JURISDICTION	:	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	:	CORONERS ACT 1996
CORONER	:	PHILIP JOHN URQUHART, CORONER
HEARD	:	13 DECEMBER 2022
DELIVERED	:	24 JANUARY 2023
FILE NO/S	:	CORC 2651 of 2020
DECEASED	:	CHILD C

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Mr J. Tiller assisted the Coroner
Mr M. Olds (State Solicitor's Office) appeared on behalf of the Department of Communities

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

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Philip John Urquhart, Coroner, having investigated the death of ***Child C*** *with an inquest held at Perth Coroner's Court, Central Law Courts, Court 85, 501 Hay Street, PERTH, on 13 December 2022, find that the identity of the deceased person was* ***Child C*** *and that death occurred on 27 November 2020 at Royal Perth Hospital, Wellington Street, Perth, from a head injury in the following circumstances:*

Table of Contents

SUPPRESSION ORDER 3
INTRODUCTION 3
CHILD C 4
THE DEPARTMENT'S INVOLVEMENT WITH CHILD C 5
Early interaction with Child C's family 5
Intervention action by the Department 6
Child C's self-selection to return to her mother's care 8
EVENTS LEADING TO CHILD C'S DEATH 10
CAUSE AND MANNER OF DEATH 12
Cause of death 12
Manner of death 13
ISSUES RAISED BY THE EVIDENCE 13
Whether Child C ought to have remained in her mother's care from 10 July 2019? 13
Record-keeping by the Department 17
QUALITY OF THE DEPARTMENT'S SUPERVISION, TREATMENT AND CARE OF CHILD C 18
IMPROVEMENTS SINCE CHILD C'S DEATH 19
CONCLUSION 19

SUPPRESSION ORDER

Suppression of the deceased's name from publication and any evidence likely to lead to the child's identification.
The deceased is to be referred to as Child C.

INTRODUCTION

1 Child C died on 27 November 2020 from a head injury after she fell from a moving car. She was 15 years and 10 months old. At the time of her death, Child C was in the care of the Chief Executive Officer (CEO) of the Department of Communities (the Department).

2 Accordingly, immediately before her death, Child C was a "*person held in care*" within the meaning of the *Coroners Act 1996* (WA) and her death was therefore a "*reportable death*".[1]

3 In such circumstances, a coronial inquest is mandatory.[2] Where, as here, the death is of a person held in care, I am required to comment on the quality of the supervision, treatment and care the person received from the Department while in that care.[3]

4 I held an inquest into Child C's death at Perth on 13 December 2022. Mr Glenn Mace, Executive Director Statewide Services, Service Delivery at the Department gave oral evidence at the inquest.

[1] Section 3, *Coroners Act 1996* (WA)
[2] Section 22(1)(a), *Coroners Act 1996* (WA)
[3] Section 25(3), *Coroners Act 1996* (WA)

5 The documentary evidence at the inquest comprised of two volumes which were tendered as exhibit 1. Mr Olds, counsel appearing on behalf of the Department, tendered an additional exhibit at the commencement of the inquest and that became exhibit 2.

6 My primary function has been to investigate Child C's death. It is a fact-finding function. I must find, if possible, how Child C's death occurred and the cause of her death.[4]

7 The inquest focused on the involvement of the Department in the later years of Child C's life, with an emphasis on her self-selection to return to her mother's residence when still under the care of the Department.

8 On the basis that it would be contrary to the public interest, the State Coroner made a suppression order with respect to Child C's name on 5 August 2022, pursuant to section 49(1) of the *Coroners Act 1996* (WA). The terms of that order are set out on page 3 of this finding.

9 In making my findings, I have applied the standard of proof that has been set out in ***Briginshaw v Briginshaw*** (1938) 60 CLR 336 per Dixon J at 361-362, which requires a consideration of the nature and gravity of the conduct when deciding whether a matter has been proved on the balance of probabilities.

