STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest: Inquest into the death of M

Hearing dates: 29 August 2016 to 2 September 2016

Date of findings: 12 September 2016

Place of findings: NSW State Coroner's Court, Glebe

Findings of: Magistrate Derek Lee, Deputy State Coroner

Catchwords: CORONIAL LAW – child death, out of home residential care, drug overdose, drug toxicity, care and protection

File numbers: 2014/120079

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Non-publication orders:	Pursuant to section 74(1)(b) of the *Coroners Act 2009* I direct that there be no publication of the names of the following persons and any information (including images) that might identify them: M, S, T, any member of M's family; BM; TG, DP, JD, MB, LS; DS. Pursuant to section 74(1)(b) of the *Coroners Act 2009* I direct that the phrase, GC, and any images of GC not be published. Pursuant to section 74(1)(b) of the *Coroners Act 2009* I direct that the contents of the following documents not be published: the affidavits of Kate Alexander dated 29 August 2016 and 31 August 2016, the affidavit of Megan Beckett dated 1 September 2016, the affidavit of Robert Mulcahy dated 1 September 2016, and the written submissions of Michelle England of counsel dated 28 August 2016 and 2 September 2016. Pursuant to section 74(1)(b) of the *Coroners Act 2009* I direct that the name of the individual, BEN, and any information that might identify him (including images) not be published. This is a temporary order which will expire after the further application for a non-publication order is heard and determined to finality by the Court on 12 September 2016.
Findings:	I find that M died on 21 April 2014 at The Children's Hospital at Westmead NSW. The cause of death was hypoxic brain injury due to multiple drug toxicity following accidental drug overdose.

Table of Contents

Introduction ... 1
Why was an inquest held? ... 1
M's life ... 2
An overview of M's history in care ... 2
(a) M's history in care: 1998 to 2011 ... 3
(b) M's history in care: 2011 to 2014 ... 4
M's time at Gordon House ... 4
What happened on Saturday, 19 April 2014? ... 5
What happened inside M's bedroom? ... 7
What happened on the morning of Sunday, 20 April 2014? ... 8
What was the cause of M's death? ... 9
What drugs did M take? ... 10
Where did the drugs come from? ... 11
Would earlier medical intervention have saved M's life? ... 12
How did Gordon House deal with drug use by residents? ... 13
How did Gordon House deal with unauthorised visitors to the house? ... 14
What was done to support M before she was due to give evidence? ... 15
Was any drug and alcohol counselling and psychological support provided to M? ... 15
What arrangements were made between FACS and UnitingCare Burnside to manage M's care? ... 17
(a) What type of care was M provided with? ... 17
(b) Were any other forms of care for M considered? ... 19
(c) How was the transfer of M's case management responsibility managed? ... 20
(d) What type of involvement did M have with her family? ... 21
Should any recommendations be made? ... 22
Findings ... 23
Identity ... 23
Date of death ... 23
Place of death ... 23
Cause of death ... 23
Manner of death ... 23
Conclusion ... 23

Introduction

1. M[1] died in hospital in the early hours of the morning on Easter Monday 2014. She was only 15 years old, and less than 2 months from her 16th birthday. Around 24 hours earlier M, as she was known to her family and friends, had taken some drugs in her bedroom. These drugs would lead to cardiac arrest and M's eventual death.

2. The people at home with M at the time tried to save her. These people were not M's family but they cared for her. Many others, who also cared for M, had tried to save her from other harms in the past. Sadly they, like those on Easter Sunday 2014, could not save M in the end.

Why was an inquest held?

3. When a person's death is reported to a Coroner there is an obligation on the Coroner to make findings about the identity of the person who died, when and where they died, and what the cause and the manner of their death was. The manner of a person's death means the circumstances in which that person died.

4. In M's case, there is ample evidence about her identity, where and when she died, and what the medical cause of her death was. The inquest was primarily focused on the manner of M's death. That is, what happened in the early hours of Easter Sunday morning 2014, and how a 15 year old girl in out of home residential care could die from a drug overdose.

5. The inquest considered a number of specific issues, namely:

   (a) What drugs did M take and where did they come from?

   (b) Could earlier medical intervention have saved M's life?

   (c) How did Gordon House, the youth residential care facility where M was living, manage drug use by its residents and unauthorised visitors to the house?

   (d) What was done to support M before she was due to give evidence in a District Court trial against a person accused of sexually assaulting her?

   (e) Was any drug and alcohol counselling, along with psychological support, provided to M?

   (f) What arrangements were made between the Department of Family and Community Services and UnitingCare Burnside, the organisation that operated Gordon House, to manage M's care?

6. At the time of her death M was under the parental responsibility of the Minister for Family and Community Services (FACS) and living in out of home youth residential care. Although M had an extensive involvement with FACS and lived in out of home care for much of her life, the inquest did not examine M's overall history in the care system. Such an inquiry is beyond the scope of the coronial jurisdiction and beyond the scope of an inquest. A Coroner only has jurisdiction to

[1] Due to the non-publication orders that have been made I will refer to M by her first initial only in these findings. There is of course no disrespect intended to M or her family.

investigate the death of a person in order to determine their identity, where and when they died, and the cause and manner of their death.[2]

M's life

7. A non-publication order has been made to protect M's identity. She has been referred to in the media by a pseudonym. But we should not forget M, the person. Before going on to consider the issues which the inquest examined, it is important to recognise and pay tribute to M's life. Even though her life had fleeting moments of joy and happiness, M brought these things to those closest to her, especially her younger twin brothers, S and T.

8. At the end of the evidence in the inquest the court was privileged to see images of M's life and hear some incredibly heartfelt and moving words about M spoken by her brothers, her father, and her Aunty VP. They all kindly shared their private memories of M in a very public forum, and during an inquest which had attracted a considerable degree of media attention, both before and during it. Bereaved families of loved ones typically do not have to grieve in such a public setting and under such scrutiny. The courage, dignity and grace that M's family showed in these circumstances was an example to all in the court.

9. By sharing their treasured memories, M's family gave those in the court who did not know M a brief, but very important, glimpse into the life of their sister, daughter, and niece. This glimpse provided an understanding of the depth of loss that M's family have experienced, and continue to experience.

10. Although M did not always have a parental figure in her life, her brothers describe her as being a mother figure to them, and more. Although the adults in M life did not always look after M, she looked after her brothers. And although the adults in M's life did not always care for M, she cared deeply for her brothers. To them, M was their best friend, and they were happiest when they were all together. She remains their inspiration.

11. M's friends and those that cared for M knew her to be a loyal, caring and determined person with a strong work ethic and who was always willing to help someone in need. They describe her as a natural leader and someone who loved a good joke. Many of those close to M fondly remember how M could light up a room with her cheeky, outgoing personality and infectious laughter.

12. M's brothers miss her smile, laughter, dancing, cooking, and simply spending time with their big sister. It is distressing to know that M's time with her brothers was too brief and that she can no longer physically be with them in their home with their Aunty VP. In life, M and her brothers were sometimes separated and living apart. This makes the separation caused by M's death even more painful. However, this is a separation in a physical sense only. M's brothers know that M will forever be part of their family, part of their home, and part of their hearts.

An overview of M's history in care

13. In order to understand the manner of M's death it is necessary to know something of how M came to be living at Gordon House in 2014. This will involve a brief summary of M's history in out of home care. The summary is not intended to be an exhaustive one. Nor is it given as a basis

[2] *Coroners Act 2009*, ss 3, 21, 24.

to examine the detail of M's care history. Rather, it is given to provide a context in order to understand why M could not be, and was not, kept safe.

14. There are four types of care available in NSW for children and young persons in statutory out of home care:[3]

    (a) relative or kinship care, where young persons are placed with an appropriate family member to offer ongoing connection and identification with their family;

    (b) care provided by authorised carers who assume the roles of parents in a young person's life;

    (c) residential care, which is typically provided for young persons who are not suited to family-based out of home care (because of their high support needs), or who express a preference not to be placed in family-based out of home care; and

    (d) secure care, which is residential care in a secure facility for extremely high needs young persons who cannot be accommodated elsewhere without risk of harm to themselves or others.

