CITATION: *Inquest into the death of Madeline Jocelyn Rose Downman* [2016] NTLC 007

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Darwin
FILE NO(s):	D0097/2014
DELIVERED ON:	8 June 2016
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HEARING DATE(s):	11 and 12 April 2016
FINDING OF:	Judge Greg Cavanagh
CATCHWORDS:	**Death in Care, self-harm leading to death, quality of care, Mental Health of deceased and treatment and response**

REPRESENTATION:

Counsel:

Assisting:	Jodi Truman
Family:	Stephen Karpeles
Department of Children and Families and Department of Health	Michael Maurice QC

Judgment category classification:	A
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IN THE CORONER'S COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0097/2014

In the matter of an Inquest into the death of
MADELINE JOCELYN ROSE DOWNMAN
ON 6 JUNE 2014
AT HARNEY HOUSE, 12 SABINE ROAD, MILNER

FINDINGS

Judge Greg Cavanagh

Introduction

1. Madeline Jocelyn Rose Downman, or "Maddy" as she was known to her loved ones, was an Aboriginal female born on 3 April 1997 at the Katherine District Hospital, in Katherine in the Northern Territory of Australia. In accordance with a request from her family, I will refer to Ms Downman as Maddy in these findings. At the time of her death, Maddy was a child subject to a long term parental responsibility order under the *Care and Protection of Children Act* ("CAPC Act") until Maddy reached 18 years of age. She had been the subject of such an order from the age of 13 years.

2. As a result of these orders and being in the care of the Chief Executive Officer ("CEO"), Maddy was seen by various professionals, including mental health professionals. As early as 2011 Maddy was showing signs of clinically significant depression strongly suggesting that she was suffering from a mood disorder. On all of the evidence, Maddy was a very troubled girl.

3. Tragically, Maddy died sometime between 12.05 am and 12.25am on 6 June 2014 at her residence of Harney House, 12 Sabine Road, Milner in the Northern Territory of Australia. This is a residential facility operated by the Department of Children and Families ("DCF"). She was found hanging from

the shower rail of the girls' bathroom and was declared deceased by St John Ambulance officers at that same address at 12.47 am after cardio pulmonary resuscitation ("CPR") was ceased. Maddy was only 17 years of age at the time that she took her own life.

4. This death was reportable to me pursuant to s.12 of the *Coroners Act* ("the Act") because it was a death of a person who immediately before her death was a "person held in care". A person held in care is defined under s.12 of the Act to include a child who is in the CEO's care as defined in the *Care and Protection of Children Act*. As a result of being a person held in care immediately prior to death, this inquest is mandatory pursuant to s.15(1) of the Act.

5. Pursuant to s34 of the *Act*, I am required to make the following findings if possible:

"(1) A Coroner investigating:

a. A death shall, if possible, find:

(i) The identity of the deceased person.

(ii) The time and place of death.

(iii) The cause of death.

(iv) Particulars required to register the death under the *Births Deaths and Marriages Registration Act.*

(v) Any relevant circumstances concerning the death."

6. Section 34(2) of the *Act* operates to extend my function such that I may comment on a matter including public health or safety connected with the death being investigated. Additionally, I may make recommendations pursuant to section 35 as follows:

> "(1) A Coroner may report to the Attorney General on a death or disaster investigated by the Coroner.
>
> (2) A Coroner may make recommendations to the Attorney General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the Coroner.
>
> (3) …"

7. During this inquest I received evidence about deficiencies and failures by DCF to follow its own policies and procedures during the time that Maddy was in the care of the CEO. As a result it was necessary to carefully consider whether Maddy was receiving appropriate care and particularly whether the CEO was complying with the obligations held as Maddy's "legal" parent. It was also necessary to consider whether such deficiencies and failures contributed to Maddy's feelings of helplessness, isolation and lack of self-worth which are all well-known contributors to circumstances where young people decide to take their own life.

8. This inquest was held on 11 and 12 April 2016. A total of eight (8) witnesses were called to give evidence, namely; Detective Sergeant Matthew Akers, John Ativie, Kendall Larsen, Leeanne Musgrave, Laura Mihalinec, Alexis Postans, Dr Robert Parker and Simone Jackson. A brief of evidence containing various statements, together with numerous other reports, medical records and police documentation was tendered at the inquest. Public confidence in Coronial investigations demand that when police (who act on behalf of the Coroner) investigate deaths that they do so to the highest standard. I thank Detective Sergeant Akers for his comprehensive investigation.

Background of Maddy

9. Maddy was born at the Katherine District Hospital, Katherine in the Northern Territory of Australia on 3 April 1997. Her mother is Cheryl Downman and her father is Greg Dempsey. Maddy had one older sister and five (5) younger siblings. She spent her early childhood living at Mount Isa in Queensland until she was approximately nine (9) years of age. At about this time her mother suffered a sudden and significant stroke and was flown to Townsville Hospital for emergency care. Maddy, her father and her siblings also subsequently flew to Townsville whilst her mother recovered.

10. Unfortunately Maddy's mother was left paralysed on one side by her stroke and her speech and coordination suffered dramatically resulting in her requiring long term care and medical treatment to learn to walk and speak again. The relationship between her parents deteriorated and they separated shortly thereafter. Family members flew to Townsville to provide assistance with the care of the children and a decision was eventually made that Maddy would move to Katherine to be cared for by her grandmother, Mrs Elaine Braun.

11. It appears that the separation of her parents and the move to Katherine was particularly difficult for Maddy. She was enrolled in primary school at Katherine but her attendance was low and she is reported as saying many times that she did not like school. In early 2009 there was a noticeable change in her behaviour, attitude and personal hygiene. She began truanting from school and running away from home. Thereafter there were a number of reports to what is now known as DCF.

12. Whilst there is no doubt from the material that Maddy had a number of difficulties in her life, it is also clear that she was well known to be very good at art, she loved music and was very creative. Maddy's artwork still adorns the walls at Yirra House, another residential facility operated by DCF where Maddy also resided for a period of time.

13. Maddy is also reported to have had a keen sense of social justice and spoke about going to University to study social work and to one day volunteer overseas. When she saw things that she did not agree with whilst in care, she would strongly advocate for change and was seen as a mentor to many younger persons in care. She loved her family very much and spoke often about how much she missed them. She is clearly missed not just by her family, but by those who worked closely with her within DCF.

Involvement of Department of Children and Families ("DCF") and Maddy's circumstances thereafter

14. Although DCF first became involved with Maddy in the Northern Territory in about August 2009, the evidence shows that Queensland child protective services received their first report about Maddy and her family in December 1998; when Maddy was only 18 months old. The concerns reported at that time were in relation to excessive alcohol and drug consumption and domestic violence. The same concerns were reported in March 1999 and an investigation took place in July 1999, but did not substantiate harm. In July 2005 Queensland child protective services were again contacted. It appears that this was after Maddy's mother suffered her stroke and recommendations were made at that time for the family to access community services.

