IN THE CORONERS COURT
OF VICTORIA
AT BENDIGO

Court Reference: 2510 / 2005

REDACTED FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of: RORY

Delivered On:	31st October 2011
Delivered At:	Bendigo Magistrates' Court 71 Pall Mall, Bendigo, 3550
Hearing Dates:	13th September to the 16th of September 2010 inclusive
Findings of:	Jennifer Tregent, Coroner
Representation:	Mr J.Buchecker appeared on behalf of the D.H.S Ms I.Bolger appeared on behalf of the mother Mr S.Kennedy appeared on behalf of the father
Coroner assisted by:	Senior Constable Tansley Hill, Mildura Prosecutions

I, JENNIFER TREGENT,Coroner having investigated the death of RORY

AND having held an inquest in relation to this death on the 13th of September to the 16th of September 2010 inclusive

at Mildura Magistrates' Court

find that the identity of the deceased was RORY

and the death occurred on 17th day of July 2005

at his home address

from:

1 (a) Oxycodone toxicity

in the following circumstances:

Rory was a four year old child when he was found deceased at or around 7.00 pm on Sunday the 17th of July 2005. He was located in his bed at his home address.

A post mortem examination conducted by Pathologist Ms Linda Iles revealed Rory died as a result of oxycodone toxicity. An 80mg OxyContin (oxycodone) tablet was identified within his stomach and oxycodone levels of approximately 0.7mg/L were detected on post mortem sampling of the femoral blood. Ms Iles noted in her report that fatalities attributed to oxycodone alone in the adult population have ranged from 0.3mg/L in femoral blood.

Ms Iles described oxycodone as an opiate narcotic analgesic and as such, its effects include stupor, coma, severe respiratory depression and cardiac arrest.

Prior to his death Rory had clinically been diagnosed as having autism and the neuropathological findings, whilst non-specific, were in the spectrum of changes observed in autism.

There was no dispute the reason for the OxyContin tablets being in the home of the deceased was due to his father, Mr S. being a prescribed the medication. It is and remains unclear though, as to actually how it was that R came to ingest the OxyContin tablet and at what time.

Background

The deceased was born on the 26th of January 2001 at the Mater Hospital in Brisbane to Ms F and Mr S. He was the youngest of three children born to Ms F and Mr S. Rory had an older brother "A" and a sister T, they were 11 years and 8 years respectively at the time of Rory's death.

A psychological assessment of the deceased was undertaken when he was three years and seven months old, which revealed he displayed developmental, language and motor skill delays. As indicated previously, he was assessed as being autistic.

The parents and others described the deceased as having abnormal behavioural, social and sleep characteristics. It was probably for these reasons, in part, that Rory's behaviour on the day of his death was not noted as being different or a reason for concern or alarm.

Statements were taken from Rory's two siblings, T and A and his parents Ms F and Mr S made statements and participated in record's of interview into the circumstances of R's death. There were several people who participated in recorded interviews with the police. It can be indicated at the outset that there were no charges laid in relation to any of those people pertaining to the investigation into Rory's death.

It is clear from the information contained in the statements of Mr S that he had little, to no involvement with Rory on the day of his death, until Ms F alerted him to something being wrong.

In relation to the information provided by Ms F, she stated Rory got out of bed early in the morning and then returned to bed, as was his usual practice. It was her evidence and that of Mr S, that Rory would often sleep intermittently at night and it was not uncommon for him to sleep on and off throughout the day.

In her statements, Ms F stated she looked in on Rory throughout the day and saw him at one time playing with his cars in bed and did not notice him to be otherwise unwell. Ms F denied in her interview with the police that either of Rory's siblings had alerted her to the fact that Rory was not well. At the inquest when giving evidence however, Ms F did agree that at some point in the afternoon A had come to her stating that "Rory's breathing funny" and she checked on him and just felt that he was snoring very heavily.

Ms F in a statement she provided to police on the 17th of July 2005 stated that Rory had woken at 9am and she gave him breakfast and he went to his room to play. She indicated that Rory was asleep for most of the day, which was not unusual as he did not sleep well at night. Ms F stated she went to check over Rory every half hour or so and he seemed fine. She indicates that she further checked him at 6.30pm and again "he seemed fine". It was not until she went in to his room at approximately 7.15pm, with a view to waking him for dinner, that she realised something was

wrong. He did not respond to her verbal requests and when she touched him, she noticed he was cold and stiff. She said she held Rory in her arms and realised he was dead.

A, the older male sibling of Rory, stated he checked on Rory frequently throughout the day as was his usual practice and upon the advice of his parents, to confirm Rory was breathing. He stated he first checked on him around 9am to make sure he was still breathing. He touched him on his forehead and he was warm. He put his hand over the top of Rory's mouth and could feel him breathing. He stated Rory looked normal at this time. It was usual for Rory to be checked regularly by A, his mum, dad or Uncle if he had been asleep for too long.

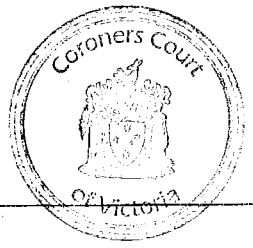
"A" stated the next time he checked on Rory was about 12 o'clock. He went into the room he shared with Rory and found Rory was still in bed and he was "breathing funny". He went on to detail that it sounded like he had something stuck in his throat and he was breathing as if he was only having a quarter of a breath. He noticed his face was pale and his forehead was cold to touch. He saw that Rory's cheeks on both sides had little round purple spots on them and his lips were blue. He was covered with two doona's.

"A" stated he went to where his mother and father were seated in the lounge room and told his mother that Rory had purple cheeks and blue lips and she told him to "wake him up". "A" returned to the bedroom and shook Rory lightly. This caused Rory to wake and he got up and took a toy car off the floor and went back to bed. "A" said "Good morning" and Rory replied. Rory went back to sleep and "A" covered him with a doona and left.

"A" was concerned that Rory was cold and had a discolouration to his cheeks and lips and felt that he was "really, really, really sick". He stated he felt that a Doctor should be called and went back into the lounge and communicated his concerns to his mother. He stated his mother responded that it was probably not that serious but went in and checked on Rory. "A" heard his mother talking to Rory asking him if he was all right and at his mother's request "A" obtained a drink of water for Rory. "A" left his mother and Rory and went outside to play.

"A" entered the room again, this time accompanied by T. He stated, when he walked into the room Rory was not breathing so he hit the bed head and when he did this Rory took a long breath and started breathing again. His dark purple cheeks started going lighter but his lips remained unchanged. "A" was unsure of what his mother and father were doing at this time, but did not report to them his observations as he felt Rory would be all right and he was breathing. "A" and T went back out to play.

"A" attended on Rory again at around 5pm to see if R wanted to join them in their play. At this time, he entered the room and Rory appeared to be asleep. He did not touch him at this time or check his breathing and noted that he remained pale and the purple patches were still on his cheeks and his lips were still blue.



A time shortly prior to dinner, "A" again looked in on Rory who, he saw from the door, remained in the bed. He did not go to wake him, as he understood his mother would be waking him shortly to have his dinner.

It was a short time later when Ms F did in fact enter the bedroom to find Rory cold to touch and his limbs were stiff. It was clear Rory had died and she called Mr S for assistance. Mr S could not locate his mobile phone to call for an ambulance and so "A" went to a neighbour's house to make the call. That neighbour, a James Newman, entered the premises and went to the bedroom where Rory lay. He checked to see if he could find a pulse and he could not. He further attempted mouth to mouth resuscitation without success.

Shortly after, the paramedics arrived and began to assess Rory's condition. Paramedic Michael Gleeson noted Rory was not breathing and felt his chest, which was still warm to touch. He then attempted to introduce an artificial airway into his mouth but found that Rory's jaw was fixed and he was not able to open it. He felt for a carotid pulse but could not locate one.

At the same time, Paramedic David Doering was also treating Rory. He also noted his chest was warm to touch but noted on rolling him over his left arm stayed stiff and outstretched. He also noted, as he was placing a cardiac monitor on Rory's back, that there appeared to be blood pooling in the centre of his back. It was his opinion, based on these observations, the patient had been dead for some time.

A reading on the cardiac monitor indicated that Rory was asystole, meaning there was no electrical activity in his heart. It was confirmed that Rory was therefore deceased and no further treatment could be undertaken.

At this stage, the police had arrived and the police and paramedics questioned both Mr S and Ms F as to their respective observations of Rory throughout the day. Mr S was not able to provide any reliable information stating the child had been checked at 7.30 and when queried that it was now only 7.20 he stated it must have been 6.30. Ms F stated that Rory had got out of bed at about 7.30am and had some vegemite toast and lollies before returning to bed as he had a tummy ache. Ms F stated she had been checking on him throughout the day. When asked what was involved with this checking she stated she had poked her head through the door and saw him to be asleep. When asked if she had ever gone into the room to touch him to see if he was okay she had said "no".

The Evidence at inquest pertaining to the cause of death

The pathologist Dr Iles was called at the inquest to give evidence. Dr Illes was asked to give a professional opinion as to a possible time of death. The facts provided were the presence of rigor mortis and lividity that was observed on Rory's body. Also, that the attending ambulance officers found that Rory's chest area was still warm, but his extremities namely his arms, legs and feet were cold. Rigor mortis had set in to his arm and jaw and there was a pooling of blood in the back region of his body. Dr Iles indicated that establishing the time of death can be very difficult due to the

number of variables. Dr Illes also stated that most of the data relates to death of adults. At most, Dr Illes could suggest was Rory had been dead for a couple of hours at the time he was found. Dr Illes indicated that there was not much science behind that conclusion. This conclusion was further expanded on by Dr Illes to state that it usually takes a couple of hours for rigor mortis to set in, but again Dr Illes qualified that it was a very general presumption.

Professor Olaf Drummer prepared the toxicology report and he stated that a number of tests were conducted on the samples of blood, organs and tissues taken from Rory's body at the time of the post mortem. The tests were undertaken to detect for the presence of alcohol, common drugs, common prescription drugs and common drugs of abuse. The only substance that was found was oxycodone in the blood at a concentration of .7 milligrams per litre and an amount of 1.2 milligrams per litre found in the contents of his stomach. There was also .5 milligrams detected in a section of the liver.

In evidence at the inquest, Professor Drummer stated that there would also have been an amount of oxycodone in the small intestine and also in his tissues. Professor Drummer was asked questions as to whether the levels of oxycodone found in Rory's body were consistent with the ingestion of one tablet alone. Professor Drummer indicated they were, but it was difficult to be more precise, particularly in the context of a small child.