(a) M's history in care: 1998 to 2011

15. A report about M being at risk of harm was made to FACS[4] in September 1998 when she was only 3 months old. Four further reports about M's family were made over the next 14 months leading to the commencement of care proceedings by FACS in March 2000.

16. M's parents took her and her brothers to Queensland but when they returned in June 2000, M and her brothers were placed with authorised carers. A year later, in June 2001, interim orders were made allocating parental responsibility for M and her brothers to the Minister for FACS.

17. In July 2002 the Children's Court ordered that M be restored to her mother's care and parental responsibility for M was shared between her mother and the Minister. In April 2003, after a number of risk of harm reports, FACS re-assumed M's care and 4 months later the Children's Court ordered M to be placed with her father. Following a second short stint in Queensland, M, and her father and brothers, returned to NSW.

18. Following further reports of harm, M and her brothers were removed from their father's care and placed with emergency short-term carers. A brief period of fluctuation of about 10 months followed when M and her brothers spent time with authorised carers, followed by a kinship placement, and then another placement with authorised carers.

19. In December 2005 final orders were made allocating parental responsibility for M and her brothers, until they turned 18, to the Minister. It was noted that the children were to live with their paternal aunt in Queensland.[5] They stayed there for the next five and a half years, during which time there were several risk of significant harm reports concerning physical abuse and unauthorised contact with their father. During this placement M took an overdose of Seroquel

[3] Exhibit 1, brief of evidence, pages 2159-2160.
[4] For convenience, I have referred to the former Department of Community Services (DOCS) by its current name, the Department of Family and Community Services (FACS) in these findings.
[5] Exhibit 1, page 2193.

tablets and was taken to hospital 11 April 2011.[6] Due to this concerning history steps were taken at the same time to remove M and her brothers from the placement.

20. M and her brothers were put in a short-term placement with authorised carers. This placement was a mostly positive one but unfortunately it did not last because the carers, despite their best intentions, could not adequately support the considerable needs of M and her brothers. After a brief period in short-term residential youth care, M and her brothers were temporarily placed with a Tongan carer family.

21. In July 2011 the siblings were moved to a kinship placement with Ms VP, known as Aunty VP. Whilst there appeared to be many positive aspects to this placement it unfortunately also broke down due to difficulties managing the behaviour of M and her brothers. At the time, Aunty VP had two young children of her own which made looking after their needs, along with the considerable needs of M and her brothers, extremely demanding.

(b) M's history in care: 2011 to 2014

22. On 29 June 2012 M was placed at GC, a residential care facility for young people. M's brothers were placed at Gordon House, another similar facility operated by UnitingCare Burnside, on 3 August 2012.

23. FACS received a report on 5 November 2012 that M had made a disclosure about allegedly being sexually assaulted by two male youth workers from GC. The youth workers were later dismissed and criminal proceedings were commenced against one of them.

24. On 28 November 2012 M asked to be moved to a different home. She indicated that she did not want another family placement due to concerns that such a placement would only be temporary and that she would have to move again. Involving M, and listening to her wishes, in this decision-making process was important.[7] Even if M had wanted to be placed with family, a placement would most likely have been unavailable and unsuitable at the time because of M's high needs and her history of past abuse during previous family placements.[8]

25. As a result, M was moved to Gordon House on 6 February 2013. Her brothers were still residents there, along with two other young persons who were also under the parental responsibility of the Minister.

M's time at Gordon House

26. It is important to look at some specific incidents during M's stay at Gordon House. None of these incidents are meant to portray M in a negative light, nor be critical of those responsible for her care. Instead, the incidents provide an understanding of the traumatic upbringing M had experienced and the difficult challenges which she and her carers faced.

27. M's stay in Gordon House was marred by frequent absconding, risk-taking behaviour such as drug use, involvement with the police and juvenile justice system, sexualised behaviour, and

[6] Exhibit 1, page 2154.
[7] *Children and Young Persons (Care and Protection) Act 1998*, s 10(1).
[8] Exhibit 1, page 2160.

inappropriate contact with older men and negative peer influences. The Gordon House residential daily logs[9] contain numerous instances of such behaviour.

28. M had her first contact with the Juvenile Justice system in February 2013, and in early March 2013 police found M in a stolen car containing a quantity of methylamphetamine (ice).[10] Later in the same month M was hospitalised after an apparent self-harm attempt and her urine tests were positive for amphetamines.[11] In April and May 2013 M had several interactions with police leading to a short stay in Juvenile Justice detention. From 19 June 2013 to 7 August 2013 M was missing from Gordon House for about 7 weeks. When she was eventually found by police in a park she was drug affected and had to be taken to hospital.[12]

29. M was later returned to Juvenile Justice detention when she was sentenced to a control order (a custodial sentence that is served in a Juvenile Justice Centre), before being released from detention on 6 September 2013. M's absconding continued upon her return to Gordon House. Her drug use and contact with police also unfortunately continued.

30. But M did have a brief period of stability in January 2014. JD, the Gordon House coordinator, explained in evidence that he believed this stability was due to the consistency in youth workers at the house during this time and the fact that M had recently spent some time at a residential facility for young people with substance abuse issues.

31. Unfortunately this brief period of stability did not last. In March and April 2014 M was away from Gordon House for 22 out of 35 nights. On 12 March 2014 the police pulled over a car that M was in and she appeared drug-affected.[13] In the weeks leading up to her death M was frequently absent from Gordon House. She was away on the nights of 1-4, 7-8, 12, and 16-18 April.[14]

What happened on Saturday, 19 April 2014?

32. DP, one of the Gordon House youth workers, began her shift at 3:30pm. The daily logs indicate that M had left Gordon House at about 3:00pm the previous day. M later sent a message at about 7:50pm on the Friday night advising that she would not be returning home.[15] After starting her shift Ms DP called M's mobile phone and left a voicemail message. A short time later at 4:41pm Ms DP received a text message from M asking Ms DP to pick her up. Ms DP called M who told her that she was at Asquith. M asked to be picked up at around 8:00pm. However, Ms DP told M that she had to come home earlier and M agreed.

33. Ms DP drove to Olive Street, Asquith and parked. From past knowledge Ms DP knew that M's boyfriend, a man named Peter Ammendola, lived in Olive Street but that M was secretive about his actual house number. After arriving Ms DP called the Gordon House staff mobile number and asked MB, M's key youth worker, to contact M to ask her to come out. A short time later, Ms MB called Ms DP back and told her the house number where M would be waiting. Ms DP moved her car, parked, and waited. About two minutes later M came out onto the street and got into the car.

[9] Exhibit 1, Tab 47.
[10] Exhibit 1, page 700.
[11] Exhibit 1, page 714.
[12] Exhibit 1, page 780.
[13] Exhibit 1, page 893.
[14] Exhibit 1, pages 903-910.
[15] Exhibit 1, page 910.

34. Ms DP suggested to M that they should have a movie and junk food night at home. M was happy with this suggestion and they drove to the supermarket to pick up some supplies before returning to the house. At this time M's brothers were not living at Gordon House but they were due to return soon. Once at home, M and BM, another resident and one of M's good friends, spent some time in T's room fixing it up in anticipation of the twins' return.

35. CCTV footage from the front of the house shows that a teenager named Angel Pereira entered the house at about 8:23pm by climbing in through the window of the middle bedroom belonging to S and T.[16] Angel visited the house regularly as he was friends with most of the residents. At around this time, Ms DP saw that Angel was in the house and she told him that he had to leave but M said that she needed him to help her move some furniture. Ms DP told M and Angel that he could stay a while longer but that he had to leave by 9:00pm, to which they both agreed.

36. CCTV footage shows that a male person, believed to be Peter Ammendola, entered the house by climbing in through the middle bedroom window at about 8:54pm. Mr Ammendola was a 25-year old man who was in a casual relationship with M at the time. At around 9:00pm Ms DP went to make sure that Angel was leaving and saw that he was already walking out the front door. CCTV footage shows Angel leaving via the front door but returning minutes later and climbing back in through the middle bedroom window. An unknown male person (possibly Ivan Pereira, Angel's older brother) climbed in through the same window at about 9:23pm.

