Chapter 5 Deaths of children in State care

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The Inquiry received information about more than 900 people during its investigation of children who had died in State care. Information came from various sources, including members of the public and the government agencies: Families SA (the department), the offices of the State Coroner and Births, Deaths and Marriages, and State Records of South Australia.

The Inquiry's term of reference relating to deaths of children in State care is set out in schedule 1 (1)(b) of the *Commission of Inquiry (Children in State Care and Children on APY Lands) Act 2004 Commission of Inquiry Act*. It is to inquire into any allegations of 'criminal conduct that resulted in the death of a person who, at the time that the alleged conduct occurred, was a child in State care, (whether or not any such allegation was previously made or reported)'.

The Inquiry has interpreted the term of reference to include situations where criminal conduct perpetrated upon a child while in State care was the direct and immediate cause of the child's death (for example, homicide, death caused by dangerous driving) and where it was a substantial cause of the child's later death (for example, the child was sexually assaulted when in State care and later committed suicide because of that criminal conduct).

The Inquiry initially asked the department to provide the names of all children in State care who had died. These were provided across eight lists during the course of the Inquiry as the department did not have any mechanism by which it could produce a single consolidated list. Evidence was also taken from people about the deaths of children who they believed were in State care.

The Inquiry found the department had failed to properly record the deaths of children in State care over the past century. The lists provided by the department contained errors, overlaps and were not complete. Even when the fact of a death was recorded, in many cases there was no information about the cause or circumstances. This not only applies to the department's administrative records but also the individual child's files. Any information about the death on the child's file was often from an unverified source. The files were only rarely kept open after the death to obtain official information (such as a post-mortem report or a police report) about the circumstances.

The inconsistency, error and minimal attention to recording and maintaining information about the death and the circumstances of the death of children in State care in departmental records supplied to the Inquiry is not solely historical. Nor is it confined to one type of record—errors and omissions were found in the State ward index cards (SWICs), on client files and on the current Client Information System (CIS).

As a result of the department's inadequate recording, the Inquiry had to request many coronial files just to ascertain the cause of the death. In some cases these files were either not available—before 1 July 2005 the death of a State child was not reportable to the coroner—or could not be found. In some cases, the only information about the cause of death was the death certificate at the Births, Deaths and Marriages Registration Office (BDM). Sometimes the paucity of information (only a stated cause of death on the death certificate, for example, drug overdose) meant that the circumstances surrounding the death could not be determined.

The poor maintenance of departmental records demonstrates an indifference to how children in State care have died.

From its investigations of records, the Inquiry has identified the deaths of children in State care as a result of criminal conduct. It has also received allegations of criminal conduct resulting in deaths of children and investigated whether the children were in State care and whether the death was the result of criminal conduct.

Method of investigation

Determining the number of children who died in State care

Information sources

The Inquiry found the department had no centralised system for recording the names of children who had died in State care. In response to the Inquiry's request for information, the department supplied eight lists of children in State care who had died. Some were drawn from specific sources such as SWICs and the Mortality Record Book, and others were generated for the Inquiry from various administrative records.

Other names were provided by people who gave evidence to the Inquiry and also sourced from non-departmental and other departmental records.

The number of people on the various lists is set out in Table 1. A discussion of each source of information follows.

Source of information	Number of names of deaths
Departmental:	
Minister for Families and Communities	40
State ward index cards (SWICs)	339
Client Information System (CIS)	186
Mortality Record Book	159
Disability SA	41
Consignment list of GRS 11086/1	4
List of files sent to State Coroner's Office 1995–2004	28
Families SA data warehouse	34
Non-departmental:	
Evidence to the Inquiry	76
Inquiry research	16
State Records of South Australia	1
Total	924

Table 1 Sources of information on deaths provided to the Inquiry

Minister for Families and Communities

A list of 40 names was prepared for the Minister for Families and Communities following the Layton report in 2003.[1] These deaths occurred between 9 June 2002 and 26 December 2004.

State ward index cards

Following a manual search of the SWICs, the department gave the Inquiry a list of 339 names. The completeness of the list depended on the death being recorded on the SWIC (which was not always the case) and the accuracy of the manual search process.

Client Information System

The department's computer system, CIS, yielded a list of 186 names of children who were recorded as having died, which was given to the Inquiry.

