28(3) gives the Coroner discretion to comment on any matter connected with the death, including public health or safety, or the administration of justice. The power to comment is separate to the power to make recommendations.

15. Subsection 28(5) also requires a Coroner holding an inquest into the death of a person held in custody to report on the care, supervision, or treatment of that person while that person was held in custody.

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4 *Plover v McIndoe & Anr* (2000) 2 VR 385 at [26]

The Ashley Youth Detention Centre

16. To understand the events leading up to Craig's death it is necessary to have some understanding of the operations of the AYDC.

17. The AYDC is a Youth Detention Centre within the meaning of the Youth Justice Act 1997. It is a facility in which young people are detained either on remand or following sentence where that is considered by the relevant Court to be appropriate having regard to the provisions of that Act.

18. The objectives of that Act are, inter alia, to ensure that, whenever practicable, a youth is dealt with in a manner that takes account of his social and family background. Section 5 of that Act articulates general principles of youth justice including that guardians are to be encouraged to fulfil their responsibility for the care and supervision of the youth and should be supported in their efforts to fulfil that responsibility.

19. AYDC runs various programmes for the residents to provide them with rehabilitation, education, and life skills. A specific regime is customised for each resident by a multi-disciplinary case management team.

20. The programmes are run on weekdays at the school on site. They do not run on the weekends, and on the weekends the residents stay in the units, except during allocated times when they can go outdoors.

21. AYDC has four units where the residents sleep, socialise, and eat when not engaged in the programmes. The units are located on one site, but physically and to some extent functionally, separated. They are:

    (1) Liffey, which is the admissions unit. Residents are placed in this unit when they are first admitted. This is the unit in which the admission procedures are completed. The residents are routinely observed on a more stringent regime than when they are in other units while they adjust to life in AYDC. They do not participate in the programmes while in Liffey.

    (2) Bronte, which is a unisex unit and for younger detainees or residents;

    (3) Huon which is a general unit for male residents; and

(4) Franklin which is also a general unit for male residents.

22. The staff operate on 3 daily shifts, morning shift or day shift from 7:00am to 3:00pm, afternoon shift from 3:00pm to 11:00pm and night shift from 11:00pm to 7am.

23. At the time of Craig's death the care and supervision of the residents at AYDC was undertaken in a hierarchical way. The governance structure is set out in (exhibit C20).

24. The day to day care of the residents was provided by youth workers. The youth workers supervise the residents while on their weekly programmes. They escort the residents between the units and the school. They supervise and interact with the residents while they are in the unit. Their duties are set out in (Exhibit C21-1). There are usually 2-3 youth workers in addition to a team leader in each unit for the morning and afternoon shifts.

25. During the morning and afternoon shifts the youth workers were supervised by more experienced youth workers who, in October 2010, were designated team leaders and were in charge of a unit. There has been a change in the title given to the team leader who is now a senior or nominated youth worker. But the evidence seems to suggest there has been little practical change to the way care and supervision is provided to the residents, except perhaps that some authority to direct fellow youth workers has been removed from what was the team leader role. The duties of the team leader are set out in (Exhibit C21-2).

26. During the morning and afternoon shifts, the team leaders reported to operations coordinators. The duties of the operations coordinators are set out in (Exhibit C21-3). Their role included staffing arrangements and general supervision of the operation of the units. They were involved in decisions to seek medical attention for residents if that involved transport off site.

27. The operations coordinators at the relevant time were Mr Ronald Westwood, Mr Rodney Simpson, and Mr Robert Barrett. They shared a roster so that one of them was on duty for the morning shift and the other for the afternoon shift. Occasionally they were relieved by an experienced youth worker who acts as the operations co-ordinator.

28. The operations coordinators report to an operations manager, Mr Ralph Beck. An operations supervisor, Mrs Fiona Atkins, also reports to the Operations Manager. Mr Beck and Ms Atkins are both onsite between 9:00am to 5:00pm approximately.

Outside their onsite hours, between 5:00pm and 9:00am week-nights and on weekends, one of them is on call. They shared a weekly roster to provide that availability.

29. The operations manager reports to the Centre Manager who in turn is responsible to the Department of Health and Human Services for the State of Tasmania.

30. At night there is one youth worker in each unit except Franklin where there are 2. In addition there is a night supervisor, generally Susan Frankcombe, who acts as both the team leader for all the units and is the equivalent of the operations coordinator. The various staff members rotate through the units to free up two of them to conduct security checks while maintaining the required number of staff members in the units.

31. Whenever a resident is in their room, other than for a short period, they must be observed by a staff member, and that observation must be recorded on a daily observation sheet. The observations procedures are set out in Standard Operating Procedure No 29 (See Exhibit C13-10).

32. The default observation regime is once every 20 minutes. Residents might also be placed on more frequent observation regimes requiring observations every 10 minutes or in some instances, every 4 minutes, based on assessment of risks to their wellbeing or security considerations.

33. The observation is carried out by a staff member looking through a Perspex viewing panel set in the door of the resident's room and utilising either a torch or natural light to check on movement or to see if the person is breathing. This task is made difficult in that residents have, over the time, scratched the inside of the Perspex panel, obviously for the purpose of making it difficult for staff to look into the room. There needs to be an improved manner to check on a resident either by using a different material in the viewing panel or removal of the panel, leaving an opening which could be covered by a sliding panel.

34. The staff generally gave evidence that the procedures were followed and observations were recorded quite meticulously. None admitted to failing to conduct, or record, any checks when they were obliged to do so, but most were aware of occasions when there had been a failure to follow the procedures. That is perhaps unsurprising. Even a well-documented and enforced procedure will have occasional compliance failures.

35. The daily routine involves the residents being let out of their rooms at about 8:00am. This was followed by breakfast and the residents would then attend daily programmes at the school. After the morning programmes the residents return to their units where they are confined to their rooms. At the Huon unit that occurs daily between 11:40 or 11:45am and 12:20 or 12:25pm (called "lock down" or "quiet time"). The residents then have lunch and then attend afternoon programmes. They return from the afternoon programmes and again there is a period of confinement in their rooms between 4:40 or 4:45pm and 5:20 or 5:25pm, after which they have tea followed by free time. That is followed by supper which was also called "SLAB". A resident's bed time is determined by their behaviour status which is colour coded. They remain in their rooms until they are let out the next morning.

36. A resident might also be in their room for other reasons, including confinement for disciplinary reasons, being unwell, or at their request when they are not required to be out of their room. On the weekends the residents are allowed to sleep in and there are generally no programmes run.

Craig's History and Previous Admissions to AYDC

37. Craig had a lengthy record of offending. His record of prior convictions runs to 22 pages. His family is known to the police. His brothers had spent time at AYDC.

38. Craig was first detained in AYDC on 20 July 2005 when he was 12 years of age. His developmental age was much less.

39. He was detained in AYDC on 10 occasions in total including the admission commencing on 7 October 2010. He spent much of his teenage life as a resident at AYDC.

40. The AYDC staff was familiar with Craig and expressed what appeared to be genuine fondness for him. They were generally familiar with some of his notable characteristics including:

    (1) Being upset when initially detained as a result of separation from his mother;

    (2) Poor communication skills;

    (3) Poor literacy and numeracy skills – staff taught him to tell the time, play numbered card games and write his name which he apparently did thereafter, on occasions inappropriately;

(4) Low intellectual functioning, which was described by many as well below his actual age;

(5) Inability to communicate his needs, and making complaints through his mother, but denying that he made any complaint to his mother when she telephoned staff to have his complaints resolved;

(6) Isolating himself in his room and staying close to staff in order to avoid confrontations with other residents; and

(7) Being essentially at the bottom of the residents' pecking order.

41. Formally that knowledge was documented within AYDC in recent times in a Case Plan Background dated 25 May 2010[5] and a SECA Psychosocial screening.[6] Earlier psychological reporting suggested that as a 13 year old he functioned at an extremely low level intellectually, with verbal and nonverbal reasoning, memory and processing of visual material.[7] Although those results may be as a result of a lack of formal education rather than limited intelligence.[8]

42. Dr William Doudle is a forensic psychiatrist specialising in adolescent health who had dealt with Craig on some of his admissions to AYDC. In a discussion with Dr George Cerchez for the purpose of an investigation into Craig's death, Dr Doudle expressed the opinion that he considered Craig would find it difficult to speak up under stress, that he would keep below the radar and may not have the ability to respond at all if under physical or psychological stress.[9]

Craig's Involvement in a Car Accident on 25 September 2010

43. The motor vehicle related offences which led to Craig's arrest and detention arose out of an accident on 25 September 2010 shortly after 9:00am. The circumstances of that accident are outlined in the police file which is (Exhibit C44). In summary Craig:

(1) Was driving at high speeds ignoring a 70km/h speed restriction on Bowen Bridge;

(2) Refused to stop for police;

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5 Ex C28
6 Ex C32
7 Ex C137 Cognitive Assessment Summary by William Doudle
8 Ex C136 Dr Georgina O'Donnell report 25 September 2006
9 Ex C138

(3) Overtook on the incorrect side of the road crossing double white lines on a blind corner in a manner which shocked the driver of the overtaken vehicle to such an extent she pulled over, unable to continue driving;

(4) Tailgated a car in front of him;

(5) Pulled out to overtake three cars causing an oncoming 4WD to brake heavily and veer off the road to avoid a head on collision;

(6) Pulled back in between the cars he was attempting to overtake requiring the car behind him to brake heavily to avoid a collision;

(7) Sped off up Grass Tree Hill; and

(8) Lost control and crashed into a power pole at speed, ricocheting off the power pole and crashing into a tree.

44. Following the accident Craig ran off. Shortly afterwards he was seen stumbling from a nearby milk bar having trouble walking. He was holding his leg as if injured. He spoke to a Mr Hutt and said he had been in a police chase and his mum was on her way to pick him up.

45. The car Craig was driving sustained major damage.

46. Craig suffered a leg injury which caused him to limp shortly after the accident. Craig's mother, Cheryl Jones, said she observed a head injury and kept a close eye on him in the days after the accident.

47. That Craig suffered a head injury is supported by the fact that the nature of the accident and the driving leading to it is such that it could be reasonably inferred that head injuries would be likely to flow from it and also the following matters:

(1) Craig told AYDC staff and residents that he had been involved in an accident. He described it as a "serious accident";

(2) The notes of Nurse Thomas indicate that on 8 October 2010, Craig told her he was "chased by police, wrapped car around power pole, caught fire."[10], although he denied to her that he had suffered any injury and said he had not sought medical attention;

[10] p3 Nursing admission sheet part of Ex C11

(3) On 8 October 2010 he told a Youth Worker, George Armstrong, that he shouldn't be here because he'd been in a car accident "driving really fast… about 180"[11] and that "he was badly shaken up and he was bruised. But he managed to walk away;"[12]

(4) Resident B describes seeing a bruise on Craig's forehead which was attributed to the accident;

(5) He spoke to a number of residents and staff about the accident. He also spoke to some of the residents about headaches since the accident.

48. On the evidence presented, Craig did not seek, or receive, any medical treatment for any injuries he may have suffered in the accident. While this may be interpreted as meaning he did not suffer any significant or observable injuries, alternatively, and I consider more likely, the failure to obtain medical treatment was through fear that it could lead to him being identified as the driver of the vehicle involved in the crash. That is supported by the fact that when he was arrested and charged in respect of the driving offences he denied he was the driver.

49. Craig was arrested and interviewed on 6 October 2010. Neither the arresting and interviewing officers observed any signs to indicate Craig was then suffering from any injury including a head injury, nor did the AYDC admissions officer, Jenny Wall, or the Liffey unit team leader, Sue Ray, on 7 October 2010.