15. Eventually Maddy returned to Katherine and DCF's involvement commenced in about August 2009. There were three (3) reports relating to Maddy being missing and two (2) reports relating to allegations from Maddy of physical and emotional harm at her home resulting in her running away. Neither investigation was substantiated, however during the investigation Maddy reported feeling suicidal and requested to move to live with her father in Queensland. DCF made a determination to provide financial assistance to support the move and on 17 September 2009 Maddy moved to Mt Isa and lived with her father and his partner. She was 12 years of age.

16. Unfortunately the move to live with her father was unsuccessful and on 2 February 2010 Maddy's grandmother travelled to Mt Isa and collected Maddy and returned with her to Katherine at Maddy's request. Maddy subsequently alleged that she was exposed to physical violence whilst in her father's care.

17. The return to Katherine however resulted in a spike in Maddy's criminal activity and she and a group of 14 other children were involved in trashing and burning rooms at a local school. Following that offence Maddy was ordered to undertake juvenile diversion, but she did not attend and again went missing. Her criminal offending continued until she was eventually placed on remand on 5 May 2010 at the Don Dale Juvenile Detention Centre facing 27 criminal charges.

18. Whilst detained at Don Dale Maddy was interviewed by a DCF officer during which time she reported smoking marijuana, drinking alcohol and sniffing deodorant cans. She also stated that sometimes she felt like hurting herself and had on one occasion cut herself with a knife and on another occasion considered hanging herself. She was 13 years of age. It was determined that Maddy was in need of protection and during her detention at Don Dale a temporary protection order was sought, which was subsequently made on 19 May 2010.

<u>Placements</u>

19. On 21 May 2010 Maddy was granted bail and placed into an emergency DCF house in Darwin. She was also enrolled to re-commence school. It appears from the records that whilst there was an initial "honeymoon" period, Maddy continued to act out and be non-compliant. There were reports of verbal abuse of youth workers and other residents, damage to property, threats to burn down the home and absconding for periods of time. Her attendance at school was also poor. Despite attempts by both DCF and family; no suitable family placement could be located. As a result, Maddy's

mother and father were each served with an application for Maddy to be declared in need of protection and orders for her long term responsibility to be with the CEO until the age of 18 years.

20. During this period, Maddy continued reporting thoughts of killing and/or hurting herself and had in fact cut her arm during these episodes. As a result, referral was made for Maddy to undertake psychological assessment with Ms Louise McKenna of Darwin Psychological Services. On 18 June 2010, when Maddy was only 13 years of age, a Protection Order was made pursuant to the *Care and Protection of Children Act* giving long term parental responsibility to the Chief Executive Officer ("CEO") until Maddy turned 18 years old.

21. In the four (4) years that she was in the care of the CEO, and as found in DCF's own internal review, Maddy had 26 separate placements. These included the Brahminy Group Youth Camp, various private provider foster carers, DCF foster carers, a residential facility provided by Lifestyle Solutions, a residential facility provided by Safe Pathways, family placements from time to time and then finally residential facilities provided by DCF namely Yirra House and the Sabine Road Group Home aka Harney House. It was at this last placement that Maddy was residing at the time of her death.

22. It is also clear from the evidence that Maddy's placement moves often occurred with very short notice and little planning. It appears that her longest placement on any single occasion was six (6) months. During some of these placements there were reports of alcohol and drug abuse by Maddy and her self-harming continued. Whilst placement moves may have occurred with little notice, it is clear that Maddy also regularly absconded from her placements. There were 63 reported occasions of Maddy absconding, sometimes for days in a row.

23. Unfortunately even placements with her own family were not successful. Maddy had alleged she was exposed to domestic violence when in her father's care. Maddy reported in 2011 that a male cousin had asked her to have sex with him and then when he found out she had told a friend about his request, he threatened to kill her. In December 2013 she also alleged that from the age of approximately eight (8) or nine (9) years old she was sexually abused by an older male cousin in Katherine and that this continued for several years. Both of these complaints were related to times when Maddy was living in the care of her grandmother and mother.

24. In June 2013 Maddy was placed into the care of a maternal aunt. During that time there were allegations that she abused alcohol and drugs and that one of her friends was sexually abused by one of Maddy's uncles who was also residing at the property. Eventually Maddy herself asked to be moved from that placement as she alleged that her aunt had prioritised a relationship with a partner who perpetrated domestic violence to which she had been exposed. It is clear that a safe family placement was simply not possible.

Mental health issues

25. As noted previously, in June 2010 Maddy was referred by DCF to Louise McKenna for psychological assessment. It appears that there was some delay in completion of that assessment due to Maddy being moved without notice, however the assessment was eventually completed in February 2011 and a copy was tendered into evidence before me.

26. Within that assessment Ms McKenna noted that whilst Maddy's "outward behaviour was full of bravado", formal testing "displayed a high level of anxiety about her own abilities" and she "needed continual reassurance that she was doing well". I note that at that time Maddy was assessed as having a reading and arithmetic academic function of Grade 3 level, spelling

academic function of Grade 5 level and a receptive language/vocabulary equivalent to age 10. She was 13 years of age at that time.

27. Ms McKenna described Maddy as "impulsive" and noted she "does not have a positive perception of herself as a learner and places unrealistic expectations on herself". She noted that "(Maddy) is suffering from a mood disorder secondary to a conduct disorder". Ms McKenna provided additional information to this court that:

> "Conduct disorder is often the diagnosis given to young people who display repetitive and persistent patterns of behaviour in which they violate the basic rights of others, age appropriate social norms and rules. Conduct disorder is often a precursor to a diagnosis of borderline personality disorder in adulthood."

28. Within her February 2011 assessment Ms McKenna concluded there was:

> "… clear evidence of clinically significant depression and little experience of pleasure in her life. These results strongly suggest that (Maddy) is suffering from a mood disorder. While she can appear to be superficially friendly and confident she has deep seated psychological issues that need to be addressed. She would benefit from long term psychological counselling to manage her moods and thought processes. Unless she obtains long term assistance she remains at high risk of self-harm and is likely to re-engage in offending behaviours".

29. I also had tendered before me a further report from Ms McKenna dated 25 November 2013 where she notes to Maddy's case worker, namely Ms Kendall Larson, that Maddy:

> "… has a history of trauma resultant from exposure to domestic violence, physical, sexual and emotional abuse. She is estranged from her family due to her persistent offending and behavioural issues. She has a history of substance abuse including petrol sniffing, chroming and chronic abuse of alcohol and marijuana".

I pause to note that by this time Maddy had been in the care of DCF for over three (3) years.

30. Ms McKenna further noted that:

> "(Maddy) suffers from severe depression and anxiety. This impacts on her self-esteem, causes her to have low energy levels, profound despondency, sleep disturbance and significant weight gain. She has little social confidence, is easily moved to anger and has limited friendships. She feels quite paralysed to participate in activities typical for women her age and prefers to avoid these".

31. Ms McKenna's opinion at that time in 2013 was that Maddy required one on one support and access to a full time Youth Worker "with whom she is able to develop a positive relationship" so as to assist her in accessing "services in the Community as well as attend specific training activities". Notably Ms McKenna ended her report stating:

> "Without such support she is at risk of becoming completely isolated and unemployable".