Mortality Record Book

The department's Mortality Record Book is an administrative record that contains a handwritten list of 159 entries drawn into columns for name, age, date of death, where placed and cause of death. The entries span the years 1927–1974. The book does not record whether the children were in State care. The Inquiry asked the department about the book's function, how information was compiled and who was responsible for its maintenance. The department could not provide this information.

Disability SA

Disability services are coordinated and funded through Disability SA, which is part of the Department for Families and Communities. The office provided the Inquiry with the names of 41 children who had died and who were receiving government disability services in supported residential care or similar facilities.

Consignment list of GRS 11086/1/P 'Records of deceased people while in care'

The department provided a list of archived files relating to four people who had died while in the care of the Minister.

[1] Department of Human Services 2003, *Our best investment: a State plan to protect and advance the interests of children*, report prepared by Robyn Layton QC, DHS Adelaide.

List of files sent to State Coroner's Office 1995–2004

The department supplied a list of 28 names of people whose client files had been sent to the Coroner's Office between 1995 and 2004. The list came from a departmental file marked 'subpoenas', but there was no other description of the list's function. It was not clear which people had died, if any, or the number who had been in State care. The Inquiry's investigations found that most of the people on the list were not dead, but their files had been transferred to assist coronial investigations into the deaths of other people known to the department.

Families SA data warehouse

The department provided a list of 34 people who had an involvement in secure care, community residential care, alternative care placements or were the subject of a care and protection order at 31 January 2005 and who had died.

Evidence to the Inquiry

The names of 76 children who had died were given to the Inquiry during evidence from more than 90 people. This information included allegations of criminal conduct resulting in the death of children thought by the witnesses to have been in State care. It included evidence from people about the death of a family member who had been in State care, but they were uncertain, due to separation, whether that family member died while in State care. Others gave evidence about deaths of people they had known while in State care or during their involvement with children in State care in a professional capacity. This included the names of 23 children from one source, who believed all were in State care. In many cases, people giving evidence were unable to provide information about the cause of death or whether the death was related to criminal conduct that occurred while the child was in State care. For these reasons investigations were conducted into whether the child was in State care, the cause of death and whether there was criminal conduct related to the child's time in State care.

Inquiry research

The names of 16 children who had died were found by the Inquiry in the minutes of the State Children's Council (SCC), indices of the City Coroner's police reports held at State Records of South Australia, and logs and registers maintained at departmental secure care, residential care and other facilities.

State Records of South Australia

State Records of South Australia (SRSA) found the name of one deceased child in Families SA correspondence files.[2]

Generating a single list from the department

The department's sources produced a total of 825 names. The earliest date of death from the sources of information was 1908. Given the disparity of sources and the paucity of information in many cases, the Inquiry undertook to verify the status of the person as a child in State care and each fact of the death. In this process the Inquiry's investigations eliminated 404 cases as being outside the terms of reference, leaving 421 names of children in State care who had died. Reasons for the eliminations were:

- Names appearing on more than one list
- One person on the CIS list was not dead. The department had recorded the person as having died at the age of 17 in 1992; no cause of death was specified. The Inquiry found that three people had been recorded on CIS with the same date of birth and name, but the first name was spelt slightly differently in each case. Each 'person' was recorded as receiving different services from the department, but only one was recorded as having died. Among other investigations, the Inquiry sought records from the State Coroner and the police recording system, but none could be found. It was resolved that the record was in error and that the 1992 date was when the child had committed a property damage offence. CIS records have been amended.

[2] State Records of South Australia (SRSA) GRS 11204, Executive files, annual single number series. Families SA, Department for Families and Communities.

- It is likely that one other child on the CIS list is not dead. The list includes two girls with the same name and date of death in 2000. It shows different dates of birth and a middle name for one girl only. After many inquiries, the Inquiry determined that the entries were for different girls. The State Coroner's Office confirmed that the girl recorded as having a middle name died in 2000. The department could not confirm that the other girl is alive, however it seems likely she is, as there is no record of her death at the Office of Births, Deaths and Marriages (BDM).
- The Inquiry also found that one person on the CIS list who died was recorded twice under different surnames.