Professor Drummer outlined what the effects of ingestion of the drug would have had on Rory. He stated that oxycodone is a very similar drug to morphine, a very strong pain killer. Its major effects on a young child would be to cause Rory to fall sleep, it might cause him to vomit. The main feature is that Rory would fall asleep and would probably fall into a coma not long afterwards as the concentration of the drug rose in his brain. His breathing would be affected and would become shallow. The rate of breathing would decline and at some point as his breathing became impaired, the oxygen in his body would start to decline and at some point, tissue damage would start to occur as a result of the low oxygen. Ultimately, death would result.

Professor Drummer was also asked to comment at the inquest on the prescription medication that had been authorised for Mr S and Ms K. The information provided to the Professor was that Mr S had between the period the 17th of July 2004 and the 17th of July 2005 been prescribed in combination temazepam, oxazepam and OxyContin. The Professor was asked to comment on the various medications. Professor Drummer stated that OxyContin was prescribed for severe pain and that temazepam and oxazepam to induce sleep and reduce anxiety. In general terms the dosage and the effect would depend on a persons tolerance levels. In the event the medications were misused, and this was clarified as exceeding the recommended dosage or administering it intravenously, then they could have the effect of making a person very drowsy, unsteady on their feet and unable to talk or think properly.

The records of the prescription medication provided to Ms K over the same period were also provided to Professor Drummer for comment. Ms K had been prescribed Tramadol, diazepam and oxazepam. Professor Drummer detailed that tramadol is also a drug to treat pain and was similar to morphine and to OxyContin. In relation to misuse of the medications Professor Drummer stated it would be the same as he stated previously as it related to Mr S's medication.

The Professor detailed that OxyContin was designed to be a slow release form of medication. The first release of about 40 percent of the drug occurs almost immediately followed by a slower release of the remaining 60 percent over a 3 hour period, compared with one and a half hours for a conventional tablet.

I asked Professor Drummer if, had somebody been aware of Rory's hampered breathing, could early intervention have prevented the subsequent outcome. Professor Drummer indicated if doctors had been able to get to Rory prior to him suffering any brain damage, they could have sustained him until the drug had been removed from his body. He stated there are antidotes or drugs that can be used to reverse the effects of oxycodone quite safely, if they get to somebody early enough in time.

The Involvement of the family with the Department of Human Services Victoria.

The case notes of the Department of Human Services (hereafter referred to as the Department) as they relate to Rory and his siblings indicate that a notification was first made to the Department as to welfare considerations of the three children on the 23rd of September 2003 when the family were residing in Mildura.

The contents of that notification as recorded in the records were of allegations the parents of the three children were frequently incapacitated when using drugs. The notifier believed the parents were using marijuana and prescription medication such that both became incapacitated to the extent they could not properly care for the children.

The notifier cited examples of a difficulty in rousing the parents from sleep and times when the parents would leave the children in the care of other residents of the caravan park where they were residing and not being able to recall with whom they had left their children.

It was at this point the Department commenced an investigation of the family. A suspicion the family, who had moved recently from Queensland, were evading the equivalent child protection authority in that state was found to be unsubstantiated. In light of the allegations the Department sought to make contact with the family. The Department found the family had left the caravan park suddenly, leaving some items of apparent value.

Attempts to locate the family through other relatives proved fruitless. The only information the Department was otherwise given was a possible movement to the Camperdown area, which was provided by Ms.D the maternal grandmother of the deceased. Ms D. she did not have any phone contact details for the family.

The Protective worker at that time made enquiries with the Camperdown primary school to discover if the children had been enrolled. When it was ascertained they had not, the worker notified the Camperdown Police and local schools in the Camperdown area, advising them of the Departments interest and seeking notification if they had contact with the family.

On the 13th of October 2003 the case was closed without investigation by the Mildura branch of the Department due to an inability to locate the family. An alert was placed on the internal Department data base in the event the family came to attention again.

The Department became involved again shortly thereafter when the family were located in the Camperdown area residing with Mr O.S (the brother of Mr S) and his partner. This was around the 20th of October 2003 and the first time the Department had an opportunity to meet with the family to discuss the protective concerns. The parents denied the allegations as to misuse of drugs and unsatisfactory care for the children. On the 24th of October 2003 the two elder children were interviewed by Department workers. At that time "A" was 10 years of age and T was 7 years of age.

It was clear to the Department at the time the current housing arrangements of the family were unsatisfactory and alternative accommodation was required. The file notes relate primarily to the issues surrounding attempts to locate suitable housing.

On the 1st of December 2003, the Warrnambool office of the Department closed the file, being satisfied the family had done what was asked of them in finding alternative accommodation. On the strength of the interviews with the parents and the fact, the two older children did not raise any concerns as to mistreatment, the Department worker concluded the allegations could not otherwise be substantiated.

It appears from my perusal of the Departments file that this opinion was reached after minimal involvement with the family, being two interviews involving the parents and one involving the two older children in late October 2003. There is no indication what transpired in terms of the involvement of Department workers between this time and the decision to close the file on the 1st of December 2003. It is concerning that even at this point in time, in the face of significant allegations of inappropriate care being provided to the children, the Department worker was satisfied, largely based on the narrative of the parents alone, that intervention was not required. I would also have thought that any discussions with the children would have to be assessed in light of the fact they were unlikely to actively criticise their parents. It also appeared to me from reading the summary of the responses the children gave was they had been prepared by someone as to how to answer any questions posed.

The Department's concern was focused primarily on appropriate housing and they simply ignored the allegations of drug misuse. Once suitable housing had been obtained that was sufficient to allay any protective concerns.

It is also unclear as to where the "appropriate" accommodation was that the family had moved to. There is a reference to a place in Portland, yet the "closure" letter forward to the mother Ms F on

the 16th of December 2003 was directed to the address in Camperdown of Mr O.S. This was the very accommodation that had otherwise been deemed as unsuitable and from which the family had allegedly re-located. It is unclear how the Department were satisfied that the family were in appropriate housing when they did not even know where that housing was.

It was not long before the Department was again involved with the family on the 11th of January 2004. This involvement came about following notification from the Camperdown police. The police had attended at the property where the family were located in relation to the execution of a warrant to search for alleged stolen goods.

The police attended an address in Camperdown and found the family to be residing in an old bus at the rear of the household premises. That attendance was a 10.20 pm on the 9th of January 2004. The police were admitted to the bus by a child of approximately 6 years of age. They observed both Mr S and Ms F to be asleep on a double mattress in the bus. In his statement S/C Clayton indicated it took some time and difficulty to wake the parents who, in his opinion, were obviously under the influence of some drug or chemical.

A search was undertaken of the bus and the police located a number of spoons with the residue of white powder. These spoons were found on a shelf near the foot of the bed, with a hypodermic needle resting on it, another one on top of the television and another near the base of the television. A further two were located under the mattress.

The freezer compartment of the fridge contained numerous empty medication packets being eight OxyContin packets, six Temazepam packets, 3 Kapanol packets and 18 empty blister packs of OxyContin.

Constable Rebecca Creed also attended at the location of the bus on the 9th of January 2004. C /Creed noted the bus smelt of mouldy mattresses, dirty dishes and wet clothing. In her statement, C/Creed described observing the three children to be dirty and thin in appearance. Their bedding requirements were inadequate, with thin blankets with holes and the children's skin was cold to touch. In her description of Ms F she described her as slow in movement and slurring incomprehensibly, she was unable to stand and as a result sat on the kitchen floor slumped over. Rory sat on his mother's lap, and was thrashing his head back and forwards hitting the cupboard behind. C/Creed intervened as Ms F was not doing anything to stop this occurring.

C/Creed returned with the officers from the Department on the 11th of January 2004 at 1.15pm and found the parents to be asleep and on waking, in an altered conscious state. They were both slow in movement, disorientated and their speech was mumbled and slurred.

One of the Department workers who attended that day, Ms Merrilyn Bartkus, was familiar with the family having been involved in the investigation in October 2003. Ms Bartkus questioned Mr S as to the accommodation that had previously been organised, which she understood to be in Portland. I assume this was the suitable accommodation that had been the basis upon which the case was

previously closed. Mr S stated that had only been temporary accommodation for 14 days and subsequent to that they had returned to Camperdown.

Ms Bartkus and her co-worker Ms Rosemary East inspected the inside of the bus where the family had been residing. The notes detailed the following observations:

- Used food bowls were on the floor of the bus, littered amongst bedding
- Two camping bunks low to the floor could be seen. A and T slept on these
- A small foam mattress was on the floor of the bus, next to a double mattress and this was where Rory slept
- There was no walkway in the bus, the writer had to step over bedding, dishes, a heater, food containers, clothes
- A small kitchen type table was littered with items such as a box of weat-bix, cigarettes, knives
- An electric heater could be seen on the floor of the bus, surrounded by bedding
- The bus presented as a high risk environment to all who inhabit it, and if a fire began in the bus the occupants would have little hope of escaping without being seriously burnt

It was clear to the workers that the children could no longer reside in that environment and as a consequence arrangements were made for the children to be placed in the care of a relative ,the paternal aunt, with the reluctant agreement of the parents. The comment contained in that report was that "the problems were of a chronic nature and serious".

It was recognised that Rory suffered developmental delay in that he spoke little and was physically limited in his ability to walk and run. A fact not previously noted, as at the time of limited involvement in October 2003, Rory had been asleep in his cot at the time of the one home visit. It was certainly not a fact that the parents had recognised or alluded to.

The report goes on to detail the protective concerns and vulnerability of the children. These concerns were stated as being that the parents regularly appeared drug affected, were not providing a safe and clean environment or adequate food. The family had a transient lifestyle and were living in unsuitable accommodation. Information had also been received the children had been "educated" in relation to the best way to answer "Welfare's questions".

Those details of concern differ little to those raised at the time of the original notification in October 2003.

It is also clear from further enquiries made at this time in consultation with the Office of Housing, which had been involved with finding suitable accommodation in September / October 2003 that the family had chosen not to take up accommodation as offered. The Office of Housing had not had contact with the family since November of 2003. It remains questionable how it could therefore have been said in early December of 2003 that the accommodation difficulties otherwise facing the family had been suitably resolved.

The placement of the children with the paternal aunt at her home in Ballarat quickly broke down as she struggled to manage the children. As no suitable alternative "out of home" care could be organised within the time frame it was agreed, by the Department, the children could return to the parents who were going to reside overnight in a caravan, as was their choice. This occurred late on the 13th of January 2003.