37. At around this time Ms DP saw that M was in her room sorting out her laundry and listening to music. She spoke to M for about 20 minutes. It is not known where Mr Ammendola, Angel, and the unknown male person were at this time although it is likely that they were in the bedroom belonging to T and S.

38. Sometime between 10:00pm and 11:00pm BM said that he saw a male person who he had never seen before, and wearing a hoodie (with the hood over his head) and a black cap, go into M's room.[17] It is likely that this person was Mr Ammendola.

39. Later, between 11:00pm and 11:30pm BM saw M walk into the twins' room to retrieve her phone. BM asked if he could use her phone and M gave it to him. M returned to her room and closed the door. BM suspected that someone else was in M's room but he could not see anyone in there.[18]

40. At about 11:30pm Ms DP did a walkthrough around the house. She saw that BM was in his room. She knocked on M's door and said good night but there was no response. Ms DP went to the youth worker's quarters to turn in for the night. CCTV footage shows Angel and the unknown male leaving the house via the middle bedroom window at about 11:47pm.

41. At some stage before she went to sleep Ms DP heard sounds coming from the laundry. She assumed it was M as M had used the washing machine earlier that night and had asked Ms DP how long she (Ms DP) would be with the dryer. It was not uncommon for M to do her laundry late at night. CCTV footage shows M running down the stairs to the laundry at about 12:16am, and remaining in the laundry for a short time before walking back upstairs.[19] Ms DP went to

[16] Exhibit 1, page 238.
[17] Exhibit 1, page 417.
[18] Exhibit 1, page 418.
[19] Exhibit 1, page 244.

sleep at about 1:30am. She got up a few times during the night to use the bathroom but did not notice anything unusual.

42. Whilst BM was using M's phone, three calls, with no number identified, were made to it. Sometime later Ivan called BM and they made arrangements for Ivan to come to the house. Ivan and another frequent visitor to the house, Sheena Lodhia, arrived at just before 1:00am and entered the house, again via the middle bedroom window. According to BM, the three of them stayed in the twins' bedroom and smoked some cannabis. CCTV shows Ivan and Sheena leaving the house via the middle bedroom window at just after 2:00am. BM returned to his room and watched a movie until he fell asleep.

What happened inside M's bedroom?

43. During a subsequent record of interview with the police, Mr Ammendola said that once he entered the house M took him to her room, said, "Look what I've got", and showed him two small rocks of heroin.[20] To Mr Ammendola the heroin appeared to be close to 1 or 1.5 points (0.1 to 0.2 grams) in size. M did not say where she got the heroin from.[21] Mr Ammendola said that he took the heroin from M and told her to "just stick to ice".[22] M apparently tried to take the heroin back but Mr Ammendola withheld it, which made M frustrated.[23]

44. Although Mr Ammendola was a heroin user himself, he apparently disliked any of his girlfriends using drugs. Mr Ammendola freely admitted to police that he had previously used drugs with M but he adamantly said that he never gave her heroin.[24] Mr Ammendola explained that he followed the same approach with all of his ex-girlfriends. That is, he believed that if they had never previously used a particular type of drug (such as heroin, in M's case) they should not start doing so simply because he used it.[25]

45. Mr Ammendola's stance on this issue is corroborated by one of his ex-girlfriends, Sharni Gelsthorpe.[26] Ms Gelsthorpe (who was not a heroin user before she met Mr Ammendola) told police that she would repeatedly ask Mr Ammendola for heroin when he would use it in front of her but he would refuse to give her any.[27] According to Ms Gelsthorpe, Mr Ammendola told M that Ms Gelsthorpe was a heroin user in an attempt to have her stay away from Ms Gelsthorpe.[28]

46. After injecting the heroin that he had taken from M, Mr Ammendola said that he fell asleep within 15 minutes and "pretty much went on the nod".[29] Mr Ammendola later woke up (possibly a couple of hours later[30] when it was just getting light[31]), saw M lying next to him and called out her name. The exact time when this happened is not known although if it was just getting light (that is, around sunrise) it would place the events at being around 6:30am at that time of year.

47. Mr Ammendola noticed that something was not right with M and knocked on BM's bedroom door to rouse him. BM came into the room and Mr Ammendola told him that he thought

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[20] Exhibit 1, page 471.
[21] Exhibit 1, page 496.
[22] Exhibit 1, pages 469, 492.
[23] Exhibit 1, page 496.
[24] Exhibit 1, page 494.
[25] Exhibit 1, page 496.
[26] Exhibit 1, page 596.
[27] Exhibit 1, page 580.
[28] Exhibit 1, page 602.
[29] Exhibit 1, pages 469, 502.
[30] Exhibit 1, page 471.
[31] Exhibit 1, page 475.

something was wrong with M. BM called M's name and she opened her eyes slightly. BM told Mr Ammendola that M was probably "in one of her deep sleeps".[32] Mr Ammendola touched M's face and chest and saw that she was still breathing.[33] Mr Ammendola and BM then smoked some cannabis before going back to sleep.[34]

What happened on the morning of Sunday, 20 April 2014?

48. At about 8:30am Ms DP got up and went downstairs. She knocked on Polly's (another one of the residents) door and woke her up because of a prior arrangement. Ms DP saw that the doors to M's and BM's rooms were closed, and returned to her quarters until the shift changeover.

49. Mr TG, another one of the youth workers, began his shift at 10:00am. His changeover with Ms DP took place between 10:00am and 10:30am. During the changeover Ms DP told Mr TG that Angel had been in the house at around 9:00pm the previous night. Obviously, at that stage Ms DP did not know that Mr Ammendola, Ivan and Sheena had also been to the house, and that Mr Ammendola was still inside the house.

50. At about 10:20am Ms DP left to go home. Mr TG did some work in the office before doing some general cleaning up in the hallways. Between about 10:45am and 11:00am Mr TG spoke to Polly in the kitchen and made her breakfast. After this Mr TG returned to the youth worker's office where he heard the sound of doors opening. He opened the office door and saw BM in the hallway near M's room. After having a brief conversation with BM, during which he gave BM some Easter eggs, Mr TG walked back to the office. As he did so he noticed that M's bedroom door was slightly ajar and he left some Easter eggs for her on the floor near the doorway.

51. Mr Ammendola said that when he woke up (for a second time) he heard what he describes as M "making a funny noise, like, it was a weird breathing noise"[35] or a "bubbly, a bubbly air sound".[36] Upon hearing this he woke up BM who came into the room and called M's name. BM went to alert Mr TG and seek help, telling Mr Ammendola to go into the other room. It is not possible to be precise as to when this happened but, according to the above timeline, it seems to have been between about 11am and 11:30am.

52. Inside the office, Mr TG heard the sound of running footsteps and, moments later, someone banging on the office door. He opened the door to find BM who said, "Come look. I don't think M's breathing".

53. At this point it should be noted that BM gave the police a slightly different account of what happened on the morning of 20 April 2014. BM said that at some stage in the early morning after sunrise he woke up and went into M's room to look for a lighter in order to have a smoke. He saw that M was in bed with the blanket pulled up to her shoulders. He noticed that M looked very pale and heard her take a breath that sounded "really weird, like nothing [he had] heard before". According to BM, M "sounded like she was struggling to breathe in air", she was making a "gurgling sort of sound", and it seemed like "there was heaps of [phlegm] in her throat".[37] BM

[32] Exhibit 1, page 469.
[33] Exhibit 1, page 473.
[34] Exhibit 1, page 469.
[35] Exhibit 1, page 470.
[36] Exhibit 1, page 474.
[37] Exhibit 1, page 419.

took hold of M by the shoulders and shook her whilst calling out her name repeatedly. M did not respond. BM said that he felt for a pulse but found none, and then ran to the office to alert Mr TG.