CHILD C [5]

10 Child C was born on 11 January 2005 at Bentley Hospital. She had a brother and sister and was the youngest of the three children. Her death not only devastated her family, but also the wider community in Pinjarra, where she lived.

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[4] Section 25(1)(b) and (c), *Coroners Act 1996* (WA)
[5] Exhibit 1, Volume 1, Tab 2.2, Victimology Information Form; Exhibit 1, Volume1, Tab 44, Transcript of Children's Court proceedings dated 22 June 2021

11 Child C attended several primary schools, which included Forrestdale, Bertram, Byford and Serpentine. She completed Years 7 and 8 at Harrisdale High School and from Year 9 she was enrolled at Pinjarra High School.

12 Child C enjoyed being with her friends and swimming at a local water hole. Her hobbies included off-road motorbike riding and horse riding. Two weeks before her death, she had commenced a traineeship in childcare at Ravenswood Childcare Centre.

THE DEPARTMENT'S INVOLVEMENT WITH CHILD C [6]

Early interaction with Child C's family

13 Child C first came to the attention of the Department in September 2008, when the Forrestdale Primary School contacted the Department raising concerns in relation to the environment and parental supervision at her home.

14 On 5 November 2008, the Department commenced a period of Intensive Family Support for Child C's family.[7] On 1 September 2009, the Department ended the period of Intensive Family Support, noting "*concerns had been resolved*".

15 In 2012 and 2013, the Western Australian Police Force (WAPF) responded to a number of family domestic violence incidents involving Child C's parents.

16 On 15 May 2013, the Department completed a Safety and Wellbeing Assessment (SWA) where harm was substantiated, and a period of Intensive Family Support commenced.

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[6] Exhibit 1, Volume 1, Tab 46.1, Report of Glenn Mace dated 29 July 2021; Exhibit 2, Supplementary Report of Glenn Mace dated 8 December 2022

[7] "Intensive Family Support" teams work with open child protection cases where families are at imminent risk of their children coming into the CEO's care. The Intensive Family Support teams provide time-limited, intensive in-home support to create safety and enable children to remain with their family.

17 On 4 February 2014, the Department completed another SWA with an outcome that emotional harm had been substantiated. However, the matter was closed, with no further action required as safety issues had been addressed. This included Child C's father no longer residing in the family home and Child C's mother agreeing to a safety plan. However, by the end of April 2014, the WAPF had responded to another two family and domestic violence incidents involving Child C's parents.

18 On 1 May 2014, the Department was advised that Child C's father had returned to live in the family home. In May 2014, the WAPF responded to a further two family and domestic violence incidents involving Child C's parents. In that same month, the Department received information that Child C's parents had resumed their relationship and were using illicit drugs. The Department was also advised that Child C and her older siblings were not attending school.

19 Over the course of the next several months, the Department closely monitored Child C's family, which included a safety plan being implemented with Child C's mother. In August 2014, after the children had left the family home, another safety plan was developed for them to remain in the care of their paternal grandmother.

20 On 13 August 2014, the primary school that Child C was attending advised the Department that Child C had said she was staying in a shed and had also slept in a car that week. On that same day, the Department attended the primary school and conducted a Child Assessment interview with Child C.

Intervention action by the Department

21 On 15 August 2014, the Department filed an affidavit and application in the Children's Court to have Child C placed into the provisional protection and care of the Department's CEO, pursuant to section 35 of the *Children and*

Community Services Act 2004 (WA).[8] The Department enacted the warrant for the provisional protection and care on the same day, and Child C was placed into the care of a foster carer.

22 On 22 August 2014, the Children's Court granted an interim order for Child C to remain in provisional protection and care.

23 For the next two years, Child C was placed into the care of a number of foster and family carers.

24 On 20 October 2016, the Children's Court granted the Department's application for a Protection Order (time-limited) under section 44 of the *Children and Community Service Act 2004* (WA). A Protection Order (time-limited) is an order giving the Department's CEO responsibility of the child for the period specified in the order.[9] Child C's Protection Order (time-limited) was for a period of two years.