The parents were now suggesting an intended full time move to Ballarat and a desire for housing in this location. It was at this time there appears to have been an impasse between the various offices of the Department, whereby Warrnambool office wanted to transfer the case to the Ballarat office. The Ballarat office was not prepared to assume responsibility for the matter until it was clear the family were actually going to make such a move to the region. The difficulty, as perceived by the Ballarat office of the Department, was the transient nature of the family generally and the fact that, notwithstanding the parents expressed intention of making a move to Ballarat, they had otherwise done nothing to secure any accommodation.

On the 16th of January 2003 a Department worker contacted Mr S to ascertain what his intentions were and was advised in that telephone call that the family were in fact travelling to Cabarita, a town near Mildura to stay with his brother. Mr S indicated the move was temporary and that they still desired to reside in Ballarat. Mr S could not provide details of the address where they would be staying but told the Department worker to call back in a few hours and they would have arrived by that time and could provide them then.

An undated file note in the Department records indicates that attempts to telephone Mr S on his mobile as directed were unsuccessful and the advice given was the phone was no longer connected. Based on the fact they had no way of making direct contact and no known address it was indicated the case will be closed. It was further stated that "should further notification be made with current address details then consideration should be given to reopening case (if it is clear risk is still evident)".

It is clear to me that the risk remained evident from the time of the first notification in September 2003 and the parents continued to flee various jurisdictions to avoid the involvement of the Department. The children remained at substantial risk of harm.

That same concern was shared by Camperdown police officer Senior Constable Peter Clayton who contacted the Department and according to a file note "was angry that the file had been closed and said that he had serious concerns for the safety of the children". This was on the 4th of February 2004. It was on the basis of this expressed concern the file was transferred to the Mildura office of the Department on the 5th of February 2004.

An address was obtained for where the family was living again from Ms D. The family were living with Ms F's brother at an address in Cabarita. A home visit was conducted on the 6th of February 2004 and the parents were interviewed.

The parents complained that they had been unable to secure accommodation in Ballarat as no one had assisted them, that they were in need of counselling but again no one had made arrangements,

and they only used prescription medication and occasionally marijuana, but never in the presence of the children. In relation to the incident of excessive drug use surrounding the attendance of the police at the caravan they were residing in, in early January, the parents described this as a "one off incident". The parents provided details of the medication they were prescribed.

In relation to Ms F, she indicated she suffered from scoliosis and cists on her ovaries and was prescribed serapax, temazepam, Kapanol, Mirtazapine and deptran. In relation to Mr S, following two significant injuries to his back, he had been on OxyContin and temazepam.

The conclusions reached were that the environment in which the family was living with the brother of Ms F was suitably clean and there were no safety concerns about the accommodation. The home was well furnished and well stocked with food and the uncle was able to offer assistance should it be required. The parents advised arrangements had been made for the children to attend school on the following Monday. The children, when spoken to, expressed no concerns as to their care. It is unclear if the children were spoken to in the presence of the parents but regardless the opinions of children of such a young age, in the context of previous observations they may have been coached as to how to respond to Department questions, would have to be of little to no value in the assessment of the family.

The family were deemed to be very cooperative with the Department. The Department workers referred the parents to a worker at St Luke's Anglicare to assist them in dealing with a duel diagnosis for a mental health assessment and assistance with their drug use. The worker to whom they were assigned was Nadia Ghadab.

On the 19th of February 2004 it was arranged for Ms Ghadab to assist by taking the family to their Drug and alcohol appointment, organising a withdrawal nurse to start work with the parents towards alternative pain management strategies and assist them in obtaining accommodation through Mallee Accommodation Support Program. It would appear that all appropriate measures were being put in place.

On the 20th of February 2004, the Department received a notification from the police that Ms F had been observed at a local shopping centre in Mildura and appeared substance affected. At the time, Rory was with Ms F, and he appeared well. At 1.10pm that day the workers attended the home in order to ascertain Ms F's current state and ability to care for the children, following the concerns raised earlier in the day.

During the visit, which lasted for an hour, Ms F remained in an unconscious state on the couch. Mr S explained that Ms F had been given Tremal by their doctor for a migraine and this was the reaction to the medication. It was agreed that, whilst in this state, Ms F was not in a suitable condition to appropriately care for the children. In addition, Mr S complained of being in extreme pain as his normal medication had been stopped and he had been in bed for the previous four days in pain. He conceded that in this condition, he too was unable to attend to the needs of the children. Mr S stated he would be seeing another doctor that day with a view to obtaining more pain relief medication and would continue to attend appointments with Drug and Alcohol Services. Mr S was agreeable for a voluntary placement of the children in out of home care over the weekend to permit

Ms F and himself to get over withdrawal symptoms. He stated he was not on prescription medication that day. He presented however, as slurring his speech, which the worker felt could have been attributed to the pain he was in and the withdrawal of medication. In my view it could equally have been attributed to misuse of some form of medication.

The worker organised to attend later in the day to speak with Ms F. On re-attending the premises later in the day, the workers found Ms F still in a substance affected state. After discussion, Ms Kelly agreed to a voluntary placement of the children over the weekend period. If such placement had not been agreed to by the parents, the Department worker had been instructed by her superiors that the children were to be removed anyway and a Protection Application made.

The children were originally all placed together with the one carer, but this placement broke down after just one night. It appears the carer's were not otherwise advised of the significant needs associated with the care of Rory who was displaying pronounced autistic characteristics of rocking, tuning out and grunting and was distressed and difficult to settle.

The arrangements were changed with T remaining in her current placement and the boys were placed with a family who had better skills in coping with a child with a disability.

It was clear the family were suffering financial hardship as well as their other difficulties. Mr S had received a substantial compensation payout as a result of injuries received in a work related accident, but the money had been spent on a business venture that failed. The fact of the payout however, limited the family's access to social security benefits and community housing. This was another obstacle that the Department and others were attempting to negotiate on behalf of the family.

An appointment was arranged for Mr S to attend upon a Doctor Sandy Brady. Doctor Brady communicated her concerns to the department worker Ms Angela Giannakoulpoulos following that consultation. She had noted Mr S was "benso" dependant and was on Diazepam, temazepam and tamax to sleep. He took Oxazepam for anxiety during the day and was usually prescribed OxyContin. His permit for the supply of this latter drug had been cancelled on the basis that Mr S was selling the drugs. Dr. Brady offered alternative forms of medication to Mr S but he was insistent that he receive OxyContin and went on unsuccessfully with his demands for two hours.

It must have been demonstrably clear to the Department that both Mr S and Ms F had significant and long standing addiction and misuse of prescription medication and had certainly done little in the past to overcome this fact or seek alternative remedies for the symptoms they otherwise suffered from.

A file note of the 23rd of February 2004 read "the pattern and history of harm documented in the current notification indicates that without **extensive assessment** of the level of risk to the children, they should remain in their current vol (sic- voluntary) placement. **Case management alone will not ensure the safety of these children".**

The children were examined by Doctor Shetty on the 1st of March 2004 and were all found to be healthy. A referral was made to a paediatrician regarding possible concerns that Rory was suffering from autism. It was further organised for the children to have access with their parents that day.

Subsequent to that access visit, Ms F made an attempt at suicide, by overdosing on 27 one milligram serapax tablets and was transferred to the Queen Elizabeth Hospital in Adelaide where she was admitted. Ms F was later discharged and returned to Mildura on the 5th of March 2004.

The worker allocated the file at this stage was Ms Giannakoulpoulos and she was the author of the majority of notes contained in the Department file from thereafter. The following bullet points are extractions from the file material as to the salient aspects recorded as to the parents having addressed the issues that gave rise to the protective concerns:

- 3rd of March 2004 Mr S advised case worker that he has started to make the appointments that he was asked to do and has his first appointment with the physio this Monday for rehabilitation
- He had also made appointments for withdrawal and is no longer smoking marijuana
- Nadia (Ms Ghadab) is to write a letter for them to attend drug and alcohol appointments
- 5th of March 2004 concern expressed by Mallee family Care worker that Mr S appeared substance affected at time of access visit with children
- 5th March 2004 Ms Kelly discharged from hospital in Adelaide and returned home
- 5th March 2004 discussion between Ms Giannakoulopoulos and Ms Ghadab as to progress of the family and noted that Mr S was to make contact with Drug and Alcohol services in order to make an appointment for him and Ms F in regards to their dependency to prescription medication and marijuana use.
- 5th of March 2004 a referral had been made by a paediatrician for Rory to go to Early intervention and the children were to remain in out of home care on a voluntary basis for a further 14 days
- 5th of March discussions with Mental Health services to ascertain if Ms F had been referred to them. Mental Health indicated would only become involved with Ms F if she made contact with them, and the same applied with Mr S.
- 5th March file note stating the family were currently engaged with the St Luke's Strengthening Families program. **That program and case management alone may not be sufficient to ensure the children's ongoing safety in the long term.**
- 10th March Ms F advises she had missed her appointment with mental health that day as she had missed the bus into town but had rescheduled the appointment for the next day. Ms F advised a house had been approved for the family to move to
- 12th of March Ms Gabada advised waiting for a psych assessment prior to setting up an appointment for Ms F with Dr Brady
- 15th of March worker from Mallee Family Care advised the voluntary placement agreement runs out on Friday and the children will be returning home and the placement could not be extended further. That observations had been made when the children were returned from access with the parents the mother Ms F was alcohol affected and had a can in her hands and also noted another can in the car, which Mr S would have been drinking.
- 17th of March Ms Ghadab advised Ms Giannakoulopoulos that Ms F had attended her mental health assessment yesterday (*I note this is contrary to what Ms F had previously advised that her appointment had been rescheduled for the 11th of March)*

- The family had not attended any further appointments with Drug and Alcohol since Ms F's crisis
- 18th of March case notes detail amongst other matters that the parents have completed all set tasks, Ms F has had a full psych assessment and will have a full medical assessment and no identified risks of children returning to the parents on the 19th of March as organised.
- Ms F denied having been drinking on the day of access stating that it was her sister and Mr S had also not been drinking
- 18th of March the children return to the parents and the family move into the new accommodation the following day
- 29th of March Ms Giannakoulopoulos conducts a home visit and made the notations from discussions that Mr S missed an appointment with an anger management consultant as the car was not working, and Ms F missed a mental health appointment for the same reason. There was to be a change of doctors as the current doctor would only provide Mr S with Panadeine forte for pain management
- 31st of March discussions between Ms Giannakoulopoulos and Ms Ghadab in relation to closure of the case. Ms Ghadab was not in favour of such a course as she had not seen the family for a week and believed they have not had an opportunity to be a family in the new house. File should remain open for a further week.
- 7th of April 2004 Ms Ghadab reports to Ms Giannakoulopoulos that "the family are going great at this time" and that she can continue to work with them for some time on identified issues
- 19th of April Ms Giannakoulopoulos attends final home visit to advise parents the case would be closed. Ms Giannakoulopoulos praised the family for having done so well and completing all of the required tasks. Ms F indicated they will not become involved with the system again as their circumstances had changed but she would continue to obtain assistance from Ms Ghadab of St Luke's
- 20th of April 2004 Case closure summary notates the reason for closure was there was no current significant risk issues identified for the children due, amongst other matters, to the parents engaging with a local doctor who was monitoring their prescription drug use which has been successfully reduced with the assistance of Drug and Alcohol Services and the mother Ms F, was linked in with Mental Health Services for treatment and the parents have otherwise successfully completed all required tasks and the children present as well cared for.
- Immediate safety is currently demonstrated with harm probability assessed as unlikely given the above

On the 20th of April 2004 the Department wrote to the parents advising them as follows:

"that following the completion of our protective investigation in relation to concerns that had been expressed to us about the care of "A", T and Rory, Protective Services will not continue to be involved with your family".

