STATE
CORONER
VICTORIA

CORONERS REGULATIONS 1996

Form 1

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2nd December, 2008
Case No: 1134/05

RECORD OF INVESTIGATION INTO DEATH

I, **JUDGE JENNIFER ANN COATE**, State Coroner,

having investigated the death of NATHAN JOHN JACKSON STEWART with Inquest held at Coronial Services Centre, Southbank on February 18, 19, 20, 21, 22, 25, 26, 27, 28, 29, March 3, 4, 5, 19 and 20, 2008

find that the identity of the deceased was NATHAN JOHN JACKSON STEWART and that death occurred on 3rd April, 2005 at Royal Children's Hospital from

1(a). HAEMORRHAGE
1(b). INCISED WOUND TO THE CHEST WHICH PENETRATED THE LEFT VENTRICLE OF THE HEART

in the following circumstances:

INTRODUCTION

1. Nathan Jackson-Stewart ("Nathan") was 16 years and 3 months old at the time of his death. He was in the care, control and custody of the Department of Human Services[1] on a child protection order. He was an intelligent and articulate boy who had been exposed to a great deal in his short life and some of it had left its deep emotional and psychological legacy upon him. At the time of his death he was living with a former family friend called Graham McLeish, with the authority of the Department of Human Services.

2. Despite expressing many reservations about Mr McLeish in the last months of Nathan's life, the Department of Human Services (DHS) continued to express to the Children's Court[2] that Graham McLeish was a suitable person as their nominee to care for Nathan.

3. At the time of his death, Nathan was suffering from depression,[3] apparently socially withdrawn and refusing to attend school.[4] The evidence before me is sadly overwhelming

[1] See definition of "person in care" in S.3(1)(a) *Coroners Act 1985 (Vic)*
[2] The Childrens Court of Victoria has exclusive jurisdiction at first instance to hear and determine child protection applications.
[3] Exhibit A4 Statement of Dr Speirs
[4] Evidence of McLeish and School and DHS

that at the time of Nathan's death he was in a poor state of mind, probably for a range of reasons and felt anxious and depressed.

4. The coronial investigation into Nathan's death traversed a range of issues over the years and months and days leading up to his death. The Inquest extended over three weeks and ran into hundreds of pages of transcript and many volumes of documents. I have not endeavoured to summarise all of the evidence. Suffice to say my findings are based upon all of the material provided to me throughout the coronial investigation including the Inquest brief, all of the documents tendered during the Inquest, the evidence of witnesses contained in the transcript and the submissions of Counsel.

5. Before turning to those matters, however, I shall address the general statutory requirements of the *Coroners Act 1985 (Vic)* which set the legal requirements and parameters of this investigation.

JURISDICTION

Reportable death

6. Deaths required to be reported to the coroner are set out in the *Coroners Act 1985 (Vic).*[5] There was no question which arose before me that Nathan's death occurred other than in reportable circumstances and thereafter fitted within the statutory definition of a ***reportable death.***[6]

Mandatory Inquest

7. The *Coroners Act 1985* sets out a number of circumstances in which an inquest into a *reportable death* is mandatory.[7] Nathan was on a Custody to Secretary Order pursuant to the *Children and Young Persons Act 1989 (Vic).*[8] Thus he was a person under the control, care or custody of the Secretary to the Department of Human Services[9] and thus the holding of an inquest was mandatory.

8. It is generally accepted that the rationale for the mandating of inquests into certain classes of deaths, is based on a recognition that there are certain classes of persons in our community who are particularly vulnerable and if their death occurs in reportable circumstances, nothing less than the public scrutiny of an inquest should occur.

Mandatory Findings

9. Section 19(1) of the *Coroners Act 1985 (Vic)* sets out the matters a coroner must find if possible when investigating a reportable death. These provisions contained in S.19(1) are

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[5] See Sections 3 and 15 *Coroners Act 1985 (Vic)*
[6] See Section 3 *Coroners Act 1985 (Vic)* for definition of "reportable death"
[7] See Sections 3,15 and 17 Coroners Act
[8] The applicable legislation at that time.
[9] See s.3(1)(a) *Coroners Act 1985 (Vic)*

generally referred to as the mandatory or compulsory requirements upon a coroner. S.19(2) gives the coroner certain discretionary powers which I shall return to later.

Section 19(1) of the Act provides as follows:

(1) A coroner investigating a death must find if possible-

(a) the identity of the deceased; and
(b) how death occurred; and
(c) the cause of death; and
(d) the particulars needed to register the death under the Births, Deaths and Marriages Registration Act 1996.

10. S.19 (1) (b) is usually interpreted to mean "the circumstances surrounding the death" and S.19(1)(c) is generally interpreted to mean the medical cause of death. The focus of a number of inquests is paragraph (1)(b) of section 19. That is, the investigation and findings focus on the circumstances surrounding the death rather than the medical cause of death. This investigation and inquest fits that category. For this reason, I have dealt with 19(1) (a) and (c) first and very briefly, as they were not contentious and then 19(1)(b), as the bulk of the investigation and inquest focused upon the circumstances surrounding Nathan's death.

19 (1) (a) Identity of the deceased

11. No issue was raised during the course of this investigation as to Nathan's identity. There was no evidence other than he was Nathan John Jackson-Stewart born on January 4, 1989. He was formally identified by his mother, Ms Michelle Stewart.

19 (1) (c) Cause of death

12. This paragraph is usually interpreted as meaning the "medical" cause of death. No issue was raised in this inquest as to the medical cause of Nathan's death as it is recorded above.

13. Professor Cordner, Director of the Victorian Institute of Forensic Medicine conducted an autopsy and provided a detailed report of his findings.[10] I shall return to Professor Cordner's opinion as to whether or not the injuries were self inflicted. Whilst there was considerable evidence and submissions about the diagnosis and treatment of Nathan's chest wound at William Angliss Hospital, there was no difference of opinion as to his medical cause of death being anything other than the incised wound penetrating the left ventricle of his heart causing a fatal haemorrhage.

19(1) (b) How death occurred

14. As stated above, it is this paragraph which has been the focus of this investigation and inquest. This paragraph (1) (b) of section 19 is generally interpreted as requiring the

[10] Exhibit D

coroner to find the facts and circumstances surrounding the death whilst ensuring that the coroner contains the investigation and subsequent findings to those matters which fall within a description of being sufficiently proximate to and connected to the death.[11] What is sufficiently proximate to and connected to the death is sometimes a difficult judgment to make in the running of an Inquest, as from time to time it is only at the completion of the investigation (which incorporates the Inquest[12]) that the Coroner will be able to decide these issues finally.

15. However, the authorities are clear that a Coroner must make his or her best endeavours to work with these limits in mind.

16. In this case, I have dealt with my statutory obligations in paragraph 19(1)(b) by dividing up the various aspects of the circumstances surrounding Nathan's death as follows:

A: Nathan's Child Protection History and Supervision

B: Nathan's Last Days

C: William Angliss Hospital

D: The police investigation

E: Contribution

F: Comments

G: Referral to the DPP

A: CHILD PROTECTION HISTORY AND SUPERVISION

Background

17. During this aspect of the investigation I considered that whilst Nathan had a long history of child protection intervention, it was the last twelve months of his life which were relevant to this investigation as being *sufficiently proximate to and connected to his death.* It is important to note at the outset, that the major evidence as to the involvement of DHS came from Ms Julie O'Brien who was the Unit Manager for DHS at that time. In September 2004, Ms O'Brien was required to take over the managing of Nathan in the wake of the departure of his allocated DHS case worker, Frances Davies. Ms O'Brien impressed as a thoughtful and measured witness throughout the days she was required to give evidence at this Inquest. She presented as an experienced professional who had been troubled and concerned by the complexities of Nathan's situation. Ms O'Brien gave evidence of the range

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[11] *Militano v State Coroner* [Unreported 18.12.92 SC Vic 10162/1991 per Hayne J]; *Chief Commissioner of Police v Hallenstein* [1996] 2 VR 1; *Clancy v West* [1996] 2 VR 647; *Harmsworth v The State Coroner* [1989] VR 989

[12] See section 3 (1) *Coroners Act 1985 (Vic)*

and complexity of duties she was required to perform at this time with many young people apparently more seriously disturbed than Nathan and in far more difficult circumstances. It is not intended in the course of these Findings to lay blame at the feet of Ms O'Brien or any other individual employee of DHS, but rather to analyse what happened in this case to, amongst other reasons, assist DHS in its stated commitment to continuous improvement.

18. Nathan was first subject to a notification to the Department of Human Services (DHS) in February 1995 when he was aged 6 and in the care of his mother, Michelle Stewart. Between 1995 and 2002 he was the subject of 10 further notifications to DHS.[13] That first notification in 1995 reported observed behaviour of Nathan which may have been an indicator of sexual abuse. Subsequent notifications raised concerns about Ms Stewart's mental health and the volatility and violence of the relationship between her and her then partner Mr Van Hostauyen and Mr Van Hostauyen's active rejection of Nathan. Subsequent notifications also contained allegations that Ms Stewart had been physically violent to Nathan and she was not coping with her two children[14] and wanted them placed out of her care.

19. It was not until 25.10. 2002 that DHS brought a formal Protection Application to the Children's Court of Victoria. Nathan was placed out of his mother's care on that day and into the care of Graham McLeish, who was recommended to the Children's Court as a "suitable person" within the meaning of the *Children and Young Persons Act 1989 (Vic).* Nathan did not return to his mother's care. At the time of his death, Nathan was still on a Custody to Secretary Order[15] pursuant to the *Children and Young Persons Act 1989 (Vic).*

20. Ms Stewart had met Mr Graham McLeish when she was 19 years old.[16] Mr McLeish had known Nathan since he was a baby. From time to time since Nathan was 8 or 9 years old, he stayed regularly overnight at Mr McLeish's home about once a week. Ms Stewart acknowledged that this was her way of trying to give Nathan a "father figure".[17] By September 2002, in the weeks immediately before the Protection Application to the Children's Court, Nathan was staying with Mr McLeish more frequently. Both Ms Stewart and Nathan were happy with this arrangement.[18]

21. For the purposes of this Finding, I do not intend to summarise the multiple volumes of DHS files nor the transcripts of witnesses to the Inquest. Suffice to say that the DHS files and reports are replete with material which goes to the original and on-going child protection issues.

22. As to the merits of the DHS intervention into Nathan's life, there were orders of the Children's Court in place at the time of Nathan's death which placed him out of his mother's

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[13] Exhibit U

[14] Ms Stewart had a second child, Hayley Van Hostauyen, the child of the relationship between Ms Stewart and Darren Van Hostauyen.

[15] A Custody to Secretary Order places a child into the day to day care and control of the Department of Human Services pursuant to an order of the Children's Court of Victoria. It is usual for such an order, that DHS will place the child into the care of a person it has assessed as a suitable carer for that child. Such placement decisions are both the right and responsibility of DHS when a child or young person is placed on a Custody to Secretary Order.

[16] Transcript 187

[17] Transcript 188

[18] Exhibit A15, Case note of 18.9.02

custody and into the custody of DHS. There was no evidence produced that these orders were subject to any form of review or appeal. Indeed, they were made unopposed by Ms Stewart. Appropriately, therefore, no issue was taken with the merits of the original and on-going need for child protection intervention in Nathan's life. There was an issue as to the quality of that intervention but not an issue as to the need for the intervention itself.

23. Thus, for the reasons given above, I have endeavoured to confine my focus to those facts in the last 12 months of his child protection history insofar as I have assessed their relevance to the circumstances surrounding Nathan's death.

24. Nathan had been removed from his mother's care in October 2002 because he was at risk of emotional and psychological harm. After orders of the Children's Court placed him into Mr McLeish's care in 2002, he settled well into this placement and appears to have progressed satisfactorily until about mid 2004.

Nathan's last 12 months

25. The evidence reveals that by the second half of 2004, Nathan's world was in turmoil and his physical and emotional state was deteriorating. The evidence throughout the Inquest was that by mid 2004 Nathan was disconnecting from school and his peers, his placement was in jeopardy, he was not attending counselling (despite orders being in place that he must do so) and the emotional and psychological condition of his primary carer, Graham McLeish was apparently deteriorating. Nathan's mother, Ms Michelle Stewart was in no condition to offer him stability or care and Nathan was refusing to have any contact with her at that time. His long term protective worker Frances Davies had left DHS and Nathan's case remained unallocated to another case worker. He was being managed by the Unit Manager, Ms Julie O'Brien.

Nathan's schooling

26. By the time Nathan died, despite still being apparently enthusiastic about learning and his education,[19] he had not been to school for most of the second half of 2004. By the beginning of 2005, he was being assisted to enrol in home schooling.

