IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 005065

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	Coroner Paresa Antoniadis Spanos
Deceased:	JH
Date of birth:	22 October 2003
Date of death:	16 September 2019
Cause of death:	1(a) Electrocution
Place of death:	Endeavour Hills, Victoria, 3802
Keywords:	Family violence; Child Protection; Suicide; Youth

INTRODUCTION

1. On 16 September 2019, JH was 15 years old when he was found deceased at home. At the time of his death, JH lived with his mother, CJ and two of his siblings in Endeavour Hills.

2. JH was born in Clayton, Victoria on 22 October 2003 to parents CJ and AH. JH is one of four children, CH, who died when she was one day old, BH, JH's older brother born on 11 November 1996 and TH, JH's younger sister who was born on 3 November 2006.

3. CJ and AH separated around 2010 and initially, JH stayed with his mother and sister TH whilst BH went to live with his father. Over the years JH's relationship with CJ became strained and JH moved back and forth between his father's and his mother's residences.

4. JH was residing primarily with CJ in the lead up to the fatal incident.

THE CORONIAL INVESTIGATION

5. JH's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

6. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

7. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

8. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of JH's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

9. This finding draws on the totality of the coronial investigation into the death of JH including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only

refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

10. On 16 September 2019, JH's mother woke him for school, but he refused to get up and was observed to roll over with his doona pulled over.[2]

11. JH's mother returned from work in the evening at approximately 5.45pm, she observed the bathroom light to be on and after making enquiries with TH, she found JH in the bathroom unresponsive.[3] It appeared that JH had strapped an exposed electrical cord to his right index finger and his left big toe.

12. JH's mother switched the power off and attempted to perform CPR whilst contacting emergency services. Ambulance paramedics arrived at 6.01pm and were unable to resuscitate JH and he was pronounced deceased at scene.[4]

Identity of the deceased

13. On 16 September 2019, JH, born 22 October 2003, was visually identified by their mother, CJ.

14. Identity is not in dispute and requires no further investigation.

Medical cause of death

15. Forensic Pathologist Dr Heinrich Bouwer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on the body of JH and provided a written report of his findings dated 20 September 2019.

16. The post-mortem examination revealed the following:

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[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[2] *Coronial Brief part 1*, Statement of Cheryse Jonas dated 6 January 2020, 19

[3] Ibid, 20

[4] *Coronial Brief part 2,* Ambulance paramedic records, 45

a) Electrical cords attached to the hand and foot with associated electrical burns. There was green staining of the skin, consistent with copper wire; and

b) Port-mortem CT scans showed a mild cerebral oedema.

17. Toxicological analysis of post-mortem samples identified the presence of fluoxetine,[5] norfluoxetine[6] and ibuprofen.

18. Dr Bouwer provided an opinion that the medical cause of death was 1 (a) Electrocution.

19. I accept Dr Bouwer's opinion.

FURTHER INVESTIGATIONS AND CORONER'S PREVENTION UNIT REVIEW

Family violence investigation

20. For the purposes of the Family Violence Protection Act 2008, the relationship between JH and his parents, was one that fell within the definition of '*family member*[7] under that Act. Moreover, the reported family violence between JH's parents that he was exposed to as a child and his experience of alleged mistreatment by both his parents meets the definition of '*family violence'*.[8]

21. In light of JH's death occurring under circumstances of proximate family violence, I requested that the Coroners' Prevention Unit (**CPU**)[9] examine the circumstances of his death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[10] I also requested the CPU Mental Health team review records for the mental health treatment provided to JH.

JH's mental health history and treatment prior to the fatal incident

22. JH was diagnosed with Asperger's Syndrome as a young child and depression when he was about 15 years. His parents separated when JH was about six and their relationship remained acrimonious. JH moved between his mother's and father's houses, and his relationship with the

[5] Fluoxetine is a selective-serotonin reuptake inhibitor typically used in clinical treatment for major depression.
[6] See above.
[7] Family Violence Protection Act 2008, section 8(1)(a)
[8] Family Violence Protection Act 2008, section 5
[9] The Coroners Prevention Unit is a specialist service for Coroners established to strengthen their prevention role and provide them with professional assistance on issues pertaining to public health and safety
[10] The VSRFVD provides assistance to Victorian Coroners to examine the circumstances in which family violence deaths occur. In addition the VSRFVD collects and analyses information on family violence-related deaths. Together this information assists with the identification of systemic prevention-focused recommendations aimed at reducing the incidence of family violence in the Victorian Community

parent with whom he was not living tended to be strained. Each parent alleged that JH was neglected in some way while he lived with the other.