The case was therefore closed. Ms Ghadab, of St Luke's was also advised of the end of the Departments involvement with the family and the understanding that Ms Ghadab would continue to provide long term assistance to them. The correspondence from Ms Giannakoulopoulos to Ms Ghadab further requested that if Ms Ghadab felt any protective concerns were raised in the future the Department would be contacted.

The reason I undertook such a detailed analysis of the records of the Department was to ascertain to what extent they had otherwise been involved, such that closure of the case was deemed acceptable after such a short engagement in light of the presenting issues of significant risk to the children.

The first true involvement with the family began on the 6th of February 2004, at which point in time everything, on the surface, seemed fine. On the 20th of February 2004, Ms F was found to be in an unfit state due to the ingestion of prescription medication and Mr S conceded, he too was unable to care for the children due to pain management issues. A voluntary placement of the children to out of home care then took place. This placement was originally only to be for a weekend but the children remained in that out of home care until 18th of March when they returned to the parents. The parents now had a home to live in that was suitably furnished and the like. As of the 31st of March, not even 2 weeks after the children had been returned and the Department worker had only attended the home on one occasion, the Department was looking to close the case.

As detailed previously the case was finally closed on the 20th of April 2004, less than three months after the initial involvement with the family. The reasons outlined in the closure summary namely that the family had addressed all protective concerns was not supported in the material.

It is clear the Department records are meticulous in terms of documenting every conversation, attendance or attempts thereat. The parents were said to have involved themselves with Drug and alcohol counselling. There was little evidence to support that these engagements had actually taken place and what the outcomes had been. There is a reference to the parents participating in one such session but thereafter there is only a reference to the fact such counselling should take place. A file note reflects that following the attempted suicide by Ms F, neither party had engaged further in any drug and alcohol counselling. There is no notation by the worker Ms Giannakoulopoulos in her notes of ever having checked if the parents were engaging with a counsellor and the success or otherwise.

There is a notation for the need to involve a withdrawal nurse with the parents, but no evidence this ever took place. There is discussion of organising assistance for Mr S with alternative pain management strategies, but again, with the exception Mr S stating he had a physiotherapist appointment, there is no notation to confirm this actually occurred. Pain management was clearly the core reason as to why Mr S. required on going medication such as OxyContin.

The conclusions also state the family were now engaged with a Doctor who was managing and monitoring their use of prescription medication. There are no file notes to confirm this. There are also no documented conversations with the Department worker and either Mr S or Ms F as to what medication they were being prescribed at that time.

There was a reference to Ms F being engaged with Mental Health Services but there was no record of a confirmation of this by the Department. As was usual, Ms Giannakoulpoulos accepted this was occurring on the basis of what Ms F said or what was relayed to her by Ms Ghabad, who was also acting on the word of Ms F. There is a reference to Ms F attending some appointments, but how many and whether they were ongoing and regular is not clear. This is of particular concern, as it was clear a significant reason for Ms F's reliance on medication was due to mental health issues.

At the outset, the Department had more than adequate information to issue a Protection Application with the Courts, but instead chose to work with the family on a voluntary basis. It was clear early on the family were not co-operating with the Department when they claimed to have stable accommodation and they did not and continued to move to different locations and not inform the Department. The family were avoiding the involvement of the Department.

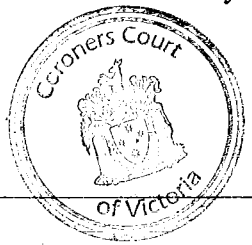
A protection application should have been instigated which would have allowed for mandated requirements of attending drug and alcohol counselling and dealing with mental health and pain management issues. The Department would have then had a truer appraisal of the parent's participation. In addition the involvement could have extended for a period longer than three months to ensure that the progress they believed had been made was maintained.

It is also of concern that much of the engagement with the family and particularly the parents was delegated to a worker from St Luke's. It is unclear what Ms Ghadab's qualifications were for dealing with people who presented with the issues such as those of Mr S and Ms F. It is also concerning that, it appears the Department workers who had involvement with the family, readily accepted the words of the parents.

It was not possible to obtain a statement from Ms Ghadab or have her called at the inquest as she could not be located. The file notes taken by Ms Ghadab were obtained by the Court. The notes largely reflect the record of engagement with the family as detailed in the notes of the Department. The concerning features of those notations is that on the 29th of April 2004 Ms Ghadab attended the home of the family for a scheduled visit but there was no one at home and they could not be contacted by phone.

The next record of the 4th of May 2004 relates to a telephone call received by Ms Ghadab from Ms Giannakoulpoulos wherein Ms Giannakoulpoulos reported that Mr S had attended the Department offices that day feeling suicidal. Mr S stated he had been to Mental health who had suggested he see a psychologist for pain management, but this was not possible as Mr S did not have the $120 needed for each visit. He queried if the Department could assist. He was advised by Ms Giannakoulpoulos that the Department could not as they were no longer involved as the case was closed.

Ms Giannakoulpoulos requested Ms Ghadab advocate on Mr S's behalf. A further file note indicates Mr S attended upon Ms Ghadab shortly after the visit on Ms Giannakoulpoulos and Mr S. explained the combination of difficulties that he and Ms F were currently facing. The car was unreliable and hence made attendance at appointments difficult to achieve, Ms F was unwell having been diagnosed as suffering from Hepatitis C and Mr S had feelings of suicide. As Ms Ghadab noted "things had fallen down somewhat". Ms Ghadab spoke on Ms S's behalf to Mental Health services and organised an appointment for Mr S to attend. It was hoped that through mental health Services involvement they could negotiate Mr S's attendance upon a psychologist.



Following the visit at the office with Ms Ghadab, it was organised she would make a home visit to the family two days later. On the morning of the scheduled visit the parents telephoned Ms Ghadab to advise they would prefer to call into her office rather than have her attend at their home. This was agreed, but the parents failed to make the appointment as scheduled. Ms Ghadab attempted to phone the parents but there was no answer. On the 10th of May 2004 Ms Ghadab again attempted to call the parents without success.

On the 20th of May 2004 the notes record that a phone call was received by Ms Ghadab from Ms Giannakoulpoulos who stated the file on the family had been closed by the Department. Ms Ghadab informed Ms Giannakoulpoulos that the family had "disengaged with St Luke's for now though the opportunity for the family to make contact still stands".

Ms Ghadab made a further attempt to contact Ms F by phone on the 24th of May 2004 and when this was again unsuccessful, Ms Ghadab wrote to the family indicating her intention to close the case, which officially occurred on the 11th of June 2004.

In all the copious and thorough notes as otherwise kept by the Department, there is no reference to those two additional contacts between Ms Ghadab and Ms Giannakoulpoulos, which were of course subsequent to the closure of the case by the Department. It is clear that those notifications should have demonstrated that the family were heading towards being in crisis, if they were not already, and the children were again at risk.

The Department no doubt relies upon the fact that it was some 15 months from when they had been involved with the family and Rory's death. In that period no notifications had been received. It is clear that subsequent to the involvement of the Department, the family again spiralled out of control in terms of the parent's misuse of prescribed medication, whether it had in fact ever stopped. It is not clear how quickly this occurred, but it is clear that at the time of Rory's death the parents were presenting in the same state as previously, namely being often too drug affected to adequately care and protect their children from harm.

Evidence taken at the inquest as to the Departments involvement

At the inquest two of the workers from the Department who had direct involvement with the family were called to give evidence. As Ms Giannakoulpoulos was unavailable to give evidence and as such, Mr Wilson attended as being the representative of the Loddon Mallee region of child protection for whom Ms Giannakoulpoulos worked. It was Mr Wilson who was assigned the task of assisting the court as to the role undertaken by the Department whilst the family was resident in the Mildura region.

Ms Rosemary East, a worker with the Department gave evidence of having been present at the time of the contact with the family on the 11th of June 2004, when she was called out by after hours following a police notification. Her involvement was limited to the extent as outlined earlier. She stated that following the events of that day she no longer had any involvement with the children. Ms East was therefore questioned on the usual practices when dealing with families. Ms East was asked

if, had she otherwise been the person responsible for the case, in the event the family were suspected of having absconded to a particular area, whether she would not only put an alert on the system but would also follow up with the police in the local area. Ms East confirmed that she would.

Ms East was asked questions about the referral of families to outside agencies for assistance. Ms East confirmed this would occur, but they would be monitoring to ensure that people were linked with the services and following through with requests. Ms East indicated she could not speak on behalf of what agencies and referrals were in place for the Loddon Mallee region and could not recall what the case practice was in 2004. She stated the current case practice is to establish a 28 day case plan meeting whereby within 28 days of the investigation commencing the family would be linked in with the services they required. In the event they were satisfied the family were achieving what was required they would then refer them to an outside organisation for ongoing monitoring.