27. Nathan attended Gleneagles Campus of Eumemmering College from year 7 to year 10 (2001 to 2004).

28. Up until 2004, Nathan's attendance and progress at school was satisfactory. It was during 2004 that his lack of attendance at school significantly increased. Despite his absences, Nathan was still assessed as making reasonable progress in Terms 1 and 2.[20]

29. From mid 2004 onwards, various members of the school staff were making contact with DHS and expressing concern about Nathan's poor attendance and its connection to the

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[19] See Ex 12 This is a letter dated 18.3.05 which Nathan addresses to his English Teacher setting out those aspects of the subject he enjoys and considers himself to have some skill in.
[20] Evidence of Ms Sue Peddlesen

behaviour of Graham McLeish.[21]

30. The school were expressing concern to DHS that Nathan's lack of attendance at school was being caused by Graham McLeish's conduct. By early August 2004, Adele Duffy (a student welfare worker at Eumemmering),[22] was advising DHS that it was the school's assessment that Graham McLeish was "sabotaging" Nathan's return to school and undermining the school. It was the strong collected opinion of the school staff dealing with Nathan, that the problem of Nathan's school attendance lay neither with Nathan nor Ms Stewart (as being alleged by Graham McLeish) but rather with Graham McLeish who did not want Nathan attending school. Ms O'Brien in evidence stated that she disagreed with the school's assessment of Mr McLeish as the only problem. She explained the basis of this view being, not that Ms Stewart may have in reality been causing a problem at the school, but that it was Nathan's perception that his mother was causing a problem for him at school.[23]

31. Mr McLeish was reporting that Ms Stewart was attending the school and making life difficult for Nathan. However, DHS were told by the school that it was Graham McLeish who was being abusive, aggressive, intrusive and deceitful with the school and in front of Nathan.[24] DHS were told that contrary to any suggestion that Ms Stewart was making life difficult for Nathan at school, Ms Stewart had not been at the school or made contact with them recently.

32. Mr McLeish raised issues even during the Inquest about Nathan's poor health contributing to his decline in school attendance. However, the medical certificates produced by Nathan's treating GP, Dr Bryce Speirs, only account for a few days of ill health for Nathan rather than the months of school which Nathan missed.

33. Nathan was an intelligent and potentially capable student. Nathan was still showing enthusiasm for school in August even after his attendance had been declining for some weeks. For example in a case note entered by Frances Davies[25] on the 4th August 2004, Ms Davies noted that Nathan was expressing to her that he was keen to return to school.

34. The evidence from the school,[26] which I accept, was that the reasons that Mr McLeish later came up with and produced to DHS as to why Nathan was not attending school, were not discussed with the school. Despite Mr McLeish expressing concern about Nathan's apparent refusal to attend school, there is no evidence that Mr McLeish sought to enlist the school's support, guidance or expertise in endeavouring to get Nathan back to school or engage with his reasons for not being able to get Nathan back to school.

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[21] Transcript 341 Evidence of Sue Peddlesen; Casis notes 10.8.04 entered by Julie O'Brien
[22] CASIS Case Note 10.8.04 entered by Julie O'Brien
[23] Transcript 715
[24] Ex G p.4
[25] Nathan's allocated DHS caseworker at that time.
[26] Viva Voce evidence of Ms Peddlesen (Acting Principal at that time)

Conclusions: Nathan's schooling

35. Based on the above, I find that the school endeavoured to manage Mr McLeish's difficult behaviour in an effort to support Nathan returning to school. The school made commendable efforts to keep DHS advised of Nathan's disengagement and their assessment of the situation. Further, the school made commendable efforts to keep Nathan engaged with his education and his peers. Sadly, despite the school's efforts it did not succeed in getting Nathan back to school or back into his peer group.

36. Further, I find that Mr McLeish was being counter-productive to Nathan's return to school and that this information was available to DHS at the time at which DHS intervention may have assisted Nathan to maintain his attendance at school.

Therapeutic counselling for Nathan

37. When Nathan came into the custody of DHS in October 2002, he was a sufficiently troubled boy for DHS to seek a condition in the Court orders to mandate therapeutic counselling for him.[27] This condition remained in place on each subsequent order up until the time of Nathan's death.

38. This condition on the Court order was not surprising given that, at age 7, Nathan was being described as anxious and depressed. Nathan had attended counselling at the Child and Adolescent Mental Health Service ("CAMHS") at age 7 in 1996 and was noted to be sad, acutely anxious and with fears of death and dying.[28]

39. Nathan had re-commenced counselling at CAMHS in 2002 with a registered psychiatric nurse Brenton Wolfe. From June 2002 to March 2003, Nathan attended Mr Wolfe. Mr Wolfe left CAMHS and Nathan then commenced attending weekly upon a psychologist called Jeff Oliver at the Andrews Centre. According to Mr McLeish, Nathan enjoyed these counselling sessions and found them extremely positive and helpful.

40. In evidence Mr McLeish described it thus ....

"He loved Mr Wolfe ..... he always believed that Mr Wolfe had some sort of magic, cause he always felt good after he left there, and he realized, because Mr- the other psychologist, had also made him feel good..he realized that Mr Wolfe didn't have any magic, it was just what he was talking about." [29]

41. Mr Oliver left his position at the Andrews Centre in June 2003. It was Mr McLeish's evidence that, despite the Court orders mandating therapeutic counselling, and despite his evidence that Nathan had both enjoyed and benefitted from the counselling, he made no other enquiries about counselling for Nathan until about mid 2004 when his condition had

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[27] A condition on the first Interim Accommodation Order made on 25.10.2002 was "Nathan must continue therapeutic counselling". This condition remained on successive Orders thereafter.
[28] Exhibit L
[29] Oral evidence of Mr McLeish TS 1316

commenced a serious decline, and DHS made none either.[30]

42. It was the evidence of Ms O'Brien that DHS did encourage Nathan strongly to attend counselling, but he was either ambivalent or refusing to attend and DHS felt that, given that the effectiveness of counselling relied upon a willing participant, there was not a lot they could achieve. Despite this, Ms O'Brien did give evidence that "it was very important for Nathan to attend counselling."[31]

43. This view of Nathan's attitude to counselling must relate to a period well after early August 2004. I infer this because in DHS own records, in a lengthy case note of August 4th entered by Frances Davies,[32] the case note states that "Nathan was keen to return to school and to see Jeff Oliver".[33] Indeed, Frances Davies left a message for Jeff Oliver, from which I infer that she was following up Nathan's wishes to resume counselling as at August 2004.

44. Further, a few days later, on the 10th August, 2004 Frances Davies entered a case note[34] that Nathan had again visited Dr Speirs and felt relieved after seeing him and believed that the GP understood his situation.

45. These two notes are at odds with the evidence of Ms O'Brien that Nathan was adamant that he would not attend counselling. These notes indicate that Nathan, at least at that time and perhaps in the right circumstances, was keen to have the support of an independent professional. Nathan was attending a doctor that he felt positive about and Nathan was expressing a wish to reconnect with his former counsellor. The later evidence is that as Nathan dropped out of school and withdrew from his peers and indeed the outside world generally, he became much more resistant to attending counselling. He was expressing that resistance to Dr Speirs too, although he was remaining more open to attending a counsellor rather than a psychiatrist.

Conclusions: Therapeutic counselling for Nathan

46. There was a court order in place mandating therapeutic counselling for Nathan. It was not an option for him or DHS. It should be noted that unlike many adolescent boys, Nathan had a previous positive experience of counselling. His positive response to Dr Speirs as reported by him to Frances Davies makes it probable that Nathan could have been persuaded to re-engage with counselling as at August 2004 had it been appropriately pursued by DHS at that time. This was at a time when Nathan's deterioration was becoming evident. Sadly, it appears that the opportunity to readily re-engage Nathan with a counsellor was lost.

47. Despite DHS saying that it was not appropriate or possible to engage a young person in counselling if they are resistant to it, Nathan was an intelligent, articulate young man who had clearly been able to benefit from counselling in the past. As at August 2004, Nathan was

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[30] Transcript p 1321
[31] Transcript 692
[32] This was during the same exchange in which Graham McLeish told Nathan he did not want him anymore.
[33] Appendix 6
[34] Appendix 6

indicating a wish to attend counselling. By February 2005, Dr Speirs had been able to persuade Nathan to feel positive about attending a psychiatrist.

48. The evidence is that DHS did not play a pro-active role in identifying a counsellor, and making arrangements for Nathan to attend and assisting him to get there. Ms O'Brien's view was that Nathan attending counselling was important[35] as, amongst other things, it enabled DHS to be provided with verbal updates as to Nathan's mental health. She also conceded in evidence that it would have been better for DHS to have linked Nathan with a counsellor and to have been more proactive in this respect.[36]

Supervision of Nathan's emotional and psychological condition in the last 12 months

49. Frances Davies, was Nathan's case worker until about the first week in September 2004 after which time she left the employ of DHS. Given that Nathan had no counsellor, the best independent evidence of Nathan's condition at that time comes from the evidence of Dr Speirs, his treating GP. Nathan first visited him on August 5th, 2004.[37] Dr Speirs assessed Nathan as an "obviously psychologically disturbed young man, who was having major problems adjusting to the real world and relating to people."

50. On August 9th 2004, Dr Spiers wrote a letter referring Nathan to Dr Sandy Youren, an adolescent psychiatrist. Nathan did not ever attend upon Dr Youren. Nathan told Dr Speirs that he did not want to attend a psychiatrist because he did not want his mother to have access to his confidential information and he did not want to be "labelled as someone with a psych problem".[38] This was consistent with the resistance Nathan was demonstrating to Ms O'Brien when she took over the management of Nathan's case. However, Dr Speirs in evidence raised that it was the fact that Dr Youren was a psychiatrist which seemed to trouble Nathan rather than a counsellor per se.

51. Dr Speirs saw Nathan again in September 2004. He described him at that time as a boy not coping with life, not coping with stresses, not coping with school and with a lot of anger and a lot of frustration.[39] Dr Speirs described him as a very bright boy who was very brittle and delicate. He did not want to attend school because he was not coping psychologically with school.[40]

52. When Nathan saw Dr Speirs on February 3rd 2005 Nathan was complaining of "significant depression caused by his destructive relationship with his mother"[41] but he told Dr Speirs that he did not want to go and see Dr Youren because he did not want to be seen as "a headcase".[42] Nathan told Dr Speirs that he spent much of his day feeling very down. Dr Speirs prescribed the anti-depressant Zoloft for Nathan.

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[35] Oral evidence of Ms Julie O'Brien TS: 692
[36] Oral evidence of Ms Julie O'Brien TS: 723
[37] Ex A4 Statement of Dr Spiers
[38] Transcript 1273 Dr Spiers
[39] Transcript 1272 Evidence of Dr Spiers
[40] Transcript 1275. Dr Spiers
[41] Ex A4 Statement of Dr Spiers
[42] Transcript 1276

53. Nathan re-attended Dr Speirs on February 21, 2005. It was Dr Speirs' assessment that by that time the Zoloft was "kicking in" and that Nathan was indicating he was agreeable to going to see Dr Sandy Youren. In his statement, Dr Speirs stated that when he discussed with Nathan at that time seeing a psychiatrist who specialized in adolescents that Nathan "was quite agreeable to this."[43] Dr Speirs felt that by that time he was starting to get Nathan talking to him and trusting him rather than everything going through Graham McLeish.[44]

54. Nathan had a follow up appointment with Dr Speirs on March 7, 2005. Mr McLeish attended that appointment but Nathan did not.[45] It is not clear why Nathan did not attend. Dr Speirs impressed upon Mr McLeish how important it was that Nathan come back and see him. Nathan did not ever re-attend Dr Speirs.

55. It was Dr Speirs' assessment that Graham McLeish was not able to take control of the situation and he was looking to Nathan for confirmation.[46] However, it was also Dr Speirs' assessment that Nathan was deeply dependent upon Graham McLeish to provide him with security and indeed at that point in his life it was what was holding Nathan together.[47]

Conclusions: Supervision of Nathan's emotional/psychological condition in the last 12 months

56. Unfortunately, despite being aware of Nathan's attendance on Dr Speirs,[48] DHS made no contact with Dr Spiers at any stage up until Nathan's death. It was the evidence of Ms O'Brien that normally DHS would welcome the assistance of a doctor, but this did not occur in Nathan's case, despite the evidence of Mr McLeish that he was relaying concerns to DHS about Nathan's state of mind.[49] What Dr Speirs had to say about Nathan's condition, his ambivalence about counselling, his condition and his relationship with Graham McLeish would have been extremely useful for DHS to hear and work with to assist Nathan through a very difficult period in his life.[50]

57. The evidence is that Nathan's emotional attachment to Mr McLeish was complex and somewhat fraught. It had already been demonstrated in many ways that, had DHS been watchful, it would have seen that the relationship was one in which Mr McLeish's conduct was becoming increasingly more destructive and unstable to Nathan's detriment. Neither Nathan nor Mr McLeish were participating in counselling or supervision. There is no clear evidence that DHS had a real sense of the complexities of that relationship and how

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[43] Ex A 4
[44] Transcript 1287
[45] Transcript 1283
[46] Transcript 1280 Evidence of Dr Speirs
[47] Transcript 1291 Evidence of Dr Speirs
[48] See Case note of Frances Davies 10.8.2004 (Appendix 6)
[49] On January 7, 2005 Mr Mc Leish was relaying concerns to DHS about Nathan's state of mind and his refusal to see a doctor about it. On 7 February 2005 Graham told DHS that Nathan had visited the doctor for his depression and had been prescribed Zoloft.
[50] For example, Dr Speirs, when asked about whether it could be counter productive with teenage boys to continue to urge them to go to counselling if they are resistant, Dr Speirs accepted that and stated that it was necessary not to "jam it down their throats" but noted "you do have to gently suggest it and gently suggest the positive values of it" (Transcript 1296) and work on building a rapport to get the young person to the psychiatrist.

unhealthy it was becoming for Nathan. The evidence of Dr Speirs that Nathan believed everything that Graham was saying demonstrates something of the complexity of the attachment.