The Inquiry was able to ascertain, after investigation, that the CIS list contained names of children who had never been placed in State care, so were outside the Inquiry's terms of reference and not investigated further. They included:

- Seven children had no contact with the department before they died. They had come to the department's attention after death for various reasons, such as concerns arising post-mortem about possible child abuse and the welfare of living siblings.
- Forty-five children came to the attention of the department for direct financial assistance only. This may have been for food, accommodation or clothing while the child was alive or assistance to pay for the child's funeral (the department has historically provided assistance for the burial of people with limited financial resources). The Inquiry often had to request departmental files to determine that the department's involvement was either post-mortem or for direct financial assistance only.
- Seventy-two children had never been placed in State care as defined by the Inquiry's terms of reference, but had come to the department's attention during their lives because of child protection notifications made in relation to them or members of their families.

In the vast majority of these cases the Inquiry found it necessary to request files from the department and State Coroner's Office to ascertain the child's status and cause of death.

After investigation of records the status as children in State care remained unclear in 39 cases. However because the causes of death did not suggest any relevant criminal conduct, the cases were not further investigated.

Seven deaths occurred after 18 November 2004. Under the Commission of Inquiry Act, only deaths occurring before that date come within the jurisdiction of the Inquiry.

Table 2 shows the number of deceased children in State care.

Source of information	Number of children in State care from source
Minister for Families and Communities' list	5[3]
State ward index cards	339
Client Information System (CIS)	45
Mortality Record Book	30[4]
Disability SA	1
Consignment list of GRS11086/1	1
Listing of files sent to State Coroner's Office 1995–2004	0[5]
CYFS data warehouse	0[6]
Total	421

Table 2 Number of deceased children in State care from departmental sources after accounting for overlap

[3] Five names on the Minister's list were not on any of the lists provided by the department.

[4] All 159 names in the Mortality Record Book were of children in State care, however 30 were not included in the SWIC list.

[5] The names of deceased children in State care on this list were already on other lists provided by the department.

[6] As per footnote 5.

Omissions in department information

The Inquiry believes the list of 421 names of children who died in State care between 1908–2004 is not complete for various reasons.

The Mortality Record Book is a hardcover foolscap book containing handwritten entries concerning persons who died between 1927 and 1974. The Inquiry compared the number of names in the book to departmental annual reports[7] that recorded deaths of State children. As the annual reports list the numbers of children who died in a particular year but not their names, it was not possible to confirm whether they were the same children named in the Mortality Record Book each year. In terms of numbers, however, there was a discrepancy between the Children's Welfare and Public Relief Board (CWPRB) annual report for the year ending 30 June 1941, which listed the deaths of one girl and two boys, and the Mortality Record Book, which did not list any deaths for the same period. Also, six children who died in State care were listed on the department's SWIC list for that year but not recorded in the Mortality Record Book. This includes the three deaths in the CWPRB annual report. From these comparisons alone, it is evident that the book was deficient by at least six deaths.

The SWIC list provided by the department was also deficient. The Inquiry is not critical of the departmental employees who performed the task of manually searching the SWICs for a recording of death at the Inquiry's request. However, the difficulty of such a task and the inevitable inaccuracies that arose serve to highlight the historical failure of the State to centrally record the deaths of children under its guardianship, resulting in its inability today to produce a comprehensive list of these children.

At least 30 deaths were missed in the manual search of the SWICs. There were 30 deaths recorded in the Mortality Record Book that were not on the SWIC list. The Inquiry found that each of the 30 children in the Mortality Record Book did have a SWIC, which recorded their death.

There was no consistency in the practice of recording the death of children after they were released from State care. Sometimes a child's death would be recorded on the SWIC whether or not the death occurred while they were in State care. For example, one male was released from State care in 1909 aged 18 and his death three years later is recorded on his SWIC. Another male was released from State care in 1913 aged 18 and his SWIC records that he died in 1918 when he was 22. Another male was released from State care in 1962 aged 18 and his SWIC records that he died in 1968, aged 24. However, the death of a female only four months after she turned 18 and was released from State care was not recorded on her SWIC.

The Inquiry also became aware from non-departmental sources of the deaths of two children while in State care, which had not been recorded on their SWICs. One child's last entry on her SWIC was 'released, term expired' in August 1989, however she had died in 1987. Exactly the same notation was made for the other child as his last SWIC entry in 1985, but he had died the previous year.