Ms East spoke of the organisation Child First that operated in her region in terms of referrals. Ms East elaborated on the work undertaken by Child First, which was largely centred on parenting issues and parental support. The involvement of families with Child First is still monitored by the Department, and a worker oversees all those notifications and their involvement. Ms East was asked to confirm, that if the parents presented with a severe drug habit that placed a child at risk they would not be sent off to Child First. Ms East responded that such a referral would not take place unless the parents had worked with them for a while and were at a point that the Department felt they could be moved across to Child First, where they could be monitored. Ms East further stated that prior to this occurring the parents would need to have already been linked in with support services and working well with them and their drug use had been reducing and that had been maintained for a period of time.

It is clear none of these criteria had been met prior to the management and monitoring of the family being left with St Luke's Family Care. There also appears to have been no planned follow up with St Luke's albeit the two occasions when there was contact between the St Luke's worker and the Ms Giannakoulpoulos , when no further action was taken by the Department on the grounds the case was closed.

The next witness called from the Department was Ms Merrilyn Bartkus who stated she had reverted to the use of her maiden name of Glynn and indicated a preference to being addressed by that name. Ms Glynn's involvement with the family occurred from the first notification on the 20th of October 2003, where although she was not the assigned case worker at the time, Ms Glynn participated in the interviews with the parents and the two older children in relation to protective concerns.

Ms Glynn became involved again when she was part of the team with Ms East who attended on the family on the 11th of January 2004. Much of the evidence provided by Ms Glynn centred on the acceptance or lack thereof of the case being allocated to a particular region. The case had initiated through after hours, who contacted Ms East and Ms Glynn to attend. Ms Glynn was attached to the Warrnambool region of the Department, but was not assigned the case directly at any point in time. Ms Glynn continued to be involved however, as the family and placement carers had no other contact details for the Department apart from Ms Glynn.

As was detailed previously from the case notes and confirmed in the evidence of Ms Glynn, shortly after the children were placed temporarily with a family member in Ballarat the parents moved down to join them. As the parents expressed an intention to become resident in Ballarat it was felt the appropriate allocation of the case was to the Ballarat office.

Ms Glynn's recollection was that her team leader was having discussions with Ballarat about the transfer of the case and that Ballarat would only accept the case if they could establish the parents were settling in the area. Ms Glynn stated she remembered being frustrated at the time because the case needed to be transferred and someone needed to take responsibility for it. It is clear it was not Ms Glynn responsibility to organise or manage the case as it was never assigned to her and as she commented herself "no region took responsibility for the case management of this case while it was in this phase".

As Ms Glynn noted from her own perusal of the Departments file, Ballarat had at some point assumed some level of involvement in the sense they attempted to make contact with the family and on being advised the family was on their way to the Mildura region the case was closed.

In summary as I see it the second notification occurs on the 11th of January 2004, the children are placed with a relative on that day with the understanding it is to be a short term option. The following day that relative contacts Ms Glynn as being the only contact she has indicating she can no longer care for the children. On the 13th of January 2004 the parents were permitted to take the children back into their care to reside at a caravan park and the file notes indicate this was to be reviewed the following day. At this point the file notes reflect that little or no contact was had with the family until the 16th of January 2004 when a phone call was made to the father. It appears nothing of a satisfactory nature was achieved from the 11th of January until the case was closed due to loss of contact with the family. The time in between had been spent with various areas of the Department in dispute as to who should take responsibility of the case until it was effectively too late and the family had left the area yet again.

In evidence Ms Glynn stated that the failure of allocation of a case would not occur today as there would be immediate contact with the region to which the case was to be referred by electronic transfer and discussion. Ms Glynn expressed the opinion that cases are not left to "drift".

Ms Glynn was questioned as to what her practice was in relation to referral of families to outside services and she indicated she would wait and assess the parent's participation with any such referral and ensure that risks that had been assessed had been addressed.

It was Ms Glynn's assessment at the time of involvement with the family on the 11th of January 2004 that a protection application needed to be made. The decision of the intake leader was for this not to occur, stating it would be better to obtain a voluntary agreement with the parents and the case would be allocated the next day for investigation and follow up.

It is unclear why the decision was made not to issue a protection application at that time given the background of this family. They had presented as being transient and there were the significant concerns raised of the environment in which the children had been residing and the fact the notifications indicated the parents were often too drug affected to properly care for the children. All these factors point to the need for such intervention.

There was questioning into what "alerts" had been made following the movement of the family to the Mildura region. As reflected by the notes, no alerts had been made to the Departments officers in Mildura where the family were suspected of travelling to and no notification to the police or schools in that area.

Ms Glynn explained that when the location of a family is unknown, an alert is raised on the Child Protection computer system and then the Department wait for a further notification. The only people who have access to this information are Department workers. In my view such "alert" can have little utility if such information is not more broadly shared with members of the police or schools who could access the information when new children came to their attention in an area. All that happens is the Department can and do little, until such case as another notification as to children being exposed to risk is again made.

The final witness called from the Department was Mr Shane Wilson who attended as the representative for the Loddon Mallee region. Mr Wilson had not himself had any involvement with the case, but had prepared a statement from the notes on file.

Mr Wilson confirmed that his review of the notes indicated that the case was opened again in the Loddon Mallee region in February 2004 following contact by the police and a colleague in the Grampians region. He stated in his evidence that as the exact location of where the family intended to move to was unknown, a formal transfer of the file could not take place. I find it hard to accept this as it was clear the family had a prior association with Mildura, the maternal grandmother lived there and additionally Mr S himself had stated he was going to stay with his brother who lived in Cabarita, a location close to Mildura. I would have thought this would have afforded more than ample information to justify a referral of the case to that location, with a view to investigations being undertaken as to the family's whereabouts.

It was put to Mr Wilson that although the family may be transient it would still be an obligation on the Department to make relevant inquiries with other family members in an attempt to locate them, to which Mr Wilson agree that such a practice should be encouraged.

It was clear Mr Wilson had, along with others who were overseeing the file, placed enormous reliance on the favourable case closure summary, which was supportive that protective concerns had been addressed and significantly overcome.

Mr Wilson was asked, if had the Department been made aware of the family disengaging with St Luke's, whether that would cause some concern. Mr Wilson responded that it would have required

Child Protection to reconsider what that meant in terms of risk for the children. Mr Wilson further stated that given the history with the family, the Department would have seriously reviewed whether they became involved again or not. Mr Wilson was unaware of the documented conversations between the St Luke's worker and Ms Giannakoulpoulos following closure of the case by the Department.

Mr Wilson put a lot of faith in the fact that for the 15 month period between the Department's involvement ceasing and Rory's death the Department had not received any notification. On that basis he expressed the opinion the family was able to function and live within the Mildura community with the supports around them without any further reports being made to Child Protection. The comment I make on that view is the children may not have come to the attention of the Department but it cannot at the same time then be assumed that the family was necessarily functioning in an appropriate manner without risk to the wellbeing of the children.

I enquired of Mr Wilson what involvement the Department had with the family following Rory's death. He stated the two siblings had been subject to protection orders and had remained out of the care of the parents since the time of Rory's death. The parents had, since Rory's death, had another child, a girl E, who was also subject to protection orders and also not residing with either parent. I enquired what were the protective concerns that meant the children continued to remain out of the parents care for a period of five years at that time. Mr Wilson indicated that he understood it was in regards to parental substance abuse and the impact that has on the parent's ability to care for the children.

Mr Wilson was taken through the files and on many occasions had to concede there was no supporting material contained therein to otherwise confirm and support the comments made in the case closure summary.

At the inquest the sibling "A" was called to give evidence. He gave evidence that at the time of Rory's death, he would usually be responsible for getting his own breakfast and breakfast for T and Rory. It was usual for him to make his own lunch and that he got himself ready for school and made sure that T was with him to take the bus. There was also evidence that "A" would walk to the shop to get food. He stated on the day of Rory's death he had suggested that he would go to the supermarket to purchase food for dinner, but his father had told him it was too late in the evening.

It appears to me that both A and T were largely self sufficient such that they could organise food for themselves and get themselves to school. This is possibly one reason the family did not otherwise come to the attention of the Department in the intervening period of 15 months.

The involvement of the use and abuse of prescription medication

The initial prescribing of pain relief medication to Mr S was as a result of a significant injury he suffered to his back. The evidence is Mr S suffered a back injury when working that required an operation to fuse some of the discs in his spine and two prosthetic discs were implanted along with

some pins being inserted. Some time after this Mr S was involved in a motor vehicle accident, which further exacerbated the problems with his back. It was at this point he became reliant on morphine based medications to deal with the pain. There was therefore, a genuine basis upon which it was that Mr S was said to need medication such as OxyContin.

It was clear at a time following the Departments closure of the case however, that the misuse of prescription medication remained high with both Ms F and Mr S. A neighbour, Mr James Newman, made a statement where he detailed that Ms F would come to his house and walk in and fall asleep on the floor or at the kitchen table. It was his impression that at these times Ms F was affected by drugs, but he was unaware of what those drugs may be. He stated he had seen Ms F in this state approximately five times over the preceding 8 months.

He was aware Mr S was also on prescription medication and believed that Mr S was dealing drugs and he recognised people who attended the house as people he knew who were morphine users. In addition the number of people who would attend and only stay a short time further emphasised his suspicions.

At inquest Mr James Newman gave evidence that most of the times that he saw Mr S or Ms F they appeared affected by drug use. Their speech, thought processes and movements were slow. There were times when Mr S would ask for a lift into town and at those times he described Mr S as appearing straight and sober. This was usually once a week when Mr S would go to town to get his pension or do some shopping.

It was clear to me from these observations and other witnesses, that Mr S could, to some extent, control his drug use so that he did not always present as drug affected.

Mr James Newman gave evidence that the children appeared well cared for but were hungry at times and he would feed them. He confirmed they appeared to have bathed regularly and wore fresh clean clothes.

Nathan Newman resided with his father, James and was almost 15 years of age when he made a statement to the police in relation to this matter. Nathan Newman detailed how he and his family had known Mr S and Ms F for some years, having lived near them on a prior occasion. His family moved from there prior location some 5 years before and Mr S and Ms F and their kids moved into his street subsequent to that.

Nathan detailed how when he would visit at the home the place was messy and there was "stuff" everywhere. He stated that on every pay day Mr S and Ms F would be walking around like zombies with their eyes half closed. Nathan was told by Mr S that if he attended the house he was not allowed to go into the main bedroom. On one occasion he did go in he saw pills and marijuana lying around. He described the pills as little orange round pills and thin long white pills and little round white pills.