32. Unfortunately, despite it being made very clear that Maddy required long term psychological counselling; there were large gaps between appointments with Ms McKenna and numerous occasions where appointments were completely missed. I pause to note that the usual reason for this was Maddy's refusal to attend. Ms McKenna provided a letter to the inquest dated 9 April 2016 in which she stated that:

> "Non-attendance at appointments was to be a regular occurrence for the duration of (Maddy's) contact with me. It was common for non-attendance to occur without any explanation provided by the Caseworker or (Maddy's) carers".

33. Throughout her time in the care of DCF Maddy was reported as feeling depressed, committed acts of self harm and attempted suicide. I note that Ms McKenna spoke with Maddy about taking medication for depression but Maddy strongly opposed such an idea believing that taking such medication would be an admission that she was "mad".

34. Ms McKenna's letter identifies that she was treating Maddy:

> "… using cognitive behaviour therapy to address anger issues, impulse control, self-esteem and to resolve her (trauma, family

> breakdown) that contributed to the emergency (sic) of conduct disorder".

35. She goes on to state that her counselling services were "restricted to individual counselling" for Maddy and that:

> "Despite the high levels of non-attendance, it was my opinion, that (Maddy) was receiving benefit from the counselling sessions that she did attend and hence I was reluctant to terminate sessions with her".

36. Unfortunately, it appears that the psychological support provided by Ms McKenna ceased on or about 30 January 2014. I received a copy of Ms McKenna's file for Maddy held by Darwin Psychology Services which contains hand written notes by Ms McKenna including one dated 30 January 2014. Those notes reveal that Maddy had been "binge drinking" and "smoking gunja with her friends and family for past few days". Maddy complained that this was because she was "bored" and "sick of waiting around" for DCF who were "not organising things for her that they agreed to do" including "school, voluntary work, visits contact with family, etc."

37. In addition Maddy also discussed her current placement, which was one that had been with a private foster care provider since 10 September 2013. The notes record that Maddy "likes her carer but feels lonely, isolated, frustrated. … wants to be in placement but sabotaging as doesn't feel it will last". Discussions are then noted to have taken place about "shared responsibility and acceptable behaviour" and "alternative activities". However, when this was discussed Maddy said "nothing works" and then left the session "in angry state". Attempts were made to:

> "… re-engage in front office but refuses to do so. Won't even make eye contact. (Shuts off). Angry".

38. Ms McKenna's file records an attempt the following day to arrange another appointment with Maddy but that she refused and said she did not need help. Contact was then made by Ms McKenna to Maddy's case worker with

agreement being reached that Maddy "could re-engage when she felt ready to do this". Relevantly the note by Ms McKenna ends:

> "Emphasised need for her to be supported to re-engage as she required support and had experienced a lot of changes in her life recently".

Unfortunately Maddy never again attended with Ms McKenna after this date.

<u>Attempts at suicide and episodes of self-harm</u>

39. I had tendered into evidence the Royal Darwin Hospital ("RDH") file for Maddy which records ten (10) separate occasions where she was seen for attempts at self-harm including:

    39.1 cuts to her forearms and/or wrists,

    39.2 attempts at overdosing on tablets,

    39.3 threats of self harm,

    39.4 swallowing of items such as small pieces of metal and also household bleach, and

    39.5 excessive consumption of alcohol and marijuana.

40. I note that Maddy's grandmother also provided a statement to police where she reported that Maddy had attempted to hang herself from a tree at her home on three (3) separate occasions in about July 2013 with each attempt apparently being reported to Maddy's case worker. The records held by DCF show that Maddy is reported to have threatened to commit suicide or to self-harm on 24 occasions and committed 20 acts of self-harm.

41. Whilst Maddy received psychological counselling from Ms McKenna, she also had involvement with other mental health care providers via the Department of Health ("DOH") through Top End Mental Health Services ("TEMHS"). It appears from the records that Maddy's first assessment by

the Top End Forensic Mental Health Team ("FMHT") was in early July 2010 when she was detained at Don Dale and had threatened to hang herself. Thereafter Maddy was seen by the following services:

41.1 In February 2011 by the Top End Crisis and Telephone Triage service ("CATT") face to face when she was taken to the Emergency Department ("ED") at the RDH having cut herself on the forearms.

41.2 In May 2011 her carer called the CATT service reporting that Maddy was threatening to self-harm.

41.3 In September 2011 face to face by the Katherine Mental Health Team ("KMHT") after Maddy had attempted to hang herself from a tree at her grandmother's residence.

41.4 In March 2012 face to face by the FMHT at Don Dale after she had tied a pillow case tightly around her neck.

41.5 In July 2012 face to face by the CATT service at the ED of RDH after taking an overdose of an antibiotic and cutting herself of the forearms.

41.6 In August 2012 face to face by the CATT service at the ED of RDH after cutting her wrists.

41.7 In October 2012 face to face by the CATT service at the ED of RDH after having been brought to the hospital by police for aggressive behaviour towards a carer and smashing a window.

41.8 In November 2012 face to face by the CATT service at the ED of RDH after threatening self-harm.

41.9 Again, later in November 2012 face to face by ED clinicians who discussed Maddy by phone with the CATT service after she had been

brought to the ED having taken a mouthful of bleach and then spitting it out.

41.10 In January 2014 her carer called the CATT service reporting that Maddy was depressed.

41.11 Again, later in January 2014, her carer called the CATT service reporting that she was concerned about Maddy's irritability.

41.12 In late March 2014 face to face by the CATT service at the ED of RDH after expressing thoughts of self harm.

41.13 In late April 2014 Maddy requested her carer to phone the CATT service as she was feeling angry and wanted someone to talk to.

42. It is apparent that the majority of these occasions were dealt with by carrying out an assessment during which advice was received that Maddy was seeing a psychologist, Ms McKenna, and Maddy would then be discharged to continue seeing her psychologist. The difficulty with these occasions however is that there appears to have been significant periods of time where Maddy was not actually attending appointments with Ms McKenna, or had not done so for a significant period of time.

43. A further difficulty is that it was not until she received the report of Dr Paton (prepared for these proceedings) in April 2016 that Ms McKenna became aware for the first time of:

> "… numerous incidents where (Maddy) engaged in destructive or self-harming behaviour of which I was never advised nor was aware of…".

44. Ms McKenna stated:

> "At no time have OCF, CATT Team or Top End Mental Health Services ever contacted me or provided me with information about (Maddy's) attendance at these services and or her extensive contact with Police since she resided in Darwin. Unfortunately, lack of

> communication with private practitioners, is common practice, particularly for those young people, with complex needs, who are in the care of OCF. The onus tends to be on the private psychologist to initiate communication with Caseworkers in an effort to advocate for the needs of the young person attending for counselling. Private psychologists do not have the time nor is it their role to undertake case management and co-ordination."

45. It is therefore apparent that whilst Maddy was being seen on an emergency (or crisis) basis, such information was not being provided to her treating psychologist. Then, in March 2014 Maddy's case worker, namely Ms Kendall Larsen, made a formal referral to the Top End Child and Adolescent Mental Health Service ("CAMHS"). This was almost two (2) months after Maddy had refused to continue seeing Ms McKenna.