25 On 27 July 2018, the Department held an internal Signs of Safety Mapping meeting in relation to Child C's Protection Order. This meeting determined that the Department would apply for a further Protection Order until Child C was 18 years old. This type of protection order is described as a Protection Order (until 18).[10]

26 On 8 August 2018, the Department sought Child C's views in relation to her expiring Protection Order and she said she believed that her mother's life was not safe or stable and that she wanted to remain living with her foster carer.

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[8] Section 35 is used by the Department when there have been incidents occurring over a period of time which have led the case management team to conclude that all options other than care proceedings have been exhausted: ts 13.12.22 (Mr Mace), p.15

[9] Section 54(1), *Children and Community Services Act 2004* (WA)

[10] Section 43(c), *Children and Community Services Act 2004* (WA)

27 On 10 October 2018, Child C confirmed with the Department that she did not wish to be reunified with either her mother or father as she was concerned her education would be impacted if that was to happen.

28 On 17 October 2018, the Department filed an application (together with a supporting affidavit and Written Proposal for the Child) in the Children's Court to revoke the Protection Order (time-limited) and replace it with a Protection Order (until 18).

29 On 3 January 2019, a separate representative met with Child C to obtain her views regarding the Department's application for the Protection Order (until 18). Child C advised that she consented to the application on the basis that she was happy and settled in her placement with her current foster carer. She also said that she wished to start spending unsupervised time with her parents and her sister, and an increased school holiday time with her parents.

30 On 9 May 2019, after an *ex parte* hearing, the Children's Court granted the Protection Order (until 18) for Child C. This meant it was scheduled to be in place until 11 January 2023.

Child C's self-selection to return to her mother's care

31 On 21 May 2019, Child C had contact with her siblings. The Department's record of that contact noted that Child C had asked her brother and sister when they were going back to school, to which they replied, "*you don't need to go to school to make it*". The following day, Child C's high school informed the Department that she had been behaving in a disruptive manner that day.

32 On 4 June 2019, Child C's foster carer advised the Department that she was still disruptive at school and had been grounded for one week with loss of electronic privileges, due to behavioural concerns.

33 On 17 June 2019, Child C's high school contacted the Department and requested that she be collected and removed from the school due to disruptive behaviour. On that same day, Child C's foster carer reported to the Department that she had been displaying "*bad behaviours*" for the proceeding few days and that this "*cannot continue*".

34 On 19 June 2019, the Department took Child C to a re-entry interview at her high school following a two-day suspension. Child C advised the Department that she did not wish to return to her placement with her foster carer and that her foster carer did not want her to return. As a result of that advice, the Department arranged an emergency placement for Child C with a previous foster carer. However, that same day, Child C absconded from her high school and was later located at a friend's house. Child C declined to return to the emergency placement that had been arranged and requested to remain with her friend and her friend's father. On 22 June 2019, Child C commenced a placement with the previous foster carer.

35 On 26 June 2019, Child C was suspended from her high school for five days due to disruptive behaviour. Three days later, she absconded from her placement with her foster carer.

36 On 1 July 2019, Child C attended a meeting with the Department and declined to return to her foster carer, citing reasons of boredom and distance to friends. She requested a foster care placement in the Harrisdale area. She declined all other placement options that were offered. Inquiries by the Department identified no suitable placements for Child C in the Harrisdale area.

37 On 9 July 2019, Child C confirmed with the Department that she would not consider returning to her previous foster carers.

38 On 10 July 2019, the Department actioned a Care Arrangement Referral for Child C that sought an emergency placement, noting Child C's preference for a placement in the Harrisdale area and providing details on her background, contacts, and behaviours. The referral indicated that Child C's behaviours were at times negatively impacted by contact with her family, and some behaviours had worsened since the making of the Protection Order (until 18).

39 However, on that same day, Child C self-selected to return to the care of her mother. At the time, she was 14½ years old. Child C remained in the care of her mother and lived in Pinjarra until her death 16 months later.