Nathan's concerns about privacy

58. There is significant evidence that Nathan was preoccupied, for whatever reason, with his mother's capacity to get at his personal health information, find out information about his private life, spread rumours about him and generally intrude in a destructive way into his life. This appeared to be creating a huge stressor for him together with being a barrier to obtaining appropriate therapeutic treatment for himself.

59. An example of these concerns being a barrier is illustrated by Nathan not ever attending upon Dr Youren. According to Mr McLeish, Ms Stewart became aware of the appointment made by Dr Speirs through DHS and thereafter she had begun to make enquiries about Dr Youren. According to Mr McLeish, DHS had told Nathan that Ms Stewart had contacted Dr Youren,[51] and this caused Nathan to refuse to see Dr Youren. According to Mr McLeish Nathan would have benefited from counselling but had lost faith in the value of counselling because Nathan believed that what he told the counsellors could be subpoenaed to court.[52]

60. Dr Youren, wrote a letter to the reviewer who conducted a Child Death Review for DHS[53] confirming that an appointment was made for Nathan on 25th November, 2004 and a letter sent to his carer Graham McLeish on 12th November, 2004 to confirm it. No confirmation was ever received back from Graham McLeish according to Dr Youren. It was Mr McLeish's evidence that Nathan would not go because he had been told by DHS that his mother had contacted Dr Youren. Contrary to Nathan's fears, there was no evidence that Ms Stewart had ever contacted Dr Youren.

61. The evidence is that at least by November 24, 2004 Ms O'Brien knew that Nathan had been diagnosed with depression[54] but she was being told by Mr McLeish that Nathan would not go to see Dr Youren because Michelle had found out the name of the psychiatrist via Medicare and therefore Nathan no longer trusted the psychiatrist. Apart from anything else, the evidence reveals some apparent duplicity on the part of Mr McLeish on this issue. That is, he told Nathan that Ms Stewart was told by DHS of his intended visit to Dr Youren, but he told Ms O'Brien that Ms Stewart had found out about Dr Youren via Medicare.

62. Nathan's complex relationship with his mother generally was obviously a source of stress for him. On July 28, 2004, in a home visit with DHS, Nathan advised he did not want contact with his mother at all. Allegations that Michelle Stewart was a serious threat to Nathan's safety and peace of mind were being made by both Mr McLeish and Nathan. Nathan was indicating that he did not want his mother to have access to his school records or medical records. He stated he did not want to have a 16th birthday as he was worried his

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[51] Evidence of McLeish at TS 1328-1330
[52] Evidence of McLeish at TS: 1322
[53] Exhibit A 17
[54] Case note of discussion with Graham McLeish entered on 24.11.2004

mother would find out about it. Ms O'Brien also knew that Nathan was not attending school apparently as a result of fears of Ms Stewart's approaches to the school both seeking and spreading personal information. It is clear from all of the material that Nathan felt "intruded upon" by his mother. According to Dr Spiers, Nathan was quite distressed about his relationship with his mother and had stated to Dr Spiers that he felt like self harming "but didn't want his mother to win." Dr Spiers described Nathan as very angry about how he had been treated in his younger years. Dr Spiers also gave evidence that Graham McLeish was being "extremely" negative about Michelle Stewart in front of Nathan.[55]

Conclusions: Nathan's Concerns about privacy

63. The weight of the evidence is that DHS did not take a proactive or decisive role in trying to investigate and allay Nathan's concerns[56] and fears about his mother's intrusion into his life, nor obtain on-going counselling for Nathan to have him work through the issues. Whilst there is reference to some legal advice having been taken about his ability to keep his health information private, ultimately it was not clear what advice was sought and what was given as to Nathan's capacity to consent to his own health care and keep his personal information confidential from his mother.[57]

64. Similarly, whilst Ms O'Brien accepted the evidence that Ms Stewart had not been "intruding" into his school life in the way in which Nathan believed, she indicated that it was Nathan's perception that she was doing so. However, the evidence leads to a finding that the position DHS left Nathan in was one in which his concerns about his mother's intrusions into his school life were not investigated and dispelled to enable him to have a better chance of resuming schooling.[58]

The condition of Mr McLeish

65. McLeish presented a very complex picture during this investigation. Whilst the evidence is that Nathan's placement initially progressed well with him, by mid 2004, there was mounting evidence that Mr McLeish was not behaving in a stable or rational manner.

66. DHS were receiving reports of Mr McLeish's behaviour at Nathan's school. He was ringing the school many times, being abusive and irrational and causing the school to openly question his mental state to DHS.[59]

67. On 4 August, 2004 at a meeting with DHS that had been called to discuss Nathan's return to school, without warning Mr McLeish told Nathan's DHS case worker Frances Davies, in Nathan's presence that he had had enough and wanted Nathan's placement to end and he was going on a cruise with his mother. Later in the day he retracted this and reconciled with Nathan and explained that Nathan had hurt him and destroyed the bathroom and that is why it happened.

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[55] Transcript 1288

[56] In Exhibit A7 there is a note from Nathan stating that he did not want his Mother to have access to his medical records; see also evidence of O'Brien TS: 699

[57] See: Comments section for further discussion on this issue.

[58] As for Footnote 57.

[59] Letter from Adele Duffy to Julie O'Brien 11.8.04

68. Ms O'Brien recorded in her own notes of 16.8.04 after a telephone call from Mr McLeish on that day that she was "very concerned about his ability to adequately care for Nathan's needs and feelings of physical safety".[60] In that conversation Mr McLeish was telling Ms O'Brien about people with "guns and balaclavas" from whom he had to protect Nathan.

69. On the 3.9.04 Mr McLeish told DHS that his dog has been attacked and Nathan was really upset and angry as he believed that Michelle was responsible. On November 11, 2004 Julie O'Brien met with Mr McLeish and Nathan who stated that they were experiencing attacks on their pets, loud noises from the street, dead animals hanging in the tree, a meat cleaver left on the premises and items smashed in front of the home. They believed that Michelle or her associates were responsible. They had planned an escape in detail which included having high powered flashlights and hoses believing that the house would be set alight. They saw their only relief as shifting to a secret location.

70. Mr McLeish told Ms O'Brien that he knew 5 cars back every time he was out driving as he was always keeping a watch out. On 14.12.04 Mr McLeish telephoned DHS to tell them that Michelle has landed on his doorstep and Nathan was terrified and "cowering in the cupboard".[61] The case notes for this period (December 2004) reveal Mr McLeish was making constant and ongoing claims that Michelle Stewart was driving past his house late at night, screaming out and attacking the house, the animals and everything in it.

71. Dr Speirs observed to the author of the DHS Child Death Review[62] that Nathan appeared to believe everything Graham was saying about Michelle's behavior and her attacks on animals and such. He said that Graham described Michelle as being psychotically ill to the GP and in Nathan's presence.

72. Dr Spiers observed to the reviewer that Graham and Nathan were describing an existence that was like living in a fort. They had moved upstairs and were living as if under siege. They told the GP of their plan to move away and change their names when Nathan turned 16 as they were so concerned about Michelle and the potential harm from her.

73. When questioned about what steps DHS took to satisfy itself about the concerns it had about Mr McLeish, the evidence from Ms O'Brien was that DHS had a conversation with Mr McLeish's former psychologist, Mr David Bruce, who assured DHS he did not think Mr McLeish was paranoid. However, the evidence is that the last time Mr McLeish saw this psychologist was many years earlier. Ms O'Brien said in evidence that she regretted not following up with Mr David Bruce.

Conclusions: The condition of Mr McLeish

74. On the evidence, it seems inescapable that by December 2004, either what Mr McLeish and Nathan were reporting as the situation inside and outside their home and the

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[60] Case note of 16.8.04 entered by Julie O'Brien Appendix 6
[61] Case note entered by Kylie Quick Appendix 6
[62] Exhibit A 17

constant attacks from Ms Stewart were true, in which case it was an unbearable situation that had to be addressed as a matter of urgency, or it was not true, in which case the placement was fundamentally flawed.[63] Fundamentally flawed because if the information was not true it would mean that Mr McLeish was manipulating the situation in such a way that he was including Nathan in his perceptions of such a fraught environment which must have been adding to Nathan's levels of anxiety and distress. There is no evidence of effective intervention by way of a proper investigation of the claims being made about Ms Stewart's conduct and it follows that no view was reached by DHS about the accuracy or otherwise of the claims and the necessary implications for the placement.

75. In the wake of the events on the 4th August, 2004, Mr McLeish was referred to a "Challenging Behaviours" program which offers counselling and support for carers of children that are not their own, but neither he nor DHS followed through with his attendance at this program.[64]

76. Whilst Mr McLeish clearly presented as a suitable option for Nathan at the commencement of his placement in October 2002, a watchful child protection agency in a parenting role as DHS were should have been spurred to significantly greater intervention by December 2004. The weight of the evidence raises a range of significant concerns about the emotional and mental stability of Mr Graham McLeish by mid 2004 and the impact of this instability upon Nathan. This is not a conclusion of hindsight but one reached by DHS at that time. The totality of the evidence raises a real possibility that Mr McLeish may have been fuelling Nathan's concerns about his mother's access to his private information as well as playing a not insignificant role in fuelling Nathan's school refusal and ambivalence about his attendance upon counsellors and his poor relationship with his mother.

77. It is not possible to conclude what was causing Mr McLeish's instability as he was not professionally assessed. It is possible to conclude that his behaviour and apparent instability in the last 12 months, and the evidence DHS had about this was such that it should have raised a far more interventionist response from DHS than was the case.

Sexual relationship between Nathan and Graham McLeish

78. Throughout the course of Nathan's placement with Mr McLeish, Ms Stewart raised concerns from time to time about her belief that Graham McLeish was either having a sexual relationship with Nathan or grooming him for one. Even during the Inquest,[65] Ms Stewart stated she believed that Graham was having a sexual relationship with Nathan. When asked about the basis for this belief Ms Stewart stated that it was her "intuition".[66]

79. This issue took up some time in the Inquest. Ms Stewart raised a couple of occasions upon which she observed some exchanges between Nathan and Mr McLeish which she

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[63] During the Inquest Ms Stewart denied all such allegations. There was no persuasive independent evidence produced by Mr McLeish corroborative of any alleged attacks on the house, or animals or being followed in his car. No neighbours produced to confirm hearing or seeing these constant attacks, no reports to police, no photos of dead or damaged animals or no vet bills corroborating treatment for the animals.
[64] Transcript 724-725
[65] Transcript 65
[66] Transcript 156

believed were indicative of some sexual interaction between them. Ultimately each of these accounts appeared innocuous.

80. Ms Stewart, when questioned again about the basis upon which she actually held this view, could produce nothing beyond explaining that she had formed this view as a result of the "unnatural closeness" she said she observed between them.

81. Mr McLeish denied any such relationship. There was no other evidence.

Conclusions: Sexual relationship between Nathan and Mr McLeish

82. The "unnatural closeness" observed by Ms Stewart is consistent with the observations of others, including Dr Spiers, but on the evidence I am unable to find that it was based on any sexual relationship between Nathan and Mr McLeish but rather an emotional and psychological dependency.

83. There was no credible evidence from any source to draw any conclusions about a sexual relationship between Nathan and Mr McLeish. Witnesses,[67] other than Ms Stewart, who had the opportunity to observe Mr McLeish and Nathan together were asked whether they had concerns about a sexual relationship between Nathan and Mr McLeish and each answered in the negative.

84. There was criticism levelled both at police and DHS by Ms Stewart for their alleged failure to properly investigate the allegations of sexual impropriety against Mr McLeish but I find no substance in those criticisms. I am satisfied that appropriate investigations were conducted by DHS and Victoria Police and that the allegations were not substantiated.[68] I am also satisfied on the evidence that the continuing allegations being made by Ms Stewart about an alleged sexual relationship between Nathan and Mr McLeish were a source of great distress to Nathan.