23. The available evidence indicates that JH had experienced suicidal ideation throughout 2019. In May 2019 he reported depressive symptoms and suicidal ideation to his general practitioner (**GP**) and was advised to attend hospital for a mental health assessment.

24. JH's GP referred him to Headspace, and he continued to see his GP regularly throughout May 2019 for mental health reviews. On 29 May 2019 JH showed his GP a video of himself standing on a building and another of himself standing on train tracks, reporting that he had suicidal ideation. JH and his mother were advised to present to hospital. JH was referred to Monash Health Early in Life Mental Health Service (**ELMHS**), however he only attended two appointments in June 2019 before declining to attend further appointments. ELMHS also referred JH to Headspace, however his mother advised that he refused to engage.

25. In July 2019, JH didn't return home and was reported missing. After self-presenting to the police station at 3.00am reporting plans to suicide, he was re-referred to ELMHS, however he only attended two further appointments before declining to engage further.

26. JH was admitted to Monash Health Child and Adolescent Mental Health Unit (**Stepping Stones**) from 5-19 August 2019 after taking an overdose of 100 paracetamol tablets. He was diagnosed with a Major Depressive Disorder[11] and commenced on the antidepressant fluoxetine. His previous Asperger's diagnosis was noted as a diagnosis of Autism Spectrum Disorder without Cognitive or Speech and Language Impairment[12]. JH was followed up by ELMHS CORE Community Treatment Team on discharge.

27. Between JH's discharge from Stepping Stones and the fatal incident, JH was in contact with both parents, having re-established his relationship with his father in August 2019. According to his mother, during this time JH appeared to be recovering, was more social and less reclusive. His father stated that he was not aware of JH's mental health issues.

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[11] Major depressive disorder is characterised by five or more of the following symptoms every day (or nearly every day) during the same two week period: depressed mood for most of the day, diminished interest/pleasure in all or most activities, decreased appetite or an unintentional change of 5% body weight in a month, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness or excessive/inappropriate guilt, diminished ability to concentrate or make decisions, recurrent thoughts of death/suicide. Of the five symptoms required for a diagnosis, one must be depressed mood or diminished interest/pleasure.

[12] Asperger's Syndrome was a diagnosis in the DSM-IV, but with the introduction of the DSM-V in 2013 Asperger's Syndrome was removed and is considered an Autism Spectrum Disorder.

28. JH saw his case manager Dr Milanda Matthews[13] on 21 August, 29 August, 4 September (at a psychiatrist review with Dr Natalie Stowe) and 11 September 2019. He reported chronic suicidal ideation with no plan or intent, was sometimes guarded, often spoke about his future plans and treatment focused on safety planning (identifying signs of distress and associated interventions). After the psychiatrist review, consideration was given to whether JH may have a prodromal schizophrenic illness[14] and/or schizoid or paranoid personality disorder[15], however these can only be diagnosed after a longitudinal assessment. Dr Matthews liaised with JH's school to gather collateral information about his presentation and provide advice on supporting him at school.

29. On 11 September 2019, JH saw Dr Matthews. He appeared well, spoke about his plans to attend TAFE to undertake a course in mechanical engineering, his newfound Buddhist beliefs and search for peacefulness. He made some remarks that he declined to elaborate on when asked, including that his brother was "*on curfew*" and about "*taking over Argentina*". Dr Matthews attempted to make an appointment for the following week in accordance with the treatment plan of weekly appointments discussed at the psychiatrist review the previous week, however JH's mother was unable to commit to an appointment the following week. Another appointment was therefore made for two weeks' time and JH's mother was asked to contact in the interim to confirm an appointment time in one week.