54. In his statement to the police BM made no mention of Mr Ammendola. The reason why is unknown. It is possible that BM was seeking to protect Mr Ammendola or, more likely, M as she was a good friend of his. In his statement BM describes his relationship with M as "being like best mates".[38] Given that BM was only 15 years old at the time of M's death, that his memory was likely affected by drug use (in Ms DP' opinion, BM appeared drug affected on the morning of 20 April 2014[39]), and that he is a vulnerable person (because of his age, because of the trauma caused by the circumstances surrounding M's death and because he was in out of home residential care at the time), he was not called to give evidence at the inquest.

55. I accept that it is possible that Mr Ammendola's memory was also affected by drug use. Mr Ammendola describes himself as "still a bit smashed" on the morning of 20 April 2014.[40] However, there appears to be no reason why Mr Ammendola would be untruthful in relation to his account of noting M to be in a "deep sleep" on the first occasion when he woke up. Furthermore his account of waking up a second time and noticing M to be experiencing difficulty breathing is more consistent with the timeline of events than BM's. For example, BM makes no mention in his statement of speaking to Mr TG (and receiving Easter eggs from him), *before* going in to the office to alert him.

56. I now return to the factual events. After BM alerted Mr TG they both ran to M's room, where they found M lying on her back in bed. Mr Ammendola was no longer in the room and CCTV footage shows that he remained somewhere inside the house, eventually leaving at around 2:00pm.

57. It appeared to Mr TG that M was not breathing so he called out to her, shook her gently, and placed his ear and hand next to her mouth. M was unresponsive. Mr TG called triple 0 at 11:26am and began CPR until ambulance officers arrived at the house at about 11:35am. By this stage M was in cardiac arrest. The ambulance officers found that M was unresponsive, cyanosed, and that her heart showed no electrical activity. The ambulance officers also noted that M's pupils were fixed and dilated, suggesting that she had suffered possible hypoxic brain injury (lack of oxygen to the brain).[41]

58. Despite active advanced life support measures by the attending ambulance officers, M remained in cardiac arrest and was taken to Hornsby Hospital, arriving at 12:10pm. Once there initial blood tests showed that M's vital organs had not been receiving blood or oxygen for a significant period, which indicated that the likelihood of her recovery was very poor.

59. After about 15 minutes cardiac output was re-established but M remained unconscious. Over the next 16 hours M remained in a critical condition and suffered further cardiac arrests. She was later transferred to the intensive care unit of The Children's Hospital at Westmead. However M did not regain consciousness and, tragically, she passed away at 4:00am on 21 April 2014.

What was the cause of M's death?

[38] Exhibit 1, page 416.
[39] Exhibit 1, page 410.
[40] Exhibit 1, pages 473, 476.
[41] Exhibit 1, page 66.

60. M was later taken to the Department of Forensic Medicine at Glebe. Professor Johan Duflou performed an autopsy on 23 April 2014 and found that the cause of M's death was hypoxic brain damage due to multiple drug toxicity. Toxicological testing showed the presence of a number of drugs in M's blood, including methylamphetamine, codeine, and morphine.

What drugs did M take?

61. Professor Alison Jones, a specialist physician, clinical toxicologist, and Executive Dean of the Faculty of Science, Medicine and Health at the University of Wollongong, was asked to interpret the toxicological results from M's blood tests. Professor Jones made a number of findings:

    (a) Firstly, the concentration of tetrahydrocannibol (delta-9-THC) in M's blood (<0.010 mg/L) indicated that M had probably used cannabis up to two days before her death, but the levels were more than what would be expected from passive exposure to smoke;

    (b) Secondly, the amount of methylamphetamine (0.98m mg/L) in M's blood was within the reported toxic to fatal range; and

    (c) Thirdly, the concentrations of morphine (0.05 mg/L), along with the levels of the active and inactive metabolites[42], were within the reported toxic to fatal range.

62. In Professor Jones' opinion the presence of morphine and its metabolites indicated that M had used heroin.[43] This is because there is, statistically, a low incidence of morphine use amongst heroin users. Also, the presence of codeine in M's blood (a likely contaminant of heroin) pointed to heroin use.

63. By analysing the pattern of blood test results Professor Jones concluded that M must have been alive for several hours following the use of heroin.[44] One of the metabolites (6-deacetyl-morphine) of heroin was not found in M's blood. This indicated that M had taken the heroin at least 3 hours before she went into cardiac arrest. It is likely that M used the heroin much earlier than this given that Mr Ammendola entered the house at just before 9:00pm on 19 April 2014. The last time M was captured on the house's CCTV cameras was at 12:16am. It is not possible to say whether M had taken the heroin by this stage.

64. Professor Jones also found that the way in which both Mr Ammendola and BM described M's breathing was consistent with methylamphetamine toxicity, as was M's subsequent cardiac arrest.[45] This is because methylamphetamine overdose is likely to cause cardiac arrhythmias, hypertension and circulatory collapse (amongst other conditions).

65. Ultimately, Professor Jones concluded that the presence of both heroin and methylamphetamine in M's blood indicated that M had taken both drugs together in a single syringe, a practice known as "speedballing".[46] This is a particularly dangerous practice because using these two drugs together suppresses their negative side effects. This in turn may make the person taking the drugs think that they have a higher tolerance for the drugs than they actually do. What this means is that a person could take a fatally high dose of heroin and not be immediately

[42] Morphine-3-glucuronide 0.45mg/L, Morphine-6-glucuronide 0.08 mg/L.
[43] Exhibit 1, page 41.
[44] Exhibit 1, page 43.
[45] Exhibit 1, page 44.
[46] Exhibit 1,page 45.

incapacitated (due to the methylamphetamine acting as a stimulant), thereby creating a false sense of tolerance until it is too late.[47] Professor Jones explained that academic research suggested that this type of delayed effect is believed to be the most common mechanism of death in speedball overdoses.

66. M had used both heroin and ice before although, according to most of her friends, injecting heroin was not a common practice for M. According to BM, M mainly used ice and would use 3 to 4 points per week.[48] BM said that M would usually smoke ice but he suspected that she may also have been injecting it. Ivan Pereira said that he never saw any drugs in M's room, and never heard her talk about drugs, although he admitted that he did smoke cannabis with M once.[49] Sharni Gelsthorpe told the police that she knew that M smoked cannabis and ice, but that M hated both needles and heroin.[50] Another one of M's friends, Nikki Wilson, also told police that M did not use needles and that she was very much against them, to the point where she told Ms Wilson that she (M) would not talk to her if she found out Ms Wilson was using needles.[51]

67. Mr Ammendola told the police that he had previously seen M inject ice[52] and that M had told him that she had previously used heroin.[53] Whether M had ever used them together in the same syringe before is not known.

68. It appears that M was not a frequent user of heroin. However she had been using ice for a significant period of time for someone so young. A risk of harm report from December 2012 contained the first mention of M using this drug. Given the toxicological results and Professor Jones' findings it seems clear that M had engaged in speedballing in her bedroom sometime after the arrival of Mr Ammendola.

69. As there is evidence that M had previously attempted self-harm, something needs to be said about the manner of M's death. That is, what may have been in her mind she took the two drugs. There is no evidence that M did so with the intention of causing harm to herself. There is also no evidence that M was contemplating self-harm on 19 April 2014, or in the immediate period leading up to this day. As a result, I conclude that M did not expect that taking the drugs would lead to her death. The manner of her M's death is therefore accidental overdose.

Where did the drugs come from?