EVENTS LEADING TO CHILD C'S DEATH [11]

40 On the evening of 26 November 2020, a number of young people, who were older than Child C, were at her mother's house in Pinjarra. Child C was present, and members of the group were drinking alcohol, and some were smoking cannabis. Although there were witness accounts that Child C was drinking alcohol, the results of a toxicological analysis that was performed later detected no alcohol or common illicit drugs in her system.[12] Accordingly, I find that Child C was either not drinking or was drinking an insignificant amount of alcohol and was not using cannabis that night.

41 At about midnight, a 17-year-old girl drove away from the address in her car. In the car was Child C, Child C's brother and two other passengers. It was intended that the group would drive to a friend's house in Pinjarra.

42 After attending the friend's house, the group then began driving back towards Child C's home. As she was driving, the driver stopped after she saw a shopping

[11] Exhibit 1, Volume 1, Tab 44, Transcript of Children's Court of Western Australia proceedings dated 22 June 2021; RPH Medical Records for Child C
[12] Exhibit 1, Volume 1, Tabs 6.1-6.2, Toxicology Interim Report dated 4 December 2020, Toxicology Final Report dated 21 December 2020

trolley on the side of the road. She asked one of the male passengers to bring the shopping trolley to her. When he did that, she took hold of the trolley and drove her car for about 500 metres, pulling the trolley alongside the car. She then stopped the car, and Child C climbed into the trolley, with the driver holding onto the front of it through the driver's window, and one of the male passengers holding onto the back of the trolley through the rear window. The driver then towed the trolley along the road for a short distance. The driver stopped, and Child C got back into the car.

43 The car was then driven along Padbury Road in Pinjarra, stopping at the junction of South-West Highway just before 1.30 am on 27 November 2020. The occupants of the car agreed that the passengers would climb onto the bonnet and the boot of the car and be carried along on the outside of the car as it was being driven.

44 The driver then drove the car for about 300 metres with two male passengers positioned on the bonnet, and Child C and the other male passenger positioned on the boot. At one point, Child C moved from the boot and began standing on the car's tow bar, with her hands in the air. As she was doing that, Child C lost her balance and fell from the car. She struck her head on the road surface and was rendered unconsciousness. Child C had sustained a very severe head injury.

45 The driver immediately stopped the car, and she and the other passengers attended to Child C, who was lying on the road. A nearby resident also attended and called emergency services. He then commenced CPR on Child C. Ambulance officers attended shortly after, and they took over Child C's resuscitation. After the ambulance officers had provided treatment to Child C, she was taken by ambulance under priority 1 conditions to Peel Health Campus (PHC). Given the serious nature of her head injury, Child C was transferred

from PHC to the emergency department at Royal Perth Hospital (RPH) where a CT neck angiogram was performed by the neurosurgical team.

46 The CT imaging indicated that Child C had brain death with the absence of cerebral arterial opacification (absence of blood flow in the brain). Child C was then transferred to the intensive care unit at RPH.

47 Family meetings were held with the neurosurgical team after Child C remained unresponsive when sedation was withdrawn, and her pupils stayed fixed and dilated. Child C's injury was described by her treating doctors as a "*catastrophic traumatic brain injury*" which was "*un-survivable*". Child C later died at 1.00 pm on 27 November 2020.

48 The driver of the car only held a provisional driver's licence and had a blood alcohol level of 0.062% at the relevant time. She was later charged with the manslaughter of Child C, together with a number of road traffic offences.

CAUSE AND MANNER OF DEATH

Cause of death [13]

49 Child C's mother objected to an internal post mortem examination being performed. This objection was accepted by the Coroner's Court.

50 Consequently, on 2 December 2020, Dr Daniel Moss, a forensic pathologist, conducted an external post mortem examination and had a CT scan performed. Dr Moss noted that Child C had sustained a very severe head injury.

51 Toxicological analysis of a blood sample taken from Child C when she was in hospital detected no alcohol or common illicit drugs in her system.