Nathan stated he had seen these pills in other locations in the house, sometimes just lying around and sometimes in little pill bottles. He had on a couple of occasions seen pills loose on the floor near the television. Mr S had described to Nathan the orange pills were morphine, the long pills he called "oxys" and the little round ones, antidepressant.

Nathan stated he was aware that Mr S was selling tablets to people, as he was present at times when this occurred and that Mr S did not try to hide. He stated Ms F would try to conceal this from the children making them sit in the lounge room.

In the statement made to police by Nathan on the 19th of July 2004 he stated that about four weeks prior to Rory's death Nathan went to visit Mr S and Ms F and described that they were "pilled" off their heads. He states they were falling asleep and waking up and falling asleep again. Nathan took the opportunity to steal some of the pills that were lying lose on top of the fridge. He believed he took about 12 pills in total.

Further in his statement Nathan details that on the Saturday prior to Rory's death, he again attended at the home of Mr S and Ms F and described them as "pilled again and they were just blubbering to me and falling asleep". Nathan took the opportunity to take more of the pills he found in the kitchen.

At the time of the inquest Nathan sought to change his evidence detailing that he had made errors in his statement. Nathan stated in evidence that he was wrong about having stolen pills approximately four weeks prior to Rory's death and that he had only ever stolen the one time. He also amended that the one time was in fact the Friday before Rory's death not the Saturday. This latter change is consistent with the evidence of his father James, who went around to the house of Mr S and Ms F on the Saturday for an explanation as to how it was that Nathan had taken the pills the previous evening.

At the inquest Nathan was also unable to quantify exactly how many tablets he took from the house, just describing them generally as the little orange ones, little round ones and one or two long pills. He stated he ingested all of these with the exception of the long pills, which he gave to his cousin. The pills made him feel very unwell the next day.

Nathan had been shown a photograph of an OxyContin pill, which is distinctive in being a blue colour with an 80 stamped impression. Nathan denied having seen or stolen any such pills.

Nathan denied that he could have dropped any of the pills he took and demonstrated how he has scooped the pills into the palm of his hand, formed a fist and placed his hand in his pocket and left the premises a short time later.

Nathan could provide no satisfactory reason for the significant change in the evidence he gave at the inquest and that contained in his statement. He thought it may have been due to the fact some days shortly prior to making the statement he had consumed a large amount of drugs.

It really is of little consequence as to whether Nathan did in fact steal pills on two occasions or not. He maintained he had been in the house on the Friday prior to Rory's death and took a number of pills at that time.

The younger Newman child William was aged 13 when he made a statement to police. He would go to the home of Mr S and Ms F about 3 times a week to play with A. He stated about 5 to 6 weeks prior to Rory's death he had stopped going to the house as there were too many drugs there. He stated that every time he went there Mr S and Ms F were "on the nod" by that he meant "they keep falling asleep because they are morphed out" from, he suspected taking morphine and other pills. He indicated he would sometimes see pills on the kitchen table and in the bedroom and they would be loose or in bottles. There was also a large number of used syringes that were in cans out the back of the house.

Ms.D, who is the mother of Ms F, made a statement to the police in relation to her knowledge of the use of medication by Ms F and Mr S. Ms D stated that she had been told by Mr S that he sold his OxyContin medication and was paid $50 per tablet or alternatively in jewellery or other items. Ms D detailed she was aware that both Mr S and Ms F were on prescription medication and stated often when they would come to visit her they "were off their faces" which I interpret to mean affected adversely by medication. Ms D. stated that Ms F had said to her that she was concerned with the fact Mr S was careless with his pills. When she was asked to elaborate on that fact when giving evidence at the inquest, Ms D stated that Ms F had told her that she often found pills on the floor in the kitchen at the home.

On an occasion some days prior to Rory's death both Mr S and Ms F and Rory attended Ms D's home. At the time, Mr S consumed a pill in her presence the description being consistent with it being OxyContin. He had taken the tablet from a little plastic container. When asked at inquest if the container had a child proof lid she responded it did not and it was just screw on.

A brother of Ms F, hereafter referred to as Mr F, came to live with the family in the middle of October 2004 and stayed for approximately six months. He detailed his observations of Ms F and Mr S. He stated that they were both using OxyContin and he saw them both inject this into their arm. They would usually be sitting at a table in the kitchen and would tell the kids to go away so that they did not see. Mr F stated they would use the drug this way two to three times during the day. He described how the drug use made them "like zombies, they were just out of it, like vegetables". It was his impression they would not have known what was going on around them. Mr F was also aware that Mr S was selling these OxyContin tablets.

Mr F described how Rory would often wake in the night and remain awake for hours. He described that during his time living with the family that he was the only adult aware of Rory and what he was doing during the night. Mr F commented that during the time he was living with the family Mr S and Ms F "would have been that pilled off and would not have been capable of looking after the children and tending to the needs of Rory or the older children". The drug use occurred everyday and as such the older children were virtually running their own lives and getting themselves ready for school and feeding themselves.

Ms Julie Powell came forward and also made a statement to police, which centred largely on her purchasing of OxyContin tablets from Mr S. Ms Powell made her statement to the police on the 4th of January 2006. Ms Powell stated she would usually purchase one tablet of OxyContin per fortnight for $50 and had done so for the previous 12 months.

On the occasions Ms Powell attended at the home she would usually be in the kitchen when she purchased the pill. At times Mr S had these in little white pill bottles or was carrying them loose. At times he would attend the main bedroom of the house to obtain the pills. She described Mr S as appearing "off his head" most of the time, but Ms F to a lesser extent.

On the day that Rory died, Ms Powell attended at the home with a view to purchasing OxyContin. Mr S indicated that he did not have any but would be getting more later in the day. Ms Powell stated that both Mr S and Ms F "looked waisted" and more so than on other occasions. Ms Powell returned later in the day around midday. She found Mr S to be lying on the mattress in the lounge room and even more affected by drugs than earlier. Mr S stated he had more pills but was not able to locate them and searched for some time. He picked up the pillows and the mattress and Ms Powell saw him locate a loose pill on the mattress. He then went in search of more and as Ms Powell described he appeared to have no idea where the pills were. After Ms Powell made the purchase she left almost straight away as she felt there was no chance of getting any conversation out of Mr S and Ms F, as they were so affected by drugs.

A couple of hours later Ms Powell returned again to the home of Mr S and Ms F to purchase a further OxyContin tablet. Mr S and Ms F continued to appear extremely affected by drugs. Ms Powell described how " I don't think I have seen anyone else look so waisted". At this time Mr S did not even get off the mattress but just reached into a cabinet and removed a pill from a white plastic bottle.

Ms Powell gave evidence that approximately two weeks after Rory's death Mr S recommenced selling OxyContin tablets. Ms Powell stated that Mr S had started keeping the pills in a silver metal container that had a lock. She had never seen Mr S keep the pills in this container prior to Rory's death.

Ms Powell stated that she was aware that following Rory's death Mr S was limited to a daily pick up of his tablets. This did not appear to have otherwise affected his ability to trade in OxyContin as Ms Powell stated she could still obtain the drug from Mr S notwithstanding this fact.

To Ms Powell's knowledge there were at least seven other people she was aware of who were purchasing OxyContin from Mr S. and that she was aware of at least five other people in Mildura who traded in OxyContin.

Ms Powell was asked about how the children appeared and she stated that in her eyes they were well looked after.

Mr S, when interviewed by the police, stated that he usually kept his OxyContin medication in his bedroom or placed high up on a shelf of a cabinet in the lounge room. He stated that he had in the day or so prior to R's death had a large number of pills stolen. As a safety measure he removed all the remaining pills from their blister packs and placed them in a small container with a screw top lid. He then locked this container into a tin and kept the key on him at all times. That explanation was not consistent with the evidence found by the police.

At the time of R's death the police inspected the premises. They found two screw top containers with a total of 15 OxyContin tablets hidden in rolled up socks in a drawer of a bedside table in the bedroom. On top of that table were the empty OxyContin blister packs. A white powder was seen on the carpet directly in front of this bedside drawer, which on subsequent analysis was found to be OxyContin.

In addition there were other plastic containers with pills stored on top of the fridge in the kitchen. There were no OxyContin tablets amongst these, however, Detective Senior Constable Buick gave evidence they were all otherwise prescription medication belonging to either Mr S or Ms F. He indicated some of the tablets were valium and other prescription medication. In the lounge room was a plastic bag that contained two unused syringes. There were also numerous spoons located throughout the premises, which were tested and found to have traces of Oxycontone on them. These spoons were found on the floor of the lounge room, kitchen bench and in the kitchen sink. In addition there was a cup on the kitchen bench with white powder residue that was found to be OxyContin. These items were clearly accessible to children.

The administration of prescription medication.

Ms Sally Mareea Keens provided a statement to the police and was called to give evidence at the inquest. Ms Keens is a pharmacist by occupation and was often responsible for filling the prescriptions presented by Mr S. During the cross-examination of Ms Keens she stated that it was not the responsibility of the pharmacist to ensure the appropriate medication was being prescribed, but more to ensure the patients understood the appropriate dose and if required that a permit existed entitling the treating doctor to prescribe the medication to a patient.

Ms Keens advised that OxyContin is a schedule 8 drug in the Drugs, Poisons and Controlled Substances Act 1981 and as such in the event a person is to be prescribed the drug for a period in excess of 8 weeks a permit needs to be obtained from the Department of Human Services permitting such prescription. Ms Keens indicated she had confirmed with the Department that such a permit existed for Mr S and as it did, she was able to supply the drug in line with the prescription.

Ms Keens was asked about the packaging of OxyContin in a blister pack and she indicated that such was not uncommon with schedule 8 drugs and she named Endone, being another form of oxycodone, Ms Contin and Kapanol both of which were morphine based drugs as also being dispensed in blister packs.

Ms Keens was asked if she could recall if Mr S ever appeared drug affected at the time he attended her pharmacy and she stated she could not.

Mr Justin Yodart Lam provided a report to the court in his capacity as Manager Treatment Approvals and Projects within the Department of Health, Drugs and Poisons Regulation group. He re-iterated the evidence of Ms Keens as to the requirements for a permit to be issued when prescribing a schedule 8 drug such as OxyContin for a period in excess of eight weeks.

At the inquest, Mr Lam confirmed that his department are almost entirely reliant upon the treating doctor making the appropriate clinical assessment as to a patients need for such medication. The method by which his department ensures that a person is not receiving the same medication from a number of doctors is their internal checking to ensure only one permit is in existence. It therefore requires the doctor to be fulfilling the legal requirement of obtaining the permit in the first place.