50. The evidence of the extent of the injuries Craig suffered in the crash, and particularly the extent of any head injury, is inconclusive. The importance of the car crash, in the context of this inquest, is not so much whether or not any injuries suffered in it led to the brain abscess rather, having the knowledge of that crash, its seriousness and the possibility of a head injury whether that should have alerted staff to a need to have Craig medically assessed.

Craig's Health on Admission

51. Craig was admitted to AYDC at approximately 7:30pm on 7 October 2010. His initial contact was with the admissions officer that night, Jenny Wall.

52. On occasions, information is given to the admissions officer that a particular person being remanded has been involved in a situation which requires that the person be kept under observation for health, or other reasons, for example, a

[11] George Armstrong Ex C22 and 23
[12] George Armstrong T188 21,22

known drug problem, suicidal ideation, etc. There is no policy requiring such information to be supplied[13]. Its provision is ad hoc.[14] No information was provided in respect of Craig on this occasion.

53. On his admission Ms Wall, the Admissions Officer, did not observe any bruising on Craig, nor did she observe him to be suffering from flu-like symptoms. She said he appeared to be in reasonable health and he made no complaint about any health issues. She said he appeared no different to other times when he had been admitted to AYDC[15].

54. The Team Leader, Colleen Susan (Sue) Ray, said that when Craig was admitted he looked like he had a bad cold, he was "a bit fluey and a snotty nose" and was distressed.[16] She thought he may have been suffering from the flu, as he had typical flu symptoms. She said he informed her he "had a little bit of a headache" but that went away.[17] In her oral evidence Ms Ray said she saw the snotty nose as part of his being teary and emotionally distressed[18], however that is not consistent with the statements in her Affidavit, or the transcript of the interview she did as part of the Serious Incident Investigation Report undertaken by the Department of Health and Human Services. In those documents she suggests what she observed was more consistent with Craig having the flu or a bad cold.

55. Youth Worker, George Armstrong, on the 7 October 2010 noticed that Craig seemed "a bit fluey or snotty"[19], and although he did not appear to be in poor health he said his health was never one hundred per cent. Mr Armstrong found it difficult to describe Craig's health. He said Craig's health did not appear to be any different to that on previous admissions to AYDC.[20] Generally, he said, Craig's health "was not good" when admitted. I infer that he was indicating that whenever Craig was admitted to AYDC in the past he was undernourished, and it was not unusual for him to have a runny nose.

56. Youth Worker, David Newland, saw no health issues with Craig during the morning shift on 8 October 2010, but noticed that he seemed to have lost weight since his last admission, which had been several months earlier. He said he

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13 Jenny Wall T115 19-45, T
14 Jenny Wall T116 11-14
15 Jenny Wall T117 17-45
16 Ex C26
17 Ex C27
18 T230 35 – T231 34
19 Ex C23
20 George Armstrong T163 42 – 164 11

appeared his normal self and did not appear to be struggling with any illness, malady, or flu.[21]

57. During the afternoon shift on the 8 October 2010, Craig complained to Youth Worker, George Armstrong, that he was not feeling well and "had a bit of a headache"[22] which, with the benefit of hindsight, Mr Armstrong thought may have been related to the car accident on 25 September 2010.[23]

58. On the 12 October 2010, he said Craig showed no signs of ill-health.[24]

59. Other residents give evidence that Craig looked unwell and complained of headaches and light sensitivity.

60. On the balance of probabilities, I am satisfied, at the time of his admission Craig appeared to be suffering from flu symptoms or a cold evidenced by a runny or snotty nose, and headaches. Whilst this was not universally observed by all of the witnesses, I am satisfied that those who did observe the symptoms, had a basis for observing them.

The Nursing Assessment on 8 October 2010

61. Upon admission, in accordance with the usual induction procedures, Craig saw the AYDC nurse, Nurse Thomas, on 8 October 2010. Nurse Thomas completed the nursing admission assessment which is contained in (Exhibit C12). She considered that assessment to be unremarkable for Craig.

62. Craig mentioned involvement in a car accident. His description was noted in the nursing assessment. He indicated he had not been injured and had not seen a doctor.

The Medical Assessment on 8 October 2010

63. After the nursing assessment, in accordance with the adopted practice for new admissions, Craig was seen by Dr. John Gray. Dr Gray examined Craig and found nothing which warranted any further medical review.

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21 David Newland T 346, 347
22 C22 and C23
23 George Armstrong T195 8-12, T196 1-7
24 George Armstrong T210

The Assault by Resident A on 8 October 2010

64. On 8 October 2010 Craig was assaulted by resident A. The circumstances of the assault were canvassed in detail in the evidence. As is often the situation where an incident occurs over a relatively short period of time, witnesses give many and varied accounts of what they observed, or how things must have happened, as opposed to what actually occurred. There were however some consistent observations.

65. Resident A says he "jumped up and smashed a coffee cup out of Craig's hands". He thought the coffee went all over Craig, including his face. He thought he hit him once to the left side of his face, at which time Youth Worker George Armstrong then intervened and stood between him and Craig. Resident A said he pushed past the Youth Worker and hit Craig a few more times, scruffed him by the jumper, head-butted him to his forehead as hard as he could, grabbed him to the back of the head and attempted to knee Craig in the face but only clipped his nose.[25]

66. Youth Worker, George Armstrong, said, in the Reporting Officer's Statement forming part of the AYDC Detention Centre Offence Conference Proceedings, which was written on the day of the assault, that he saw resident A push Craig against the wall. He told resident A to stop the assault but resident A kept punching Craig. Armstrong said he put his arms around resident A from behind and he was being assisted by team leader, Sue Ray. He said resident A continued the assault and head-butted Craig. Armstrong said he then managed to separate resident A from Craig.[26] In his oral evidence Mr Armstrong said that resident A threw 2 or 3 punches before he got there[27] and that the head-butt was hard enough to be heard and given with enough force to cause a lot of pain. By way of explanation he said it was enough to bring tears to Mr Armstrong's eyes if he had been on the receiving end of it; albeit it was given from a short distance, about six inches.[28] While Mr Armstrong did not see coffee thrown, he said Craig was wet and said coffee had been thrown on him.[29]

67. Ms Ray says she became aware of the disturbance and saw resident a head-butt Craig to the forehead as she attempted to break resident A's grip on Craig.

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25 Ex C63
26 C24 p2 of 12 and Ex C22.
27 T182 18
28 T182 44 – T183 17; T203 40-45, T204 27-31
29 T182 3-11

68. The on call diary kept by Fiona Atkins[30], the on call supervisor, contains the entry:

> "*8pm – resident A threw hot coffee in C Sullivan's face & then head-butted him x2…"*

69. That reflects a similar entry in the Operations co-ordinators handbook made by Mr Simpson which also refers to Craig being head-butted twice.[31]

70. On the evidence, I find the relevant features of the assault involved:

    (1) Punches to the head;

    (2) At least one forceful head-butt to Craig's head and perhaps 2;

    (3) Hot coffee splashing onto Craig's face and clothing; and

    (4) Perhaps a glancing blow to the nose from an attempt to knee Craig in the face.

71. The assault gave rise to injury. In the Liffey Changeover book Ms Ray made an entry, "Sullivan burnt face, will not blister and no lump forming on forehead. Ice applied to both."

72. In explanation of the entry Ms Ray said Craig complained of hot liquid contacting his face and during checks throughout the night there was no evidence of blistering; that first aid had been applied.[32] She says there was some redness to his face initially but no major cuts or bruises and his eyes appeared okay.[33] His eyes were clear.[34]

73. Jenny Wall says she observed no red marks or injury to Craig's face and that he was teary, and she applied an icepack under his left eye. Craig did not complain of pain, nausea, or a headache.[35]

74. Mr Armstrong says he observed red marks on Craig's forehead but was unable to recall their location. He attributed the marks to where Craig was head-butted and not to redness caused by the coffee being thrown on Craig's face[36].

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30 Ex C1
31 Ex C6
32 T248 35 and following
33 Ex C26
34 TT249 43
35 T134 1-21
36 T184 16-30

75. Mr Rodney Simpson, the operations coordinator on duty at the time, arrived and helped with first aid. He observed that Craig's face was very red on one side though he could not remember which side[37]. He also saw a small mark just under Craig's left eye.[38]

76. Youth Worker, David Newland, was informed by the night shift worker for the Liffey unit that Craig had a lump on his forehead; however Mr Newland did not observe it. He said he did see slight redness on Craig's forehead and cheek which he attributed to coffee affecting Craig's face.[39]

77. The assault was clearly capable of causing a head injury. I am satisfied that the assault caused redness to Craig's face and a red mark on his forehead. While it is possible that the assault could have been a cause of the brain abscess, the medical evidence presented taking into account the circumstances in this particular instance, suggests this to be highly unlikely.

78. The relevance of the injuries suffered in the assault is, whether the knowledge of the occurrence of the assault and the injuries either alone or together with other information should have led to additional medical treatment being sought for Craig.

Eye Problem over the Weekend of 9 and 10 October 2010 and Shortly Thereafter

79. There is evidence that over the next few days after the assault Craig had a problem with his eye or eyes.

80. Mr Newland, a youth worker, says he did not observe anything wrong with Craig's eye on the weekend of 9 and 10 October 2010, or at least on the Sunday morning of the 10 October 2010, and did not know how Craig came to have an eye patch. There were varying comments as to Craig wearing an eye-patch.

81. Mr Haywood worked with Mr Newland on the Saturday morning 9 October 2010 and he says he may have been informed Craig had a red eye, but he could not recall observing it[40].

82. Mr Walters, who worked with Mr Newland on the Sunday morning the 10 October 2010, said he noticed Craig's eye was a reddish colour, but not that it was swollen. The red was on the white part of his eye in the corner of his eye, not near his nose.

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37 T675 34-41
38 Ex C39
39 ExC29 and T350 and 372 23-44
40 T 1601 15 – T1602 43

He said it was like it was bloodshot, but not right through the white part. Craig had complained to him of it being sore though he did not appear to be rubbing it.[41]

83. Oliver Wellard, the team leader on the Saturday and Sunday afternoon of 9 and 10 October 2010, said during the afternoon shift of 9 October Craig complained of his eye playing up. Wellard said it looked red, as if Craig had been rubbing it.[42] He described the redness as being on the white of the eye itself on each side of the pupil. But there were no protruding veins coming out of the eye.[43]

84. On the afternoon shift of Sunday 10 October Mr Wellard observed that Craig's eye seemed inflamed and worse than the day before. He said Craig's mother had rung and told Mr Wellard that Craig's eye was itching and hurting.[44]

85. As a result of his observations and the phone call from Craig's mother, at 10:22pm, shortly before leaving work, Mr Wellard emailed the AYDC nurse requesting that she check Craig's eye the following day.

86. Mr Simpson says that when he saw Craig on Monday morning 11 October 2010 Craig had a black eye. It was puffed up and black, "very black in the corner of the eye and red in the corner of the actual eye itself". It was half closed. Mr Simpson attributed the injury to the head-butt on the Friday. Mr Simpson was aware that Craig was wearing an eye patch at some stage around then although he did not see it himself.[45.]

87. Ms Sue Ray told the nurse on 12 October 2010 that Craig's eye was improving. His eye problem had resolved when Craig was seen by the nurse on 20 October 2010.

88. I am unable to make a definitive finding as to the cause of Craig's eye problem. The evidence is far from conclusive and it could have been caused by the flu-like symptoms he was suffering, from the head-butt, or an undiagnosed illness. However at some time over between 8 October 2010 and 12 October 2010 there was some swelling around his eye, it appeared blackened and half-closed and Craig wore a patch. Any problem resolved within a few days.