[13] Exhibit 1, Volume 1, Tabs 5.1-5.4, Interim Post Mortem Report dated 2 December 2020, Post Mortem Forensic Consultation Report dated 2 December 2020, Supplementary Post Mortem Report dated 2 December 2020, Statement of Dr Daniel Moss dated 17 February 2021; Exhibit 1, Volume 1, Tabs 6.1-6.2, Toxicology Interim Report dated 4 December 2020, Toxicology Final Report dated 21 December 2020

52 At the conclusion of the external examination, and after reviewing the medical records for Child C from PHC and RPH, Dr Moss expressed the opinion that the cause of Child C's death was a head injury.

53 I accept and adopt this conclusion by Dr Moss as to the cause of death.

Manner of death [14]

54 Prior to the inquest, the driver of the car pleaded guilty to the manslaughter of Child C.

55 On 22 June 2021, the President of the Children's Court sentenced the driver to 16 months' detention and disqualified her from holding a driver's licence for three years.

56 I have considered the outcome of the Children's Court proceedings and had regard to section 53(2) of the *Coroners Act 1996* (WA), which requires that my finding not be inconsistent with any earlier proceedings where a person has been charged in regard to the question whether that person caused the death.

57 Accordingly, I find that the manner of Child C's death was unlawful homicide.

ISSUES RAISED BY THE EVIDENCE

Whether Child C ought to have remained in her mother's care from 10 July 2019? [15]

58 It is not uncommon for teenagers under the care of the Department's CEO to self-select back to their family.[16] That can place the Department in a potential difficulty if it forms the view that the family environment is either unsuitable or

[14] Exhibit 1, Volume 1, Tab 44, Transcript of Children's Court proceedings dated 22 June 2021
[15] Exhibit 1, Volume 1, Tab 46.1, Report of Glenn Mace dated 29 July 2021; Exhibit 2, Supplementary Report of Glenn Mace dated 8 December 2022
[16] ts 13.12.22 (Mr Mace), p.23

dangerous for the child and the child expresses an intention to remain with their family.

59 As of July 2019, the Department's Case Practice Manual (the Department's Manual) at 3.4.23 titled "*Unendorsed Placements*" provided child protection workers with guidance regarding the assessment and management of self-selected living arrangements.

60 The Department's records show that Child C's mother had regular contact with the Department throughout Child C's time in her care. In an email dated 23 April 2019, the Department noted that although Child C's mother had previously used methylamphetamine, there was no evidence to suggest she had used illicit drugs since September 2017. The email also noted that she worked as a volunteer for a charitable organisation, providing counselling in alcohol and drug issues. In addition, it was recorded that Child C and her siblings were initially bought into care for neglect and emotional abuse arising from exposure to family and domestic violence perpetrated by their father upon their mother. By July 2019, Child C's mother had ceased contact with Child C's father and had been able to maintain stable accommodation and avoid relationships characterised by family domestic violence.

61 On 29 July 2019, the Department attended the home of Child C's mother and completed an environmental practical checklist. Risk factors within the household and physical environment were documented, with the requirement for these to be addressed prior to the progression of an approved placement. The Department identified that smoke alarms were not fitted, and Child C's mother agreed to address this. On the same day, the Department wrote to Centrelink to advise that Child C was residing with her mother in Pinjarra and had been in that arrangement since 10 July 2019.

62 Throughout August 2019, the Department had regular contact with Child C's mother regarding Child C. On 23 August 2019 and 18 November 2019, the Department requested Child C's mother undertake urine drug screening.[17] The Department also maintained contact with Child C's mother regarding Child C's schooling.

63 On 6 January 2020, the Department undertook a further home visit and updated the practical checklist undertaken on 29 July 2019.

64 On 8 January 2020, the Department documented that consideration was to be given to withdrawing the Protection Order (until 18) made in relation to Child C.

65 Despite the positives identified by the Department regarding the care Child C's mother was providing, by March 2020, Child C's high school had informed the Department that her attendance was at 25% and, due to her non-engagement, the school would be looking at alternative options for her.