I enquired of Mr Lam whether his department had any method of monitoring the number of prescriptions that may be written for certain medication to discover if, for example, there was a disproportionate number being obtained in a particular location such as Mildura or a disproportionate number being written by any particular medical practitioner. Mr Lam stated there was no routine monitoring system in place, but did agree that such a system may be of benefit.

Currently it is the situation that the legislation places the onus on the doctors to act appropriately. He conceded that at times some doctors do not comply with the legislation and his department are unaware of this unless alerted by the pharmacist who is being sought to dispense it. He stated it is not, however, the pharmacists' responsibility to confirm a permit is in place. When question if, in his view, such a requirement would be of assistance, he responded that such a task would be too onerous on pharmacists. I agree with that proposition as no doubt there are a vast number of prescriptions written for schedule 8 drugs and I would anticipate most would be done according to the appropriate legal requirements.

Mr Lam was asked if his department would be concerned if a patient had been prescribed a particular schedule 8 drug over a ten year period. Mr Lam stated that they would contact the doctor to advise that the patient should be seen by a pain specialist to confirm the ongoing need for the medication.

It was confirmed with Mr Lam that benzodiazepines such as valium and serapax were not schedule 8 drugs and as such no permit was required, notwithstanding their possible addictive nature. Mr Lam again indicated his department were reliant upon the doctors who otherwise prescribe such medication or any notifications the department may receive from pharmacists who may have some concerns.

The difficulty as I perceive with this last proposition is the pharmacists rely, as with the Department of Health, on the professional opinion of the doctor and are therefore unlikely to doubt such opinion. In addition for a pharmacist to raise a concern the prescriptions would need to have been dispensed by that one pharmacy in order for a pattern or concern as to addiction to arise.

I queried whether random audits were ever undertaken on particular doctors, to which the response was "no" as such a practice would be beyond the limited resources that are available to his department.

Mr Lam was questioned as to how the classification of schedule 8 drugs occurs. Although not directly aware of the evaluation process, Mr Lam stated it was his understanding it was through a Commonwealth body. He believed it was the nature of the product and whether or not it has a potential for misuse or abuse such that there are extra precautions and requirements prior to it being prescribed.

Mr Lam was also asked who made the decision in terms of how schedule 8 drugs were packaged. Mr Lam indicated that again was a decision made at the Commonwealth level. Mr Lam was asked for his opinion as to whether it would be beneficial to have schedule 8 drugs packaged in a child safe container as compared to blister packaging as it related to possible ingestion by children. Mr Lam agreed that it would provide an extra barrier in case a child accidentally came across a packet of tablets.

Subsequent to the conclusion of the hearing of evidence at the inquest Mr Lam provided the court with copies of the permits that had been issued to Doctor Kanandalea Shetty for schedule 8 drugs.

Doctor Shetty, a general practitioner, provided a statement and was called to give evidence as to his professional involvement with the family. He gave evidence that he had been consulted by Ms F since approximately 1990. He commenced prescribing medication over a long period of time to Ms F for depression. Such medication alternatively or in combination consisted of Valium, serapax (both benzodiazepines) and mogadon. In addition Ms F complained of suffering from back pain and as such her prescribed Tramil. Doctor Shetty was asked if he had referred Ms F to a psychiatrist to treat Ms F's depression and he responded that if is for doctors to treat depression.

Doctor Shetty indicated that he was aware Ms F was dependent on benzodiazepines. It was suggested to Doctor Shetty that given this dependence it would have been appropriate to seek to withdraw the medication or arrange for her to attend drug rehabilitation to overcome the addiction. Doctor Shetty stated that such rehabilitation is not possible when a person does not want to comply and that was the case with Ms F.

Focusing on the period in 2005 the medication being prescribed to Ms F at that time was much the same, with the occasional attendance at his surgery to obtain a morphine injection for flare up of back pain.

Doctor Shetty agreed if the medication was not used appropriately it could cause a person to be drowsy but stated he had never observed Ms F in that condition.

Doctor Shetty was contacted by the Department at a time following the death of Rory when Ms F had given birth to another child. He was contacted by the Department to enquire if Ms S could cease her medication. Doctor Shetty stated to the Department that she could. Doctor Shetty further gave evidence that Ms F cut down her use of benzodiazepines because the Department took her child away from her, but could not completely go off the medication.

Doctor Shetty first saw Mr S as a patient in 1997, at which time Mr S was seeking medication for pain that was associated with a significant back injury he had suffered in approximately 1994/1995. Doctor Shetty confirmed this information with Mr S's surgeon who performed the operation and on the basis of this information, along with the advice that a Doctor in Queensland had also been prescribing such medication, he commenced Mr S on the morphine based drug Kapanol. At some point in time Mr S was changed to OxyContin, as it was a stronger drug for pain management.

At times Mr S was also on Temazepan, tramil, valium with the occasional fortnightly visits for an injection of morphine when the pain would flare up. Mr Shetty was asked if he was suspicious that Mr S may be selling the medication to others. Mr Shetty indicated that he was, but felt powerless to do anything as Mr Shetty would attend in what appeared to be serious pain and needing medication. He described it as a "Catch 22".

Mr S consulted with another Doctor for a period of time and returned to Doctor Shetty on the 15th of July 2005 requesting a prescription for a 1 month supply of OxyContin that equated to 60 tablets. Mr S stated that another doctor had given him monthly prescriptions. On the basis of Mr S's statement and following a check to ensure a valid permit existed Doctor Shetty wrote the prescription. On that same day Doctor Shetty gave Mr S two sample tablets of Stilnox, a very strong sleeping tablet.

Doctor Shetty was asked if he had ever considered referring Mr S to a pain management clinic, to which he responded he had not as he did not believe in Mr S's case such a clinic would have anything to offer. As the back injury had not been overcome with surgery and Mr S continued to experience pain it was his view that "There is no alternative. Either you suffer the pain or you take the drugs".

Doctor Shetty was also the doctor to young Rory. He stated the last time he had seen Rory was on the 12th of May 2005 when he had attended with his mother in relation to symptoms of vomiting, diarrhoea and a cough. He provided treatment that was appropriate. The Doctor stated that Rory was not otherwise an overly sick child.

Doctor Shetty confirmed he had made a referral for Rory to a Paediatrician on the attendance of the father at his surgery with a request for same. He had not had any involvement or contact from St Luke's Anglicare. He later stated that a second appointment made with the paediatrician had not been attended.

Doctor Shetty was asked if anyone, around February 2004, from St Luke's Anglicare or the Department of Human Services had ever verified that there had been a reduction in the drug use by

Ms F or Mr S. He indicated that there had not. Doctor Shetty was further questioned as to whether anyone from again either of those organisations had asked him to manage their medication with a view to reducing it. Again he responded that he had not.

There were questions of Doctor Shetty in relation to the manner in which drugs such as OxyContin were dispensed in blister packs and if there could be an alternate packaging that would ensure a greater difficulty for access by children. Doctor Shetty stated, as far as I understood his evidence, that originally such medication was dispensed in ordinary screw top containers. Subsequent to pressure being applied by the medical profession the companies were required to put the medication in blister packs for dispensing. Doctor Shetty stated that it is very hard for a child to get tablets out of blister packs. He did go on to say that if the drugs were in a child proof safety container this would be a good idea.

COMMENTS

Pursuant to section 67(3) of the Coroners Act 2008, I make the following comment(s) connected with the death:

The primary focus of this enquiry was to review the role of the Department of Human Services as to their involvement with the family and to assess what part the misuse of prescription medication by the parents may have impacted on Rory and his siblings well being.

It is clear that Rory died as a result of having ingested Oxycodone medication in the form of a single OxyContin tablet. It remains unclear as to how it was he came to ingest such a tablet and at what time. There are however, no sinister connotations to be drawn, it was an accidental event.

One of the objectives of a coronial enquiry is to seek to establish if changes can be implemented to avoid a death occurring in similar circumstances. It is important when performing this function not to lay or apportion blame.

The involvement of the Department of Human Services

As detailed in this finding, the Department first became involved in late September of 2003 following a notification in Mildura that the parents were abusing drugs and /or prescription medication such that they were unable to properly care for their three children. The family were located in the Camperdown area and following an investigation, which consisted of one interview with the parents and one with the children the case was closed on the 1st of December 2003. This closure was due to the Department being satisfied that the protective concern they identified as a lack of appropriate housing had been addressed. It turns out it had not, and the Department would have been aware of this if they had maintained some form of contact with the family in the intervening period prior to closure. There was no investigation into the issues of misuse of medication which was primarily the basis upon which notification had been made. The workers too readily accepted the answers and explanations provided by the very family they were investigating.

The second notification came to light when the family moved back to the Camperdown area and were residing in a converted bus in the backyard of a friends premises. This was on the 11th of January 2004. Department workers visited the family at this time and found the parents were in a drug affected state and the living conditions raised concerns for the health and safety of the children. As a result of a voluntary agreement the children were placed with a family member in Ballarat. It is unclear why it was that, at this point in time, a Protection Application was not made given the extreme and significant risk factors that had been exposed, which were identical to those relating to the first notification.

The placement of the children with a family member quickly broke down. In the mean time the case remained "unallocated" as issues arose within the Department as to which region would assume responsibility, given the transient nature of the family. The case should have been allocated to someone initially regardless of where the family were ultimately to be resident. Due to this unsatisfactory state no one was appropriately managing the case. One of the workers who had attended as part of the after hours team, became the liaison person.

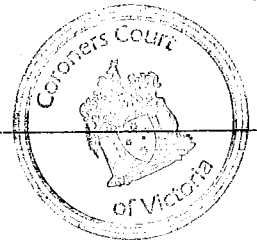
Notwithstanding the significant issues identified, the Department agreed the children could return to the care of the parents when it was clear the relative could no longer assist. It is unclear why the Department again did not make a Protection application and take the children into safe custody and place the children in out of home care.

The children were permitted to be returned to the care of the parents with the indication a worker from the Department would make contact with the parents the following day. There are no files notes as to any attempts of contact with the family until the 16th of January 2004. On the 16th of January 2004 a phone call was made to the father who indicated they were travelling to Cabarita a location near Mildura to visit a relative. He could not provide an address of this location but advised the worker to call him back. Future attempts to make this contact were unsuccessful and as a consequence the case was closed without investigation with the following notation "Should further notification be made with current address details then consideration should be given to reopening case (if it is clear risk is still evident)". There was then a failure to place any alerts on the system and no attempts were made to locate the family.