46. Following receipt of that referral and further information CAMHS determined not to accept the referral on the basis that Maddy should continue to be treated by Ms McKenna given she already had a therapeutic relationship with Maddy and an extensive history with her. It appears however that CAMHS were not advised that Maddy was at that time refusing to see Ms McKenna. As a result, no formal treatment was undertaken by Maddy with CAMHS and she continued not to receive any psychological treatment.

Substance abuse

47. When Maddy was first interviewed by a DCF officer at Don Dale in 2010 she reported smoking marijuana, drinking alcohol and sniffing deodorant cans. Thereafter she was placed into care; however DCF's own records evidence 25 reports of concern that Maddy was either misusing alcohol, marijuana or was again sniffing. It is clear that this abuse was also negatively impacting on her emotional wellbeing.

48. At stages Maddy was reported as being "paranoid" and that her drug use was "out of control". There were also reports that Maddy had stated that she had

debts owing from her drug use and had received threats for payment. It does not appear however that she was ever referred to a specialist service in relation to her substance abuse. I note reference to referrals to services such as the "Daisy" program or "Headspace", but as stated in DCF's own internal review there is no evidence of any specialist referral for substance abuse.

Generally

49. Maddy was a young person with significant needs and mental health issues whilst she was in the care of the CEO. She had refused to attend school, and then refused to regularly attend an education program to re-introduce her to school. She had refused to attend psychological appointments with Ms McKenna after 30 January 2014, and then when attempts were made for her to attend elsewhere she refused to attend those appointments stating; "I'm not going to see any counsellor".

50. On occasions Maddy would express a desire to obtain employment, but then would refuse to go to bed, or not go to sleep until the early hours of the morning, resulting in her then refusing to get up in the morning in order to go to any appointments for employment. She clearly had very complex needs and this made the obligations upon the CEO as her sole legal parent all the more onerous.

Events leading up to her death

51. On 5 June 2014 Maddy had arranged to travel to Batchelor for the graduation ceremony of one of her relatives. For reasons not readily apparent Maddy did not attend, but did later visit with family in Darwin. After having dinner with her family, Maddy returned to Harney House at approximately 10.00pm. I had tendered into evidence a number of statements from family members who spent time with Maddy that evening and they each stated they did not notice anything unusual about Maddy and that she appeared to have enjoyed her evening with them.

52. In this regard, I pause to note one of the comments made by Maddy's grandmother Mrs Elaine Braun, which I consider raises an important point about the particular difficulties associated with ensuring and providing for her needs:

> "I don't know of any problems (Maddy) was having in Darwin or in Katherine. I don't really know what triggered her to hang herself last night and as far as I know she never really talked to people about what she was feeling. I didn't notice anything unusual about her behaviour; she was her normal self yesterday and last night. I didn't notice anything different in (Maddy's) behaviour the three times she previously tried to hang herself last year either. ***There never were any signs***". (My emphasis added).

53. Upon returning to Harney House, Maddy spoke with staff on duty, namely John Ativie and Laura Mihalinec. There was only one other young person resident at the address that evening. That young person provided a statement to the police where she notes that Maddy:

> "… seemed normal and was acting just like every other day, she was mostly always happy".

54. Ms Mihalinec provided evidence that when Maddy returned that evening she said to her something about being "a failure" because she was in care. Ms Mihalinec discussed this with her and noted that later Maddy seemed in better spirits and was playing with her IPad and going in and out of her room as she got ready for bed. Ms Mihalinec stated that she did not see or hear Maddy do anything that made her think she would kill herself. Ms Mihalinec then finished her shift, completed hand over to Anthony Miller and Leanne Musgrave and left Harney House for the evening.

55. Mr Miller's statement to police recalled that Ms Mihalinec and Mr Ativie left the residence at about 11.50pm. He saw little of Maddy that evening but when he did she appeared happy. He noted that when he was sitting in the office Maddy walked past and called out "Hello, Uncle Tony"; which is what she called him. At about 12.05am on Friday 6 June 2014 he recorded

Maddy coming out of her room and going outside for a cigarette. She returned a short time later and as she walked past the office again he recalled her saying something like; "Goodnight Uncle Tony" and she appeared "happy".

56. At about 12.25am Mr Miller decided to go outside and have a cigarette. As he proceeded to the courtyard he saw a light on in the girl's bathroom and heard water running. He recalled a previous incident where Maddy had fallen asleep in the shower and blocked the sink causing the bathroom to flood. As a result, he became concerned that she may have done the same thing again and returned inside and asked Ms Musgrave to check on Maddy. The next thing he recalled was hearing Ms Musgrave screaming Maddy's name.

57. Ms Musgrave provided evidence before me. In her statement to police she said that not long after she first arrived on duty she spoke briefly with Maddy. She saw her again later that evening and Maddy said she was going to Katherine the next day. Maddy made comment about wanting to make sure she had enough money in her account for the trip, but said she had also made alternative arrangements to travel with an uncle if necessary. She appeared happy.

58. After Mr Miller asked her to check on Maddy, Ms Musgrave recalled walking down the hallway and banging on the door. There was no answer. She discovered that the bathroom door was locked and decided to check on Maddy's bedroom first. It was then that she noted that Maddy's bedroom was empty and she began "bashing" on the bathroom door. At this stage she was shaking and said:

> "… something inside me must've felt something was wrong".

59. Ms Musgrave unlocked the bathroom door with a key and saw Maddy hanging from the shower rail. She began screaming Maddy's name and tried

to hold her up to reduce the pressure around her neck, but was unable to do so on her own. Mr Miller then ran into the bathroom and lifted Maddy up whilst Ms Musgrave undid the knot. The pair laid Maddy on the floor, removed the rope from her neck and Mr Miller began CPR whilst Ms Musgrave called for an ambulance.

60. Mr Miller noted that during the process of CPR he already knew Maddy was deceased as there was a blue tinge to her finger tips. There was also no pulse, but he continued compressions. Police arrived before the ambulance and they too assisted with compressions. After the SJA officers arrived they observed no signs of life and pronounced Maddy deceased at the residence at 12.47am.

Cause of Death

61. An autopsy was conducted by Dr Terence Sinton on 10 June 2014 and a copy of his report was tendered into evidence before me. The report noted that the signs of recent injury were "(a) ligature and consistent mark around the neck" with the only noted "old injury" being "numerous fine irregular linear scars" on the left arm "in a manner and pattern consistent with attempted self-mutilation". Samples of blood were sent for toxicological analysis and there were no signs of any drugs or alcohol in Maddy's system.

62. Dr Sinton noted the significant findings to include the following:

    62.1 A Body Mass Index (BMI) calculated at 39, consistent with clinical obesity.

    62.2 A ligature and consistent mark around her neck.

    62.3 Evidence of apparent self-harm in the past.

    62.4 Fatty damage to the liver.

    62.5 Early chronic inflammatory damage to the thyroid gland in the neck.

63. Dr Sinton expressed the opinion that Maddy died from hanging. There is no evidence to suggest this is incorrect. I accept Dr Sinton's opinion and find this to be the cause of death.

Issues for consideration

Was Maddy's care appropriately provided for?