30. Following this appointment, Dr Matthews informed Dr Stowe of JH's odd comment about taking over Argentina, which led to contact with the Monash Health Endeavour Team Coordinator and Consultant Psychiatrist requesting an appointment for JH to be reviewed for clarification of potential early psychotic symptoms.

Child Protection involvement with JH and his immediate family prior to the fatal incident

31. Child Protection provides child-centred, family-focused services to protect children and young people from significant harm caused by abuse or neglect within the family. It also aims to ensure

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13 Clinical neuropsychologist.

14 Schizophrenic illnesses refer to those in the Schizophrenia Spectrum and Other Psychotic Disorders diagnostic category, where the primary symptom of the disorder is psychosis.

15 A personality disorder is an enduring pattern of inner experience and behaviour that deviates markedly from the norms and expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time and leads to distress or impairment. Paranoid personality disorder is a personality disorder characterised by pattern of distrust and suspiciousness such that others' motives are interpreted as malevolent, which does not occur exclusively during the course of a schizophrenic illness or other medical condition.

that children and young people receive ongoing support to deal with the effect of abuse and neglect on their wellbeing and development.

32. The available evidence confirms that Child Protection had significant contact with JH and his family with a total of 16 reports occurring prior to the fatal incident.[16] Three reports were investigated and 13 were closed at intake.

33. Most of these reports detail incidents in which CJ was physically and verbally violent towards her children.[17] Reports also noted that CJ was a '*long term heavy drinker'*[18] and that there had been a history of family violence between the parents that the children had been exposed to.

34. A report was made to Child Protection on 30 August 2018 in relation to '*significant concerns for TH in mother's care'*,[19] advising that CJ had been verbally and physically violent towards TH and JH, with CJ allegedly '*pinning'* TH down and '*choking her with her hands'*.[20] This report indicated that TH was self-harming and that CJ was drinking to excess on a daily basis and presented as '*more "violent*" when she is intoxicated'.[21]

35. This report appears to have progressed to investigation and it was agreed that TH would reside with her father, with the matter being closed on 24 October 2018.[22] The available evidence provided to the Court is unclear as to whether concerns were also held for JH on this occasion and whether he was in his mother's care at this time.

36. On 6 December 2018, a report was made to Child Protection in relation to TH and JH.[23] Given the focus of the coronial investigation, the following account of events only deals with engagement between Child Protection and JH.

37. This report detailed concerns that JH and TH were living with their father, AH, in an unsafe property.[24] The report stated that JH and TH were '*skinny'*[25] and '*often seen in the same clothes and do not look clean'*.[26] The reporter advised that the children were often seen outside the

[16] Department of Families, Fairness and Housing, Child Protection Records of JH, 167 - 179.
[17] Department of Families, Fairness and Housing, Child Protection Records of JH, 167 - 179.
[18] Department of Families, Fairness and Housing, Child Protection Records of JH, 164.
[19] Department of Families, Fairness and Housing, Child Protection Records of JH, 164.
[20] Department of Families, Fairness and Housing, Child Protection Records of JH, 163.
[21] Department of Families, Fairness and Housing, Child Protection Records of JH, 163.
[22] Department of Families, Fairness and Housing, Child Protection Records of JH, 167-168.
[23] Department of Families, Fairness and Housing, Child Protection Records of JH, 161-182.
[24] Department of Families, Fairness and Housing, Child Protection Records of JH, 161-182.
[25] Department of Families, Fairness and Housing, Child Protection Records of JH, 176.
[26] Department of Families, Fairness and Housing, Child Protection Records of JH, 176.

home as though waiting for their father to return to let them inside and that there had been '*three fires in the home'*[27] with '*gas bottles and electrical wires everywhere'.*[28]

38. On 7 December 2018, Child Protection contacted Victoria Police and were advised of AH' criminal history and informed that there were no active family violence intervention orders or community corrections orders in place.[29] Victoria Police informed Child Protection that AH was required to report to police every Tuesday and Thursday to Reservoir Police Station as a condition of his bail and that there were several pending charges for cannabis related offences issued in February 2018.[30]