70. It is not possible to say where the ice came from. No forensic evidence of it (or heroin) was found in M's bedroom when it was later searched by the police. A bowl containing green vegetable matter was located on top of a tallboy cupboard in M's bedroom.[54] A syringe packet was found next to the bowl. Opened packets of medical paraphernalia, such as a syringe packet and an alcohol wipe, were found on, and underneath, an ottoman in M's room.[55] Another alcohol wipe and a cotton wool ball were found in a plastic garbage bag on the west side of the room.[56] One small plastic resealable bag was found on the floor in the doorway, and another was found in a plastic garbage bag. Mr Ammendola told police that after leaving the house he threw the

[47] Exhibit 1, page 46.
[48] Exhibit 1, page 416.
[49] Exhibit 1, page 534.
[50] Exhibit 1, page 570.
[51] Exhibit 1, ages 641-643.
[52] Exhibit 1, page 467.
[53] Exhibit 1, page 466.
[54] Exhibit 1, page 263.
[55] Exhibit 1, page 262.
[56] Exhibit 1, page 265.

syringe that he had used to take the heroin that he took from M, as well as the bag containing it, into a bin.[57]

71. It is possible that Mr Ammendola may not have used all of the heroin that he took from M before he succumbed to its depressive effects. If this had occurred then it is also possible that M used the leftover heroin. According to Ms Gelsthorpe this scenario was not beyond the realm of possibility. Ms Gelsthorpe recalls an occasion (when she was still in a relationship with Mr Ammendola) when Mr Ammendola fell asleep and left some heroin in a needle. Ms Gelsthorpe said that she then used this heroin to inject herself. She also described previous occasions where Mr Ammendola would inject heroin in her presence but only have the chance to inject half the shot before he would "go on the nod again" and the needle would fall out of his arm.[58]

72. Given this evidence, and the evidence regarding M's frustration when Mr Ammendola took the heroin away from her, it appears most likely that M used some leftover heroin in Mr Ammendola's syringe after he had used it first.

Would earlier medical intervention have saved M's life?

73. Associate Professor Anna Holdgate, a senior staff specialist physician in emergency medicine and Director of the Emergency Medicine Research Unit at Liverpool Hospital, was asked to consider this question. Associate Professor Holdgate concluded that the most likely scenario is that the combined drugs that M took reduced her level of consciousness. This in turn meant that the reflexes which would normally protect her lungs and airway became depressed, reducing the ability of the lungs to supply oxygen to the rest of the body. This situation led to a period of reduced oxygen supply to M's brain (hypoxia) and other vital organs, which eventually caused cardiac arrest.

74. Associate Professor Holdgate concluded that if there had been medical intervention to support M's breathing and protect her lungs, this would have stopped the damage caused by the lack of oxygen, which would have in turn prevented cardiac arrest. According to Associate Professor Holdgate, the key point in time when this intervention may have changed M's outcome was when Mr Ammendola woke on the first occasion to find that M was, according to BM, in a "deep sleep".[59] As noted from the timeline described above, this was possibly around 6:30am, making it some 5 hours before M went into cardiac arrest.

75. If M was still breathing and opening her eyes (in the way that both Mr Ammendola and BM describe) then, according to Associate Professor Holdgate, this suggests that M had not yet suffered severe hypoxic brain injury. Medical intervention (in the form of intubation, artificial ventilation, and delivery of supplemental oxygen) would have likely prevented further deterioration and very likely would have prevented cardiac arrest resulting in M's death.[60]

76. However, Associate Professor Holdgate also concluded that there was a "very small possibility" that the level of methylamphetamine in M's blood (which Professor Jones found was in the toxic to fatal range) was enough on its own to cause M to go into cardiac arrest even if she had

[57] Exhibit 1, page 481.
[58] Exhibit 1, page 597.
[59] Exhibit 1, page 68.
[60] Exhibit 1, page 70.

received medical intervention.[61] Given this factor, it is ultimately not possible to definitively say whether earlier medical intervention would have saved M's life.

77. What is clear is that neither Mr Ammendola nor BM appreciated the grave danger that M was in during the early hours of Sunday morning. The fact that both of them were likely drug affected did not help them to understand the precariousness of M's situation. Further, as Mr Ammendola explained to police, although (at the time of M's death) he had been using heroin for 2 or 3 years[62], he could not just "look at someone and say, oh, they're on this, they're on that".[63] If Mr Ammendola's version of events is accepted, he had taken the heroin away from M and was unaware that she had taken it (or any other drug) before he fell asleep.

How did Gordon House deal with drug use by residents?

78. The staff at Gordon House were aware that the residents, including M, had a history of drug use and that drugs were occasionally used inside the house. However it is inaccurate to describe Gordon House as a "drug house" where drug use was openly tolerated. The frequent visitors to Gordon House, some of whom have already been referred to above, did not describe it in this way.

79. Angel Pereira told the police that he frequently went to Gordon House to hang out and play music with BM and M's brothers. He admits to having previously smoked cannabis with M's brothers but says that this happened out of the house at a park.[64] Ivan Pereira, who visited Gordon House often with Angel, said that he never saw anyone using drugs there.[65] Sheena Lodhia was another frequent visitor. She told the police that she knew about drug use at Gordon House and that she used to go there to smoke cannabis on occasion, but it was not all the time.[66] She said that she had never seen any other drug, such as heroin or ice, being used there. Finally, Sharni Gelsthorpe told the police that Gordon House was not known as a place to go to use drugs and that the youth workers did not condone such behaviour. Sharni said that the residents would often be verbally abusive to the youth workers if they came into their bedrooms whilst they were smoking cannabis. This would result in the residents closing their bedroom door and swearing at the workers to leave.[67] Sharni also told the police that she never saw any drugs, other than cannabis, used at the house.

80. At the time of M's death UnitingCare Burnside (Burnside) had policies in place for its youth workers to deal with drug use by its residents.[68] Policies were in place for room searches to be conducted if the safety of a resident was a concern. Similarly, there were polices in place for the police to be called in extreme cases if a resident was in potential harm.

81. There is no doubt that Burnside had an obligation to keep M, and the other residents of Gordon House, safe. One of the ways that they tried to do this was by creating a sense that Gordon House was their home, and not just a house. To do so they had to create a feeling of trust in the residents and ensure that their privacy was respected. Residents, like M, had previously placed their trust in other adults who had abused this trust and taken advantage of it. There was

[61] Exhibit 1, page 70.
[62] Exhibit 1, page 497.
[63] Exhibit 1, page 498.
[64] Exhibit 1, page 533.
[65] Exhibit 1, page 542.
[66] Exhibit 1, page 551.
[67] Exhibit 1, page 590.
[68] Exhibit 1, pages 1050-1051.

therefore a delicate balance to be struck between meeting the goal of maintaining the trust of the residents and ensuring that the residents remained safe. This problem was not unique to Gordon House or any other similar youth residential care facility. As Ms DP acknowledged it is a long-standing problem which confronts many young persons and those that care for them.[69]

82. It was clear to the Gordon House youth workers that M had a history of drug use. However, as will be explained further later, the youth workers were not drug counsellors. The youth workers nevertheless did take opportunities to direct M towards seeking help from suitably qualified counsellors. Ms DP, who had a particularly close bond with M, explained in evidence that it was not her place to challenge M about her drug use if M did not want to tell Ms DP about it. Ms DP sought to use other avenues (such as M's disrupted sleeping patterns because of drug use) to open a dialogue with M about her drug use and the negative impacts of it.

How did Gordon House deal with unauthorised visitors to the house?

83. Burnside also had policies in place regulating the frequency of visitors to Gordon House, and visiting times.[70] At Gordon House this was a difficult issue to manage. The physical layout of the house and the location of the staff quarters presented one challenge in monitoring who was entering and leaving the house. The ease with which residents' bedroom windows could be used as a means of access was another challenge.

84. Ms DP explained that there was again a delicate balance involved between enforcing Gordon House's visitor policy and respecting a resident's privacy.[71] Violation of the latter created a risk of absconding, which the youth workers obviously wanted to minimise. Mr TG pointed to further difficulties. He explained that asking a resident to have a visitor leave created the risk of prompting an aggressive, or even violent, response which necessitated the police being called.[72] Such an outcome would be detrimental to the overall residential care which the house sought to provide to the residents.

85. In M's particular case, attempts were made to prevent unwanted intruders from entering, or coming to, the house. An apprehended domestic violence order was obtained in relation to an adult male who M had previously been in a harmful relationship with. The youth workers were also able to issue trespass notices or call the police when visitors refused to leave the house.

86. When M was picked up in cars by older males who came to the house, the Gordon House staff took down licence plate details and alerted the local police. But the staff could not forcibly keep M at the house and prevent her from absconding. If M was absent for a significant time the youth workers would contact M's friends and family to try to locate her or, in extreme cases, file a missing persons report with the police.