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[41] T409 13,14 and T423
[42] Ex C31
[43] T 458 19 – T459 22
[44] Ex C31[44]
[45] T676 10 – T677 43

Vomiting and Loss of Appetite on Sunday Morning 10 October 2010

89. On Sunday morning, 10 October 2010, the evidence of Mr Walters was he heard Craig vomiting in his room at around 8:00am.[46] He said Craig leant out of his bed and was sick on the floor next to his bed.[47] Mr Walters told Mr Newland[48] who then dealt with it.

90. Craig did not eat breakfast that day. He did not eat lunch. He spent most of his time in his room, coming out on 2 occasions, once for some cordial at some time in the morning, perhaps around 8:45 to 9:15am and on the second occasion for some outside time at approximately 12 noon.[49]

91. Mr Newland in his Affidavit said Craig was out of his room for the whole shift and had lunch. When he made his affidavit, he did not have access to (Exhibits C3 and C7).[50] Having perused those exhibits, he accepted that he had recorded Craig was in bed in his room, and not as stated in his affidavit.[51] He said he had a tentative recollection of taking Craig some chips but could not say whether they were eaten.[52]

92. I find that Craig had vomited on Sunday morning, 10 October 2010, that he did not have breakfast or lunch and spent most of the day, up until 3:00pm approximately, in bed watching the motor racing on television except for a few occasions when he came out for a few short periods.

A Headache on the Morning of 10 October 2010

93. Mr Newland said Craig had complained to him of a headache on 10 October 2010.[53] He said he thought Craig may have been using the pretence of a headache as an excuse to go back to his room because of a dispute with other residents over the use of a Playstation.[54]

94. I am satisfied, and so find, that on the morning of the 10 October 2010, Craig had complained of and was suffering from a headache.

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46 Ex C30
47 T398 3,4 T400 9-13
48 Ex C30
49 Ex C30, T412 30 – T414 33; Ex C3 entry 10/10 and Ex C7 observation records and T355, 381 - 382.
50 T379 34-36
51 T355, 382
52 T395 42 – T396
53 T351,354-356
54 T356

The Nursing Consultation on 11 October 2010

95. Craig saw the AYDC Nurse, Anne Thomas, on the Monday 11 October 2010. The nurse described Craig's right eye as moderately swollen making the eye look half closed. There was no irritation or redness in the eye, no gritty feeling and no pus discharge, although the eye watered. No infection was observed. Nurse Thomas had been informed that Craig had coffee thrown over him but was not informed he had been head-butted, she learned of this at a later time. Nurse Thomas documented she thought the eye condition may have been the result of hot coffee on the skin or the result of another undefined illness which was also producing a raised temperature, snotty nose and vomiting. In evidence she said she suspected the condition of the eye was the result of the assault, even though Craig maintained it was not.[55] When questioned as to what she meant by undefined illness she said she equated the condition to drug withdrawal, it being a condition she had frequently observed.

96. Nurse Thomas assumed that the eye-patch worn by Craig had been provided by staff which she said was a good first aid measure to alleviate light sensitivity. This suggests such sensitivity was observed, reported, or at least suspected, as a possibility at that point.

97. None of the staff recall applying the eye patch. But it was there on the Monday and presumably was applied at some stage over the weekend. Some of the residents recall seeing it over the weekend. One says Mr Newland applied it.

98. As a result of her observations, Nurse Thomas sent an email to Mr Wellard suggesting Craig's eye condition be monitored and that the eye-patch be kept in place, and Craig be allowed bed rest. She also organised an appointment with Dr Gray for Friday 15 October 2010 for a review of Craig's eye. From her examination she observed nothing else that required medical assessment by a doctor.[56]

99. She intended to follow up on Craig's eye the next day, being Tuesday 12 October 2010, but was told by the Liffey Unit team leader that Craig's eye was better. She was also informed about the assault that had occurred on Friday 8 October 2010. Having been informed of the assault for the first time, she made a note in the medical records on the 13 October 2010, as to those matters. As Craig was to be

[55] Ex C103 p5
[56] T1770 4-11

seen by Dr Gray on 15 October 2010 she took no further action as none was required.

Non-attendance at Doctor's Appointment 15 October 2010

100. Craig was required to attend Court in Hobart on the 15 October, he was not able to attend the doctor's appointment, and no follow-up appointment was arranged.

101. Craig had now been moved from the Liffey unit to the Huon Unit. When he returned from Court later in the day on the 15 October, Mr Timothy Atkins, the team leader in Huon, said Craig had mumbled something about the possibility of being sent to the remand centre when he gets sentenced. As expressed that comment could be interpreted as a possible lack of sensitivity to Craig's disabilities. Such an insensitivity could be further evidenced by a note Mr Atkins made in (Exhibit C12) on 18 October 2010 which said:

> *"Down in the dumps again today. Well behaved mostly but needs to remember he is 18 not a little boy."*

Such a comment is inconsistent with the weight of the evidence which suggests Craig's functional age was much lower than his chronological age.

Nursing Attendance 20 October 2010

102. Nurse Thomas saw Craig again on 20 October 2010. Her note of that attendance is:

> *"R) eye resolved. Cleaned ears gently. Moderate soft wax."*

Her observations and notes indicated that no further nursing or medical follow up was required in relation to Craig's health at that time.[57]

Other Evidence of Craig's Health During his Detention

103. Some of the residents gave evidence that Craig complained to them of headaches and such complaints were made in the presence of staff members. Resident A said that in the Liffey unit Craig asked him about what it means "if you have a headache and it hurt looking at the light". Shortly before the weekend of the 23 and 24 resident A commented that Craig looked like he was going to die and Craig responded that he felt like he was dying.

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[57] T1770 4-11

104. There was some variance as to the observations by various residents.

105. Resident C said Craig looked sick, was not moving around much, was not eating, and complained of headaches which resident Cattributed to the car crash which Craig had spoken of. He also said that Craig complained about wanting to see the nurse and the doctor.

106. Resident D said that in the middle of the week prior to Craig's death he noticed Craig looked unwell and Craig had complained to him of having head pains.

107. In his Affidavit resident E said Craig looked pale and sick when he arrived at the Huon unit.

108. In his Affidavit resident F said that Craig appeared "okay" and was eating well in the Huon unit.

109. Resident G said that Craig was not eating much and complained of headaches.

110. Resident H said Craig complained of headaches to him on a couple of occasions and other residents over the couple of weeks after he came to the Huon unit.

111. Resident B's evidence is that Craig would say every second day or so that he had a headache and that Craig told him that he had told the workers he was still having headaches and wanted to see the nurse or doctor.

112. There was some evidence that Craig appeared to have lost weight during his time in detention. One of the residents gave evidence that he had told Craig to lift up his shirt and he had observed Craig's ribs were showing.

113. When Craig was seen by Dr Gray on 8 October 2010, his weight was 53kg. Presumably he was fully clothed when that weight was recorded. At the autopsy Craig weighed 51.3 kg clad in boxer shorts. It is unlikely there was any significant weight loss in the short time Craig was in detention.

114. There was also evidence about Craig having lost weight since his last or previous admissions. However Craig's weight on his second last admission was 52.9 kg. There appears to be little difference in weight between those admissions.

115. The observation of weight loss might be consistent with a general appearance of being unwell, but is not suggestive of a serious health problem.

116. No significant issues relevant to creditworthiness were put directly to any of the residents who gave evidence. No doubt they would have denied any adverse suggestions as to their credit. Without making a formal finding as to creditworthiness of any of the residents, I note that their evidence might have been coloured to suggest that staff could or should have done more to obtain treatment for Craig and to draw, optimistically, an adverse finding against the AYDC. I am unable to make a definitive finding as to the creditworthiness of their evidence. I can make a finding that each of them gave their evidence in a straightforward manner. I certainly cannot reject their evidence or fail to give it due consideration unless there is a compelling reason to do so.

117. However the balance of the evidence generally suggests that apart from being unwell at the commencement of his admission, Craig did not complain to AYDC staff of being unwell and he was not observed by staff to be unwell until the weekend of 23 and 24 October 2010. Aside from the evidence of the residents about what they observed and what Craig told them, there is little, if any, evidence which would suggest that staff would have been aware or should have been aware of any health issues being suffered by Craig save and except those that were noted in the medical records and the day sheets.

Evidence of Craig's Health on the Weekend of 23 and 24 October 2010

118. A significant matter to be resolved in considering Craig's health on this weekend is the number of occasions he vomited. If there was compelling evidence to make a finding that Craig had vomited on two separate days, both on the 23 and 24 October, this would be a factor relevant to a determination whether there had been a serious misjudgement in failing to arrange for Craig to see a doctor over the weekend or have him transported to hospital.

119. To resolve this issue it is necessary to consider the total evidence surrounding the event. It is a matter of weighing the evidence.

120. On Saturday 23 October 2010 the evidence is that Craig came out of his room and had his breakfast. Mr John Staal, the team leader that morning, noticed Craig had a runny nose because he asked for a tissue. He also seemed a little quieter than normal.

121. Another resident H, says he saw vomit in Craig's room that morning. When it was suggested to him he may have been mistaken, he was adamant he was not and was certain that Craig vomited on both the Saturday morning and the Sunday morning.

122. I note there is evidence from other sources as to this:

(1) There is also a note in Fiona Atkin's on-call notebook (Exhibit C1) that Mr Simpson rang her on that day and she says the note records that she was told by Mr Simpson that Craig had been suffering headaches and vomiting.

(2) There is also a note (Exhibit C12) made by Mr Staal on 24 October 2010 which refers to Craig refusing to clean up his room after vomiting "yesterday and this morning." That suggests Craig had vomited on Sunday 24 October 2010 and the day before. There is also a note by Mr Staal the previous day that Craig refused to do a chore. No-one was able to identify what that chore might have been. If it was refusing to clean up vomit on Saturday morning that would clarify the two notes made by Mr Staal, and supports the fact that Craig had vomited on the Saturday and the Sunday.

123. On the other hand the Huon Unit communication book does not disclose that Craig vomited on the Saturday morning. The staff members on duty at that time and the previous night referred to Craig vomiting the next day, i.e. Sunday 24 October 2010. It is, in my view, unlikely they would not have done so on this occasion if it had occurred. They had no reason not to do so.

124. Mr Simpson denies any knowledge of vomiting until the Sunday morning occurrence. After having spoken to Mr Simpson before she gave evidence, Mrs Atkins said Mr Simpson may not have reported vomiting on Saturday 23 October, but on Sunday 24 October 2010. She maintains however that she made the note referring to headaches and vomiting on 23 October 2010, but that by referring to vomiting she just meant being sick, not actually vomiting.

125. I find her explanation dubious. It would be a more plausible explanation if for some reason she inserted the note about headaches and vomiting later, after she had found out about Craig's vomiting. Perhaps her note was made after the vomiting had occurred, but before Craig's death, or having become aware of Craig's death, she had gone back over things in her mind and recalling matters that had occurred and attempted to correct an oversight in not mentioning the vomiting and added it to the wrong date. Whatever the situation was, or is, I find no intentionally deceptive conduct on her part.

126. Mr Staal in referring to his note said it was not intended to convey anything other than that there had been more than one occasion on which Craig had vomited as reported by other staff and not a separate occasion of vomiting on 23 October

2010. He was unable to say what chore Craig refused to do which led to the note on the Saturday morning. Why he would be able to explain one note and not the other is not clear, but could be explained by the foibles of human memory.

127. On Saturday, 23 October, Craig spoke to his mother at approximately 9:55am, or 10:00am, and told her that he was feeling sick and was going back to bed. In her statement Mrs Jones' account was as follows:

> *"I received a call from Craig on Saturday morning just gone. I don't know the date. In the first phone call Craig told me that he had pains in his head at the back. He told me that he was holding his head and it felt like he wanted to get his head chopped off. Craig was specific that the pain was in the back of his head. Craig told me that he was going to go back to his room and lie down. I told Craig that I was ringing Ashley's and getting them to take him to the hospital. As soon as Craig hung up I rang Ashley's straight back."*

128. Significantly, there was no evidence to suggest he informed his mother that he had vomited at that time.

129. There is a note in the observation sheet (Exhibit C8) that Craig had TV time at 10:30am. This would have occurred outside Craig's room. Unlike some of the other items in the list of incentives for that day it had not been ticked off, suggesting it might not have occurred.