39. On 10 December 2018, Child Protection spoke with JH's high school who informed them that JH '*always looks filthy, smells, and looks dishevelled. Further, JH appears hungry and very skinny'*.[31] The school noted that they had had minimal contact with AH and that he did not engage in parent teacher interviews and also '*doesn't look well presented'*.[32]

40. Following consultation with the Team Manager, this report was opened for investigation on 11 December 2018 noting that '*further Child Protection investigation is warranted to assess the safety and wellbeing of the children'*.[33]

41. On 20 December 2018, Child Protection undertook a home visit to AH' address. JH and AH were both present during this visit and were both spoken to by Child Protection practitioners.[34] A summary of this visit was noted as follows:

> *In consultation with T/M Jackie, the decision was made not to substantiate concerns based on the following protective factors.*
>
> - *Food sighted in fridge*
> - *Child advised he felt safe*
> - *Child made no disclosures in regards to father*
> - *Father willing to work with Child Protection*
> - *Although home was cluttered, no immediate risks were identified*
> - *Child and father appeared to have a strong attachment with each other*

[27] Department of Families, Fairness and Housing, Child Protection Records of JH, 134.
[28] Department of Families, Fairness and Housing, Child Protection Records of JH, 175.
[29] Department of Families, Fairness and Housing, Child Protection Records of JH, 177.
[30] Ibid.
[31] Department of Families, Fairness and Housing, Child Protection Records of JH, 178.
[32] Department of Families, Fairness and Housing, Child Protection Records of JH, 178.
[33] Department of Families, Fairness and Housing, Child Protection Records of JH, 181.
[34] Department of Families, Fairness and Housing, Child Protection Records of JH, 127-135.

It was discussed that Child Protection will assist with the Rubbish [sic] skip and in providing a support letter for Centrelink to aid father with financial aid.[35]

42. Attempts to contact AH were unsuccessful on 2 January 2019[36], 23 January 2019[37], 11 February 2019.[38]

43. On 12 February 2019, Child Protection made contact with JH's school who noted that there had not been any concerns and that further conversations with JH regarding his welfare would occur.[39]

44. On 14 February 2019, Child Protection were contacted by JH's school who advised that JH had attended and that '*he didn't present very well. She said that his uniform was very dirty and he had an odour coming from him as if he had not had a bath in days'*.[40] JH reportedly did not provide any information to the school regarding his welfare but noted '*everything was ok'*.[41]

45. On 26 February 2019, JH's school was contacted again and advised that JH was presenting better *but 'doesn't talk much and does not share much about what happens at home he does not give anything away'.*[42]

46. A further phone call occurred with JH's school on 4 March 2019 advising that they had spoken with JH's older brother, BH, and that JH had moved back with his mother '*because there were problems with the father but [BH] would not say what kind of problems'.*[43] The school advised that BH had informed them that the family '*had not yet made a decision on where JH will be staying but they will advise when they have a decision'*.[44]

47. On 5 March 2019, a letter was sent to AH requesting contact.[45]

48. On 7 March 2019, Child Protection undertook a planned home visit at CJ' residence and spoke with JH.[46] It is unclear from the records whether he was spoken to alone. When JH was spoken to, he advised that he had left his father's home as '*he did not get the resources he needed'*,[47]

[35] Department of Families, Fairness and Housing, Child Protection Records of JH, 134-135.
[36] Department of Families, Fairness and Housing, Child Protection Records of JH, 126.
[37] Department of Families, Fairness and Housing, Child Protection Records of JH, 124.
[38] Department of Families, Fairness and Housing, Child Protection Records of JH, 123.
[39] Department of Families, Fairness and Housing, Child Protection Records of JH, 121.
[40] Department of Families, Fairness and Housing, Child Protection Records of JH, 117.
[41] Department of Families, Fairness and Housing, Child Protection Records of JH, 117.
[42] Department of Families, Fairness and Housing, Child Protection Records of JH, 110.
[43] Department of Families, Fairness and Housing, Child Protection Records of JH, 109.
[44] Department of Families, Fairness and Housing, Child Protection Records of JH, 109.
[45] Department of Families, Fairness and Housing, Child Protection Records of JH, 108.
[46] Department of Families, Fairness and Housing, Child Protection Records of JH, 102-103.
[47] Department of Families, Fairness and Housing, Child Protection Records of JH, 103.

that there were unpaid utilities and that his father left him alone unsupervised. JH advised that he had returned to his mother's house as he could '*get the resources I need*'[48] including access to utilities noting that he wanted '*to be provided with resources and be sure about my condition*'[49], noting that he likely would stay living with his mother but was yet to confirm this decision.