87. However, the Gordon House staff could not patrol the boundaries of the house nor keep a constant watch over the footage from the CCTV cameras outside the house. At the time of M's death the Gordon House youth workers worked on a rotating shift which comprised a sleepover component from 11:30pm to 6:30am. There was no provision for an "awake person" to be on shift during these times, although this was trialled for a brief period and will be discussed further later.

[69] Exhibit 1, page 1149.
[70] Exhibit 1, page 1042-1043.
[71] Exhibit 1, page 1143.
[72] Exhibit 1, page 1136.

What was done to support M before she was due to give evidence?

88. Shortly after making the complaints of sexual assault by the two former GC youth workers, M was offered support and counselling by the Child Protection Unit at the Sydney Children's Hospital and also referred to Rosemount Sexual Assault Counselling Service.[73] However, M declined to engage with these two counselling services.

89. The District Court trial for one of the former youth workers was due to commence on 11 May 2014. M was to give evidence at the trial. A Witness Assistance Service (WAS) Officer from the Office of the Director of Public Prosecutions was assigned to M in April 2013.[74] Information about the court process and about giving evidence was sent to M at Gordon House on 20 May 2013. Similar information was also sent to DS, M's FACS caseworker, on 5 September 2013 and plans were made in November 2013 to begin preparing for the trial.

90. On 14 March 2014 there was a meeting between M, the WAS officer and JD. They discussed arranging for Ms DP to be at court during the trial as a support person for M, and for M to give her evidence from a remote witness room so that she did not have to see the accused or be in the same room as him. Arrangements were also made for M to meet with the prosecutors conducting the trial, along with the WAS officer, on 29 April 2014 to discuss the trial process and any concerns that M might have had.

91. The upcoming trial and the prospect of giving evidence was a stressful and difficult experience for M. Mr JD explained in evidence that M found the whole process to be extremely challenging and difficult to talk about. He, and the other youth workers at Gordon House, tried to support M by reminding her how courageous she was and that she was doing the right thing.

92. All of the evidence indicates that M was appropriately supported in the period leading up to the expected District Court trial. She had been offered counselling from an early stage and had been provided with information about the court process. Gordon House was aware that Ms DP' presence at court would likely have helped M and so arrangements were made for Ms DP to attend the trial. M also received specialist support from the WAS officer. There is therefore no evidence that any lack of support for M in the lead up to the trial contributed to her death.

Was any drug and alcohol counselling and psychological support provided to M?

93. During her time at Gordon House, various attempts were made to engage M in substance abuse counselling and treatment. This included informal counselling from the youth workers, outpatient counselling through Juvenile Justice, and a referral to PALM (Program for Adolescent Life Management), a residential facility for young people with substance abuse issues run by the Ted Noffs Foundation.

94. M was in detention at Juniperina Juvenile Justice Centre for most of August 2013. This created a degree of stability in M's life as she was abstinent from drugs whilst in detention. After leaving Juniperina, M told the Gordon House youth workers and her FACS caseworker that she had enjoyed the structure whilst in detention, and said that alcohol and drug use was no longer a problem for her.[75] However, Juvenile Justice staff said that they had been unable to engage with

[73] Exhibit 1, page 2167.
[74] Exhibit 1, pages 677-678.
[75] Exhibit 1, page 86A-17.

M on any meaningful level about her risk-taking behaviour. Furthermore, concerns were raised that M was at increased risk of the harmful effects of drug use. This was because her tolerance for drugs had been reduced by her forced complete abstinence whilst in detention, following a period of heavy use.[76]

95. After leaving Juniperina arrangements were made for M to attend compulsory drug and alcohol counselling sessions with Juvenile Justice. This was a court-ordered condition of her release from detention. M was initially compliant with this condition. Later, arrangements were made for M to enter PALM on 11 November 2013. Initial reports indicated that she was stable there, making progress, and that she had built a connection with one of the PALM counsellors. Unfortunately M's placement lasted only 3 weeks as she was asked to leave the program on 29 November 2013 following an incident involving drugs being introduced to the facility by another program participant. Shortly after her departure M was offered another place in the program but she chose not to take up this offer. Regrettably, after leaving PALM, M stopped attending her drug and alcohol counselling sessions with Juvenile Justice.

96. Psychological support was provided to M in the form of referrals to community youth mental health services. Also, as part of the condition of her release from detention, M was assigned to a Juvenile Justice counsellor and caseworker who she was supposed to meet with on a weekly basis. However, M frequently missed these appointments.

97. M was also referred to a consultant psychologist so that a behaviour support plan for her could be developed. The Gordon House staff recognised that M would likely not keep her appointments and so arrangements were made for the psychologist to go to Gordon House.[77] Regrettably, M refused to engage with the psychologist and was frequently not at home during the scheduled appointment times. But the Gordon House youth workers never gave up on M. Mr TG explained in evidence that even though M's key youth worker was primarily responsible for M, all the youth workers took it upon themselves to look after her. Part of this care involved talking to her about her drug use. Mr TG said that he repeatedly had conversations with M to try and get her interested again in drug counselling and therapy. Mr JD said that he spoke to M about the fact that her behaviour was placing her at risk. He specifically spoke to her about the harmful effects of heroin and this prompted M's eventual admission to PALM.

98. Despite these genuine efforts, they were ultimately unsuccessful. In order to know why this was the case, it is necessary to understand the impact of the trauma and abuse that M suffered during her upbringing. Dr Christopher Lennings, a very experienced clinical psychologist with a speciality in adolescent psychology, was asked to provide a report explaining the effects that M's upbringing had on her. To summarise, Dr Lennings concluded that M's childhood had caused enormous emotional and psychological harms to her.

99. Dr Lennings elaborated by explaining the importance of secure attachment between a child and their parents, that is, the emotional bond between them. This attachment makes it easier to train children to not engage in socially undesirable behaviours.[78] However, if a child is subjected to abuse or neglect in early life (between the ages of 12 to 18 months) this can result in neurotransmitter changes that adversely impact upon emotional regulation and secure attachment. This was certainly the case for M.

[76] Exhibit 1, page 86A-107.
[77] Exhibit 1, page 1311.
[78] Exhibit 1, page 90-2.

100. Dr Lennings went on to explain that positive socialisation experiences in a child's later life can sometimes mitigate earlier damaging experiences. However, in M's case these later experiences were the opposite; they were negative and abusive which had the effect of compounding the problems that M faced. The accumulation of these abuse experiences, with no positive experiences to offset them, created "a severe and likely entrenched pathological personality structure for M".[79] Dr Lennings ultimately concluded that it is likely M would have developed a severe personality disorder had she lived.[80]

101. Dr Lennings explained that if M had returned to PALM when she was offered her second placement it is likely that she would have had a good response to treatment.[81] However, neither the operators of the program nor the youth workers at Gordon House could compel M to return. A court order would have been required for this to happen. But given M's tendency to be resistant to authoritarian institutions such as the police and the courts, there is no guarantee that M would not have simply absconded if she was forced to return to PALM.[82]

102. Dr Lennings explained that there are significant philosophical and therapeutic difficulties in forcing young people to do things they do not want to do.[83] This has already been referred to above in the context of M's drug use, and the frequent unwanted visitors to Gordon House. It is also reinforced by Mr JD who said in evidence that this was certainly his experience. Mr JD explained that when the opportunity came for M to return to PALM he discussed the issue with her. Mr JD said that initially M was interested in the idea but "when push came to shove" M indicated that she did not need the help of PALM anymore and the discussion rapidly deteriorated so he backed away.

103. Dr Lennings concluded that, due to her traumatic upbringing, M was unlikely to have tolerated any counselling or psychotherapy in any meaningful sense.[84] The distressing reality is that the abuse and trauma that M had experienced during her upbringing meant that she was unable to take advantage of the support services that she so desperately needed.

What arrangements were made between FACS and UnitingCare Burnside to manage M's care?

104. As a result of parental responsibility for M being allocated to the Minister, FACS held case management responsibility for M. This meant that FACS was responsible for planning, implementing, monitoring and reviewing M's care plan which had been developed as part of M's Children's Court care proceedings. From February 2011, four different FACS caseworkers were assigned to M, with the last being DS, who was M's caseworker from March 2013 until her death.