64. The orders of 18 June 2010 included a Protection Order pursuant to the *Care and Protection of Children Act* ("CPC Act") giving long term parental responsibility to the CEO until Maddy reached 18 years of age. This meant that the CEO was vested with all the powers, rights and responsibilities for Maddy that would ordinarily be vested in her parents. The CEO was therefore Maddy's legal parent.

65. I note that the *CPC Act* sets out its "objects" at section 4 as follows:

> "(a) to promote the wellbeing of children, including:
>
> (i) to protect children from harm and exploitation; and
>
> (ii) to maximise the opportunities for children to realise their full potential; and
>
> (b) to assist families to achieve the object in paragraph (a); and
>
> (c) to ensure anyone having responsibilities for children has regard to the objects in paragraphs (a) and (b) in fulfilling those responsibilities."

66. It is with these objects in the forefront of my mind that I have carefully considered the care provided to Maddy by the CEO.

Analysis of the care provided by DCF via its own review

67. DCF conducted its own internal review in relation to the care provided to Maddy. As a result of that review a report was prepared dated 24 November 2014. It was therefore a timely review in light of Maddy's passing on 6

June 2014. I was pleased to see that DCF had taken a proactive response to Maddy's passing; however the review itself contains findings in relation to numerous failures by DCF to comply with its own policies and procedures which are of significant concern.

68. The review itself notes the fact that Maddy's case was managed by the Katherine office, even though she was living in Darwin, and that "at times" her case managers had "excessive caseloads" which contributed to the failure by the CEO, through her employees, to meet policy and legislative requirements in relation to Maddy. I pause to note here however the direct evidence from Maddy's case manager, Ms Larsen that she did not consider her case load to have been high and she gave clear evidence that she did not consider it impeded her ability to manage Maddy's case in particular. The review also noted that there was a high turnover of staff which compounded issues further and I note that staff retention has long been a matter of concern within DCF.

69. DCF's own review found failings in the following key areas:

    69.1 DCF's own protection investigation concerning Maddy,

    69.2 DCF's delivery of out of home care services whilst Maddy was in care,

    69.3 DCF's assessment and management of Maddy's high risk behaviour, and

    69.4 DCF's collaboration with other agencies which were called upon to provide assistance to Maddy.

70. DCF's own findings included that:

- "(Maddy's) complex needs and high risk behaviours made it very difficult to locate adequate placements for her due to limited placement options and lack of resources to support carers. This

resulted in (Maddy) being placed in unsuitable placements where her needs were not met.

- DCF did not utilise the provisions in the chapter 19.8 and 19.9 of the Care and Protection Policy and Procedures Manual ("CPPPM") to approve (Maddy's) aunt as an emergency carer and did not complete the needed checks before (Maddy's) placement. DCF allowed (Maddy) to self-place for three months while the interim assessment was completed notwithstanding significant concerns reported by other professionals regarding (Maddy).

- When (Maddy) self-placed and DCF was aware that she was at risk of harm, consideration was not given to use the power under section 84 and 85 of the Act to inspect where she resided, apprehend her and return her to her designated placement.

- Stakeholders raised concerns regarding the training and knowledge of residential workers and carers in particular regarding management of young people engaged in high risk behaviours. These deficits were exacerbated by lack of information sharing by case workers (through placement agreement meetings and relevant paperwork i.e. care plans) with providers which led to carers not knowing (Maddy) and being unable to respond to her.

- Proactive interventions were not offered when placements were in crisis to prevent placement breakdown leading to instability and repeated moves for (Maddy).

- DCF's files do not demonstrate adherence to transition planning when placements broke down leading to important information about (Maddy) and issues that needed to be followed up to be lost. All carers interviewed spoke about the limited effort invested to assist

(Maddy) to maintain continuity in her relationships and social networks.

- Throughout (Maddy's) time in care there was lack of compliance with the legislative and policy requirements for preparing and reviewing care plans and distributing these to relevant stakeholders.
- Planning for (Maddy's) leaving care did not commence in a timely manner and was impacted by crisis driven casework and a focus on (Maddy's) immediate needs which distracted from planning for her long term needs.
- (Maddy) had not consistently received face to face contact which was commensurate with her assessed needs and some of the contact was not meaningful, as it did not explicitly address the issues identified in the care plan.
- DCF had not facilitated regular and safe contact between (Maddy) and her family and as a result she was exposed to harm".

71. These ten (10) separate findings are supported by the evidence tendered before me and represent significant failings that negatively impacted on the care that should have been provided to Maddy by the CEO during the term of her protection order.

i. Findings by DCF as to their assessment and management of Maddy's high risk behaviour.

72. DCF's own findings in this regard included that:

- "After (Maddy) came into care DCF caseworkers did not liaise with the relevant professionals to collate information for a baseline assessment and this resulted in delays in understanding (Maddy's) needs and responding to them.

- The severity and frequency of (Maddy's) emotional distress correlated with self-harming and suicide attempts were under-assessed as the mental health assessments completed were crisis centred and did not holistically consider (Maddy's) needs in the context of the complex trauma she experienced.

- All stakeholders believed that (Maddy) was depressed and at high risk of suicide. DCF could have more assertively supported (Maddy) to attend a specialist assessment to determine what interventions could have been deployed to support her.

- DCF offered no support to (Maddy) regarding her substance misuse despite evidence that this was negatively impacting on her emotional wellbeing and she was receiving threats as a result of incurring drug debts."

73. Again, these four (4) separate findings are supported by the evidence tendered before me and again represent significant failings that negatively impacted on the care that should have been provided to Maddy by the CEO.

ii. Findings by DCF as to interagency collaboration

74. One of the findings by DCF within its own review was that Maddy:

> "… had a good professional support system comprised by her case managers, the Youth Support Worker, a psychologist, a teacher from Malak Re-Engagement Centre, previous foster carers and residential case workers".

75. Whilst I accept that individually each of these persons were attempting to do what they could to provide for Maddy's needs, it is apparent that there were no regular meetings, or sharing of information, between these individuals to ensure that the knowledge they each possessed about Maddy was known to all. I note that a number of Maddy's residential case workers and youth workers gave evidence that they either never met Maddy's case manager or

were not able to communicate with her directly and they considered this had a negative impact on the level of care provided to Maddy and their ability to meet her complex needs.

76. I find that a collaborative approach between those attempting to provide for Maddy's day to day needs and the resulting sharing of information between such individuals may have resulted in better outcomes for Maddy.

77. I also note the other finding by DCF within its own review in relation to interagency collaboration:

- "Care planning including preparation for leaving care did not consistently occur in collaboration with all relevant stakeholders (carers, residential workers, psychologist, youth worker) and this created confusion over goals and the interventions needed to support (Maddy)."

78. Given the significant anxiety that Maddy had expressed about what was to happen to her when she turned 18 years of age and the protection order came to an end, I find the failure by DCF to properly plan for her leaving care in accordance with its own policies and legislative requirements to have been a significant failure. It should have been done and there is no reasonable excuse that this did not occur.