The relationship between Mr McLeish and Ms Stewart

85. The complexity of the relationship between Graham McLeish and Michelle Stewart added a dimension to Nathan's welfare and the ability of DHS to protect and support him in his placement. It was Mr McLeish's evidence[69] that up until the Children's Court proceedings commenced in October 2002 that he and Ms Stewart had a very good relationship in which they would talk up to a couple of times a day on most days. The evidence is that this was a constantly changeable situation, both as between Mr McLeish and Ms Stewart. Ms Stewart would support the placement with Mr McLeish in one moment and then wish to occupy large amounts of DHS time berating Mr McLeish. Mr McLeish was apparently doing the same. Ms O'Brien described the relationship as "enmeshed" with a high degree of communication and conflict.[70]

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[67] Eg Dr Speirs, Ms Kim Klemecki
[68] T 774-777 Evidence of Ms O'Brien.
[69] Transcript P. 1308
[70] Transcript 699

86. Their views about each other and reports to DHS were constantly changing and therefore hugely demanding upon the resources of DHS. It is a sad litany of chaos personified to read the notes of DHS during the second half of 2003 and all through 2004. This period was rife with allegation and counter allegation as between Ms Stewart and Mr McLeish.

87. For Nathan, the relationship between Mr McLeish and Ms Stewart meant he was never free of its complications. It was one in which the struggles between Ms Stewart and Mr McLeish, whatever their origin played out in front of Nathan.[71] Whilst the placement with Mr McLeish had the advantage of being one that was what Nathan said he wanted as he did not want to be with a stranger, its huge disadvantage was the destructive complexity of that relationship. Mr McLeish had Nathan believing he would protect him from Michelle Stewart. He could not do that. In my view, that was at least in part because he did not want to sever ties with Ms Stewart.

88. He said as much in his evidence.[72] When being questioned about an Intervention order applied for by Det S/C Molloy in the wake of some alleged threats to kill made by Ms Stewart, Mr McLeish indicated he was reluctant to go on with the intervention order application. His evidence was that he "would forgive her" what ever she did and then they would start again. From this evidence I infer that his attitude to Ms Stewart was full of mixed messages and emotions. Ms O'Brien described it as "enmeshed". The complexity of this relationship added to Nathan's detriment in that placement.

Conclusions: The relationship between Ms Stewart and Mr McLeish

89. I find that the behaviour of Mr McLeish and Ms Stewart was characteristic of an acrimonious battle between two warring adults over a child of the relationship. The evidence is not reassuring that DHS were fully aware of how detrimental that relationship most probably was for Nathan, nor that DHS had developed a strategy to endeavour to proactively manage their conduct and their demands.

Monitoring/Changing Nathan's placement

90. It was Ms O'Brien's evidence that despite feeling very concerned about Nathan's placement with Mr McLeish, she felt unable to do anything about this situation because Nathan was so adamant that he did not want to be anywhere else and thus this put DHS between "a rock and a hard place".[73] That is, it felt as if it only had two options. It must either leave Nathan in his placement, which Ms O'Brien conceded was very concerning, or move him out which created a range of different concerns including the risk that he would run away.

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[71] Evidence of Dr Speirs
[72] Transcript 1311
[73] Transcript 712

91. Leaving to one side the possible kinship placement option which it has been conceded was not explored by DHS,[74] there is little evidence of a structured, organized plan to fully support the placement with a set of firm assessments and interventions and follow through that addressed some of the gaps highlighted in the findings set out above. Whilst there was a "rock and a hard place", the decision to leave Nathan in that placement with Mr McLeish as the evidence mounted about its disintegration required great vigilance and care to support it.

92. It was submitted by Counsel on behalf of DHS that the appropriateness of leaving Nathan in the placement must be seen in the context of Nathan's age, intellect and deep emotional attachment to Mr McLeish and the commitment that Mr McLeish had historically demonstrated towards Nathan. It was further submitted that there was a real risk that Nathan would run away if required to move placement and therefore be at far greater risk of detriment.

Conclusions: Monitoring/Changing Nathan's placement

93. I am in no doubt that DHS were faced with a very complex, troubling and exceptionally demanding situation. The demands of managing both Ms Stewart and Mr McLeish must have been draining. No doubt they distracted DHS from its main function and focus to protect the child. Further I am in no doubt that with all of the demands of the work of a child protection manager generally, to have a young person in a placement of this nature and committed to it in the way Nathan was, meant it was understandable how Nathan's situation could seem much less pressing than a young person on the streets engaging in high risk behaviour.

94. The placement, whilst initially an apparently appropriate one, declined into a fraught and difficult one in which Nathan's mental and emotional state and social ability and connection to the outside world deteriorated. His only available anchor was Graham McLeish. It was not surprising that Nathan clung to him as he did. The evidence is that DHS knew the situation was not good but felt "powerless" to change it.[75] This was because Nathan was an intelligent and articulate boy who was being extremely firm and consistent with Julie O'Brien and Nicola Ross about his wish to stay with Graham McLeish and threatening to run away if moved.[76]

95. However, there is a sense from the evidence that Nathan's situation was seen as an "all or nothing" situation. That is, either Nathan was moved to another placement or he had to stay and DHS had to accept what they had with Graham McLeish. It is not difficult to see

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[74] Nathan had extended family who were expressing concerns about Graham McLeish's behaviour and offering themselves as alternatives. The evidence is that there was no organized and appropriate assessment of extended family placement possibilities for Nathan despite there being real possibilities of viable placement with extended family. For example, the case notes contain reference to Nathan having completed a work experience placement with his maternal Uncle Wayne at his factory in December 2003. Nathan reported that he had really enjoyed that experience. The case notes also reveal that this same Uncle together with his partner were willing to be assessed as possible suitable carers for Nathan. The failure to pursue this option seems to be borne out of a conclusion that Nathan would not accept such a move because of his wish to stay with Mr McLeish and his fear of exposure to his mother. In evidence Ms Julie O'Brien conceded a kinship care assessment appeared to have been "overlooked" in this case.

[75] TS 711 (Julie O'Brien)

[76] TS 711-712

why the decision was made to leave Nathan where he was, but the obligations to Nathan did not end there. Giving telephone numbers for referrals or having discussions about what might be a good idea will not suffice in a situation such as this.

96. DHS had sufficient information in the last few months of 2004 of the instability of Mr McLeish, Nathan's depression and withdrawal from society and his anxiety about his mother's alleged attacks upon his psychological and physical space to have required far more intervention from DHS.

97. DHS in the role of custodian are required to act as a reasonable parent would in the circumstances and in the best interests of the child. In Nathan's case on the evidence before me, DHS did not demonstrate the vigilance, care and support for a troubled boy one would expect of a reasonably vigilant parent.

B: NATHAN'S LAST DAYS

98. Graham McLeish's account of what took place during the last few days of Nathan's life was set out in his statement tendered to the inquest.[77]

99. In summary, Mr McLeish stated that a couple of days before the evening of the 29th March, 2005 he had told Nathan that he must move out as a result of yet another bout of Nathan getting into a rage and damaging furniture and property in the house.[78] Despite that discussion, the household apparently continued relatively unchanged until the early hours of the morning of March 30, 2005.

100. In the early hours of the morning of March 30, 2005 (sometime between 3am and 4am) after having taken Nathan out to get something to eat at McDonalds at midnight, Mr McLeish noticed a light on indicating Nathan was awake. Mr McLeish states that he went into the upstairs kitchen of the house and met Nathan in there. He questioned Nathan as to what he was doing still up and Nathan told him that he was doing correspondence school work.

101. Nathan produced a piece of writing to Mr McLeish which Mr McLeish assessed as Nathan wanting to find a way to repair things between them. More words were exchanged between them and Mr McLeish stated he then went downstairs for several minutes.[79]

102. He states that when he returned upstairs, Nathan showed him his inner forearms stating "Look what I have done". Mr McLeish observed cuts to Nathan's inside forearms.

103. Mr McLeish stated that more words were then exchanged in the kitchen with him telling Nathan that he needed hospital treatment for the wounds. Mr McLeish also stated that he told Nathan that he had now just made it more likely that he (Nathan) would be removed

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[77] Ex A5 p 4-5
[78] Mr McLeish gave an account of these events to Nicola Ross he says "sometime after the incident.". See Ex A5 p4
[79] In his original statement Mr McLeish assessed this time as 3 to 4 minutes but in his viva voce evidence he corrected his statement to 7 to 8 minutes.

from Mr McLeish's care if they attended a hospital as a result of inflicting those injuries upon himself.

104. Mr McLeish states that Nathan then said "If I can't stay, I've got no life" and opened a kitchen drawer, took out a knife and holding it in both hands plunged the knife into his chest and pulled it back out again in one motion and then dropped the knife onto the floor.

105. Mr McLeish stated that he responded to this by running and grabbing a pillow and getting Nathan to hold the pillow over the wound to his chest. Mr McLeish tried to phone an ambulance but decided it would be quicker to put Nathan in the car and get him to the closest hospital, which was the William Angliss Hospital.

106. Mr McLeish stated that on the way to the hospital[80] Nathan and he discussed the situation. Mr McLeish states that Nathan threatened to jump from the car if Mr McLeish told the hospital that he had stabbed himself. His evidence is that he then told Nathan he would do anything to ensure that he had a home for life with him.

107. Mr McLeish states that he and Nathan then concocted a story which was told on their arrival at William Angliss Hospital, to explain the injuries to Nathan's chest and arms. This story was that Nathan was up late finishing his school work and when he went to turn off his stereo, he slipped and put his hand through the glass louvers and then pulled his hand back into his chest causing splintered glass to cut him.[81]

108. During the Inquest, Mr McLeish did not seek to resile from this being the story that he told to the hospital and that Nathan collaborated in. Mr McLeish explained his reason for doing so was in order to get treatment for Nathan without having to "betray" Nathan as he saw it and put him at risk of being removed from his care (despite having told Nathan he would have to move out). It was Mr McLeish's evidence that he believed that the story he told at the William Angliss Hospital was what the hospital staff and doctors needed to know to get Nathan the treatment he required.[82] That is, his evidence was that he believed that this concocted story was sufficient to convey that Nathan had suffered a penetrating wound to his chest and would therefore get appropriate treatment.

C: THE WILLIAM ANGLISS HOSPITAL

109. In this aspect of the investigation into Nathan's death, I addressed the question of whether the overall medical care and supervision of Nathan was satisfactory and, if not, whether any deficiencies caused or contributed to Nathan's death?

110. Nathan presented twice at the William Angliss Hospital on the 30th March, 2005. The first occasion was at about 4.38am on March 30, 2005 and the second was at about 11pm on March 30, 2005. It is the treatment that Nathan received on the first of these

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[80] Ex A5 p.6
[81] Ex A5 p.7
[82] Transcript P;1405-1407

presentations set out above that was the subject of considerable criticism by both Ms Stewart and Mr McLeish.

111. There were no issues raised before me during any part of the investigation including the inquest or on the material before me that raised any concerns about the care given to Nathan during his second presentation to the William Angliss Hospital or his transfer to the Royal Children's Hospital or treatment at the Royal Children's Hospital. Thus, the part of the Inquest which touched upon Nathan's medical management in his last days focused around what did or did not happen during the first presentation. For this reason, this aspect of my findings focuses only on the first presentation to the William Angliss Hospital.

112. Nathan was triaged by nursing staff at the William Angliss Hospital when he arrived in the early hours of March 30, 2005 in the circumstances set out in part B (above). He was initially observed to be distressed,[83] and pale and vomiting[84] and dry wretching with an unrecordable blood pressure.[85] Shortly after the initial unrecordable blood pressure, Nurse Stevenson (by 5am) was able to obtain a BP of 90/50.[86]

113. Dr Kenneth Lim was the Senior Emergency Registrar at the William Angliss Hospital who examined Nathan that morning. He obtained the initial triage notes which recorded that Nathan fell through a louvre glass window. Dr Lim was given the history as set out above. That is, that Nathan's arms and chest had been lacerated by a fall through glass. This was a version of the concocted story that was reported by Nurse Woodbridge[87] that Mr McLeish had told her he removed a sliver of glass from Nathan's clothing after the fall, which he (Mr McLeish) believed had caused the wound.

114. On examination, Dr Lim found no bubbling from the wound to suggest a pneumothorax. Nathan's heart sounds were normal on examination, with good air entry bilaterally into his chest with equal air movements. Dr Lim ordered a chest x-ray for Nathan which did not reveal any lung or heart injury or any glass remaining in the wound.[88] The chest x-ray revealed a normal sized heart. Dr Lim digitally explored the wound with a local anaesthetic and concluded that it was not penetrating through muscle.