105. After her placement at Gordon House, Burnside held the day-to-day care responsibility for M. This meant providing housing, food preparation, ensuring that M attended education activities, medical and other appointments, providing transport and arranging for and supervising family and social contact.

(a) What type of care was M provided with?

[79] Exhibit 1, page 90-5.
[80] Exhibit 1, page 90-5.
[81] Exhibit 1, page 90-7.
[82] Exhibit 1, page 90-7.
[83] Exhibit 1, page 90-10.
[84] Exhibit 1, page 90-8.

106. According to the UnitingCare Burnside Residential Care Daily Practice and Procedure Manual 2013, Burnside utilised a therapeutic care framework at Gordon House, and at its other residential care programs. This framework focused on understanding the impact that trauma can have on a young person's development, behaviour and relationships.[85] This provides an understanding of the meaning behind a young person's behaviour which, in turn, provides a foundation on how to support and care for them.

107. However, it is important to distinguish Burnside's therapeutic care framework from a therapeutic care model. Dr Lennings explained that Gordon House provided residential care, not therapeutic care. This means that Gordon House was not supposed to provide rehabilitation or therapy for M. Its youth workers were not trained to do so. Their role was to support M and help her stay in contact with specialists (such as counsellors and psychologists) who could provide the therapy that M needed. The presence of the youth workers had a therapeutic focus in the sense that they were to provide a structured environment for M and the other residents. As Hugo Madrid, the Burnside Manager of Residential Care, explained, Gordon House was not a program or refuge, but a home to its residents.[86]

108. Dr Lennings acknowledged that supported accommodation can provide reparative experiences for young people but M's needs were greater than what Gordon House could meet.[87] The philosophy of residential care is that young people have to want to engage with their home environment. Dr Lennings explained that M, sadly, did not have the capacity to do this. This is because the accumulation of traumatic experiences that she had suffered during her childhood meant that she had a chronic distrust of adults. Mr DS said in evidence that of all the young people that he had met in his 26 years of experience as a youth worker and caseworker, M easily had the least reason to trust adults. So much is clear from even a brief look at the trauma that M experienced during her childhood. Mr DS went on to explain that his main aim, and that of the youth workers, was to get M to be able to trust adults in a meaningful way so that help could be given to her.

109. By not being able to form secure emotional bonds M had not developed an ability to self-regulate her behaviour. Put another way, M's placement required attachment and self-regulation, but she was too damaged by her upbringing for this to occur. According to Dr Lennings, the damage done to M by the time she reached Gordon House was all but irreversible[88] and, as a result, M's behaviour was essentially uncontrollable.[89]

110. In hindsight, Dr Lennings said that it was unrealistic to hope that M would form attachments with the Gordon House youth workers and meet them halfway in relation to following the rules of the house.[90] This was so even though the youth workers were patient with M and encouraging towards her.[91] Dr Lennings said that the Gordon House youth workers simply lacked coercive measures or resources necessary to enforce the rules of the house.

111. Dr Lennings concluded that a number of other factors minimised the effectiveness of Gordon House: M often bickered with her brothers despite the affection that they felt for each other, the unauthorised visitors with anti-social intent to the house did not make the house feel safe, drug

[85] Exhibit 1, page 1029.
[86] Exhibit 1, page 1251.
[87] Exhibit 1, page 90-9.
[88] Exhibit 1, page 90-5.
[89] Exhibit 1, page 90-8.
[90] Exhibit 1, page 90-5.
[91] Exhibit 1, page 90-5.

use deregulated M's behaviour, and her absconding brought her under the influence of older and harmful peers.[92]

112. The supports put in place for M (education, counselling, curfew, psychologist, juvenile justice counsellor) might have been more effective if M had been less disturbed and her behaviour less volatile. However because she could not engage with these supports Dr Lennings concluded that it was difficult to see what other supports could have been put in place for her to utilise.[93]

113. None of this is to say that M's situation was hopeless or that her caseworker and youth workers ever lost hope. M was a determined person, and her caseworker and youth workers did their best to support her.

(b) Were any other forms of care for M considered?

114. Dr Lennings considered that M needed an intensive placement that was focused on repairing the broken attachments that M had experienced in order to help her develop ways to regulate her behaviour.[94] The two options were to either keep M in foster placement with intensive supervision and support, or move her to a more secure residential setting.[95]

115. Both options were considered by Burnside and FACS. Mr JD and Mr Madrid explained that Burnside asked FACS for a Child Assessment Tool (CAT) assessment for M. In general terms, this is a measure of a young person's needs and the assessment helps to determine whether there is a need for extra funding in order to provide additional support to the young person. Some of the additional supports considered were reducing the number of residents at Gordon House from 6 to 5, increasing staff numbers, considering a brief period of respite for M away from Gordon House, and having a youth worker remain awake overnight in order to deal with the issue of unauthorised visitors.

116. The last of these measures was actually put in place by Burnside for a short time in the hope that funding would be given to allow it to continue. However, as Mr JD explained, such a measure was not without its limitations. For example, having an awake person may have created a security issue if a youth worker was required to confront an unauthorised intruder in the middle of the night. Also, having an awake person who the residents were unfamiliar with could have adversely impacted upon Gordon House's ability to create a stable and calm home environment.

117. Ultimately the CAT assessment did not proceed. It is not possible to say whether it would have made any difference to M's outcome. Given Dr Lennings' conclusions about the cumulative and lasting effect of M's traumatic upbringing, it is likely that any impact that the assessment would have had would have been, regrettably, minimal.

118. Consideration was also given to referring M to Intensive Support Services (ISS) at FACS. This is a specialised stream within out of home care that works with young people who have a range of high needs and challenging behaviours such as violent or sexualised behaviours, engaging in criminal activities, engaging in self-harm, mental health issues, absconding, and presenting a high risk of harm to themselves or others. A referral for M to ISS was considered but no referral

[92] Exhibit 1, page 90-9.
[93] Exhibit 1, page 90-6.
[94] Exhibit 1, page 90-5.
[95] Exhibit 1, page 90-9.

was eventually made because, although M's needs were compelling, there were numerous other adolescents considered to be at higher risk than her.[96]

119. Instead, the expertise of the FACS Western Sydney District's High Needs Kids team (now known as the District Adolescent Team) was drawn on to guide the casework for M. This included 7 meetings involving Mr JD and Mr DS between February 2013 and January 2014, with the casework manager of the High Needs Kids team being present for some of the meetings.

120. At the time of M's death FACS operated a secure therapeutic residential program named Sherwood House. It was developed to support young people with complex trauma symptoms and chronic behavioural challenges that pose a risk to themselves and others, and who could not be supported in community settings. As it is a coercive program placement at Sherwood House requires an order to be made by the Supreme Court of NSW.

121. At the time of M's death there were 6 places available at Sherwood House for all children in out of home care in NSW. It is obvious that demand far exceeded supply. Lisa Charet, the District Director of the Western Sydney District of FACS explained in evidence that whilst M may have met the individual criteria for entry to Sherwood House at different stages in her life, entry is usually reserved for young people who meet the criteria all at once.

122. Dr Lennings concluded that even if a place had been available for M at Sherwood House, it is unclear whether an intensive care placement would have been helpful.[97] Although the restrictive and coercive regime would have kept M safer, she still would have needed to be able to build attachments and develop self-regulatory skills. This was a challenging undertaking for M because of her past trauma. Dr Lennings explained in evidence that it was hard to say whether even a facility like Sherwood House would have been capable of working on the trauma that M had experienced and have been successful in undoing the damage caused by it.

(c) How was the transfer of M's case management responsibility managed?

123. One issue which arose during the inquest was the transfer of case management responsibility for M from FACS to Burnside. This issue was first raised on 27 November 2013. Burnside suggested delaying the transfer for several months because FACS case management was regarded as a stabilising factor and M was reportedly stable whilst in the PALM program. As Mr Madrid explained in evidence, Burnside considered Mr DS to be a valuable resource in M's care, both because of his experience and because he helped the Gordon House staff to understand whether they were making progress with M. Because of M's past traumatic experiences, Mr DS was aware that any measurement of M's progress had to start from a low base. As Mr Madrid explained in evidence, when M stayed at Gordon House for two consecutive nights this represented considerable progress as she had rarely done this during previous placements. Mr DS's experience helped the Gordon House staff redefine what progress and success meant in M's case.