49. A further discussion was had with CJ on 15 March 2019 and Child Protection were advised that '*JH was much better now*'[50] and that she would be re-enrolling him in their local school.

50. On 15 March 2019, Child Protection closed this investigation with no further investigation, noting that JH was now living with his mother and that '*previous concerns regarding mother's substance abuse (alcohol) have been addressed*'[51] and that TH '*has advised that mothers [sic] does not drink as she used to. JH has said he is happy to remain in mother's care*'.[52]

51. A wellbeing report was made to Child Protection on 17 April 2019.[53] This report noted that JH's eldest brother had recently left CJ' home '*given she has alcohol issues or an alcoholic and they had a fight*'[54] no details relating to this were provided. Child Protection encouraged the reporter to explore this report further with BT's '*given it is unclear what the mother's drinking and the subsequent effect on her functioning and parenting*'[55]. There was no further action taken in relation to this report and it was classified as a wellbeing report 'based upon the information provided'.[56]

52. On 21 May 2019 a request was made by North-Eastern Melbourne Area Orange Door for Child Protection History. No further details of this consultation were recorded.[57]

FINDINGS AND CONCLUSION

53. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was JH, born 22 October 2003;

[48] Department of Families, Fairness and Housing, Child Protection Records of JH, 103.
[49] Department of Families, Fairness and Housing, Child Protection Records of JH, 103.
[50] Department of Families, Fairness and Housing, Child Protection Records of JH, 100.
[51] Department of Families, Fairness and Housing, Child Protection Records of JH, 99.
[52] Department of Families, Fairness and Housing, Child Protection Records of JH, 99.
[53] Department of Families, Fairness and Housing, Child Protection Records of JH, 39-58.
[54] Department of Families, Fairness and Housing, Child Protection Records of JH, 14.
[55] Department of Families, Fairness and Housing, Child Protection Records of JH, 14-15.
[56] Department of Families, Fairness and Housing, Child Protection Records of JH, 15.
[57] Department of Families, Fairness and Housing, Child Protection Records of JH, 13.

b) the death occurred on 16 September 2019 at Endeavour Hills, Victoria, 3802;

c) the cause of death is Electrocution; and

d) the death occurred in the circumstances described above.

54. The available evidence supports a finding that JH was facing a number of significant life stressors at the time of the fatal incident, including significant mental health issues and long-term Child Protection involvement with his family.

55. While I have made comments below that appear appropriate to me as they arise from the coronial investigation into JH's death, the available evidence does not support a finding that there is any causal connection between the circumstances highlighted in the comments and JH's death.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

Appropriateness of proximate mental health treatment provided to JH

56. JH had a longstanding diagnosis of Autism Spectrum Disorder and in the four months prior to his death he began reporting suicidal ideation resulting in a diagnosis of Major Depressive Disorder. JH was still undergoing an ongoing process of diagnostic clarification, with suspicions of a potential psychotic element to his presentation of yet unknown etiology.[58] JH's ongoing risks were recognised by the Monash Health treating team, including his social and emotional difficulties resulting from Autism Spectrum Disorder, his early stage of recovery, his psychosocial stressors and diagnostic uncertainty.[59] However, there was no indication of acute risk factors or a mental health deterioration in the weeks prior to his death. Conversely, JH's mother reported that his mental state appeared to be improving since his discharge.[60]

57. A review of JH's discharge from Stepping Stones on 19 August 2019 appeared reasonable. JH remained on the ward until appropriate pharmacological treatment could be commenced and remained for nine days to monitor the initial stages of treatment. No significant concerns arose

[58] Medical records provided by Monash Health 9 of 357.
[59] Ibid, 245 of 357.
[60] Medical records provided by Monash Health 2, 112 of 350

during this time.[61] Prior to discharge, JH utilised day leave and weekend leave without concerns.