115. Dr Lim stated that he concluded that Nathan's hypotension was probably due to a vasovagal response to pain rather than due to blood loss given he had no tachycardia.[89]

116. Dr Lim then cleaned and sutured the wound to Nathan's chest. Dr Lim stated that Nathan's condition improved over the hours that he was in the Hospital. He was discharged when he was freely walking around the emergency department.[90]

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[83] Ex N Statement of Nurse Stevenson
[84] Ex M Statement of Maxine Woodbridge
[85] Ex N
[86] Ex N p2
[87] Ex M
[88] Ex J Statement of Dr Lim (p.1)
[89] Ex J Second statement of Dr Lim (P.1)
[90] Ex J First Statement of Dr Lim (P.1)

117. Dr Lim stated that he had discussed Nathan's case that morning with Dr Angelo Annunziata, an Emergency Physician at the William Angliss Hospital. Dr Annunziata[91] had suggested it might be useful to have an ultra sound of the chest wound later that morning to eliminate the possibility of glass remaining in the wound. Dr Lim stated that in further discussions with other medical colleagues at about 8am that morning, given that Nathan had improved considerably and was stable and the chest x-ray was clear, it had been agreed that the ultra sound was unlikely to be of any further benefit and that Nathan could be discharged.[92]

118. Nathan was discharged home with instructions about how to care for the wound and to return if he experienced chest pain or shortness of breath. He was discharged home at 8.45am. The last nursing entry was 7.15am at which time Nathan was noted to have vomited a small amount of bilious fluid.

119. Having received those discharge instructions, Mr McLeish took Nathan home. Mr McLeish described Nathan as thereafter spending the day "sleeping, watching videos and reading".[93]

120. The evidence is that Mr McLeish called his friend Kim Klimecki, on several occasions during that day, the first of those calls that she took being at about 5am.[94] Ms Klimecki is a trained nurse. She stated that Mr McLeish was very distressed and told her that Nathan had inflicted a stab wound to his chest with a kitchen knife. Mr McLeish told her that he and Nathan had agreed to say that Nathan had slipped through a plate glass window and that a sharp jagged piece of glass had penetrated his chest wall. She stated that Mr McLeish wanted to know if that story would fit for the purposes of getting medical treatment for Nathan. Ms Klimecki's evidence was that she told Mr McLeish the truth would be better. She stated that Mr McLeish also told her that Nathan had been vomiting before they left the hospital and that he had been told by the hospital that this was a reaction to the morphine. Ms Klimecki stated that "this was not right".[95]

121. Ms Klimecki stated that she received a number of calls from Mr McLeish throughout the day telling her that Nathan was still vomiting and wanting her to understand why he could not tell the truth about what happened.

122. Mr McLeish stated that Nathan was vomiting regularly throughout the day. Mr McLeish stated that he called William Angliss Hospital at about 2pm because he was concerned that the vomiting had not stopped. He agreed that he was told during that phone call to bring Nathan back to the hospital if he was concerned about his condition or temperature. Evidence from Nurse Cox[96] was that it was her that took that call and she told Mr McLeish during that phone call that she was unable to say what was causing Nathan to be unwell and that maybe he should bring him back to the hospital if he was worried. She advised Mr McLeish that Nathan's vomiting was unlikely to be caused by the morphine he

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91 See Ex O
92 Ex J Second Statement of Dr Lim (P.2)
93 Ex A5 p.8
94 Ex V
95 Ex V p.3
96 Ex P

had been given some hours earlier. Nurse Cox stated that she could not give advice over the telephone and if he was concerned he should get his son to hospital.[97] No issue was taken during the Inquest with the accuracy of that information given to Mr McLeish.

123. Mr McLeish states that Nathan woke up again at about 6.30 to 7.30pm feeling nauseous but unable to vomit. There was another discussion about going back to the hospital but Nathan indicated he did not want to go because he was not prepared to wait 2 or 3 hours for treatment. Mr McLeish stated that Nathan agreed for Dr Speirs' surgery to be contacted so a locum could be sent. Mr McLeish stated he contacted Dr Spiers' locum service and he was told it would take 3 to 4 hours for a locum doctor to attend upon Nathan.

124. The telephone records of Mr McLeish obtained by Victoria Police establish that such a call was made at about 2010.[98] A transcript prepared from a recording of that call reveals that Mr McLeish told the service receptionist that Nathan had a temperature and was vomiting. Mr McLeish was very angry and distressed about the 3 to 4 hour wait. He was told by the receptionist he should get Nathan back to the William Angliss Hospital.

125. Mr McLeish gave evidence that at some stage after this call he was sitting on the bed beside Nathan when he saw his expression change. He said ..... "he was staring through me and he didn't answer me for a few seconds. Nathan also had both his fists clenched and he was hot and sweaty at this time."[99]

126. Nurse Sloane from William Angliss Hosptial stated[100] that she took a call at about 2200 from a man identifying himself as "Graham". She was unable to be definite about the time as the call was not recorded by her. She stated that the caller stated that his son had been at the hospital the night before as he had injured himself in the chest and that he had been sutured and discharged home. Nurse Sloane stated that the man stated that his son was vomiting and he seemed distressed. She advised him that he should bring him in for review. She also stated that she could hear noises in the background and was then told by the caller that his son had fallen out of bed. She again confirmed that if he was worried he should call an ambulance. The telephone records of Mr McLeish confirm that there was a call from his phone to William Angliss at 2200 hours.[101]

127. It was in the wake of this episode that Mr McLeish called an ambulance whilst trying to administer various life saving techniques to Nathan.

128. At 2225 the call was made to the ambulance. When the paramedics arrived they were able to restore circulation to Nathan and he was thereafter conveyed back to William Angliss Hospital.

129. Upon arrival at the William Angliss Hospital, Nathan was diagnosed with a left haemothrorax and an intercostal catheter was inserted. He was stabilized and transferred to

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97 Ex P p.2
98 Ex A 10
99 Ex A5 p.9
100 Ex Q
101 Ex A10

Intensive Care Unit at the Royal Children's Hospital. He arrived at the Royal Children's Hospital at about 5.20am on March 31.

130. He underwent cardiac surgery at the Royal Children's Hospital which revealed a 6mm laceration to the left ventricle of his heart which was repaired. However, by the time Nathan underwent this surgery his neurological state was very poor. He had lost a considerable amount of blood. He did not regain consciouness.

131. The Royal Children's Hospital records reveal that an MRI on Nathan performed on April 2, 2005 showed severe hypoxic-ischaemic damage to basal ganglia and cerebral cortex with progressive deterioration in his central nervous system function. His pupils were unresponsive to light. Nathan was diagnosed as brain dead by two doctors at 5pm on April 3, 2005 and ventilatory life support was withdrawn at 6.05pm on April 3, 2005 after which Nathan died on April 5, 2005.

132. As stated above, a number of aspects of Nathan's treatment and subsequent discharge on his first presentation to the William Angliss Hospital were brought into question during the course of the Inquest including the adequacy of the history taking by the medical staff, the impact of the false history given by Mr McLeish and Nathan, the quality and thoroughness of Dr Lim's examination of Nathan given that he was presenting with a wound to the chest area above the heart and the timing of his discharge. I have addressed each of those issues below.

The adequacy of the history taking

133. The adequacy of the history obtained by Dr Lim was raised in the Inquest as an issue. Dr Lim was questioned extensively by Counsel both for Ms Stewart and Mr McLeish about how he endeavoured to establish the mechanism of the chest injury to Nathan. The basis for this questioning, it was submitted by counsel for Ms Stewart was that Dr Lim, failed to accurately establish the mechanism of injury and therefore Dr Lim was content to make "assumptions" about the depth of the wound, instead of using the "worst case scenario" as the bench mark for the breadth of examinations and tests he should have performed. It was submitted that "the worst case scenario"[102] was the proper approach for an emergency physician and Dr Lim had fallen short of that proper approach.

134. The requirement upon a doctor generally to verify the history he or she is given by a patient or accompanying adult was the subject of evidence from a number of the medical witnesses. The weight[103] of the medical evidence was that it is considered proper and appropriate practice for a doctor to rely upon a history given by a lucid and plausible patient (and/or accompanying person) together with a clinical presentation apparently consistent with that given history.

135. For example, Dr Sandra Neate, who is currently employed as an Emergency Physician and Director of Emergency Medicine Training at St Vincent's Hospital in

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[102] Transcript 1092. This was the opinion of Dr Raftos, an emergency specialist doctor since 1983 from NSW who was engaged by Ms Stewart.
[103] Evidence of Drs Lim, Harley, Thomson and Neate

Melbourne prepared two statements at the request of the William Angliss Hospital which were tendered into evidence.[104] In oral evidence, Dr Neate[105] explained on presentation, if the patient is able to give a history, or the people accompanying the patient, that is the primary source of information. She stated it was not usual to go behind the accuracy of what the patient is saying. There is also information available from the triage nurse and observations of vital signs and others such as ambulance officers if relevant. The doctor is then required to form a clinical impression which will guide investigations and management. Dr Neate agreed that it was the doctor's responsibility to get an adequate history, but she added that if a seemingly coherent patient tells lies, there is little a doctor can do.

Finding: Adequacy of history taking

136. The considerable amount of questioning and criticism of Dr Lim directed at his failure to ask more questions of Nathan and or Mr McLeish is borne from a sense that more questions would have elicited the truth or at least information that would have produced a scenario closer to the truth. However, the story of the penetrating glass was a lie, intentionally told. Mr McLeish firmly believed that the hospital had what they needed to know. His lies and misleading information were intentional and maintained throughout the day. There is no evidentiary or other basis to make a finding that more questioning by Dr Lim or William Angliss staff would have produced information that was going to clarify the history given. If speculation were to be engaged in, it would be a far more appropriate to speculate that more questions would have elicited more lies. I conclude that on the basis that there was nothing about the evidence of Mr McLeish during this Inquest which suggested otherwise. He believed then, and appears to remain of the belief that the hospital had enough information to treat Nathan and that he need not "betray" Nathan by telling the truth to the hospital.

137. I am bolstered in this view by the evidence of what Mr McLeish did throughout the 30th March, 2005. Even after Nathan's collapse and the attendance by the paramedics when Nathan was found not to be breathing and with no pulse, Mr McLeish did not tell the truth about the mechanism of the injury to either the paramedics or the hospital.[106]

138. Given this, there is no basis to infer that more questioning from any member of William Angliss hospital at the time of Nathan's first presentation would have been likely to elicit a more accurate version of the mechanism of injury. All of the questioning about the shape and length and description of the glass and the force used, falls into the same category. There was no glass shard that caused this wound. A more accurate description of what was a fabrication carries no logical or scientific purpose in these circumstances.

139. The only inference it is appropriate to make on the evidence is that more questioning would have elicited more lies and produced no helpful elucidation.

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[104] Ex A2 Statements of Dr Sandra Neate (Dr Neate had been requested by solicitors for William Angliss Hospital to provide an opinion on the actions of the Hospital.)
[105] T 1184
[106] The statement of Nicole Briggs, one of the ambulance officers who attended upon Nathan at 10.40pm, after his collapse, states that Mr McLesih told her that Nathan had fallen through a glass window.

Examination, diagnosis and treatment of Nathan's chest wound

140. There was a considerable focus on the adequacy of the assessment of Nathan's wound by Dr Lim in particular as to whether a proper medical inquiry was made by Dr Lim to establish whether or not Nathan had a penetrating or a non-penetrating injury to his chest. Dr Lim provided two statements[107] in which he set out what examinations he undertook and he gave oral evidence as to what he did.

141. Dr Lim's evidence was that he took a history from Nathan and Mr McLeish and thereafter he gave consideration as to whether the wound to Nathan's chest was a penetrating one. He reported that he found Nathan alert and orientated and not in obvious distress. He noted there was no bubbling from the wound to suggest a pneumothorax.[108] He found Nathan's heart sounds were normal and he had good air entry bilaterally with equal chest movements. He ordered a chest x-ray which did not reveal any lung or heart injury or any glass remaining in the wound. He noted Nathan had a normal sized heart, not showing any distension from bleeding into the pericardium. He explored Nathan's chest wound digitally and did not find it to be penetrating through muscle. He noted and treated Nathan's hypotension, assessing its cause as more likely to be a result of a vasovagal response to his pain as Nathan had no tachycardia and his vital signs stabilized.

142. As stated above, Dr Lim discussed Nathan's case with an Emergency Physician at William Angliss, Dr Annunziata who suggested an ultra sound. However, by about 8am, Nathan had stabilized and improved and Dr Lim again consulted with other doctors at the Hospital who agreed that an ultra sound was unlikely to be of any further benefit. Dr Lim then discharged Nathan after advising both Nathan and Mr McLeish what to do in the event of any chest pain or shortness of breath.