130. During the morning Craig's mother rang AYDC on two occasions, however I am unable to determine the actual times. On the first occasion she spoke with both Ms Richardson and Mr Simpson and on the second occasion to Mr Simpson only. She said Craig was having bad headaches; he had been in a car crash and suffered a head injury. She demanded that he be taken to hospital.

131. The operations co-ordinator Rodney Simpson visited the unit and spoke to Craig about his headache. Ms Carol Richardson went with him to Craig's room. Mr Swain also went and stood outside the room. Mr Swain says he went to observe as an independent witness although the need for that is not clear. While there are some differences in the evidence the effect of the discussion emerges reasonably consistently from the witnesses.

132. The most comprehensive evidence before me as to the conversations with Craig's mother and the subsequent events on that day was given by Mr Simpson both in his Affidavit sworn on the 3 November 2010 and in his evidence before me[58].

133. There is no dispute that between 11:30-12 noon on Saturday 23 October, Mr Simpson has visited Craig in his room in the company of Youth Worker Carol Richardson. There is further evidence that Shane Swain was outside the room, and was able to observe and hear the conversation with Craig.

134. Some observations about that conversation are appropriate. Mr Simpson asked Craig to rate the severity of his headache on a scale of 1 to 10. Given Craig's numeracy difficulties that may not have been a particularly helpful way to gain a picture of the severity of the headache. However Craig said he had a headache which was 3-4/10. Craig indicated that his mother was exaggerating, but Mr Simpson interpreted that to relate to an issue raised by Mrs Jones other than the headaches.

135. The Huon communication book (Exhibit C4) contains a note at 11:23am. The note was made by Ms Richardson. It indicates that Craig was offered Panadol in his room for a headache, but he refused to take it. Mr Simpson said he responded saying "pills make him sick and that he would spew if he took some". It can be observed that Craig was in his room, but there is no corresponding entry in the observation sheets (see Exhibit C8) for that time. This is evidence of at least one failure to record an observation.

136. Rodney Simpson reported the phone call from Craig's mother to Fiona Atkins and also discussed with her that Craig's symptoms appeared flu like. The result of that discussion was a note by Mrs Atkins that Mrs Jones was being a nuisance. Mr Simpson accepts that he may have intimated that belief to Mrs Atkins.

137. However, that does not mean he did not give serious consideration to Craig's condition, and he did take it serious enough to visit Craig personally, and to ascertain his condition. His own assessment differed from what Mrs Jones described to him on the phone.

138. Whilst I accept that neither Mr Simpson nor Mrs Atkins were in a position to make a medical assessment, as they did not possess the relevant qualifications, I am satisfied that they were in a position to form a view as to Craig's condition to determine if it was of a nature where a medical assessment was required. There

[58] See Transcript Pages 686-687

was no medical person present, but from the conversation with Craig he did not give any reason that would require he undertake a medical assessment. Craig's mother was responding to what Craig had told her, but when spoken to, Craig did not support what his mother had complained of to staff, quite the contrary. In my view, the course adopted by Mr Simpson was the appropriate one in the circumstances.

139. Mr Simpson's assessment led him to doubt the need to take the course Mrs Jones was demanding.

140. I accept the evidence from Mr Simpson as accurately reflecting the events and discussion that occurred at that time and where there is any inconsistency with other witnesses, I accept the evidence of Mr Simpson.

141. There is some evidence that Craig did not have his lunch on that day. Some of the residents suggested that Craig did not come out of his room all weekend. However, I accept the evidence of Mr Staal who stated that Craig had 2 bowls of soup, but refused toast. He said Craig looked pale and sick and did not say much.

142. There was no evidence that any of the staff who had contact with Craig on this day observed Craig vomiting, nor was there evidence of any vomit being in his room. In all the circumstances, I am satisfied that Craig did not vomit on the morning of Saturday 23 October 2010.

143. After lunch Craig told Mr Staal he had headache and wanted to go to his room. He said he wanted to make a phone call to his mother before the shift change. This is corroborated as it occurred. Although Craig was clearly in his room until shortly before the change of shift, again no observations were recorded of that on the observations sheet (Exhibit C8).

144. After lunch Mr Simpson spoke to Mr Staal who advised that there was no change to Craig's condition.

145. At the shift changeover Mr Staal told the oncoming team leader, Mr Timothy Atkins that Craig had complained of a headache and had a runny nose.

146. Mr Simpson advised the oncoming operations coordinator, Mr Westwood, of the phone call from Mrs Jones that Craig had a headache for which he had refused Panadol and that Craig wanted to lie down, but the headaches were not getting worse.

147. The observation sheets for that day do not show Craig in his room at the start of the afternoon shift, or any time during that shift, except during quiet time and after he went to bed. Mr Atkins maintains that is the fact.

148. However he made a note in (Exhibit C12) that Craig was segregating himself in his room. Mr Atkins says he made that comment based on information provided to him by Mr Staal as to Staal's observation during the earlier shift. Why Mr Staal would not make that note himself is not explained by the evidence. And there is evidence which suggests Craig was in his room at the start of the shift and between then and quiet time.

149. Youth Worker, Danny Haywood, says that he had been allocated to work on another unit, but when he arrived to start the afternoon shift he was asked to work at the Huon unit. When he arrived at the Huon unit at about 3:30pm Craig was in his room. He says he saw Craig on his bed while doing regular checks between then and quiet time at 4:45pm. On those occasions Craig appeared drowsy. Mr Haywood says that Mr Atkin's note (see Exhibit C12) is an accurate reflection of his observations of Craig between 3:30pm and 8:00pm on that day when Mr Haywood returned to the unit he had originally been allocated to work on.

150. Mr Haywood says that he convinced Craig to come out of his room for tea and sat with him while he ate between half and ¾ of the tea.

151. After tea Craig read a magazine in the common room and Mr Haywood put a phone call through to Craig's mother. He says Craig was not out for evening supper at 7:15pm.

152. Ms Vock says she put Craig to bed at about 7:00 - 7:30pm that day when Craig asked to be put to bed because he had a headache and was feeling sick. She says that was after SLAB or supper.

153. However, another resident, resident H said that Craig did not come out all day. Another resident, resident B said Craig did not come out all weekend.

154. I am satisfied that Craig was in his room for most of the day. I find he did leave his room for short periods in the morning, perhaps for television and to talk to his mother on the phone. In the afternoon he came out at tea time and for a short while thereafter, but went to bed before evening supper and did not come out after that time. On the occasions Craig was his room I am unable to find whether no observations were made of him, or whether there was a failure for them to be

recorded. It is clear the Observations Standard Operating Procedure was not complied with. On this issue I reject the evidence of Mr Atkins.

155. I am unable to say whether that meant matters relevant to Craig's wellbeing, and whether or not he should be taken to a doctor, were not observed. Certainly such observations were not recorded. The desirability of properly performing and recording observations in those circumstances is self-evident.

156. In the early hours of Sunday morning 24 October 2010 Craig vomited on three occasions.

157. The first time was at 1:30am. He was heard to give a raspy cough. Staff spoke to him from outside his room. He said he wanted the light out.

158. The second time was at approximately 2:20-2:30am. Youth Worker Tanya Elmer and the night shift supervisor, Susan Frankcombe, spoke to him then. He said he felt sick, and had an upset stomach. He said he did not have a headache and did not want Panadol. He also said he did not want to clean up the mess then and just wanted to be left alone. He wanted the light turned off.

159. The decision was made to place Craig on 10 minute observations at that time. Those observations commenced and were recorded (see Exhibit C84). They show that Craig generally spent time sleeping and settled in his room.

160. The third occasion was at 4:25am. That was noted by Ms Elmer on the 10 minute observation sheet (Exhibit C84) and she told Ms Frankcombe when she returned from yard checks.

161. A note was made in the Unit communication book to the effect that Craig had vomited and at the changeover with the morning shift on Sunday 24 October 2010 the fact that Craig had vomited 2 or 3 times was passed on. The fact that Craig had vomited 2 or 3 times was also recorded in the operations coordinators' book.

162. Mr Staal was the team leader again on Sunday morning. At the start of the shift Craig told him that he was a bit funny in the stomach.

163. A mop and bucket was taken to his room and help was offered to clean up the vomit. That was declined

164. The 10 min observations were continued. They reveal that Craig stayed in his room. He was seen to be on his bed and awake at 9:40am.

165. At 10:00am Craig said he was feeling better but did not want breakfast.

166. There is evidence from Mr Burridge a youth worker who was working in one of the other units, who said that he had spoken to Mr Staal that morning, and suggested he should arrange for Craig to see a doctor to avoid trouble from Mrs Jones. However, Mr Staal denies such a conversation, and evidence given by Mr Burridge in cross-examination by Mr Turner raises doubts about the credibility of Mr Burridge's account.

167. Mr Burridge was forthright in the manner in which he gave his evidence-in-chief, however, under cross-examination it became obvious that he was mistaken as to matters upon which he had been definite. I attribute this to the severe assault to which he had been subjected to at an earlier time and which in his own words caused him to have "suffered significant memory loss". I make no criticism of Mr Burridge; however, I formed the view that much of his evidence was a reconstruction of events after having learned of Craig's death and much soul searching as to whether or not there were signs which may have been overlooked. It is often much easier with the benefit of hindsight to form conclusions which were not apparent at the time.

168. I am satisfied that Craig did not come out for lunch. At approximately 2pm Craig was still in his room. He said he did not have a headache, but his stomach was funny. He said he did not want to clean up the vomit yet. Mr Staal reported that to Mr Simpson who passed that information on to Mrs Fiona Atkins.

169. At the changeover to the afternoon shift Mr Staal told the oncoming team leader Mr Atkins that Craig had no breakfast or lunch and that the cleaning gear to clean up the vomit was in Craig's room.

170. Mr Staal noted (see Exhibit C12) that Craig had refused to clean his room after having vomited. Perhaps there can be no criticism of the objective way in which that fact is expressed. However, it might be considered somewhat callous to have left the vomit in the room when Craig was clearly unwell, expecting him to clean it himself with or without assistance. Having said that, it is difficult to judge such attitude, as I assume there have been incidents when residents have vomited for other reasons apart from a genuine illness and they have been required to clean up after themselves.

171. Mr Westwood was the operations coordinator, and Mr Atkins the Huon unit team leader, on the afternoon of 24 October 2010. They decided during the afternoon to

revert to 20 minute observations for Craig on the basis that his condition had improved, or at least had not worsened. How Craig's condition was viewed as different other than the absence of vomiting is not made clear by the evidence.

172. Craig stayed in his room for the rest of the day. Ms Vock saw Craig apparently sleeping in his room during the afternoon of 24 October 2010.

173. Craig did not come out for tea. At about 6:00pm he told Mr Atkins that he was "okay", but did not want to come out. Mr Atkins observed that he looked tired. At that stage the vomit on the floor next to Craig's bed still had not been cleaned up. However, the mop and bucket were removed at 8:00pm. Craig had cleaned the vomit sometime between 6:00pm and 8:00pm.

174. Between approximately 9 and 9:45pm Craig twice used the intercom from his room to the unit office to ask for passage lights to be turned off. He was told that could not be done until the other residents were in bed.

175. At 1:00am on Monday morning 25 October 2010 Craig's mother rang concerned that she had not heard from Craig on the Sunday. Mr Howe, the youth worker told her Craig was "okay".

176. At some stage during the night, estimated by him to be about 1:00am, resident H, another resident in the Huon Unit at AYDC called out to Craig and asked him if he was going to programmes. Craig responded to the effect "I reckon".