58. JH was noted to begin to engage more throughout the admission and engaged in some therapeutic work around safety planning and early warning signs, it appeared that rapport building with JH was a slow process. JH was therefore unlikely to achieve significant benefit from psychotherapy in the short term and significant period of rapport building and psychoeducation was likely required before engaging him psychotherapy.

59. The available evidence suggests that it was in the community that JH's mental state appeared to have improved, and no acute risks were evident.[62] However a longer-term risk of suicide was recognised in the context of his chronic stressors, neurodevelopmental difficulties and early phase of recovery. This risk was unlikely to have changed significantly with ongoing admission. Optimisation of his medication, monitoring for treatment emergent suicidality[63] and the rapport building that would be required for JH to engage in psychotherapy could occur in the community, where JH could be in his home with his family and return to his usual activities.

60. According to his mother, he appeared to have improved after his discharge from Stepping Stones, which would support that he was recovering at the time of discharge and his mental state would continue to improve with treatment in the community.

61. JH's treatment in the community after discharge appeared appropriate. He was reviewed within two days post-discharge and saw a psychiatrist 2.5 weeks after discharge. Dr Matthews engaged in safety planning with JH, his mother and his school. In consultation with Dr Matthews and Dr Stowe, a treatment plan was made for weekly appointments to engage in talking and activity-based therapy, and this was adhered with.[64]

62. Although there was no weekly appointment scheduled on the week of JH's death, this was due to JH's mother being unable to commit to an appointment time and there was evidence that Dr

[61] Ibid, 206 of 350

[62] Ibid

[63] There is some evidence to suggest treatment-emergent suicidal in people under 25 years who commence selective serotonin reuptake inhibitor (SSRI) antidepressants. There is indirect evidence to suggest that, at a general population level, the use of SSRI antidepressants may have been associated with a reduction in overall suicides. Fluoxetine is an SSRI antidepressant, but is also a first line antidepressant and is the preferred antidepressant for use in children and adolescents as it has the most favourable risk/benefit profile . Fluoxetine, along with all other antidepressants in Australia, carry a warning about clinically worsening depressive symptoms and suicide. Those who are prescribed antidepressant medication are more vulnerable to suicidal ideation and behaviours by the nature of the illness that antidepressants are prescribed to treat.

[64] Medical records provided by Monash Health 2, 100-114 of 350.

Matthews continued in her attempts for weekly appointments.[65] Regardless, the next weekly appointment would have been scheduled for the week commencing 16 September 2019 and given JH passed away on 16 September 2019, it's unlikely that scheduling the weekly appointment would have prevented his death. There was no evidence of acute risks at any of the four appointments post discharge, however when evidence of possible early psychosis was noted, Dr Matthews escalated and actioned this in a timely manner.[66]

Adequacy of Child Protection (CP) services provided to JH and his immediate family

63. There are several concerns identified in relation to the investigations undertaken by Child Protection in response to the reports made to their service on 12 December 2018 and 17 April 2019.

64. The Child Protection manual in place at the time of this report indicates that practitioners are required to determine the '*extent and nature of the reported concerns, or any other concerns that are identified during the investigation, and whether the child is in need of protection'*.[67] The Manual also suggests that practitioners must consider '*past and immediate risks to the child and the likelihood of future harm'*.[68]

65. The available evidence suggests that Child Protection did not appear to have undertaken steps to adequately determine the risk posed to JH during their involvement with the family. When meeting with JH on 7 March 2019, JH advised that he had returned to live with his mother as he wished to have his '*basic resources'* met. JH provided little information regarding his experience of living with his mother and only referenced the benefit of having access to access to basic necessities at her home.

66. During this engagement, Child Protection appear to have been satisfied that JH required no further assistance on the basis that CJ was '*able to provide [him] with basic thing [sic] that he needs for school'*.[69] Information regarding JH's wellbeing or safety in his mother's care was not explored despite previous concerns for CJ' use of alcohol and perpetration of physical and verbal violence towards her children.