143. Dr Nerina Harley, a Senior Intensive care Specialist and Director of the Intensive Care Unit of the Royal Melbourne Hospital was requested by the Coroner through the Royal Australasian College of Physicians to provide an expert opinion to this coronial investigation. Dr Harley's initial position was that it was a difficult issue to decide whether the examining doctor in this situation, Dr Lim, should have pressed further as in her view what Dr Lim did was "somewhat contributed to by a misleading history" when the patient presented.[109]

144. Commenting upon the chest X-ray ordered by Dr Lim, Dr Harley noted that a chest x-ray may reflect injuries such as those sustained by Nathan as significant blood loss indicating a penetrating injury might have been expected to show on the chest x-ray, but a chest x-ray does not exclude cardiac injury as it is relatively insensitive.[110] It was Dr Harley's opinion that whilst appropriate investigation of a penetrating chest injury is to

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[107] Ex J
[108] Ex J p.1
[109] I shall return to this below under the heading: "What if the correct history had been given?"
[110] Ex Z 2nd report p 1

perform a chest CT scan and an echocardiogram, these tests are done in the context of the history given, the physical signs and the clinical signs. She stated[111] that it is very appropriate for a doctor to use the patient's vital signs to assess whether the injury is a penetrating injury.

145. In this case, she noted that the tracking of Nathan's vital signs could quite reasonably have been attributed to a vasovagal episode, as his blood pressure was low but his heart rate was normal. Dr Harley stated that Nathan complaining of pain and having difficulty breathing also fitted with a reasonable assessment that he was having a vasovagal. On assessing the likely cause of Nathan's initial haemodynamic instability Dr Harley stated that on clinical grounds, it was also reasonable to conclude that the likely cause was a "vasovagal response to the incident associated with the pain."[112]

146 She also stated that a tachycardia would have been expected in the event of an injury penetrating the heart.[113] In fact Dr Harley expressed the view that she did not think Nathan was in hemorrhagic shock at the time Dr Lim examined him. She agreed that the development of a pericardial effusion can occur over hours.[114]

147. In summary, when questioned about the adequacy of the range of tests performed by Dr Lim at the time and in all of the circumstances, Dr Harley expressed the view that a doctor cannot do every test known on every patient. Judgment must be exercised based on the history given and the results of the examinations and investigations. It was the opinion of Dr Harley that at the time Dr Lim's judgment was made about the injury being a non-penetrating one, it was a reasonable assessment given all of the material he had.

148. Dr Harley stated that the decision not to undertake further referral was "understandable" in the circumstances of the history given and the physical and clinical presentation; although she thought it would have been reassuring to have a surgeon contacted for further advice and if necessary, transfer. Dr Harley agreed that if one did not have a good suspicion based on evidence that a penetrating injury had occurred, it would not be unreasonable to not seek a transfer with the caveat that the patient would return if symptoms emerged and he was going home with a responsible carer. Dr Harley was also satisfied that the level of supervision of Dr Lim was comparable to that received by trainees of the Royal Australian College of Physicians.

149. Dr John Raftos prepared a report and supplementary report at the request of Ms Stewart's solicitors. Both documents were tendered into evidence in the Inquest.[115]

150. Dr Raftos is a Senior Specialist in Emergency Medicine in NSW. He stated in his first report (9.6.06) that "Nathan died because he was inadequately assessed and managed when he presented to hospital with a stab wound to the chest at about 0500 hours on 20 March 2005". Contrary to the view of Dr Harley, it was the view of Dr Raftos that a doctor

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111 T 1051
112 Ex Z: P.1
113 T 1052
114 T 1053
115 Ex A1

presented with a potential penetrating wound to the chest should always work on the basis of the "worst case scenario" until proven not to be so.

151. I note at this point that whilst Dr Harley agreed with Dr Raftos' opinion as to the appropriate treatment of a stab wound, she distinguished this case because of the misleading information given to the hospital. Dr Harley therefore took issue with the opinion of Dr Raftos more generally on the basis that his opinion of what should have been done was based on the presenting injury being a stab wound rather than the misleading history the hospital was given.

152. Dr Raftos agreed in cross examination that glass penetrating the heart was very, very rare[116] and accepted that there were only four reported cases in the last 30 years in the world.

153. However, it remained Dr Raftos' opinion that any injury to the chest such as the one Nathan presented with should have caused a doctor to obtain the surgical registrar's opinion and if there was evidence that the chest wall had been penetrated then there should be a chest x-ray, an echocardiogram and a thoracic CT scan. Dr Raftos stated during cross examination by Counsel for Willliam Angliss Hospital that a pericardial effusion by echocardiogram may not have been visible at 9am. He also conceded that he had not ever viewed an incised wound to the heart using an echocardiogram even though he gave evidence that it was 85 to 95% likely to show an incised wound to the heart. He also stated that whilst a chest x-ray will not exclude heart injury, it is unusual to have a heart injury and a normal chest chest x-ray.[117]

154. Further, it was his view that even if all of the investigations he stated should have have been done were done and produced no evidence of injury, that the patient should still be kept for 24 hours observation.

155. In Dr Raftos' opinion the only explanation for Nathan's vital signs and clinical observations on presentation was serious internal organ injury[118] and to not recognize that was a major departure from acceptable standards. In his report he rejected completely the opinions of Drs Lim, Harley and Neate that Nathan's presentation could have been a vasovagal attack. In his view that did not explain either the shortness of breath or the chest pain. He was the only medical witness to hold that view.

156. When questioned about the relevance of the improvement in Nathan's vital signs which were observed and noted in the medical records of William Angliss, Dr Raftos' response was somewhat non responsive in that he stated that an emergency physician should always treat every case as a "worst case scenario". When questioned about the relevance of the absence of a tachycardia he was somewhat evasive and non-responsive.

157. Dr Neate also gave an opinion upon this aspect of Nathan's treatment by Dr Lim. She observed that Dr Lim's examination findings upon first assessing Nathan document a

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[116] T1107
[117] T 1122
[118] Ex A1 Statement of Dr John Raftos

"normal primary survey". On the issue of the vital signs, it was Doctor Neate's view that the vital signs were treated appropriately by Dr Lim and Nathan responded to that treatment.

158. Dr Neate stated in her report that *"all penetrating injuries to the chest should be treated with suspicion that the penetration of vital organs may have occurred.... "* She went on to say however that *"the investigation and management of an injury caused by a sliver of glass would differ significantly from a stab wound to the chest with a long bladed knife. This potentially misleading history must be considered to have had an impact on the assessment and investigations undertaken by Eastern Health."*

159. Contrary to what Dr Raftos had to say, Dr Neate, like Dr Harley stated that in her opinion the management of Nathan in all the circumstances corresponded to accepted practice and followed the appropriate path for a patient with penetrating medial chest trauma and a normal x-ray.

160. It was Dr Neate's initial opinion in her first report that an echocardiogram was indicated in the presence of an abnormal chest x-ray and that was not the situation in Nathan's case. However, in her second report Dr Neate noted that a normal chest x-ray does not preclude going on to perform an echocardiogram. She stated:

"The management was of a chest wall laceration (non-penetrating) rather than a penetrating chest wound. In the setting of the history available from the patient and relative and the examination findings, the improvement in the patient's condition with intravenous fluid and analgesia and the findings on examination of the wound, this would seem a reasonable conclusion and reasonable management."[119]

161. Doctor Neate rejected the suggestion that Nathan should have been referred for surgical intervention or a CT scan on the information available to Dr Lim at the time. Dr Neate stated that the diagnosis initially made that this was a non-penetrating wound was a reasonable one to make in the circumstances.[120] Her reasoning was that a history of laceration from glass, no features of a pneumothorax, no air in the chest wall, a normal chest x ray which showed a normal sized heart (and therefore assessing there was no blood in the pericardial sac would have been a reassuring negative finding) and the apparent improvement in Nathan's condition over time was the basis for her conclusion that the actions were reasonable.

Should there have been a referral for an echocardiogram?

162. A controversial issue was whether or not an echocardiogram should have been sought for Nathan. It was accepted that this machinery was not available at the William Angliss Hospital and therefore Nathan would have had to be transferred to another hospital for an echocardiogram. The Victorian medical witnesses, familiar with the system all agreed that the transferring doctor seeking an echocardiogram must provide a sufficient basis to the receiving hospital for requesting the transfer. That is, the transferring doctor would have to justify it on the basis of patient history given and the clinical information obtained. It was

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[119] Ex A2 2nd Report
[120] T 1187

the evidence of Dr Thomson from the William Angliss Hospital that a transfer for echocardiogram would have been unachievable in the circumstances.[121] Drs Neate and Harley effectively agreed with Dr Thomson that it was reasonable in the circumstances not to proceed to the next level, that is, to order an echocardiogram as the evidence was not there to support the transfer.

163. Further, the evidence was that it was not clear what an echocardiogram would have shown, particularly if it had been performed in the earlier part of the day. That is, Nathan may have experienced a slow pericardial effusion which may have not been evident from an echocardiogram until some hours after his discharge.

Seeking an opinion from a surgical registrar

164. Dr Raftos gave evidence that Dr Lim should have sought the opinion of a surgical registrar. During cross-examination, Dr Raftos conceded that he had made this observation without knowing that Dr Lim was only four months from completing his qualifications as an Emergency Physician and that having that knowledge changed his view about the need for referral to a surgical registrar. Neither Dr Neate nor Dr Harley thought that the opinion of a surgical registrar in these circumstances was going to add much, although Dr Harley had initially stated that she thought it would have been reassuring.[122]

What if the correct history had been given?

165. There was no real variance of medical opinion that had Nathan's injury to his heart been discovered on his first presentation, he had a good chance of survival. It was Dr Raftos' view that had Nathan been properly assessed and managed he had a 90 to 100% chance of survival. There was no real variance of medical opinion on this issue.

166. This of course begged the question as to whether or not the false history contributed to the injury to his heart not being discovered at his first presentation.

167. A number of the medical witnesses were asked to express a view upon the question as to whether or not the correct history being given may have led to a different outcome. The weight of the medical opinion was that it would have caused a very different regime of investigation and treatment.

168. It was only Dr Raftos who gave an opinion somewhat at odds with this. As stated above, it was his view that every chest wound should be treated as a "worst case scenario" and therefore every test should be conducted regardless of the history. This was not a view shared by any of the other medical witnesses.

169. Dr Harley's answer to this question was to state an expectation that Nathan would have been treated, investigated and observed differently had the truth about the mechanics of his chest injury been known. She stated that she believed it would have made a very real

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[121] T619
[122] Ex 2

difference to the course of the investigations.[123]

170. Dr Neate expressed a similar view that had a history of a knife wound been given it would have been treated differently to the history of a laceration from glass. It was Dr Neate's view that the rarity of shards of glass penetrating the heart would have contributed to the exercise of the treating doctor's clinical judgment. It was also Doctor Neate's view "that the potential to save Nathan's life lay with an accurate and true history and with either further observation or return to hospital when his symptoms became worse".

The Discharge

171. The issue of the appropriateness and timing of Nathan's discharge after his first presentation was raised. The evidence was that at the time the decision was made by Dr Lim to authorize Nathan's discharge, his blood pressure had returned to normal; his respiratory rate had been slightly fast and had returned to normal; his heart rate had been initially low and returned to normal; his pallor had returned to a much better colour; he was up and walking around and appearing quite comfortable and was with an apparently responsible and concerned and appropriate adult carer who was given instructions about bringing him back if his condition deteriorated.

172. In her first report Dr Neate stated that based on her observations of the medical records it appears Nathan's symptoms had not adequately settled at discharge. She did note however that what is not clear from the medical record is the other factors which may have influenced these decisions such as the patient's wishes and discussions which may have occurred between the patient and doctor regarding discharge plan.

173. In her oral evidence[124] she stated that the sorts of observations that Dr Lim relied upon, that is, that there was no evidence of any abnormal vital signs, Nathan was looking much better, he was not vomiting or sweating and he was up and around and apparently comfortable and with an adult carer, these are the sorts of pieces of information that are relied upon all the time to discharge patients.

174. Dr Neate went on to say that it was not possible to say how long a patient should be kept for observation as it is a dynamic thing. She did say however it was not possible, even now, to say at what point Nathan's symptoms may have either settled or deteriorated. In her second report, Dr Neate stated that if Nathan's pain had been controlled with oral analgesia, his vomiting had settled and it was established that his oxygen saturation levels were normal without the administration of supplemental oxygen and he was not feeling short of breath, if these criteria had been satisfied at discharge then discharge was reasonable.

175. Dr Harley stated in her report that although at the time of discharge Nathan appeared to be stable, his pain had resolved and there was no evidence of deep penetrating injury after 4 hours of observation, "it would nevertheless have been prudent to continue to observe the patient given the persistent nausea and vomiting that had been otherwise unexplained and if

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[123] Transcript 1057
[124] T1190

not settling, pursue a diagnosis with further investigations if required".[125] In evidence however, Dr Harley said given that Nathan was up and walking about and going home with a responsible caring adult who would be able to bring him back or call for help, she did not think it would be unreasonable for him to be discharged at that time with the advice he was given about returning in the event of further pain or shortness of breath.[126]

176. It was not contentious that upon discharge, Graham McLeish was advised by Dr Lim to bring Nathan back to the hospital if he became more unwell or the pain intensified or he became short of breath. The evidence is that Mr McLeish got that advice at discharge but did not follow it.