177. There is evidence from some of the residents that they heard coughing during the night at about 3:00-4:00am followed by male and female voices outside Craig's room and increased observations on Craig. Resident H says he called out to Craig and received a response at that time.

178. At 4:20am on 25 October 2010, the night shift supervisor, Ms Frankcombe, heard Craig coughing. She went to check on him. She did not receive a verbal response, but Craig rolled over and covered his face.

179. The Huon night shift youth worker, Mr How, did his last check on Craig at 6:35am. Mr How observed Craig's arm was over his head and he was facing into the room.

180. At approximately 8:00am on the morning of Monday 25 October 2010 the oncoming team leader for the Huon unit, David Lee, noticed that Craig was not up

for breakfast. He went to Craig's room and found him lying on his bed facing the wall and unresponsive.

181. He called for assistance from Cheryl Beaumont. Ms Beaumont says Craig was very hot to touch.

182. The ambulance was called but Craig was not able to be revived.

The Cause and Development of the Brain Abscess

183. Dr Louise Cooley, the director of Microbiology at the Royal Hobart Hospital and an infectious diseases specialist, and Dr Christopher Lawrence, the State Forensic Pathologist, gave evidence as to the brain abscess which was found to be the cause of death. That evidence suggests the following conclusions.

184. Craig died as a result of the rupture of a large brain abscess.

185. Brain abscesses are a relatively rare or uncommon condition. Dr Cooley deals with an average of about 2 per year. They are a condition a GP would not come across commonly.

186. There are a number of different causes of brain abscesses. It is likely that the abscess Craig experienced was caused by extension of a sinus infection to the site where the abscess formed. That is supported by the microbiological results. It is possible, but less likely, that the abscess was caused by an injury from the car accident on 25 September 2010, or the assault on 8 October 2010. It is possible it could have been caused by some other unknown cause.

187. I am satisfied on the basis of the evidence presented it is highly likely that the abscess was caused by an extension of a sinus infection.

188. The forensic examination revealed that the brain abscess had formed a capsule which indicated that it had been present for at least 10 days, the evidence presented suggested it was likely to have formed sometime prior to the 14 October 2010, although there is no certainty as to the exact date.

189. Symptoms suggestive of brain abscess include:

- headache, particularly persistent, fluctuating headache;
- vomiting;
- fever;
- reduction in conscious state; and
- localised seizure activity.

190. Before an abscess ruptures it is possible the clinical signs might be quite non-specific and very mild:
    - mild light sensitivity;
    - mild neck stiffness;
    - headache;
    - fever; and
    - dehydration.

191. The size and location of the abscess determines the severity of the signs and symptoms caused by it. The forensic evidence suggests the type of abscess suffered by Craig can be less symptomatic.

192. With a frontal lobe abscess it is possible for a person to appear with a headache and light sensitivity, even vomiting, and being in bed, but maintaining an appearance of relatively normal functionality, and with no apparent signs of suffering from a life threatening condition.

193. With such a relatively rare condition and with fluctuating symptoms it would be difficult for many general practitioners to be able to identify the condition, let alone a lay person.

194. There is nothing recorded in the medical examination on 8 October 2012 which would warrant a CT scan to investigate the existence of a brain abscess.

195. The observations made by Nurse Thomas on 11 October 2010 are consistent with a number of pathologies. There was no reason to surmise at that stage there was anything other than an infection of some sort. At that point Craig's presentation may have been consistent with a brain abscess, but may also have been consistent with many less serious conditions, such as sinusitis, or a common cold, or flu. An appropriate response to that situation would be "wait and see". That approach is vindicated by the fact that no issues were observed on 20 October 2010.

196. As at 13 October a wait and see approach was appropriate once there was evidence of the swollen eye improving. As at 20 October 2010 it is possible Craig was asymptomatic. The symptoms of a brain abscess fluctuate so a person can function normally and have intermittent symptoms. If Craig appeared to be normal at that stage there was no need for a medical referral.

197. In the case of Craig's abscess there may have been no signs of it on 15 October 2010. He may have had a normal clinical examination at that time; though he

might have had signs of raised intracranial pressure, equally, he may not have had such pressure.

198. Any signs that may have existed would be consistent with other pathologies including sinusitis, cold, or flu. Signs of sinusitis include nasal discharge, swelling around the eye, or sinuses, and tenderness of the sinuses.

199. The very late stages of an abscess can manifest in a decreased conscious state, drowsiness, and difficulty in being awakened, high fevers, signs of raised intracranial pressure, light sensitivity, sometimes low blood pressure and maybe vomiting. But it is unusual for a person to present for medical treatment that late.

200. It is unusual for a person to die from a brain abscess without having sought medical attention beforehand. There is usually some manifestation.

201. If an abscess was suspected a CT scan would be undertaken, usually within an hour of hospitalisation. A patient presenting with vomiting, fever and a swollen eye, dehydration and light sensitivity, may be referred for a CT scan to rule out a brain abscess, particularly if the doctor had some experience or knowledge of such abscesses. But a reasonable response for a GP to a patient presenting in that condition would be to wait and see with a review within 48 hours to see whether the symptoms worsened indicating something more serious. If the symptoms persisted beyond that a specialist referral would be appropriate. But if on review after 48 hours the patient was presenting as being well generally, no further treatment would be warranted.

202. If Craig had presented at hospital prior to the rupture with the entire history of a car accident, two weeks of symptoms, fevers and persistent headaches, intermittent headaches, intermittent vomiting, a CT scan and blood tests would have led to the diagnosis of the brain abscess.

203. Treatment of the abscess pre-rupture is antibiotics, aspiration, or surgical removal of the abscess. The treatment post rupture is to reduce the intracranial pressure using the drug Mannitol and then neurosurgical treatment.

204. A headache on 23 October 2010 of itself would not justify medical review, but if Craig had taken to his bed, had fevers, was not his normal self, and was complaining about light hurting his eyes, he would need to be reviewed then.

205. With the benefit of hindsight, Craig did have significant signs of a brain abscess on Sunday 24 October 2010. He was unwell. He was in bed. He complained about the light. He had vomited.

206. By Sunday night 24 October, the history of persistent headaches and vomiting mean Craig should have been referred to the doctor. Even without any previous history, the significant deterioration over the weekend means he should have been reviewed.

207. Given the headache on the Saturday and vomiting on the Sunday morning he should have been reviewed by someone with medical experience. He should certainly have been referred for medical review over the weekend.

208. An abscess can rupture spilling most of the infective contents into the surrounding tissue causing infection. If medical attention is received before rupture there is a greater than 90% chance of survival. That is not affected by how late the presentation occurs, so long as it is before rupture, even if there has been some leakage of the contents of the abscess.

209. Once rupture occurs there is more significant inflammation of the meninges. That is usually associated with a marked decline in the patient's wellbeing. Often the headache will become more severe and the photophobia will get much more severe. The patient will just lie there and not want to move and there may be persistent vomiting. The patient will present as very unwell, with low blood pressure, irregular heartbeat and affected conscious state.

210. Light sensitivity can be a sign of rupture of the abscess. That could also be the result of a leak of infective material from the abscess causing inflammation of the meninges covering the brain.

211. The increased intracranial pressure resulting from the inflammation caused by the rupture stops the blood flow from the brain stem causing the cessation of breathing and heart failure within a very short space of time.

212. It is possible for the rupture to occur without warning followed by very acute deterioration.

213. In Craig's case it is clear that the abscess ruptured into the ventricular system of the brain causing widespread meningitis.

214. It cannot be determined with certainty whether the rupture occurred on Saturday 23, Sunday the 24, or early Monday morning

215. The latest the abscess could have ruptured would be immediately before Craig's death, i.e. on Monday morning. The earliest it could have ruptured would be Saturday night, particularly if it was just a leak, or partial rupture. If that occurred it would be likely he would have simply lain in bed, semi-conscious for most of the day, unwell, vomiting, and drowsy.

216. The vomiting in the early hours of Sunday 24 October 2010 suggests increased swelling in the brain and meningitis, so the rupture may have occurred before then. There could have been a partial rupture or leakage by then and later a complete rupture.

217. However, if it is accepted that Craig cleaned up the vomit in his room between 6:00pm and 8:00pm on Sunday 24 October 2010, and used the intercom to ask for the passage light to be turned off between 9:30 and 9:45pm that night, it is reasonable to assume the rupture occurred after that time.

218. The time for survival after the rupture would be 12 hours at most. It is highly probable the abscess ruptured sometime on the Sunday night.

219. After rupture, presentation to hospital would certainly lead to diagnosis of a brain abscess. However, once the abscess ruptures the mortality rate is 85%. That is the case whether or not there has been leakage.

220. Craig would be in a more favourable group for survival considering his age, but it is the amount of infective material that is released which reduces the survival rate. Forensically the size of the abscess suffered by Craig could elevate the mortality rate much higher than 85%.

221. For a patient in Northern Tasmania presenting post rupture the chances of survival are reduced because of the time required to travel to Hobart to receive neurosurgical treatment.

222. I am unable to find that if Craig had been presented to hospital post-rupture, treatment would have changed the outcome.

223. The inquest has raised a number of issues that need to considered and addressed and I will deal with those specifically.

Knowledge within AYDC of Matters Related to Craig's Health

224. The evidence indicates that at various times various people within AYDC were aware of some of the facts which suggested Craig was unwell, possible causes of his condition and factors which suggest he could have benefited from review by a doctor. But they were not all known to everyone dealing with Craig. For example:

    (1) While Dr Gray, Nurse Thomas, many of the residents, and some of the youth workers, knew of Craig's car accident, a number of the youth workers did not become aware of it until after Craig's death;

    (2) The operations coordinator, Mr Simpson, did not know of the car accident until Mrs Jones told him on 23 October 2010; nor was he aware of Craig vomiting on 10 October 2010, until after Craig's death.

    (3) Some staff members observed Craig with a runny nose and flu like symptoms. Others did not.

    (4) Some staff members were aware that Craig had complained of a headache or headaches. Others were not.

225. The observations and complaints, when they were recorded, were recorded in various places including a communication book for the unit in which Craig was staying and if the operations coordinator or night shift supervisor was made aware of the condition, in the books kept by them. Other relevant notes were placed in a suspension file (See Ex C12) which was kept in Centre Support after it was completed and was not available to the unit staff. Records of observations and notes made on the daily observations sheet were also forwarded to administration. The evidence in this case establishes that all of those records might contain information relevant to a resident's health. But the information is not duplicated, or collated, or made available to staff who might usefully want, or need, to see it to make decisions about a resident's care.

226. The record keeping system was essentially unit based. Observations about a resident's health were not passed between units when the resident transferred to another unit.

227. If past information about Craig was to be obtained it would have to be gleaned from a number of different sources in different places. Those sources all contained information which was relevant to Craig's health, care, and supervision as well as

much information that was entirely irrelevant to those matters. The relevant information about Craig would need to be sifted from all that other material. There was no system of recording relevant matters in a way that ensured those caring for a particular resident could have a comprehensive picture of a resident's health over time.

228. Had all that information been available to Mr Simpson in one place it would have created a very clear picture of a young person who had been unwell for some weeks, that some unknown medical condition was causing fluctuations in his health, there was a marked deterioration in Craig's condition over the weekend of 23 October 2010 and 24 October 2010. It is at least possible, and I find it likely, that arrangements would have been made for Craig to see a doctor if all the information available had been recorded in an accessible way.

229. I acknowledge that staff were concerned as to matters relating to privacy and the privacy laws, however where a person is being held in a place, and where there is a duty of care, the laws as to privacy should not create impediments for those who have the responsibility of providing that duty of care.

230. It would appear that many persons are confused by the laws of privacy and I would recommend that consideration be given to amending any relevant legislation to exclude those laws from applying to the situations I have outlined.