[65] Ibid, 114 of 350.
[66] Medical records provided by Monash Health 2, 100-114 of 350.
[67] Child Protection Manual, *Advice and Protocols – Investigations*, (1 March 2016).
[68] Ibid.
[69] Department of Families, Fairness and Housing, Child Protection Records of JH, 22.

67. Furthermore, these concerns do not appear to have been explored with CJ and the family do not appear to have been provided with any ongoing support within the community. Despite the absence of documented enquiries into CJ' alcohol use, Child Protection's closure summary for this report stated that '*previous concerns regarding mother's substance abuse (alcohol) have been addressed as the [sic] daughter has advised that the mothers [sic] does not drink as she used to'*.[70]

68. The available evidence indicates that Child Protection made no reference to these discussions in their notes and that an assessment of CJ' alcohol use appears to have relied solely on the account of a 12-year-old child.

69. At the time of Child Protection's closure, practitioners had not confirmed JH's decision to remain in his mother's care and had not undertaken adequate inquiries regarding JH's safety in his mother's care or CJ' use of alcohol. Without this information or investigation, there is concern with Child Protection's capacity to assess the risk posed to JH's welfare and adequately determine his safety was compromised.

70. At the time of closure, JH and his family did not appear to be linked with any ongoing support services. The Child Protection Manual at the time of this engagement notes that practitioners should use the closure phase to '*ensure linkages and collaborative community plans have been developed and are operational so as to further protect the child, promote their development and strengthen families'*.[71]

71. Despite this practice direction, practitioners do not appear to have utilised their engagement with the family to discuss their support needs or explore community-based support options that could work to promote safety within the home. It appears that Child Protection practitioners failed to explore the needs of the family and take steps to address any needs that may have been present.

Investigation and Assessment of Risk – 17 April 2019

72. The information provided to Child Protection on 17 April 2019 indicated that CJ was using alcohol to excess and that this had resulted in an altercation with her eldest son causing him to leave the home.

[70] Department of Families, Fairness and Housing, Child Protection Records of JH, 99.
[71] Child Protection Manual, *Advice and Protocols – Closure phase*, (25 March 2019).

73. Given the known history relating to CJ' use of violence and alcohol, Child Protection's decision to classify this notification as a wellbeing report, requiring no further investigation, may have been in contradiction of the policies and procedures in place at the time of this report.

74. At the time of this report, the Child Protection Manual noted that practitioners are required to '*gather relevant assessment information from other professional sources including information holders or service agencies where possible, including interstate child protection history where relevant'*[72] following a report to intake.

75. There is no evidence in the records provided to the Court that Child Protection undertook any further investigations to determine JH's safety following this report and instead encouraged the reporter to obtain further information, which they were advised was unlikely to be possible.

76. It is concerning that Child Protection practitioners did not appear to seek further clarification regarding the risks posed to JH and his sibling, by contacting JH's school or other services he may have been engaged with. Without this information, it would have been difficult for Child Protection to formulate an informed assessment of the risk posed to JH's safety and wellbeing and determine the need to intervention.

Assessment of cumulative harm

77. The Child Protection manual in place at the time of this engagement notes that cumulative harm 'may be caused by an accumulation of a single recurring adverse circumstance or event (such as unrelenting low-level care); or by multiple circumstances or events (such as persistent verbal abuse and denigration, inconsistent or harsh discipline, and/or exposure to family violence)'.[73] To assess cumulative harm, practitioners '*are required to assess each report as bringing new information that needs to be carefully integrated into the history and weighted in a holistic assessment of the cumulative impact on the child, rather than an episodic focus on immediate harm'*.[74]

78. The obligations to consider the effects of cumulative harm are reiterated in the *Children, Youth and Families Act 2005* (Vic), which notes that Child Protection must consider '*the effects of cumulative patterns of harm on a child's safety and development'*[75], noting that '*harm may be*

[72] Child Protection Manual, *Policies and Procedures – Intake*, (7 January 2019).
[73] Child Protection Manual, 'Cumulative harm – Best interests case practice model' (2012), 5.
[74] Child Protection Manual, 'Cumulative harm – Best interests case practice model' (2012), 5.
[75] Section 10(3)(e) of the *Children, Youth and Families Act 2005* (Vic).

constituted by a single act, omission or circumstance or accumulate through a series of acts, omissions or circumstances.'[76]

79. The available evidence suggests that Child Protection did not account for the impacts of cumulative harm in their management and response to the notifications made relating to JH on 12 December 2018 and 17 April 2019.