Conclusions: The actions of William Angliss Hospital and Dr Lim.

177. It was the submission of Counsel for Ms Stewart that the hospital made a number of errors which were such that they departed significantly from the standards of a reasonable medical practice and the hospital should constitute a cause of Nathan's death. Whilst the William Angliss staff and Dr Lim could have been more proactive in asking questions about the facts they were presented with given that the hospital staff had thought Graham McLeish's behavior was sufficiently odd to notice things such as he did not leave Nathan's bedside, Nathan did not say very much and Nathan bore the classic marks of self inflicted injury to his inner arms, the weight of medical opinion was that a doctor is bound by an apparently reasonable history given consistent with the observed injuries.

178. The effect of the weight of medical evidence was that whilst it may have been a more cautious medical practice to have kept Nathan for several more hours, the rationale for the discharge at that time was acceptable and given that it was done in circumstances where Nathan was with an apparently responsible adult carer advised about the need to return if the situation changed, it was acceptable.

179. The evidence is that the only medical witness who remained firmly critical of both the hospital and Dr Lim was Dr John Raftos. His views and opinions were out of step with the weight of medical opinion in the Inquest, including that of experienced, senior and independent doctors. It was my view that Dr Raftos relied somewhat on the benefit of hindsight rather than a fair assessment of the circumstances facing Dr Lim at the time he made his assessment of Nathan. Dr Raftos was the only doctor who expressed the view that the appearance alone of the injuries to Nathan's forearms should have alerted a doctor that the wound was caused by a mechanism other than the history given. Dr Raftos was the only medical witness who took the view that what Dr Lim did fell below peer professional standards in Australia.

180. The remainder of medical witnesses (including the Court's independent expert Dr Harley) took the view that all of the investigations which would reasonably have been expected in the circumstances were carried out.

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[125] Ex Z p2
[126] T1063

181. As to the time and circumstances of Nathan's discharge, it was the view of Dr Raftos alone that Nathan should have been kept in for observation for 24 hours. This view appears to be against the reality of clinical hospital practice at least in Victoria. Further, this opinion was against the weight of the remainder of the well reasoned medical opinion which was that it was a reasonable discharge decision in all the circumstances.

D: POLICE INVESTIGATION AND DECISION NOT TO PROSECUTE

182. This section of the Finding addresses the questions raised during the coronial investigation as to whether the police investigation was satisfactory or whether it was contaminated or lacking in such a way that it compromised the coronial investigation? Implicit in these questions are necessary Findings as to whether or not Nathan's injuries were self inflicted, whether his actions were calculated to take his own life and whether or not any referral to the DPP should be made.

The Police Investigation

183. The Inquest brief in this matter was prepared by Senior Constable Molloy who took over after the investigation was initially commenced under the supervision of Detective Senior Sergeant Bezzina from the Homicide Squad.

184. The adequacy and professionalism and impartiality of the police investigation was raised as an issue by Counsel for Ms Stewart. For example, an issue arose on the last day of the evidence in the Inquest in which Senior Constable Molloy was criticized for producing telephone records on the second last day of the evidence instead of putting the actual telephone records into the Inquest brief. Reference to the existence of those telephone records was contained in Senior Constable Molloy's statement in the Inquest Brief. All of the parties had the Inquest Brief for a considerable time before the Inquest commenced and could have sought the records from Senior Constable Molloy if proper attention had been paid to the contents of his statement and the records were thought important to inspect. The implicit criticism of Senior Constable Molloy on this issue was without substance at all.

185. The police were criticized in submissions for not having pursued a criminal prosecution against Mr McLeish. Whilst Detective Senior Sergeant Bezzina gave evidence to the Inquest that there was not sufficient evidence for a prosecution on his assessment, both he and Senior Constable Molloy were clear that the investigation remained open in the event that more or other evidence became available.

Conclusions: Re Police investigation

186. I find no substance in the criticism of the police preparation or supervision of this matter. In my view a thorough Inquest Brief was prepared. It was a very difficult investigation to perform which appears to have been conducted impartially and professionally.

Was Nathan's injury self inflicted?

187. During the course of the inquest and in written submissions, Counsel for Ms Stewart submitted that Mr McLeish could not be ruled out as the perpetrator of the fatal wound to Nathan.[127] In his closing oral submissions,[128] Mr Fitzpatrick conceded quite properly that there was insufficient evidence to make such a finding. That is correct.

188. The only direct evidence as to the infliction of the wound to Nathan comes from Mr McLeish. I accept the account of Mr McLeish as to how Nathan's injuries occurred. I do so because it is consistent with all of the evidence as to Nathan's oft repeated determination to want to stay with Mr McLeish, with his diagnosed depression, with Professor Cordner's evidence that the injuries to Nathan's arms were a common site of self inflicted injury and consistent with the marks of self infliction and with Professor Cordner's evidence of the injury to Nathan's chest also being consistent with a self inflicted injury[129] and with Senior Sergeant Bezzina's evidence of self inflicted injuries and types and Nathan's injuries being consistent with his experience of those.

189. Further, there was no evidence that Mr McLeish was ever violent to Nathan or had ever threatened any form of violence to Nathan.

190. This conclusion is also supported by the evidence of Dr Spiers as to Nathan's dependence on Mr McLeish and the evidence that it was all "that was holding Nathan together" together with his diagnosis of depression and Nathan's withdrawal from society. I infer from Dr Speirs' evidence that if put at risk of losing Mr McLeish, as he was by Mr McLeish's ultimatum to him a few days earlier that he would have to leave, Nathan was likely to act in a very emotional way.

191. It is also supported by the evidence of Kim Klemecki of Mr McLeish's distressed call to her in the early hours of March 30 and his account of Nathan stabbing himself and his checking with her whether or not his false history of the cause of injury would be sufficient for the hospital to treat Nathan. This early account is consistent with all of the later versions given by Mr McLeish.

192. Mr Fitzpatrick also sought to make a "grab bag" of allegations against and criticisms of Mr McLeish. These included Mr McLeish's failure to keep the knife away from Nathan, that his reasons for not calling an ambulance were fabrications, that his explanation for the bruise noted under his chin was a lie, that he was motivated to lie at the hospital for reasons other than what he says, and that generally Mr McLeish was not a person to be believed illustrated by a litany of lies.

193. Whilst I do not accept all of the evidence of Mr McLeish, on this issue of how the injury to Nathan's chest occurred, I do accept his account for the reasons set out above.

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[127] Written Submissions on behalf of Ms Stewart p.2
[128] Transcript p. 1762
[129] Ex F p2 and Transcript 111

194. As for the other aspects of the submission set out in paragraph 98, I turn to the suggestion that Mr McLeish should have kept the knife away from Nathan. To suggest that a knife should not be kept in a kitchen is simply ludicrous. As to the other parts of the submission that are put together to raise some oblique possibility that Mr McLeish and Nathan had a physical altercation which resulted in Mr McLeish stabbing Nathan and then fabricating the story at the hospital to cover his actions and then later delaying calling the ambulance to further cover his actions, there is no cogent evidence to support such a theory.

Conclusion: Were Nathan's injuries self-inflicted?

195. For the reasons set out above, based on the evidence I am satisfied that the injuries described in the post mortem report of Professor Cordner were self inflicted. I am satisfied that in the last days of Nathan's life, in the presence of Graham McLeish, Nathan plunged a knife into his chest which lacerated the left ventricle of his heart and caused his death.

Was Nathan's act one of suicide?

196. Nathan was stressed and depressed and emotionally extremely fragile. He was isolated. However, the evidence falls short of being able to conclude that when Nathan plunged that knife into his chest, he actually intended to end his life. I interpret his action, in the context in which it occurred, as a dramatic manouvre to indicate his distress to Mr McLeish, and to indicate the dilemma he felt placed in by a possible unplanned removal from his placement into the unknown.

197. There is no evidence that Nathan had indicated any self harming behaviour at school. Dr Spiers was satisfied that he was not a suicide risk when he spoke to him. Dr Spiers gave evidence that he did not at any stage see Nathan as a high suicide risk and noted that he had actually actively asked him about any active planning.[130]

198. Nathan's preparedness to obtain treatment for himself at the hospital on his attendance at the hospital adds to this picture. He gave no indication of any emotional or psychological distress at the hospital and indeed the evidence is that he complied with all of the treatment given to him. Mr McLeish gave evidence that Nathan had settled in back at home upon his return from the hospital and was busying himself with his school books during the day.

Conclusion: Suicide?

199. Based on the evidence outlined above, although I find that Nathan's injuries were self inflicted, I do not find that he was endeavouring to end his life when he stabbed himself in the chest.

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[130] Transcript 1290 to 1293

E: DID ANY PERSON OR AGENCY CONTRIBUTE TO NATHAN'S DEATH?

200. The issue of ***contribution*** was the subject of a number of wide ranging submissions from Counsel, both as to the legal principles of "contribution" in this jurisdiction as well as more specific submissions about contribution specific to this case.

201. The former statutory requirement to find contribution contained in Section 19(e) of the *Coroners Act 1985* was repealed as from July 1, 1999. This removed the mandatory requirement for Coroners to make findings as to the identity of any person who contributed to the death.

202. The rationale behind that amendment was set out in the Second Reading speech of The Honourable Jan Wade Attorney General in Hansard.[131]

"A finding that as a matter of fact a person contributed to the death of another person could be understood as a finding that the person is in some way legally responsible for the death. This may lead to such persons suffering from unwarranted feelings of guilt or blame. For instance, the obligation under the act means that if a person commits suicide by leaping in front of a train, a coroner is obliged to find that the train driver contributed to the cause of death, even though there may have been nothing that the train driver could have done to avoid the death.
There is a very real danger that a simple finding of contribution can be misinterpreted or misrepresented, despite attempts of the coroner to explain otherwise.
To address this situation, the bill removes the obligation on a coroner to make a finding about the identity of a person contributing to the death of another person. However, the removal of the obligation does not preclude a coroner from making a finding of contribution in appropriate cases under existing provisions of the act."

203. The effect of this amendment was to remove the mandatory requirement upon a coroner to find contribution. It was submitted in closing submissions that as a result of the amendment and the development of the case law since that time, coroners are now prohibited from making a finding as to contribution. I do not accept that as a correct statement of the law.
Indeed, the final sentence quoted above from the Second Reading speech extract makes it clear that was not Parliament's intention.

204. Prior to this amendment to the Act, the meaning of "contribution" was discussed by Hedigan J In *Commissioner of Police v Hallenstein*[132] thus:

"The issues of causation and contribution have bedeviled philosophers for centuries and attracted consideration by the superior courts in all jurisdictions and places for more than a century. The inclination to expound, in an authoritative way, the connection between human behaviour and consequences has proved seductive. The estimation of the nature and extent of this connection may be described as the evaluation of "contribution". The law has also

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[131] Hansard : Coroners (Amendment) Bill Second Reading Speech 25 March 1999 P. 185
[132] [1996] 2 V.R. 1

espoused minimalism in attempting definition of the causative or contributing effect of conduct." .....

205. In summary, Hedigan J stated that contribution is a matter of the application of common sense and experience on a case by case basis. He said that whilst in most cases a finding of contribution is likely to involve legal liability, he found that it was not the intention of the Act that it must necessarily be so or pronounced as such.

"It is enough to say that, since it is not simply an exercise in the logical progression of events, some element of departure from the reasonable standards of behaviour will ordinarily be thought to be required, and must properly be established."[133]

206. This concept was developed by Callaway JA in *Keown v Khan.*[134] His Honour explained that the test of contribution is *....."solely a test of whether a person's conduct caused the death".* His Honour found that there could be more than one cause of death. He also found that to distinguish causal from non causal features ..... *"it will be sometimes necessary to consider whether the act departed from the norm or standard or the omission was in breach of a recognized duty but that is the only sense in which parargaph (e) mandates an enquiry into culpability".*

207. Both of these cases were decided before the *Coroners Act* was repealed to remove "contribution" findings as an **obligation** upon coroners. However, I can find no reason to accept that the test for finding contribution has been changed by this amendment.

208. Endeavouring to distill the essence of these cases to come up with a test for contribution which requires the coroner, in the application of common sense to the facts, I conclude that one would have to find that the act or acts departed from the reasonable standards of conduct applicable to the circumstances of the case.

209. The standard of proof for finding any such contribution is well known as the Briginshaw standard and comes from the most oft cited judgment of Dixon J[135].....

"But reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences".