The identity of any person who contributed to the cause of death.

231. Sub-paragraph 28(1)(f) of the Act obliges the Coroner to consider, and if possible, identify any person who contributed to the cause of death.

232. In order for a finding of contribution to be made the following factors must exist:

(1) The conduct must be properly established to the *Briginshaw* standard; [59]

(2) The conduct must also have been a cause of the death as a matter of ordinary common sense though it need not be the sole, or even the most significant cause.[60] It is not a matter of simply following the logical progression of events;[61] and

[59] See *Chief Commissioner of Police v Hallenstein* at p 19 quoting from and applying the judgment of Dixon J in *Briginshaw v Briginshaw* (1938) CLR 336 at 361-3; Also see Findings Deaths in Custody Inquest 26 March 2001 at p6.

[60] See *Chief Commissioner of Police v Hallenstein* at p 18; *Keown v Khan & Anor* at [16].

[61] See *Chief Commissioner of Police v Hallenstein* at p 20

(3) There will be occasions when the conduct will need to involve some element of departure from reasonable standards of behaviour or in breach of a recognised duty[62].

233. There is no need to and indeed it is inappropriate for there to be any finding of legal liability to establish contribution. [63]

234. In this case the question of whether any person contributed to the cause of death will arise in the following ways:

(1) Whether the assault by Resident A led to the brain abscess;

(2) Whether any of the AYDC staff should have obtained a medical assessment for Craig and if so whether that would have prevented his death from the brain abscess;

(3) Whether the assessment by Dr Gray was adequate; and

(4) Whether the nursing assessments and responses by Nurse Thomas were adequate.

Did Resident A contribute to the cause of death?

235. The assault by Resident A is a possible cause of the brain abscess from which Craig eventually died.

236. The absence of evidence of a bone fracture and the location of the abscess mean that the assault is an unlikely cause of the abscess. The evidence establishes a sinus infection was more likely the cause of the brain abscess and could not be found to be related to, or consequential to, the assault.

237. I do not find that resident A contributed to the cause of death within the meaning of s28(1)(f) of the Act.

Did any of the staff at AYDC contribute to the cause of death?

238. Section 28(1)(f) does not require, or authorise, a finding against an institution. It requires consideration of contribution by individuals. However before considering whether any such findings can be made it is appropriate to consider circumstances relating to all the staff.

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62 See *Chief Commissioner of Police v Hallenstein* at p 18; *Keown v Khan & Anor* at [16]
63 See *Chief Commissioner of Police v Hallenstein* at p20; *Keown v Khan & Anor* at [16].

239. There was no act of any staff member which led to Craig suffering the brain abscess from which he died.

240. It is likely the brain abscess was caused by a sinus infection. Having formed, the abscess developed and progressed of its own accord until it ruptured leading to the physiological processes which resulted in Craig's death. No act of any of the staff members of AYDC, or indeed of any person, led to the development and progression and ultimate rupture of the abscess once it had formed.

241. However, if Craig had been referred for medical assessment and the abscess identified and treated, it is possible that a failure to refer him for that assessment could have contributed to the cause of death within the meaning of section 28(1)(f) of the Act.

242. In order for that contribution to be found it would necessitate that I would have to be affirmatively satisfied that Craig should have been referred for medical assessment before he died, and that the failure to do so was a departure from the reasonable standard which could be expected of one or more members of staff at AYDC in fulfilling their duty to care for and supervise Craig while he was in detention. That would require a finding that the only reasonable course to have been taken by the staff members at Ashley was to refer Craig to the hospital.

243. Dr Cooley in her evidence said if Craig had been diagnosed as suffering from a brain abscess before it ruptured, there is likelihood that treatment would have been successful[64], however this is dependent on a number of factors including, but not limited to, the impact the travelling to a hospital may have had on his condition, whether or not a diagnosis would have been made at that time, whether qualified staff and equipment would be available to undertake the necessary investigation. On this basis, the only finding reasonably open to me on the factual circumstances is that by Craig not being taken to a hospital on either the 23 or 24 October 2010, he was deprived of the opportunity of receiving appropriate treatment and the possibility that he may have survived. That possibility, as I have found earlier, cannot be elevated to a probability that Craig would have survived had he been taken to a hospital on those dates.

[64] Dr Cooley T1119 lines 14-30 and T1132

244. Such diagnosis and treatment would have taken some time. Craig would have had to travel from AYDC to the LGH. Blood tests and a CT scan would have been required to ascertain the cause of his condition, and perhaps a lumbar puncture. The results of those investigations would need to have been interpreted and appropriate treatment implemented. That might have involved transport to Hobart for surgery. All of that is likely to have taken some hours during which time the abscess may have ruptured in any event.

245. Both Dr Lawrence and Dr Cooley when questioned as to when the abscess ruptured were reluctant to be categorical as to a specific time. It could have ruptured sometime over the weekend, although the evidence suggests it would have ruptured at some time either late on Sunday night or early Monday morning.

246. I am unable to find that if Craig had been referred for a medical assessment at or before 5 o'clock on Sunday, 24 October that he would have survived as there are too many uncertainties to which I have already referred. I accept that it is a possibility, but I am unable to place it any higher than that.

247. For completeness, and on the basis of submissions made, I will proceed on the basis that there was a possibility; Craig would have survived, had he been referred for a medical assessment during his final weekend. In such a case it would be necessary to determine whether the failure to refer him could lead to a finding of contribution to the cause of death by one or more of the AYDC staff members.

248. If it could be said that referral for medical assessment would have resulted in successful treatment, the question for determination is "Whether there was a departure from the reasonable standard care expected of the AYDC staff members". For the reasons which follow I am satisfied there was no such departure.

249. In order to satisfy the test under section 28(1)(f) it is necessary to make a finding that the only course reasonably open to the staff on duty on the weekend of 23 and 24 October 2010 was to refer Craig immediately for medical assessment.

250. I find that it would have been reasonable for Craig to have been referred for medical assessment at least by 23 and 24 October 2010. That is the clear conclusion which flows from the following matters:

(1) Craig's involvement in a serious car accident on 25 September 2010;

(2) The serious assault on him on the evening of 8 October 2010;

(3) His complaints of headaches on 8 and 10 October;

(4) His sore eye on the weekend of 8 to 10 October and shortly thereafter;

(5) The fact that he vomited on Sunday morning 10 October;

(6) That he didn't have breakfast or lunch and stayed in his room for most of the morning of 10 October;

(7) That he was febrile and was sensitive to light when seen by the nurse on 11 October and sensitive to light on occasions thereafter, particularly on the weekend of 23 and 24 October 2010;

(8) Craig appearing to have a snotty, or runny nose, and flu-like symptoms from 7 October to at least 11 October 2010;

(9) Craig appearing unwell to other residents suggesting he would also have appeared unwell to AYDC staff members even though that may have been manifested in a fluctuating way;

(10) The demand by Craig's mother on 23 October 2010 that he be taken to hospital because he was complaining of severe headaches, particularly in light of the objective of the *Youth Justice Act* 1997 requiring significance to be given to the role of the youth's guardian;

(11) Craig complaining of a headache on Saturday morning 23 October 2010;

(12) The fact Craig stayed in his room for at least Sunday 24 October 2010, and probably much of the Saturday 23 October 2010;

(13) Craig ate less than normal on Saturday 23 October 2010 and did not eat on Sunday 24 October;

(14) Craig vomited 3 times in the early hours of Sunday morning 24 October 2010; and

(15) Craig was generally compliant and a low security risk. He had been taken off site in the past without any difficulty and in his state of ill health would not have posed a significant security risk.

251. The strength of that conclusion probably increases with time through the weekend of 23-24 October as Craig's condition persisted for the entire weekend. Although

as the weekend concluded the time at which the nurse would be able to assess him was drawing closer.

252. The almost unanimous evidence of the various staff members is that had they been aware of all of those matters, or even some of them, they would at least have considered referring Craig to a doctor and may have decided to take him to hospital, at least by Sunday 24 October 2010 and perhaps earlier. Mr Simpson said he would have used the Corrections Primary Health Service after hours on-call medical advice service if it had been available then.

253. With the benefit of hindsight it is clear that Craig should have been referred to a doctor, or taken to hospital, at some stage on the weekend of 23 and 24 October 2010. Again, with the benefit of hindsight one could conclude that was the only reasonable course to take.

254. However, the assessment of whether the failure to take that course was reasonable must be done at the time the failure occurred.

255. The following factors suggest that it was reasonable not to refer Craig for medical assessment:

(1) The various staff members did not have all of the information outlined above. Craig's complaints of headaches were not always made to staff and were not always recorded. Some staff members were not aware that Craig had been involved in a car accident. Others did not know he had been assaulted. Others did not know he had vomited on the 10 October 2010. Others were not aware he had had a sore eye;

(2) In response to direct queries about how he was feeling by staff members Craig responded indicating that he was "okay" despite being unwell;

(3) As lay people, albeit with first aid training, the various staff members could not be expected to detect, or understand, the significance of what might be subtle signs of a potentially serious and rare condition. For example, light sensitivity may be reasonably mistaken for a desire to be left alone or a desire to sleep. It was not unreasonable to assume that Craig's condition was consistent with a person suffering from flu or a cold. Craig's wish to remain in his room could well have been interpreted as Craig's way of dealing with problems from other residents; particularly, as he had been observed during his previous periods at AYDC to retreat to his room when confronted by

other residents. In other words, it was not unusual for Craig to spend time in his room;

(4) From the evidence it would seem that Craig's symptoms fluctuated, this may have contributed to why many of those who came into contact with Craig formed a view that he was suffering from minor conditions. Craig was not observed to be particularly unwell by some staff members;

(5) The indications that Craig was unwell, such as a runny nose, lethargy and even vomiting were consistent with and explicable as relatively minor conditions such as a cold or flu, or stomach upset, for which medical assessment would not be required immediately, or at least before the nurse was available on the Monday morning;

(6) Formal instructions had been given to staff to exercise extreme patience with Craig's mother suggesting that she might exaggerate Craig's complaints;

(7) Craig said his mother was exaggerating his complaints, at least as to problems with his canteen, and the severity of his headaches;

(8) It was not abnormal for Craig to stay in his room and avoid contact with other residents because he was the subject of intimidation by them;

(9) There was no policy guidance for the circumstances in which medical treatment was to be sought for a resident. That was left to the judgment of the operations team, in particular the operations coordinator when on duty;

(10) No medical or nursing staff were available on site after hours during the week or on the weekend, and medical assessment required transport to a hospital off-site which raised issues of security;

(11) Craig had been assessed by a doctor on admission and no follow up was required;

(12) Craig had seen the nurse on 3 occasions during his detention and no follow up was required;

(13) The apparent likelihood that Craig would die if the staff waited until the nurse returned on Monday 25 October 2010 would have to be regarded as very low;

(14) A brain abscess is a relatively rare and serious condition which without expert medical knowledge, or experience, might not be contemplated as a likely cause of Craig's condition, particularly when his condition was consistent with and commonly associated with less serious illnesses;

(15) On the weekend before Craig died, the likelihood of the cause of Craig's problems relating to a head injury as a result of an assault occurring 2 weeks previously, or a car accident one month previously, could only be viewed as remote, particularly when his condition was consistent with less serious illnesses; and

(16) There was no record available to youth workers and other supervising operational staff which gave an overview of observations about, and complaints by Craig, about his health, and no consistent recording of that information.

256. Reliance on many of those factors could be criticised. Explanations consistent with the serious condition from which Craig was suffering can be found now, however I am unable to find with any degree of certainty, or otherwise, even with the knowledge of the various symptoms, that a reasonable person would have been able to form a conclusion that Craig's condition was likely to become serious.