66 During discussions with the Department on 30 and 31 March 2020, Child C's mother reported difficulties managing her behaviour, which she attributed to Child C's desire to maintain social networks. Child C's mother was also concerned that her daughter may be using illicit drugs. On 1 April 2020, the Department provided Child C's mother with counselling options and requested an in-person meeting to occur on 6 April 2020 to plan for Child C and her schooling. No home visit eventuated as Child C's mother was reluctant to participate in an in-person meeting due to COVID-19.

67 On 22 May 2020, the Department of Education advised the Department that Child C intended to enrol in a Certificate 3 Course in Early Childhood at

[17] Unfortunately, the outcome of these requests was not noted on the Department's records.

Mandurah commencing on 26 May 2020. The Department arranged funding for Child C to attend this course. However, Child C only attended the course for one day before advising she wished to remain enrolled at high school.

68 Although Child C's high school had reported an improvement in her attendance on 19 June 2020, by July 2020, it was evident she was not engaging with her schooling.

69 In August 2020, Child C's high school recommended that she be considered for a service provided mentoring, counselling, and holistic therapy (including equine therapy), within a farm setting as an alternative to schooling. The Department agreed to assess the suitability and funding options for this program, noting Child C had an ongoing interest in horses.

70 Despite the Department's best efforts, it remained unsuccessful in persuading Child C to enter an education facility outside of high school. However, on 27 October 2020, the Department of Education confirmed that Child C had visited Fairbridge College and was considering an enrolment there for 2021.[18]

71 On 16 November 2020, the Department had a home visit to Child C and her mother. At that visit, Child C was provided with a pre-paid card to purchase clothing. Options were discussed for ongoing case management, with the Department stating that its preference was for Child C to remain in support care, but that further consultation could occur to consider the Department applying for a withdrawal of the Protection Order (until 18). Child C's mother said that she and Child C will consider the matter further and advise the Department of their preference. There was limited opportunity to provide that advice as Child C died 11 days later.

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[18] Fairbridge College is an independent school with campuses in Pinjarra and Kalgoorlie, specialising in working with 12 to 18-year-old students who have difficulty achieving success in mainstream education and are at risk of disengaging with school.

72 The above is a summary of the contact the Department had with Child C and her mother from the time Child C self-selected to be in her mother's care. Not every contact has been detailed. Nevertheless, this summary provides a sufficient basis for me to find that it was reasonable for Child C to remain in the care of her mother and that the Department acted appropriately in its assessment of that arrangement. Although once Child C was in her mother's care, her attendance at school was inadequate (and when she did attend, her behaviour was often poor), Child C was behaving in a similar manner when she had previously been placed with foster carers.

73 I am satisfied that Child C's mother had made improvements to the home environment once Child C self-selected to stay with her. I am also satisfied that it would have benefitted Child C to be living with her brother and sister.

Record-keeping by the Department

74 The Department's Manual acknowledges that some children in the CEO's care may refuse to remain in the care arrangement made by the Department and, instead, they may self-select to reside with one or both of their parents.[19] The Department's Manual outlines that children living with their parents must have a Care Plan which outlines the decisions and rationale which lead to the child living with their parents, and all Care Planning processes must be complete.

75 Mr Mace properly made the concession that the Department did not complete all of the required Care Planning processes for Child C:[20]

> There were missed opportunities for [the Department] to complete all of the required Care Planning processes for [Child C] while she was residing with her mother, including sighting [Child C] to complete Quarterly Care Reports, and an annual Health Care Planning assessment.
> …

[19] Case Practice Manual at 3.4.18 "*Living with Parents*": Exhibit 2, Supplementary Report of Glenn Mace dated 8 December 2022, Attachment 4
[20] Exhibit 2, Supplementary Report of Glenn Mace dated 8 December 2022, pp.21 and 22

> [The Department] did not have records to indicate if Team Leader endorsed and District Director approved documentation regarding the reasons to support or not support the placement. Subsequent actions by the Armadale District indicate that [the Department] did support the arrangement continuing. There was a missed opportunity to record the decision-making process, rationale, and approval.