210. A coroner making adverse findings against any person must take into account the possible damaging effect upon the character and reputation of the individual before making a finding of contribution.[136]

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133 [1996] 2 VR 20
134 [1999] 1 VR 69 at 76
135 Briginshaw v Briginshaw (1938) 60 C.L.R. 336 at 361-3
136 Anderson v Blashki [1993] 2 VR 89; Annet v Mc Cann (1991) 170 C.L.R 596

Conclusions: Contribution

211. In this case, it was the submission of Mr Fitzpatrick, that I should find that DHS contributed to the death of Nathan by failing to provide adequate care and supervision to him. I should find that William Angliss Hospital also contributed to Nathan's death by failing to provide adequate medical care to Nathan in the range of ways discussed above and that I should find that Mr McLeish contributed to Nathan's death because his behaviour was so far below that of a reasonable person in the position of a parent as to be a clear cause of Nathan's death.[137]

DHS

212. On balance, on the basis of the evidence set out above I find that Nathan stabbed himself to the chest after inflicting superficial injuries to his arms minutes earlier, consistent with the account given by Mr McLeish. I find that Nathan did so in the heat of an exchange in circumstances where his mental and emotional well being were seriously destabilized by months of deterioration in his condition.

213. It follows from this, that I do not conclude that DHS should have predicted that Nathan was at risk of what ultimately occurred, as I do not find that he intended to take his own life. Further, there was not sufficient evidence to ground a reasonable apprehension that Nathan was at risk of fatal self harm.

214. But I do find that the poor mental and emotional condition Nathan was in bore a direct correlation to the level of supervision and decisive action and support being exercised by DHS at the time of his death, which was below the level which would be expected of a parent in the same circumstances.

215. Further, Mr McLeish's mental and emotional state appeared to be very fragile and fluctuating. He was giving a number of signals albeit mixed that he was feeling unable to cope with Nathan. He was being given referrals to programs to assist him but no accurate assessment was made of his condition nor was there follow up by DHS as to his attendance at a support program. Nathan clung to the placement in the face of suggestions he may have to consider moving. Indeed, he so desperately clung to the placement that on the night he stabbed himself, he did so in the face of Mr McLeish telling him a couple of days earlier he would have to go.

216. Given the above findings and conclusions, although I find that the level of supervision of Nathan was inadequate, I do not find that Nathan's death was "the logical progression" of events which would reasonably follow from the inadequate supervision referred to above and therefore I do not find that DHS contributed to his death.

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[137] Written submissions p.10

William Angliss Hospital and Dr Lim

217. Given my conclusions as to the actions of Dr Lim and the William Angliss Hospital set out above, I do not find that either Dr Lim or the William Angliss Hospital contributed to Nathan's death in that I did not find on the weight of the expert evidence that Dr Lim's conduct fell below the accepted standards of his peers in all of the circumstances.

Graham McLeish

218. The question of whether Mr McLeish contributed to Nathan's death is a fraught one. He made an enormously positive contribution to Nathan's life in Nathan's earlier years. He was Nathan's only consistent adult carer in the last few years of Nathan's life. However, there is not insignificant evidence that Mr McLeish's relationship with Nathan became quite destructive by the latter part of 2004. Further, there is evidence that Mr McLeish, for reasons which remain unexplained, was not really setting about to help his own situation by following through with referrals that were being given to him by DHS.

219. As to what Nathan did, which caused his death, Mr McLeish knew Nathan's fragile state of mind and that he was prescribed antidepressant medication for it.[138] He knew that Nathan feared being ejected from the house because he had seen the reaction of Nathan in August 2004 when he had made his public rejection of Nathan before Frances Davies. Mr McLeish had been counselled by Frances Davies about this and had given an undertaking not to do it again and to make any such decision to terminate Nathan's placement in a planned way in the future and communicate this to DHS to allow proper planning.

220. On this night, in breach of that undertaking, he told Nathan he had to go. Nathan reacted to this news by taking the knife and acting dramatically in front of Mr McLeish to demonstrate the impact of what Mr McLeish was doing to him.

221. However, in stabbing himself in the chest with the knife as noted above, I do not find that Nathan did so with the intention of actually ending his own life, but rather to demonstrate to Mr McLeish the impact he was having on Nathan. Further, at that point, even though that stab wound to his chest was intentionally done and the injury which caused Nathan's death, on the evidence, the injury was eminently treatable at that point.

222. It is from this point on that the evidence of Mr McLeish's contribution to Nathan's death becomes more overwhelming. The evidence is that Mr McLeish sought medical assistance for Nathan in the immediate wake of the injury. However, the evidence also is that his failure to tell the true history of Nathan's injury to the hospital misled the medical investigations. The evidence is that the accurate history would have caused a different medical response and may well have resulted in the true extent of Nathan's injury being discovered on his first presentation.

223. It is not possible on the evidence to say whether those different investigations or the treatment response would have caused the discovery of the actual injury to Nathan's heart at

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[138] It should be noted however that the toxicology report did not detect anti depressant medication in Nathan's blood at the time of his death.

his first presentation, but I do conclude on the evidence that Nathan's chances of a correct diagnosis would have been significantly enhanced by the true and accurate history being given to the hospital at his first presentation.

224. The evidence is that Nathan's prospects of survival from that injury with appropriate diagnosis and timely treatment were not in question. Mr McLeish, despite his own views about what the hospital needed to know was told by his own friend whose counsel he sought early that morning, that he should tell the truth. Throughout the day he made several calls seeking advice as to what he should do. The calls indicate a sufficient level of concern on his part that caused him to continue to ask for advice. It was all the same advice. Advice that he should return Nathan to the hospital and have him re-assessed. Advice he did not take at any point up until it was too late. Even after Nathan lapsed into unconsciousness Mr McLeish did not tell the truth to the treating paramedics or doctors.

225. I conclude from the weight of the evidence that had Nathan been returned to the hospital earlier in the day, even in the wake of the call Mr McLeish made at about 2pm and then given a true account of the mechanism of Nathan's injury, Nathan's prospects of a correct diagnosis and appropriate treatment and therefore survival would have been reasonable.

226. He did not do that. In my view, Mr McLeish was clearly in the role of the primary carer of Nathan. His so-called "loyalty" to Nathan or fear of betraying him simply does not stand up to scrutiny in such a serious situation as between an adult and a child. He was the adult in this situation who had a responsibility to act as one would expect any reasonable adult to do in this situation. In my view Graham McLeish's failure to give a true account to the hospital of Nathan's mechanism of injury, compounded by his failure to return Nathan to the hospital in circumstances where his condition remained unimproved and he was sufficiently worried to be calling for advice and receiving advice to return Nathan to the hospital contributed to Nathan's death.

F: COMMENTS

Accuracy of DHS Court Reports

227. The Department of Human Services derived its custodial powers and responsibilities at that time from the *Children and Young Persons Act 1989 (Vic)*. Pursuant to that Act, Nathan was placed on a series of Court orders. Each application to the Children's Court for an order extending, varying or seeking a new order requires DHS to provide a report to the Court as to the circumstances of the young person. These court reports form the basis of the material upon which the Court will consider what orders to make in the best interests of the child. These are documents placed before the Court by the state authority charged with the responsibility for the care of children on court orders. The entire system is predicated upon the Court having confidence that it can rely upon the accuracy of these reports as a true and correct records.

228. In my view, the series of reports being produced and provided to the Court in the last year of Nathan's life neither revealed the considerable strain the placement was under, nor

clearly advised the Court that Nathan was not complying with the requirement that he must attend therapeutic counselling. If material before the Court is not reliable, the entire system of independent judicial supervision is put in jeopardy.

Supporting and protecting the placement

229. Throughout the course of the coronial investigation and in this finding a number of references were made to the possible ways in which Nathan could have been supported and protected in his placement by DHS. That is, once DHS decided it was "stuck" with the placement, it was incumbent upon it to set about to address some of the most troubling aspects of the placement.

Application pursuant to the Crimes Family Violence Act 1987 (Vic)

230. DHS at all times had available to it the capacity to bring an application for a restraining order against Ms Stewart based on the material being provided by Nathan and Mr McLeish. For example DHS could have sought an order on behalf of Nathan seeking to prohibit Ms Stewart from attending at the school, driving past the house or loitering near the house. Such an application would have had the advantage of having all of the allegations tested in a Court and if found established to the applicable standards, Nathan would have had police protection available to him upon any repeat of the behaviour. If the allegations were not found to be established by a Court, it would have been a basis for DHS to investigate where those allegations were coming from and perhaps question the on-going viability of the placement in a more rigorous evidence-based way.

Nathan's concerns about the privacy of his health information

231. The evidence is replete with examples of Nathan's concerns about his mother's intrusions into his personal life and space. The evidence of Dr Speirs demonstrates Nathan's distress about this issue and his reluctance to obtain therapeutic treatment for himself at least in part out of fear that his mother would obtain information about him. Whatever the basis for these fears, there were avenues open to DHS to endeavour to allay Nathan's fears and promote his sense of comfort and enhance the possibility of him engaging in appropriate therapeutic care.

232. The law with respect to the ability of a young person to obtain health treatment independent of their parents and maintain confidentiality over that treatment is not straightforward. It is probably fair to say it is somewhat under developed in Australia. However, the majority of the High Court in *Department of Health and Community Services v JWB and SMB (Marions's Case)*[139] approved of the UK decision of *Gillick v West Norfolk and Wisbech Area Health Authority and another*[140] which is authority for the proposition that children who are under 16 years old but have the intelligence and understanding to be competent to give consent to a particular treatment, may give consent for themselves. It follows from this that it was open to DHS to bring on an application before the Children's

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139 [1992]175 CLR 218 (6 May 1992)
140 [1986] AC 112

Court to seek a ruling that allowed Nathan to maintain his privacy as to his health information.

233. Having made the above findings and drawn the conclusions I have from those findings about a range of shortcomings in the provision of appropriate care to Nathan, it is pleasing to note that I have been provided with material from DHS which addresses a number of issues that have been raised on the evidence before me in this Inquest.

234. I have been provided with an Affidavit of David Clements (the Acting Director of Child Protection and Family Services) affirmed on March 18, 2008 which sets out a range of reforms and proposed reforms introduced into child protection policies and procedures in the wake of Nathan's death in April 2005.

235. These reforms include a significant piece of work examining and recognising the need to strengthen the supports provided to young people in out of home care.[141]

236. I have also been provided with a very detailed and substantial piece of work setting guidelines for investigating concerns about the care of children in out-of-home care.[142] According to the Foreword, the guidelines are designed to support the appropriate exercise of professional judgment by child protection staff as well as staff of community service organizations. There is no doubt that both the task of caring for young people removed from their families of origin and being responsible for the supervision and monitoring of those young people in out of home care is a hugely complex and challenging task. The production of these two pieces of work is recognition of that and it is hoped will be supported with appropriate resources including training and supervision to those charged with the weighty responsibilities of such work. It must be said that the guidelines will provide small benefit only without the full range of training and resources needed to support such endeavours.

G: REFERRAL TO THE DPP

237. It was the submission of Counsel for Ms Stewart that I should refer Mr McLeish to the DPP for the offence of manslaughter by criminal negligence. To this end I was referred to the cases of *R v Wilkinson* [1999] NSWCCA 248 and *R V Hall and Hanslow* [1999] 108 A Crim R 209. Both were cases in which an adult had failed to get medical care for a deceased where that failure could be assessed objectively as criminally negligent.

238. The *Coroners Act 1985*, currently contains two sections relevant to the exercise of this power. In my view however, when one endeavours to apply these sections, an insoluble problem is created. Section 19 (3) specifically prohibits a coroner from making any reference to the possibility that any person may be guilty of a criminal offence. A coroner must not make any determination of criminal liability on the part of any person. There is an express prohibition in s.19(3) for making any findings that a person has committed an offence. However, s.21(3) requires the Coroner, if he or she forms the belief that an

141 Kinship Care - Care by Relatives and family Friends Green paper dated November 2007

142 Guidelines for responding to quality of care concerns in out of Home Care. This is a 247 page document which was provided to me Final Working Draft dated November 2007.

indictable offence **has** been committed **must** refer that to the DPP. That is, this section mandates the Coroner, once the coroner has formed the belief that an indictable offence has been committed, to refer the matter to the DPP. There is no doubt that the DPP is under no obligation to prosecute but that is not the point. The point relates to what is seemingly required of a Coroner. On the one hand the Act prohibits the Coroner from making any reference to the possibility that a person may be liable for a criminal offence, on the other hand the Act contemplates the Coroner forming the view that an indictable offence **has been committed,** and if so, thereafter must refer that person to the DPP.

239. The only way to reconcile these two sections currently is to conclude that any referral to the DPP pursuant to s.21(3) must be done outside the published finding (to avoid falling foul of s.19(3)) and therefore in a separate document. The rules of natural justice would dictate that the party subject to such a referral should be given a copy of the document sent by the Coroner referring the matter to the DPP.[143]

240. I direct the distribution of this Finding together with the Comments to the following:

Ms Michelle Stewart

Mr Graham McLeish

William Angliss Hospital

Secretary to the Department of Human Services

Det. S/c Molloy of Victoria Police

Attorney-General of Victoria

Gleneagles Campus of Eumemmering College

Clinical Liaison Service

Judge Jennifer Coate
State Coroner
2nd December, 2008.

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