79. I also note the evidence of the failure by DCF to advise Maddy's treating psychologist, Ms McKenna, of her attendances upon other mental health professionals or attendances at RDH in relation to episodes of self-harm. In relation to this issue I note that Ms McKenna sets out within her letter of 9 April 2016 that:

> "Currently communication is ad-hoc and fragmented resulting in private health providers not being informed of their client's presentation at public mental health services. There is a high reliance on the client being required to report such presentations, which may not occur for a number of reasons".

80. I note that the failure to communicate such information with Ms McKenna was also part of the review of TEMHS systems conducted by Dr Michael Paton, Consultant Psychiatrist and Clinical Director of Mental Health Drug and Alcohol, Northern Sydney Local Health District, on behalf of DOH. As described by Dr Paton:

> "This was regrettable given that she (Ms McKenna) was clearly the key clinician who had provided Miss Downman's care over four years, and was her current therapist".

81. I agree with this opinion and find that such failure to communicate meant that essential information relating to Maddy's mental health was not being provided to the very person who was being tasked to provide Maddy with psychological counselling in order to address her mental health issues. I find this negatively impacted on the ability of Ms McKenna to ensure that she had a complete and up to date picture with respect to Maddy's mental health and to ensure that Maddy's needs were being properly addressed.

Submissions on behalf of the family as to the care provided by DCF

i. Collaboration

82. In addition to the previously identified lack of communication between DCF and Ms McKenna, it was submitted on behalf of the family that it was also significant that DCF had failed to advise the CAMHS of Maddy's unwillingness to attend upon Ms McKenna whilst they were considering Maddy's referral. I agree that such information should have been provided by DCF to CAMHS, however I also agree with the evidence provided by Dr Paton that:

> "Had alternate decisions been made about (Maddy's) referrals, the conclusion cannot reasonably be drawn that her death would have been prevented".

ii. Placements

83. I have already identified DCF's failures with respect to Maddy's numerous placements. Submission was also made on behalf of the family that there was "a tendency to place Maddy where there was a bed available". There was no evidence to support this submission and I do not accept it. It is clear that placements were very difficult as Maddy's needs were extremely complex and she regularly absconded. Unfortunately, short of restraining her in some way it is clear that if Maddy made a decision that she was going to leave, there was very little that could be done to change her mind. I accept however that attempts were made by DCF each time to persuade her otherwise as best they could.

84. I also find that although many placements were crisis driven at commencement, steps were subsequently taken to attempt to make each new placement as stable as possible, as quickly as possible. I do not accept the submission made on behalf of the family that "the residential care facility in which Maddy was placed during her final three months was inappropriate". In fact I find the facility at Sabine Road to have been appropriate and agree with the submission made on behalf of DCF that Maddy appeared to have formed good relationships with her carers at that facility. The facility was also one that gave her a degree of autonomy, which I agree was important given the need for her to learn new skills for independent living.

iii. Training/Qualifications of carers

85. I note that submission was made on behalf of the family that there were issues in relation to the training and qualifications of carers at the residential care facility. Whilst I accept that DCF's own review found issues relating to the engagement between Maddy and some of her carers, I do not consider that these had any material relationship to Maddy's death and I make no further comment, particularly in light of the significant changes in training that have occurred at DCF since this death.

iv. Inadequacies of care planning

86. Submission was also made on behalf of the family that Maddy's care plan did not address the gaol of reunification and did not address her cultural needs, thus further negatively impacting upon the level of care provided to Maddy. I do not agree with this submission. I find that great efforts were made to attempt to place Maddy with family, all of which proved entirely inappropriate. I also find that Maddy herself was well aware that being placed in the care of her family was not in her best interests and had previously placed her at risk on occasion. It is also clear that Maddy was permitted to regularly spend time with, and speak to, her family with DCF having gone so far as arranging for Maddy's family to be assisted to travel to Darwin in order to protect Maddy but still connect her with her family and thus her culture.

87. A further submission concerned the failure to develop an adequate care plan. I have already confirmed the findings of DCF's own internal review in relation to the failure to comply with its own policies and legislative requirements in relation to Maddy's care plan and will not repeat those findings here. I note that DCF has already made changes to its systems to ensure compliance in future with respect to care plans. These changes are important as care plans are significant documents that help guide the care to be provided to a child and the outcomes sought to be achieved. They also assist in the exchange of information between carers. With the well-known high turnover of staff at DCF this becomes all the more significant. Given the changes said to have been instituted by DCF since this death and the accepted significance of such care plans, I would hope to never again see in another inquest a failure by DCF to have a properly prepared and regularly reviewed care plan in relation to another child in care.

88. In relation to the exchange of information, during submissions made on behalf of the family I noted that it appeared agreed that verbal handovers between case managers were not appropriate. I also noted the evidence of Ms Simone Jackson, General Manager of Operational Services Group for

DCF that she would expect that professional people would behave professionally and ensure appropriate handovers occurred. Whilst I agree with this sentiment, given the importance of the exchange of such information at the handover of management of care of a child, I consider it appropriate that there be a direction given by DCF to all case managers that there be formal written confirmation of any and all information exchanged between them at the time of handover of any case and I shall make a recommendation to that effect.

89. In relation to submissions made as to the failure to have developed a behaviour management plan, I agree that this should have occurred in accordance with DCF's own policies. It is unfortunate that one had not been formally devised, however I am satisfied that those case workers, youth workers and Maddy's case manager, who were directly and regularly involved in her care were all well aware of her behavioural issues and were constantly engaging with her in an attempt to bring about behavioural change. I also note that it appears likely that by the time any such plan may have been prepared for Maddy's "behaviour", it would have been redundant given her constantly changing behaviours and the need to be able to respond to these changes quickly. I find that failure to have in place a written plan to deal with such behaviours did not negatively impact upon the care provided to Maddy or contribute to her death. I am also satisfied that changes have been introduced by DCF to ensure compliance in future.

90. In relation to submissions concerning the failure to have developed a safety plan for Maddy, I agree that the evidence establishes that carers were aware of the existence of such plans. I note that DCF confirms that this failure was again not in accordance with policy that had been introduced three (3) months prior to Maddy's death and has since been rectified. Again, I am satisfied that the case workers, youth workers and Maddy's case manager, who were directly and regularly involved in her care were very aware that Maddy had a history of "at risk" behaviours and were constantly monitoring

her in light of that history. I find that failure to have developed a safety plan with respect to Maddy did not negatively impact upon the care provided to her or contribute to her death and I am satisfied that changes have been introduced by DCF to ensure compliance in future.

Other matters

91. Some of the residential carers who were involved with the day to day care of Maddy provided evidence that “in hindsight” there were perhaps warning signs that Maddy intended to attempt to take her life. Reference was made to Maddy appearing to have gone out of her way in the days prior to her death to see people who had been involved in her care such as family members and one of her foster carers with whom she had been placed with for several months. I note however that the plan to meet her family on 5 June 2014 appears to have been a longstanding one and not spur of the moment, although there were changes to the exact arrangements on the day.

92. Reference was also made to the fact that Maddy had received news on 5 June 2014 that one of her carers that she was close to was leaving the service. When that carer came to speak to Maddy, she refused to speak with her and said “You’re abandoning me”.