124. FACS agreed with Burnside's request for a delayed transfer and a transition plan was eventually developed with transfer to be reviewed on 30 January 2014. Transfer was later accepted by Burnside at this meeting.

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[96] Exhibit 1, page 2162.
[97] Exhibit 1, page 90-6.

125. In hindsight, Ms Charet said that case management transfer of M should not have occurred when it did.[98] She explained that, as a result, both Gordon House and M lost the benefit of Mr DS's experience with M. However, Mr DS explained that at that time case management transfer from FACS to a non-government organisation would usually occur within 3 weeks of a young person's placement with that organisation.

126. In M's case this did not occur, and the transfer process was significantly delayed in recognition of the complex needs that M presented with. It is not possible to say if the transfer had not occurred whether this would have made any difference to M's eventual outcome. Unfortunately, it is likely that it would not have given the conclusions reached by Dr Lennings.

(d) What type of involvement did M have with her family?

127. It is concerning to know that the positive family influences in M's life, such as her Aunty VP, did not know of the harm that M was experiencing and the risks that she was exposed to whilst she was at Gordon House. Mr DS agreed in evidence that there was a strong argument for keeping Aunty VP better informed about the details of M's life and its challenges. However, he went on to explain that M's wishes and her privacy also had to be considered.

128. There is evidence that the Gordon House staff made attempts to encourage M's connection with her Tongan heritage and cultural background. The youth workers provided transport when M wanted to visit family members and M spent Christmas Eve 2013 with her brothers at Aunty VP's house.

129. However, as Mr DS explained in evidence, the need to keep M's family members informed and to encourage M's cultural connections was often in competition with the concerns that the Gordon House staff had about M's day-to-day safety. That is, M was frequently at high risk and the staff resources required to manage the crises that M was often experiencing allowed few opportunities for her to have a greater degree of involvement with her family. Mr DS acknowledged that it was possible that greater family involvement would have helped with the management of some of these challenges.

130. Dr Lennings was conscious of the fact that some members of M's family had been involved in past harmful behaviour towards her. However, he agreed that if M's family shared the same goals of M's caseworker and youth workers, and if they could be mobilised into a supportive network, that M could have benefitted from their involvement. Again, it is impossible to know whether this would have changed the outcome for M. It is acknowledged that M's family feel that it could have made some difference. Given that M had few adults in her life with whom she could form a secure attachment, it seems that a nurturing adult family member such as Aunty VP, would have been a positive and nurturing force in M's life.

131. The overall description of M's time in care, and in particular her time at Gordon House, paints a bleak and confronting picture of the extreme difficulties that a 15 year old girl had to struggle with. Although she was supported by many people around her, in some ways she was still alone.

132. But there were positive aspects to M's life at Gordon House. She left a lasting impression amongst the residents and staff there, who both admired and respected her resiliency and

[98] Exhibit 1, page 2170.

determination. She garnered the love of friends because of her sense of loyalty and her feeling that it was her responsibility to make those around her happy.

133. Given her fractured upbringing, and despite her absconding, there is a real sense that M considered Gordon House to be her home. Even when she was away from home, M called to tell the staff where she was, which represented major progress in the context of her overall history. [99] Before her departure, M was making encouraging progress at PALM, which also represented a significant step for her. She had earlier (during her time at GC) completed most of a 12 week educational program designed to develop social and personal skills for young people who have disengaged from schooling. Part of the program involved voluntary work. M worked as a waitress in a café and although she was only required to be there once a week, she enjoyed the work so much that she often went two to three times a week. M told the youth workers that she was interested in modelling and sometimes spoke to them about her plans for the future. It is tragic that M never had the opportunity to live out these plans.

Should any recommendations be made?

134. Section 82 of the Act allows a coroner to make recommendations in relation to any matter connected with a person's death. The words of section 82 say that such recommendations may be made if the coroner considers them to be necessary or desirable. Issues of public health and safety can be, and often are, the subject of recommendations.

135. M's case immediately raises questions about how harm could come to M in a place that was meant to keep her safe, and whether more could have been done to prevent her death. The answer is that more could have been done. But that is an overly simplistic answer to a difficult and complex problem. The reality is that M was surrounded by people who tried to protect her and keep her safe. Several of them gave evidence at the inquest. They all impressed as genuine and decent people who showed kindness and respect to M, two things which she had not always been given in her life.

136. It is of course both necessary *and* desirable for us, as a community, to keep our children safe, and to nurture and protect them. But there is no single recommendation that can be made to reinforce something which is clearly obvious. One can only hope that these findings, and other information gathered about the circumstances of M's death, are used to inform how we, as a community that cherishes all human life, can achieve this necessary and desirable goal.

137. There is evidence that some of this has occurred, and is still occurring. For example, there is now a better understanding within FACS of the need for a more gradual transition care management process (if one is to occur at all) for young people with high needs.[100] There is also now a greater understanding of the child protection role that FACS retains, even after the transfer of case management, and the need to respond to risk of significant harm reports. There are increased resources and supports for families to make family homes safe for children in the long term and FACS has accepted greater responsibility for supporting family carers. The District Adolescent Team, which previously operated as a consultative team has now become a casework team, and there has a greater focus on working with other services (such as the police, Juvenile Justice, and education services) to achieve a better outcome for high needs young people. [101]

[99] Exhibit 1, page 86A-13.
[100] Exhibit 1, page 2171.
[101] Exhibit 1, pages 2171-2175.

138. On behalf of Burnside, changes were made in 2014 to restructure residential placements. At the time of M's death, Burnside operated three residential care homes with six residents each. Since 2014, Burnside now operates four residential care homes, two with a maximum of five residents, and the other two with a maximum of four residents.[102] Furthermore, one of the homes is specifically catered to meet the needs of residents between 12 to 14 years. A second home is specifically catered to meet the needs of residents between 16 to 18 years as they reach the age of leaving care and transition to independent, or semi-independent, living. The increase in staffing ratios, and focus on the needs of specific age groups, is aimed at providing greater support for the complex needs of the young people who live in these homes. Burnside has revised and updated its daily practices and procedures to better address and manage issues surrounding drug use by residents.[103] Gordon House has closed and been replaced by a different house which is at a location that makes unauthorised entry more difficult. Rosters for youth workers have changed from a rotating roster to a fixed roster, which means more consistency for residents, one of the factors which seemed to have created stability for M in January 2014.

Findings

139. Before turning to the findings that I am required to make, I would like to acknowledge and thank Ms Donna Ward, Counsel Assisting, Ms Alina Anderhuber, instructing solicitor from the Office of the General Counsel, and Senior Constable Warren Hitchon for their tireless work and invaluable contribution both before, and during, the inquest.

140. The findings I make under section 81(1) of the Act are:

Identity
The person who died was M.

Date of death
M died on 21 April 2014.

Place of death
M died at The Children's Hospital at Westmead.

Cause of death
The cause of M's death was hypoxic brain damage due to multiple drug toxicity.

Manner of death
M died from an accidental overdose of multiple drugs.

Conclusion

141. M once told Mr DS that she wanted to stay out of trouble, get a good job, and live in a nice place when she turned 18 and left Gordon House.[104] Her brothers also wanted this for her and wrote to tell her this. No doubt M's family and those who cared for her wanted this as well. Mr DS told M that her current way of her life was not who she is. Many of the matters that the inquest

[102] Exhibit 1, page 1297.
[103] Exhibit 1, page 1054.
[104] Exhibit 1, pages 86A-12, 86A-69.

considered are not who M was. She was how her brothers remember her: as a big sister who was their best friend and shining light in their lives.

142. On behalf of the coronial team I would like to offer my sincere and respectful condolences to M's family, in particular her brothers, S and T. It is fitting to conclude with their words:

"Ofa atu, M".

Magistrate Derek Lee
Deputy State Coroner
12 September 2016
NSW State Coroner's Court, Glebe