76 In his evidence at the inquest, Mr Mace properly accepted that the failure to record decision-making processes impacted on the ability to review the material.[21]

77 Nevertheless, I have found that the decision-making by the Department regarding the maintenance of Child C's self-selection to reside with her mother was appropriate. As noted by Mr Mace:[22]

> Although not particularising all documentation, [Child C's] age, views and wishes would have been a considered factor in all interactions with [Child C] and actions undertaken to support [Child C] during her care. [Child C's] views and wishes were also a considered factor in the decision to apply for a long-term protection order and subsequent planned considerations as to whether a long-term protection order remained in [Child C's] best interests post self-selection of her living arrangements.

QUALITY OF THE DEPARTMENT'S SUPERVISION, TREATMENT AND CARE OF CHILD C

78 After careful consideration of the documentary evidence and having heard the evidence of Mr Mace at the inquest, I am satisfied that the standard of the Department's overall supervision, treatment and care of Child C was appropriate. One oversight I have already identified was the Department's record-keeping. Another oversight was the fact that Child C's self-selection remained as an unendorsed placement and was never formally endorsed. As noted by Mr Mace at the inquest, "*there could have been a more timely decision*

[21] ts 13.12.22 (Mr Mace) p.31
[22] Exhibit 2, Supplementary Report of Glenn Mace dated 8 December 2022, p.23

about that."[23] However, neither of these oversights impacted on the standard of care that the Department provided to Child C.

IMPROVEMENTS SINCE CHILD C'S DEATH [24]

79 The Department has initiated a number of practice improvements since the death of Child C. As would be expected of all government departments, the Department should always be on a pathway of continual improvement. I commend these improvements which were set out in Mr Mace's supplementary report and included the following:

- Current practice guidance has implemented language changes that strengthens guidance for child protection workers by using the word "*must*" instead of "*should*".
- In October 2021, the Department's Specialist Child Protection Unit commenced the Unendorsed Placement Project to review the Department's management of children in Out of Home Care who are classified living in self-selected living arrangements.
- The Department has recently developed and released the At-Risk Youth Strategy 2022-2027 (the Strategy) to improve life outcomes for young people aged 10-24 years with multiple and complex problems who are at risk of self-harm and increased vulnerability of not transitioning positively into adulthood. The Strategy focuses on young people most at risk of requiring intervention at the tertiary and statutory level, including child protection, justice, police, and acute mental health responses.

CONCLUSION

80 When she was 14½ years old, Child C self-selected to return to her mother's care, following the placement breakdown with her long-term foster carer. Before this decision, Child C had been demonstrating disruptive and non-compliant behaviours at the home of her foster care and at school. I note that Child C

[23] ts 13.12.22 (Mr Mace), p.26
[24] Exhibit 2, Supplementary Report of Glenn Mace dated 8 December 2022

self-selected her living arrangements at the same age as her two older siblings had done.

81 I am satisfied with the intervention action taken by the Department and the decisions it made to obtain various orders under the *Children and Community Services Act 2004* (WA) with respect to Child C. I am also satisfied with the Department's decision to accept Child C's self-selection to reside with her mother.

82 Additionally, I am satisfied that Child C's mother did everything she could to provide a safe home environment for her daughter. I find that Child C's mother was entirely blameless for what happened after the 17-year-old driver drove away from her house with four passengers in her car. Before she went to bed, Child C's mother had told the group that no-one was to drive anywhere, due to the alcohol that the group had consumed.[25] It was no doubt completely heartbreaking for Child C's mother to then receive the news of her youngest daughter's accident in the early hours of 27 November 2020.

83 I offer Child C's mother, other members of Child C's family, and Child C's friends my sincere condolences for their loss.

PJ Urquhart
Coroner
24 January 2023

[25] Exhibit 1, Volume 1, Tab 7, Statement of Child C's mother dated 21 December 2020, p.4