93. It is also clear that Maddy was very worried about what was to happen to her when she turned 18 years of age because the protection order would then cease and she would no longer be in the care of the CEO. It was noted by a number of the carers that Maddy had often discussed her concerns about this issue and on occasion had also stated “I’m not going to make it to 18” and “youse don’t give a fuck, no one gives a fuck about me”. When these types of comments were made however, attempts would be made for Maddy to attend counselling or her psychologist, but then Maddy would refuse to attend. It is also apparent that such comments were often made by Maddy but did not always result in her carrying out an act of self-harm.

94. Whilst it is easy to be wise in hindsight, and whilst I accept that such persons are attempting to make sense of Maddy's death, I note also the evidence of Ms Musgrave that at the relevant time:

> "Honestly I thought we were in for a great night because she seemed so – like talking to me about what she's doing tomorrow straight away has taken me off guard of anything being, you know, a little bit off because she also was a little concerned about (Master R), you know, um, so to me it – I can't believe this happened, you know.
>
> I've seen nights where I've watched her like a hawk 'cause I thought she was, you know, being a little strange but that night was not one of them".

95. I also note the evidence provided by Dr Michael Paton, Consultant Psychiatrist and Clinical Director of Mental Health Drug and Alcohol, Northern Sydney Local Health District, where he stated:

> "Prediction of individual suicide attempts or completion of suicide is not possible with any certainty. It is not possible to determine that a failure to take any specific action or treatment by the Top End Mental Health Service, including the Child and Family Mental Health Service or any other agency, would have prevented Miss Downman's apparent suicide on the 6th of June 2014."

96. I include in Dr Paton's reference to "any other agency", reference to DCF. I do not find, on the evidence before me, that there was anything said or done by Maddy on 5 or 6 June 2014 that should have alerted those close to her, or involved in her immediate care, that she intended to take her own life.

97. As already noted during the course of these findings, there was significant evidence led before me during this inquest concerning Maddy's mental health, the irregularity of her attendances upon her psychologist Ms McKenna, the lack of a sharing of information between the mental health providers that Maddy saw and the fact that there was no formal diagnosis ever made of Maddy. In light of the evidence as to Maddy's significant need for long term psychological counselling it is indeed unfortunate that

Maddy was not attending regularly upon Ms McKenna and had not attended upon her at all after 30 January 2014 up until her death.

98. However the evidence is equally clear that Maddy was resolute in her refusal to see, not just Ms McKenna, but anyone else in relation to her mental health. Whilst on occasion after 30 January 2014 Maddy indicated that she "may" be willing to see "someone", when Maddy was advised that referral to CAMHS had been refused she again indicated that she would not have attended anyway. I also find that there had been occasions where counsellors had attended at the residential care facility to see Maddy and she had refused to even come out and speak to them. The evidence also establishes that Maddy had capacity to make decisions and to provide informed consent and in such circumstances I find there was little more that DCF could do to *make* Maddy attend on any mental health professional.

99. I have already made findings in relation to the need for there to have been a stronger collaborative approach taken with respect to the sharing of information. This should have occurred better and so much is acknowledged by DCF and changes have been made.

100. I note too that the DOH has undertaken its own review with the assistance of Dr Paton's analysis and are considering the eight (8) recommendations that have been made by Dr Paton as a result of Maddy's death. I note the evidence given by Dr Robert Parker, Director of Psychiatry, TEMHS that a Draft Action Plan is presently being refined by TEMHS for approval by the Chief Operating Officer of TEMHS. I recommend the DOH to consider the recommendations that have been made by Dr Paton with a view to their implementation as soon as possible in accordance with any Action Plan finalised by TEMHS. I annex a copy of Dr Paton's recommendations in this regard.

101. It is also important that the Draft Action Plan referred to by Dr Parker be finalised as quickly as possible and submitted for approval as soon as

possible in order to begin the process to effect the recommended changes. Although I do not intend to make a formal recommendation to this effect, I would strongly encourage the Minister for Health to ensure that the DOH is sufficiently resourced to implement such recommendations should they be deemed appropriate by TEMHS within any finalised Action Plan. I consider that TEMHS are the most appropriate service to determine whether such recommendations by Dr Paton are appropriate in the context of the mental health system within which they operate.

102. A further issue that arose in this inquest was that there was never any formal diagnosis made of Maddy. I note that it was Dr Paton's opinion that this was "(t)he most significant deficiency in the application of established systems and procedures". Dr Paton opined that:

> "The making of a diagnosis is essential in subsequent decision-making process about the provision of evidence-based care, so it (is) reasonable to suggest that without one appropriate care planning and clinical decision-making were impeded".

103. I note also that it was Dr Paton's opinion that Maddy "was in all likelihood suffering from a Borderline Personality Disorder (or an emerging Borderline Personality Disorder)". It appears that Ms McKenna had raised this potential diagnosis with Maddy's case manager back in 2011 but had noted that Maddy was "too young" to be formally diagnosed. Dr Paton also set out within his report that "some specialist clinicians may be reluctant to make a diagnosis of Personality Disorder in a person under the age of 18 years, as personality is considered to be still developing until at least this age".

104. In relation to this issue, it is clear that there is presently a difference of expert opinion as to the appropriateness or otherwise of diagnosing a person under the age of 18 years with Borderline Personality Disorder. I note Dr Parker's evidence indicated a reluctance to diagnose a person under 18 with such a disorder, just as had been noted by Ms McKenna back in 2011.

Given the conflict in evidence between the experts I do not, in the context of this case, consider myself sufficiently informed to be able to make a finding about the appropriateness of one expert's opinion over another as to whether such a diagnosis *should* or *could* have been made in this case and I decline to do so.

105. It is also important to keep in mind that it is apparent from Dr Parker's evidence that even if such a diagnosis had been made it would have been unlikely to have changed the outcome in relation to the arrangements made for Maddy's psychological treatment. This was because such a diagnosis would not have resulted in Maddy being found to have a "mental illness". As a result, Maddy would not have fallen within the provisions of the *Mental Health and Related Services Act* ("MHRSA") in order to have been made subject to an involuntary treatment order.

106. Further, although there were crisis events involving Maddy's mental health, in particular episodes of self harm and threats to commit self-harm, the evidence does not establish that Maddy was ever sufficiently "mentally disturbed" to the extent that this term is understood under the MHRSA. That is to say, that there was no evidence before me that Maddy's behaviour was ever "so irrational as to justify" her "being temporarily detained". Dr Parker in fact gave evidence that Maddy was "able to give informed consent" and yet she refused to consent to attending further psychological treatment.

107. I therefore do not consider that any "failure", if it were to be accepted that there was a failure, in diagnosing Maddy with Borderline Personality Disorder would have made any difference to the manner in which Maddy was treated and the level of care provided.

Final comments

108. There is no doubt that Maddy was a very troubled girl with very complex needs making provision for her care extremely difficult. When I first began to hear and consider the evidence I was disturbed by the significant number of placements, the fact that Maddy was not attending school or employment, her failure to attend psychological counselling, a lack of collaboration both within DCF itself and with other agencies such as CAMHS and Ms McKenna, her continued use of alcohol and marijuana and the continued attempts at self-harm. I was also concerned by the numerous failures found by DCF itself to have not complied with their own legislative and policy requirements. However, having considered all of the evidence, I find that despite these matters this was not a case (as I have found in the past) that any of these failures and errors necessary led to the death or contributed to this death.