257. The basis for this conclusion is as follows:

(1) Some of the known facts, such as headache and vomiting after an assault involving a head-butt could in some cases be a cause for concern, however in this instance; Craig was seen by the nurse the following day, 11 October 2011 and discussed the vomiting with him. His condition improved and no follow up was required. There was no manifestation of any serious problem requiring further examination, nor any outward signs of any underlying problem;

(2) It has been submitted that some staff knew of Craig's limited intellectual, communication, numeracy, and literacy skills and that he had a tendency to under report because of his general character, and accordingly staff should have been more pre-emptive as to his medical condition. On the evidence there is nothing to support a finding that his needs were ignored. An example of this was Mrs Beaumont, who mothered Craig when he was at the AYDC, and had deeply felt his loss; she had spent time talking with Craig and I have no hesitation in finding that if there had been any outward

manifestation of any impending health problems she would have taken every step to have them addressed, irrespective of the day of the week, or the time of day. Whilst giving her evidence Mrs Beaumont was emotional and her caring for Craig was evident;

(3) It has also been submitted there are times when a carer needs to make an objective assessment of a person's well-being based on known history and personal observations as to a person's medical condition rather than solely relying upon that person's view, particularly with younger people. I am satisfied that on the 23 October; Mr Simpson did not simply rely on Craig's mother's opinion as to Craig's health, or even Craig's own opinion as to his health. He spoke to Craig personally to assess his health, and despite Craig suggesting he was not that ill, he had him placed on regular monitoring (10 minute observations) so his condition could be watched carefully.

(4) It has been submitted further, that a person who has undertaken First Aid training should be sufficiently competent to know that benign signs and symptoms can be indicative of serious illness thereby rendering medical assessment desirable. But he was seen by a Nurse and by a medical practitioner. Neither of these persons were able to identify that Craig was suffering any symptoms which required any further medical assessment. They treated Craig for the conditions that they diagnosed, and in doing so the conditions improved. I also note the forensic evidence which indicates that there may not be apparent signs of an impending burst abscess, or even the presence of an abscess, until shortly prior to its eruption. It would be unjust to expect any person with first aid training to be in a position to determine that urgent medical assessment was required which necessitated travelling to the nearest hospital.

(5) I accept the submission by Counsel Assisting that it was well known, at least to some staff, that Craig would not complain or raise concerns directly with staff, but would do so through his mother. When Craig's mother had raised concerns about Craig's treatment, those concerns on investigation, were found to have some substance. An incident relating to Craig's shoes was one such example. It is likely that Craig's shoes had been taken. When spoken to by staff he denied they had been taken. Another occasion was when Craig had complained to his mother that another resident had "stood over" him taking his canteen. Again Craig denied this had happened, but more likely than not it did occur. It could be suggested that rather than doubting what

had been said by Craig's mother, Mr Simpson should have accepted it at face value rather than making his own determination on a matter he was not qualified to make. I reject any such submission. It can easily be said, with the benefit of hindsight; however it has to be judged as at the time when the situation arose. Craig's mother said he told her "he was holding his head and it felt like he wanted to get his head chopped off". I have no doubt this would cause concern to anyone, and it did with Mr Simpson. He went to speak to Craig. Craig did not convey to Mr Simpson that the headache was of such severity, even if no weight was given to the scale used. Craig said his mother exaggerated, he did not ask to see a doctor, and certainly he gave no signs of suffering a life threatening condition. The observations of Mr Simpson and Mrs Beaumont and from the contents of their conversations with Craig did not support the account given by Craig's mother. As I have found earlier I have no doubt that if Mrs Beaumont had been told by Craig his head was hurting so much he wanted it chopped off, she would have arranged to have him taken to hospital, and I have no doubt Mr Simpson would have adopted the same course.

(6) It should be remembered Craig was in a detention centre, there is an inherent risk when a person is taken from such places of detention out into the public. There is a risk of escape, a general risk to the community, and the property of persons. Craig had not demonstrated a propensity to escape in the past, but it could not be presumed it would not happen, he was getting older, and he was facing serious charges, all of these factors needed to be considered. To suggest that Mr Simpson, having spoken to Craig, should reject his own observation and ignore the discussions he had with Craig is unreasonable. The steps taken by Mr Simpson were appropriate in the circumstances existing at that time.

(7) I accept the submission that inconvenience and security risks should always be subordinate to serious health risks, particularly when dealing with youths being held in a detention centre, but those health risks have to be perceivably serious. The nature of Craig's illness was not perceivable either by Mr Simpson, or any staff member, however, I am satisfied that had any one of the staff had a suspicion that Craig needed to be assessed by a medical practitioner, none of them would have stood back and taken no action.

(8) I accept also the submission that in October 2010 there was the availability of a Medi-Alert help line which could have been consulted, if it was

considered that a resident was suffering from, or suspected of suffering from, a serious medical condition. I note on the evidence that this availability was not known by all staff, and further the telephone number was not readily available to staff in the event of a need arising, particularly at weekends.

258. What is clear is that when staff became aware of issues relating to Craig's health they referred those matters of concern to the nurse who examined Craig when she was on duty. On the weekend of 8-10 October 2010 matters of concern were brought to the attention of the nurse and dealt with appropriately. At least in respect of his eye, Craig's condition improved and there is no suggestion he vomited again until the weekend before his death; that first incident of vomiting does not appear to have been related to the abscess which developed at a later time.

259. On the weekend before he died Craig's condition appeared more serious, but again it appeared to stabilise, at least in the sense that Craig was not vomiting after the early hours of Sunday 24 October 2010.

260. The staff on duty were faced with a choice of sending him to hospital or referring him to be seen by the nurse again on the Monday. That was a judgment call made with incomplete information and inadequate expertise to be able to foresee Craig's actual medical condition. In saying this, I again stress, that many qualified medical practitioners may not have possessed the necessary expertise to diagnose Craig's condition on the information available to staff. Tragically, as events unfolded, it was the wrong choice. It cannot be said that the choice made was unreasonable in the circumstances existing at that time. Immediate referral to hospital may be considered to be appropriate; however it was not the only course reasonably open in the circumstances.

261. In my view, the decision not to have Craig transported to a hospital was not an omission that could support a finding that any particular staff member contributed to the cause of death within the meaning of section 28(1)(f) of the Act.

262. Before leaving this matter it is appropriate to deal with the issue of when attempts to resuscitate Craig were commenced.

263. The evidence strongly suggests the CPR was not commenced immediately when Craig was seen by staff, nor were substantial steps immediately taken to resuscitate Craig. CPR was not commenced until after the ambulance was called by Mr Lee and he was advised by the 000 operator to commence CPR.

264. Ms Beaumont insists that she commenced CPR virtually straight away. I am satisfied that the shock of finding Craig caused significant distress to her and this would explain her failure to commence CPR immediately. As I have said earlier, Ms Beaumont had a deep fondness for Craig, and would mother him like he was her own child.

265. The evidence of Mr Lee, Mr Barrett, and Mr Beck, the position in which Craig was first found and subsequently seen, and the 000 recording strongly suggest that CPR was not commenced until after the ambulance had been called. That may have been a minute or some minutes after Craig was found.

266. In my view the failure to commence CPR immediately would not have changed the outcome, and this is apparent from the evidence of Dr. Lawrence. It is clear on the evidence that when Craig was found the abscess had already burst and any resuscitation attempts would not have been successful, and I am satisfied that the failure to commence CPR immediately did not contribute to the cause of death in any way.

267. I do not raise it as a criticism, but it does highlight the need to ensure that all staff are provided with first aid training and annual refreshers to enable them to render first aid efficiently; but, having said that, an inerrant response to an emergency cannot be guaranteed even with appropriate training.

The Conduct of Dr Gray

268. Dr Gray's evidence was that he conducted an appropriate examination (See C11) on 8 October 2010 and did not observe any signs indicative of any illness which required further investigation. I note the evidence suggests that as at the 8 October it is possible the abscess had not yet, or was only just forming at that time.

269. Had Dr Gray seen Craig again on 15 October as arranged there is a possibility Craig's condition may have warranted some further investigation and diagnosis; however this is far from certain. It is equally possible no outward manifestation of the brain abscess would have been discernible at that time nor would his presentation have been indicative that he was suffering any other life threatening illness that required further investigation. This is merely speculative, as Craig did not attend the appointment as he was due to appear in the Magistrates Court in Hobart; Craig was not referred to, nor on the evidence, did he request to see Dr Gray, or any other medical practitioner, after this date.

270. I find that Dr Gray's treatment of Craig was appropriate and is not open to criticism, there is nothing to suggest any fault lies with Dr Gray, or that he contributed to the cause of death.

The Conduct of Nurse Thomas

271. I found the evidence of Nurse Thomas difficult to follow at times and initially I formed the opinion she was being defensive and non-responsive to questions at times. I subsequently formed the opinion that her presentation needed to be judged in the light of a number of factors which were raised, for example her perception that she was overworked, differences/disputes with management as to her job description, and her duties, and her style of communicating. Further, at the time of the hearing she was on stress leave and obviously this would have affected her ability to deal with questioning and cross-examination. I am satisfied she generally gave her answers to the best of her ability.

272. Given Craig's presenting condition on 11 October 2010, Nurse Thomas was faced with a choice at that point to refer Craig for medical assessment by a doctor, or wait and see. She chose to do both. She referred Craig to see Dr Gray in respect of his eye on 15 October 2010 and advised the youth workers to keep an eye on him and if anything of concern arose to arrange a medical assessment. It might have been desirable to her to detail what matters the youth workers should be looking for to cause concern. However, her advice to the youth workers could not fairly be criticised in the context of a busy nursing practice at AYDC.

273. In any event, Nurse Thomas was told by Sue Ray on 13 October 2010 that Craig's eye had improved. In addition she saw Craig again on 20 October 2010. That appointment was not arranged in respect of any concerns for Craig's health, but simply to clean his ears. At that time she noticed Craig's eye had healed and she did not see anything that caused her concern for Craig's health.

274. She did not arrange for a follow up appointment for Craig when he was unable to see Dr Gray because Craig was in Court in Hobart. But by 20 October 2010, before the next doctor's visit could have occurred, the need for that appointment no longer existed.

275. Due to the demands on her time Nurse Thomas did not record Craig's temperature when she saw him on 11 October 2010. But in the context of this inquest that is a minor criticism.

276. The evidence clearly indicated that Nurse Thomas believed she was under significant pressure at work. She was the sole nurse employed, and in her view, she was expected to fulfil both the clinical nurse consultant role and the AYDC nurse role.

277. To enable her to meet the demands of her expected workload she endeavoured to have staff utilise their first aid training to deal with more mundane and minor issues without reference to her. While this practice was trialled for a time, a management decision was made that it was inappropriate for staff to be making decisions that should be made by appropriately knowledgeable and experienced nursing or medical personnel.

278. While this would not have pleased Nurse Thomas, it is indicative that management recognised the needs of residents and their well-being, and were not prepared to permit unqualified staff to attend to needs of the residents, while the nurse was on duty. It appears, however, that the same principle was not recognised or applied to the out-of-hours and weekend needs of residents.

279. As the sole nurse at AYDC, Nurse Thomas could not be expected to attend on site and then be expected to be on call after hours 7 days a week. In fact staff were directed not to contact her out-of-hours and on weekends. This direction was in place in October 2010. Unfortunately, no arrangements were in place for nursing or medical assessment out of hours, unless there was an emergency. While this was a significant oversight, it was not the responsibility of Nurse Thomas and no criticism can be directed towards her for this oversight.

280. Dr Cooley in her evidence suggested, and I accept, Nurse Thomas cannot be criticised for her dealing with, or medical treatment provided to Craig, and she acted in a professional and appropriate manner.

281. I find there is no basis upon which the conduct of Nurse Thomas could be found to have contributed to the cause of death within the meaning of section 28(1)(f) of the Act.