80. Since JH's birth, Child Protection had received 16 notifications to their service relating to parental violence, neglect, physical abuse, alcohol misuse, high risk behaviour of JH's siblings, poor school attendance, concerns for parental mental health and family violence.

81. The available evidence suggests that practitioners did not consider the reports made to their service on 6 December 2018 and 17 April 2019 in the context of the historical reported concerns made to Child Protection and JH's cumulative exposure to instability, harm and violence.

82. Without contextualising these reports, Child Protection's engagement with JH and his immediate family did not provide a nuanced consideration of the risk posed to JH's safety and wellbeing and appreciate the cumulative impacts that exposure to these adverse experiences may have had on JH's wellbeing and safety. Failing to consider the most recent reports to Child Protection in this context compromised the ability to adequately assess the risk posed to JH and determine the intervention required to promote his wellbeing and safety.

Improvements to CP practice since the fatal incident

83. I confirm that since JH's passing, Child Protection has written to the Court and provided information confirming that the Southern Melbourne Area office which covered the area of service where JH lived have considered and undergone significant improvements.[77]

84. The Southern Melbourne Area office confirm that:[78]

    a) Practitioners are encouraged to use practice resources including 'My Views' booklets which support capturing the voice of the child in Child Protection practice;

    b) Improvements to area-based collaboration with key stakeholder agencies;

[76] Section 162(2) of the *Children, Youth and Families Act 2005* (Vic).
[77] DFFH correspondence to the Court dated 28 July 2023.
[78] Statement of the Deputy Area Operations Manager (Child Protection) dated 27 July 2023, 7-9

c) Forums delivered monthly to all staff with varied practice topics including working with adolescents, children with a disability and cumulative harm. Weekly brief information sessions by the area Practice Leader on topics including case planning, substantiation, working with children with disabilities and engaging children;

d) Including an embedded co-located specialist family violence practitioner from the local funded family violence specialist service, WAYSS; and

e) Internal and external training opportunities targeted to developing specialist skills and knowledge, strengthening partnership with key stakeholders and deepening practice skills.

85. Child Protection confirm that practitioners now receive the following mandatory training:

a) Commencing in September 2019, professional judgement training to guide the use of the SAFER Children Framework (SAFER) with one being held in each Division across the state. The one-day workshops provided an opportunity to introduce practitioners, leaders and managers to the new risk framework coming to Child Protection and enhance practitioner (leaders and managers) knowledge of the five elements of professional judgment and their relationship to decision-making in child protection. The training focused on introducing SAFER and application of professional judgement to the assessment and management of risk, for children within a statutory context. This training was a precursor to the SAFER training which commenced in November 2021.

b) During 2020-21, all Child Protection practitioners received mandatory training in MARAM.[79] The training program introduced a new practice model (*Tilting our Practice*), which is underpinned by an evidence-based intersectional, trauma and violence informed approach to addressing family violence. The model has four key elements: child experience, perpetrator accountability, working collaboratively with the affected parent and practitioner safety.

I convey my sincere condolences to JH's family for their loss.

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

[79] MARAM is the Family Violence Multi-Agency Risk Assessment and Management Framework ensures services are effectively identifying, assessing and managing family violence risk.

I direct that a copy of this finding be provided to the following:

CJ, Senior Next of Kin

AH, Senior Next of Kin

Liana Buchanan, Principal Commissioner, Commission for Children and Young People

Dr Neil Coventry, Chief Psychiatrist, Office of the Chief Psychiatrist

Dr Cate Banks, COHEALTH

Mr Peter Ryan, Senior Corporate Counsel, Monash Health

Leading Senior Constable Matthew Anderson, Coroner's Investigator

Signature:

Coroner Paresa Antoniadis Spanos

Date: 17 October 2023

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.