109. Maddy was a 17 year old young person at the time of her death, only 10 months away from turning 18 years of age, which would have resulted in her no longer being subject to a protection order and the CEO no longer possessing long term parental responsibility. Because of her age and her clear capacity to give informed consent, I find that there were certain limitations as to what the CEO, and thus DCF, could do when Maddy refused to comply with their requests to attend things such as school, employment and psychological treatment. There was no capacity by DCF to lock Maddy up simply because she refused and nor should there have been. Further it was also important for Maddy to learn skills to be able to make arrangements and decisions for herself, particularly in light of the fact that she was going to turn 18 the following year.

110. There is no doubt that things should have been done better by DCF in terms of complying with their own policy and legislation. This is recognised within their own review and I note that changes have already been made and

continue to be made. This recognition by DCF is appropriate and commendable. The CEO must continue to ensure compliance in order to appropriately provide for children in her care who have already been determined to be in need of protection and who are therefore already very vulnerable.

111. There is also no doubt that improvements can be made to the systems and procedures within the DOH in relation to the provision of mental health services, in particular in relation to services to young persons like Maddy who appear to be able to easily slip through the gaps in such services. This appears particularly so where the young person is on the cusp of turning 18 years of age. I note the eight recommendations contained in Dr Paton's report and the clear evidence of Dr Parker that each of these recommendations are being carefully considered. I encourage that process to be finalised as quickly as possible and that the Minister of Health appropriately resource those recommendations that are determined by TEMHS to be appropriate.

Formal Findings

112. On the basis of the tendered material and oral evidence received at this Inquest I am able to make the following formal findings:

   i. The identity of the deceased person was Madeline Jocelyn Rose Downman born 3 April 1997 at the Katherine District Hospital, Katherine in the Northern Territory of Australia.

   ii. The time and place of death was 12.47am on 6 June 2014 at Harney House, 12 Sabine Road, Milner in the Northern Territory of Australia.

   iii. The cause of death was self-inflicted hanging and the death was intended.

iv. Particulars required to register the death:

a. The deceased was a female.

b. The deceased's name was Maddy.

c. The deceased was of Aboriginal descent.

d. The death was reported to the Coroner.

e. The cause of death was confirmed by Dr Terence Sinton on 10 June 2014.

f. The deceased's mother is Cheryl Downman. Her father is Greg Dempsey.

g. The deceased lived at Harney House, 12 Sabine Road, Milner in the Northern Territory of Australia and was a student at the time of her death.

RECOMMENDATIONS

113. That the Minister for Children and Families direct all case managers provide formal written confirmation of any and all information exchanged between case managers at the time of handover of any case relating to a child in the care of the Chief Executive Officer pursuant to any order under the *Care and Protection of Children Act*.

114. That the Minister of Health favourably consider the outcomes described in paragraphs 100 and 101.

Dated this 8th day of June 2016.

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JUDGE GREG CAVANAGH
TERRITORY CORONER

I have made reference to or described in my report a number of areas in which improvements to systems of procedures could be improved, and in which improvements in the application of current procedures could also be, made which I re-iterate and list in brief below.

1. The Department of Health should consider and prioritise the inclusion of the development of specific Youth Mental Health service or stream within its service mix, within the context ongoing mental health service planning. Such a service organisation would likely result in better clinical services and outcomes for young people with emerging personality disorder.

2. Reliance on risk assessment as a basis upon which to guide clinical care is increasingly being challenged internationally within mental health services. This concern derives from the low frequency of actual severe adverse events (such as suicide) amongst the population serviced by mental health services overall despite the fact this same group has very high rates of suicidal thoughts and behaviours. There is no reliable capacity to predict which individuals with such behaviours, thoughts or feelings will go on to commit suicide. A focus on risk can divert service attention away from that of providing a focus on the provision of high quality clinical care, based on clinical assessment, empathic engagement with an individual and his or her circumstances and the provision of evidenced-based therapies. The Department of Health should consider a review of its policies and procedures to ensure that mental health services focus foremost upon the provision of high quality clinical care, to the greatest extent possible, whilst not neglecting the consideration of risk within the specific context of the individual's context and diagnoses. It is arguable that the most effective way to reduce adverse outcomes is by providing the highest possible quality of care.

3. The Department of Health should consider the development of a policy or procedure outlining the requirements for the management of referrals to specialist mental health services, including if or when a face to face assessment is required, an indication of which clinical staff are responsible for making decisions in regard to the acceptance of referrals, and the specific feedback and preferred method of response to the referrer.

4. The Department of Health should develop a systemic approach to the assessment and management to Personality Disorder within Mental Health services, most specifically Borderline Personality Disorder. Such approaches are underway in other jurisdictions in Australia, for example the established SPECTRUM services in Victoria and the Project Air initiative being rolled out currently across

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New South Wales. The latter service is an evidence-based whole of service approach which highlights contemporary training packages, access to information, the importance of explicit and accurate diagnosis, positive messages about good treatment outcomes, the engagement of families, working collaboratively across agencies and the establishment of a dedicated capacity to provide short term follow up to clients in crisis, whilst appropriate referral is determined, essentially within existing service constraints. Such an approach assists in establishing that effective service responses to Personality Disorders are core business of public sector mental health services, even though they are not defined as mental illness under legislation.

5. The Department of Health engage in a service development process such that it may develop as a core function of Child and Adolescent Mental Health services an inter-agency leadership role in the coordination of care in complex cases. Such a clearly defined role would enhance interagency efforts, clarify that the subspecialist service need not necessarily be a primarily or secondary care provider, but provide diagnostic assessments, care plans and education to such the multiple agencies involved in a given case. Such a role will be increasingly required with the implementation of the National Disability Insurance Scheme and enhanced Commonwealth-funded NGO and private care packages. Child and Adolescent Psychiatrist should provide leadership within the interagency approach.

6. The Department of Health should develop a guideline or policy to guide clinical staff in regard to working with private mental health care providers, such that referral and communication pathways are open and clear, that the care to be provided between services is agreed and delineated, and that escalation avenues are available when required, and if necessary joint supervision and case discussion is facilitated.

7. The Department of Health develop a guideline or policy articulating the requirement for and role of Aboriginal Mental Health professionals and health care workers in the provision of consultation to general services or the provision of specialist Aboriginal mental health services, if required, including the provision of advice and assistance in routinely providing culturally appropriate mental health services to Aboriginal clients and their extended families. This would provide clarity for services, referral agencies and clients in regarding availability and appropriateness of such consultation or care provision.

8. The Northern Territory Mental Health Service give consideration to enhancing the awareness of and services for drug and alcohol services and interventions specifically for young people, such that

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appropriate diagnoses of drug and alcohol abuse or dependence are made and appropriate advice and/or referral to drug and alcohol treatment services are routinely considered.

Should you require any further information or clarification in regard to the content of this report or the recommendations, please do not hesitate to contact me.

Yours sincerely,

Dr Michael Paton

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