In my view the risks remained clear and evident and an attempt to locate the family should have been done immediately. The Department had sufficient information at its disposal to undertake such a task.

The Department did ultimately locate the family in Cabarita using that information, but it was only instigated following a police officer involved in the Camperdown "bus" notification calling the Department and indicating his anger on being advised the case had been closed.

It is not uncommon for families to not co-operate with the Department or to leave the jurisdiction to avoid involvement. In situations however, when risk remains high the case should not be simply



closed, but active measures should be undertaken in an attempt to locate the parents and children. It is not enough to wait for another notification to come through. (recommendation 1)

There are of course limitations as to what can be achieved when searching for a family and if the area to which they may have relocated is known, local police and schools can be notified of the Departments interest. Currently, as I understand the alert, which is placed on the Department's system, is only accessible to Department workers. It may be desirable to afford other people in authority, such as senior members of the police or Principals of schools the same access. This would enable people in those positions, who may have concerns, an easier method of access to such information. (recommendation 2)

The case was ultimately assigned to a worker in Mildura. Thereafter as detailed in the main body of this finding there was little direct involvement with the Department worker and the family. The worker too quickly abrogated her responsibilities by referring the family to St Luke's Anglicare and expecting the worker from Anglicare to effectively perform the role of the Department. I must emphasis that there is no critism of the manner or role performed by the St Luke's Anglicare worker.

It is clear organisations such as St Luke's Anglicare and Child First have a significant role to play in assisting families who come to the attention of the Department. There are of course limitations as to what this role should be. It was with the unanimous agreement of the Department representatives who gave evidence at the inquest, that it should not extend to monitoring and managing problems associated with drug and alcohol issues. I accept that the manner in which this case was handled by the worker is outside the usual practice required of Department workers. There should however, have been greater monitoring of the file by the more senior case managers.

I understand from the evidence there is currently a system in place where any referrals to Child First are monitored by a senior worker within the Department. I would hope such a system was in place for any outside referral. (recommendation 3)

The case was again closed without sufficient evidence to confirm the significant risk factor, abuse of prescription medication by the parents, had been overcome. The Department in submissions made to me relied heavily on the fact the case closure summary indicated the protective concerns had been addressed. As was patently clear during the course of the inquest and from a detailed examination of the Department records, there was no evidence to confirm the protective concerns had been addressed.

The Department also relied heavily on the fact that the family were able to function in the community without concern for a period of 15 months prior to the notification, such notification was as a result of Rory's death. I find little comfort in that submission as it was clear the parents were observed on regular occasions over a long period of time to continue to present as in a drug affected state.

It would be naïve to accept that a person who has a significant drug use over an extended period of time, here a decade, can merely resolve that issue in the space of some months. Throughout all the dealings with the family, too much acceptance was placed on the assertions of the parents, without independent checking.

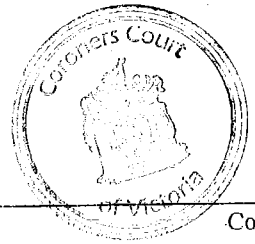
The Department workers would benefit from professional training to assist them in identifying when a person may be alcohol or drug dependent and the best strategies to use when dealing with them. It is not uncommon for them to lie about the nature or extent of that alcohol or drug use. Better education would assist workers with how best to interpret and manage people's responses. It would also give them insight into the fact that a long standing and significant drug problem does not disappear rapidly. (recommendation 4)

Subsequent to the case being officially closed on the 20th of April 2004 two follow up conversations occurred between the worker at St Luke's Anglicare and the Department worker. The details of these latter contacts do not form part of the Departments file notes, but are contained in the notes of the St Luke's worker. The response generally was the Department were no longer involved as the case was closed. Given the circumstances of what was being alluded to in those conversations it was clear the parents were again moving towards crisis. The Department should have re-opened the file following receipt of this information, but it did not.

At no time was there any formal Protection application in place. Instead the Department chose to engage with the family on a voluntary basis. Had protection orders been obtained the Department would have had been able to put in place mandated requirements to bring about behaviour change in the parents and ensure the children were not placed at risk.

The primary worker involved with the family in Mildura was unavailable to give evidence, therefore there is little guidance as to why it was a Protection application was not sought. There were clearly short comings involved in the management of this case but it would be unfair to be critical of the individual worker who no doubt had an over bearing work load at the time. The decisions, which are made, are the responsibility of all in the Department.

The Department in written submissions to me, subsequent to the hearing of the inquest, stated that since Rory's death significant reforms have occurred in many areas of Child Protection practice as a result of the introduction of the *Children, Youth and Families Act 2005* (Vic). It was further submitted that "in light of systemic improvements introduced to Child Protection practice by the *Children, Youth and Families Act 2005* (Vic). and the policies and guidelines developed to support the implementation of the legislation following Rory's death, that it was unnecessary for any recommendations to be made in relation to Child Protection practice in this inquest". The accuracy of that submission, made in December of last year, must be called into question given the contents of the report of the Acting Ombudsman, Mr John Taylor tabled in Parliament on the 24th of October 2011. I have not had the opportunity to read that report in its entirety, but even on a cursory review it can be said that many of the concerns raised in the management of this case continue to remain prevalent.



The significant failings in this matter by the Department relate to a failure to properly investigate, decisions made not to issue applications for protection of the children, decisions to close the case too quickly without ensuring the protective needs of the children have been met and failing to acknowledge the risk associated with the care givers abuse of prescription medication. I understand the report of the Acting Ombudsman concerned the very same issues and related to an investigation also of the Loddon Mallee Region in which this case was also located.

The use and abuse of prescription medication

The use and abuse of the prescribed medication OxyContin is increasingly being recognised as a problem in our community. The focus of this enquiry has not been limited to that drug alone but more generally to the abuse of other types of prescription medication.

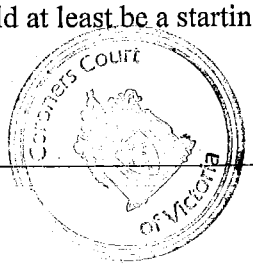
It was the ingestion of the OxyContin that brought about Rory's death, but it was not that fact that required investigation, but more the fact that due to the abuse of medication the parents were unable to ensure a safe environment for the child. It is not known how Rory managed to obtain the OxyContin tablet, but it must be assumed the tablet was not appropriately stored. In addition, the parents, because of their abuse of medication, were at times incapable of ensuring the well-being of their children.

Doctor Shetty was responsible for prescribing the medication to the father and did so, on the basis of his clinical assessment of genuine need. This was supported by appropriate enquiries as to a severe back injury suffered by the Mr S. The Doctor obtained the appropriate permits to permit subscription. The Doctor had also been responsible for the long term prescription of medication to Ms F, primarily in relation to a diagnosis of depression.

The Doctor conceded he had suspicions Mr S may be abusing his medication and further Mr S may be selling it, but felt powerless to do anything about it. He was of the view both Mr S and Ms F were drug dependent, but did not believe there was any mechanism available for change. The Doctor was dismissive of suggestions that Mr S be referred to a pain management clinic as he deemed such help would not be effective in Mr S's case. He was of the opinion only ongoing use of medication could manage that pain.

In relation to a suggestion that Ms F may benefit from seeing a psychologist or psychiatrist to address her depression, the Doctor stated that it was his responsibility to treat depression.

It is my view, with the greatest respect to Doctor Shetty, that a more comprehensive treatment regime needs to be undertaken to minimise dependency on medication. A more therapeutic approach, such as engaging the services of other professionals to avoid the use of medication, must always be considered. I accept however, that such an approach will not be successful for all but it should at least be a starting point. (recommendation 5)



I originally had concerns the OxyContin medication was distributed in blister packs as distinct from "child safe" containers. Doctor Shetty gave evidence the blister packaging of such drugs had occurred as a result of lobbying by members of the medical profession who were concerned the previous method of packaging such medication did not address child safety concerns. The Doctor stated the blister packaging is a preferred option as it is very difficult for children to gain access to the tablets. He agreed the same would apply to "child safe" containers. I am not proposing to make any recommendations as to the packaging of medication. It appears to be something that has been given consideration by others. It is also not clear how Rory had access to the OxyContin tablet, but the more likely scenario is that it was loose pill, somewhere on the ground and he did not remove it directly from the packaging.

In evidence given by Mr Lam, a representative for the Department of Health, Drugs and Poisons Regulation group (hereafter referred to as the Department of Health), he stated there was no current monitoring of individual doctors and their provision of prescription medication pursuant to permits. I note that there may be some medical practitioners who will more readily prescribe certain medication over others. As was clear from the evidence at the inquest when Mr S was refused a prescription by one doctor for OxyContin he merely went to another who was prepared to provide it. The Department of Health rely on the professional opinion of the medical practitioner when prescribing medication. It may be helpful, however, if the Department of Health undertake regular audits of its records to ascertain if a particular medical professional is prescribing certain medication at a significantly higher ratio than other practitioners. (recommendation 6)

RECOMMENDATIONS

Pursuant to section 72(2) of the Coroners Act 2008, I make the following recommendations connected with the death:

1. That where a case has not been investigated by the Department of Human Services or has been investigated and a significant risk to the well being of children has been identified, in the event the family leave the jurisdiction without notifying the Department the file should remain open and every endeavour be made to ascertain the location of the family. There should also be periodic reviews of such cases whilst the whereabouts remains unknown.
2. That information as to children whose whereabouts are unknown be maintained by the Department of Human Services and accessible to appropriate authorities such as high-ranking members of the police force and Principals of schools.
3. That the Department of Human Services ensure a state wide practice of a worker being made responsible to oversee and liaise on a monthly basis with outside organisations that are engaged to provide assistance to clients of the Department.
4. That the Department of Human Services workers receive education centred on drug and alcohol dependency with a view to being able to readily identify these issues and how best to deal with people suffering such effects.
5. That the Australian Medical Association consider making it a mandatory requirement, that part of the continuing education taken by its members who prescribe addictive medication, is for training and education as to how to identify drug dependency and drug abuse and the strategies that can be implemented to limit it. In addition, such education

could include alternative means of addressing the issues that give rise for the need for such medication in the first place.

6. That the Department of Health undertake regular audits of its records to ascertain if any medical practitioner is obtaining a disproportionately high number of permits for schedule 8 drugs compared with usual practice of other practitioners and investigate why.

Signature:

Coroner's name: Jennifer Tregent
Date: 31st October 2011

Coroners Court of Victoria