REPORT ON CARE SUPERVISION AND TREATMENT – SUB-SECTION 28(5)

282. The next matter for consideration is the appropriateness of the care, supervision, or treatment of Craig while he was in detention. I do not intend to repeat the facts relevant to this issue as they are fully covered in the preceding paragraphs, and those facts should be read in light of the findings I have made to this point.

283. While I am satisfied the individual staff members at AYDC did not contribute to the cause of death there are a number of systemic issues which existed at the date of Craig's death in relation to the operation of AYDC which are open to criticism.

284. In particular:

(1) There was no policy dealing with when, and from where, medical assessment should be obtained for a resident. That matter was left to the judgment of unqualified staff members who only had first aid training.

(2) No formal arrangement existed for obtaining medical assessment and treatment for resident's out-of-hours during the week and on weekends when there was no nurse on site. The only practically available step that could be taken, and within a detention facility it is a relatively impractical one, was to take a resident to a hospital with the attendant security risk that involved.

(3) There was no system of collating all information into a single comprehensive file for each resident. Evidence was given that the privacy laws prevent this from being done. I am not satisfied the laws are so restrictive, but if it is open to that interpretation the laws should be amended to remove any such restriction where a person in detention is being held whether a youth, or an adult, this person may be suffering from contagious medical conditions, staff who are going to be in regular contact with those persons need to be aware of the person's medical history. Consideration should be given to excluding privacy laws in relation to information pertaining to a person's health, both medical and physical, whilst in detention. There is an obligation to provide a safe working environment for persons employed in detention centres and prisons, and the availability of the information is of benefit to the detainees as all information pertaining to their health is available. The concerns as to a person's privacy and the risk of personal health information being released to others outside, the establishment can be secured as it is with any nurse or doctor's receptionist. They must not disclose information as to a patient to any person outside the office, or in this case, the place of detention. It would also be covered under the oaths taken by public servants working in areas with sensitive information.

(4) On occasions observations of residents were not carried out, on other occasions they were not accurately recorded. The staff members who gave evidence were generally aware of occasions when others had not done the required observations, or not properly recorded them, although none

accepted they had ever seen it done, or the fact they personally had failed to record all information accurately. The failure to record Craig being present in his room for most of the Saturday prior to his death is an example of the failure to record observations, and may be evidence of a failure to conduct the observations.

285. In Craig's case the combination of matters (1) - (4) above meant Craig and the staff members caring for and supervising him had to rely on incomplete information, their own inexpert judgment about his condition, the likely reason he was unwell, and the appropriate response to his condition.

286. Of course there will always be a requirement for some lay judgment to be exercised. Trivial matters could be legitimately left to staff trained in first aid. Application of a band aid to a paper cut need not be done by a doctor, or even the nurse. And it might often be that a headache can be treated with Panadol, as appeared to be the standard practice in October 2010.

287. However, as this matter tragically demonstrates, a headache, or at least persistent or intermittent headaches, can be a manifestation of a more serious problem. Routine treatment of headaches by unqualified staff offering Panadol might give rise to complacency, or an approach, which ignores the fact that persistent or ongoing intermittent headaches need to be medically assessed.

288. Many of the staff members said they treated Craig as they would their own children. They measured their actions in this case by saying that when dealing with their own children, if faced with what they observed in Craig, they would have responded in the same way and would not have sought a medical review.

289. I consider that to be an inappropriate health care policy in an environment such as AYDC. Even where the care is delivered diligently, and compassionately, an approach which simply asks what one would do as a parent is inadequate.

290. A parent will have more continuous care of their child. There are no shift changes or days off. The health history is experienced first-hand not by a method of 'Chinese whispers' in different written records in disparate locations. The complications of a custodial environment are generally not present in the ordinary parental decision making process. Neither are the complications of a population of convicted or accused offenders and the greater incidence of illness in that population.

291. A greater responsibility exists were a person is being detained in a detention centre or prison. In an environment such as AYDC where young people are involuntarily detained it is inadequate to leave staff members to exercise their judgment in the way they would as a parent. A proper risk management system needs to be implemented. As the circumstances of this matter demonstrate it is better to err on the side of caution, and to the full extent practicable, eliminate lay judgment on health issues.

292. Fortunately, this has been recognised and steps have been taken to ensure that approach is implemented in the future. Those steps include the issue of the memoranda contained in (Exhibit C19 and a new policy number 34 contained in Exhibit C34). Access to medical assessment is now available at all times.

293. Had those policies and facilities been available on the weekend of 23 and 24 October 2010 it is likely Craig would have been medically reviewed. If Craig had been medically reviewed on that weekend prior to sometime in the evening, perhaps the early evening of 24 October 2010, it is possible the brain abscess would have been diagnosed and successfully treated. If that is the case the absence of effective policies and arrangements for obtaining medical review of residents who are unwell on weekends could be a factor that contributed to Craig's death. Even if that cannot be affirmatively concluded, it cannot be excluded as a factor contributing to his death.

Matters of Concern now Addressed

294. Since receiving submissions from all parties who appeared at the inquest, a number of matters that were raised at the Inquest and contained in the submissions have now been addressed by the various Government Departments, and it is appropriate that I commend the relevant Government Departments for their willingness to address some of those issues without delay.

295. One of the recommendations I intended to make was the provision of a defibrillator at the Centre. I have been informed that "A defibrillator is now a part of the equipment at the health service and clinical staff are trained to use it".

296. A major project in recent times has seen a transformation of the Ashley Youth Detention Centre Health Service and Custodial Services in the Centre. A new service model has been developed with increased investment in clinical services, governance arrangements, standard operating procedures (SOPs) and training for custodial and clinical staff.

297. Nursing capacity has increased substantially to 12 hours a day, seven days a week.

298. The operation of the Health Service has been transferred to State-wide Forensic Health Services via a service level agreement with Children and Youth Services. This change has joined Ashley to a robust system of clinical governance that includes well-documented procedures and a web based healthcare information system that stores and shares all client information from one place.

299. Tele-health services have also been established and this allows remote consultation 24-hours a day, seven days a week.

300. The health facility at Ashley has been refurbished and a wide range of new clinical equipment purchased. This has increased the comfort and safety for sick young people.

RECOMMENDATIONS:

301. Two investigations were undertaken at the instigation of the Department of Health and Human Services following Craig's death. One was Clinical Assessment of the AYDC Current Policy and protocols of Health Issues dated 30 November 2010 which is (Exhibit C41). The other was a Confidential Serious Incident Investigation Review – AYDC Death of a Youth in Custody which is Exhibit C116. The materials relied on in that report are in (Exhibit C143). The reports, and the material relied on to compile them, form part of the evidence in this inquest.

302. Generally the conclusions contained in those reports are consistent with the evidence in this inquest.

303. Those reports make a number of recommendations. Steps have been taken to implement some of the recommendations. Some have been substantially implemented and others have not yet been implemented at all.

304. I consider they are all appropriate and can be adopted as recommendations of this inquest to the extent they have not yet been fully implemented.

305. There is one further matter about the implementation of the new arrangements for dealing with residents who are unwell which warrants comment and recommendation. It is important that the judgment as to health matters which an unqualified staff member has to exercise is kept to a minimum. The memoranda in

(Exhibit C19) and the new Standard Operating Procedure No. 34, if complied with, will achieve an appropriate result in that regard.

306. However, the evidence of the operations coordinator, Mr Westwood, suggested he was of the opinion it would be a matter for the judgment of the staff and operations co-ordinator to determine whether to use the new facilities if a resident vomited. When he gave his evidence last year he considered that staff dealing with residents with headaches, or vomiting, would only be referred to the nurse, or the out of hours service, after an assessment of whether that was required. The basis he suggested he would use to make that assessment in respect of vomiting was difficult to understand[65].

307. This demonstrates that the requirements of the (Exhibit C19) memoranda and the new policy in respect of health issues were not properly comprehended by him. There is a risk that if senior staff do not appreciate the importance of adopting and following the new procedures, other staff may adopt the same attitude. I therefore recommend appropriate training and other steps to ensure rigorous compliance with the requirement to obtain medical review of residents who complain of being, or who appear to be, unwell should be undertaken.

308. In addition it is desirable that all matters relevant to the health of a resident be recorded in a way that ensures they are available for the staff responsible for the care and supervision of residents and for medical personnel reviewing a resident. An appropriate system would have the following characteristics:

(1) All complaints by a resident indicating they are unwell whether as a result of injury or otherwise should be recorded;

(2) All observations of staff that a resident is unwell whether as a result of injury or otherwise should be recorded; and

(3) Those matters should be recorded so that a complete history of all matters which might have a bearing on the wellbeing of the resident are available in one place and that they be accessible to all staff caring for the resident and medical personnel reviewing the resident. I submit there is little reason why staff members should not be required during and/or at the end of each shift to record progress notes which would include such matters.

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65 See at T625-627

309. An associated matter is that it would be desirable to ensure that information about the health of a resident obtained by medical personnel is communicated to the staff caring for and supervising the resident. One can anticipate possible difficulties associated with the confidentiality which would usually be afforded to that information. However, those difficulties could often be overcome with consent and in any event the obligation to maintain confidentiality is not inviolate, particularly where that confidentiality might give rise to a serious public safety risk or serious health risk for the resident.

310. It is easy to imagine cases where it is desirable for medical personnel to suggest signs and symptoms for staff members to watch for. Nurse Thomas's email of 11 October 2010 illustrates such an occasion.

311. I therefore recommend consideration be given to implementing a practice of exchanging such information, at least where there is no legally binding obligation of confidentiality, good medical reason or other appropriate reason to maintain the confidentiality.

312. During the course of the evidence it became apparent that staff do not have access to thermometers to assess whether a resident has a raised temperature. While not wanting to encourage untrained interpretation of the causes for such a condition it would be appropriate for staff to have access to a thermometer on each unit rather than relying on touching the resident to see if they are hot. That is a relatively minor matter, but a recommendation to that effect is appropriate.

313. It appears CPR was not commenced immediately. It might be hoped that effective training would ensure the delay which occurred in this case does not occur in the future. However, it appears such training is delivered by appropriate organisations and is kept up to date. No amount of training can fully prepare a person for the inevitable shock of actually having to implement the training. There is no suggestion the training was inadequate and in those circumstances it is difficult to formulate an appropriate recommendation dealing with that.

314. The evidence also suggested that it may have been convenient for staff to have access to a portable phone in the course of the 000 call on 25 October 2010. I therefore recommend consideration be given to providing such phones if appropriate.

315. I previously observed that observation of the residents in their rooms was made difficult by the damage to the material through which the observations are to be

made. I therefore recommend investigation be made into an improved manner to check on a resident either by using a different material in the viewing panel or removal of the panel, leaving an opening which could be covered by a sliding panel.

Finally the evidence demonstrated that steps had been taken to ensure that staff comply with the observation policies. That is done by a review of the CCTV now installed in the Centre and checking it against the observation sheets. Some occasions of non-compliance have been discovered. Nonetheless the audit procedure does not appear to be particularly rigorous. I therefore recommend a review of the audit procedure be undertaken and any other appropriate steps be taken to ensure compliance with the observation policies.

CONCLUSION

316. Craig's death at AYDC was the tragic result of the rupture of an abscess in his brain.

317. He was not referred for medical assessment before he died.

318. I am satisfied with the progress made to date and the implementation of the recommendations contained in these findings the likelihood of a similar incident arising in the future will be remote. While I am not in a position to say that had all the recommendations been in place at the time of Craig's admission to AYDC the outcome for Craig may have been different, it does, however, minimise the risk of such an incident in the future.

319. Before I conclude this matter, I wish to convey my sincere condolences to the family of the deceased.

320. This matter is now concluded.

Dated: 6 day of November 2013 at Launceston in the State of Tasmania

Donald John Jones
CORONER