The Inquiry also found that the department's CIS list was not complete or consistent. Eight deaths discovered by the Inquiry from non-departmental sources were recorded on CIS, although they were not on the CIS list provided to the Inquiry.

Sometimes, but not consistently, the department would record the death of a child on CIS, whether or not the death had occurred while the child was in, or had left, State care. Further, the recording of the death on CIS was not always timely. For example, one boy died in State care in January 1994, but the death was not recorded on CIS until five months later, in June. One girl died in State care in 1994, but the death was not recorded on CIS until 1996.

The Inquiry became aware, through evidence and research, of the deaths of three State children that were not recorded on CIS. Two should have been recorded because they had died while they were in State care, one as a result of a homicide.

7 State Children's Council (SCC) annual reports 1896–1926; Children's Welfare and Public Relief Board (CWPRB) annual reports 1927–65; Department of Social Welfare (DSW) annual reports 1966–70; Director of Social Welfare and Aboriginal Affairs annual report 1971; Department for Community Welfare (DCW) annual reports 1972–75.

The Inquiry's finding that the list of 421 names is not complete is clearly demonstrated by the fact that non-departmental sources provided 55 names of deceased State children that had not been advised by the department. Of the 55, 45 arose from evidence given to the Inquiry (13 of these children were in State care when they died), nine from the Inquiry's research into other topics (three were in State care when they died) and one from State Records' research. Therefore at least 16 children had died in State care but their deaths were not recorded by the department.

There were an additional three names provided by witnesses where the allegation was that the children had been in State care when they died. Those three names were not on the departmental lists, however, none of the deaths could be verified by the Inquiry's investigations and therefore no criticism is made of the department for not recording these three deaths. In relation to one death, according to the person who gave evidence, the death was due to alcohol consumption. Departmental records show the child was placed in State care in 1981 aged nine and released on turning 18 in 1990. No records of him were found at the Coroner's Office or BDM. The departmental file notes that he was believed to be living in Alice Springs when released from State care, which may explain the lack of records in South Australia.

In the other two cases, it was alleged by the witnesses that both children had died while in State care. In one case, it was not possible to determine that the child existed or died in the alleged circumstances. In the other case, a police investigation concluded that no such death occurred. These two names are included in the final list of children who died while in State care as being 'undetermined' and the other as being an 'allegation of criminal conduct' which was investigated.

Of the nine names arising from the Inquiry's research, the three names of children who had died in State care were found incidentally by the Inquiry in other departmental records. One child had died in custody, one had committed suicide and the Inquiry found an allegation in CIS that the other was murdered.

Adding the 58 names from non-departmental sources to those from the department gave the Inquiry a list of 479 children in State care whose deaths had to be further investigated in terms of any link between the death and criminal conduct that occurred during the child's time in State care.

Determining the cause of death of children in State care

Deficiencies in departmental records

The department's failure to properly record the cause of death of State children made it very difficult to determine, from departmental records, whether any deaths resulted from criminal conduct.

Of the 339 names recorded on the SWIC cards, 108 recorded only the fact of death, not the cause. The entry was commonly 'released – died'. Where a cause of death was recorded, there was no indication of the source of the information.

The Mortality Record Book lists 159 deaths. A column is dedicated to the causes of death, which for 15 people were:

- Blank column (seven children)
- Entry simply '?' (6)
- 'Died' – no details (1)
- 'A spastic child' (1)

For an additional seven children a cause of death was listed, but followed by a question mark.

The CIS list gave no cause of death for 17 of the 44 children in State care listed. Where causes of death were included, details were scant, for example:

- 'Died in care, possibly accidental'
- 'Cerebral palsy sufferer'
- 'Health problems'
- 'Natural causes'
- 'Possible heroin overdose'
- 'Died in house fire'

There is rarely any indication of the information's source or any record of later verification by the department where 'possible' causes had been recorded initially.

The Inquiry requested department client files on each of the dead children. Most files had no information about the circumstances of the death. In the minority that did, the quality of information varied, ranging from a newspaper clipping to a memo to the chief executive / Minister providing advice about the fact of the death, to a copy of a police report to the coroner following an investigation.

However, carers for children in State care were legally required to provide information to the department about children's cause of death for only six years, from 1966–72.[8] Otherwise, they were only required to notify the department of the fact of the child's death.[9]

As a result of the lack of information from the department, the Inquiry had to request many files from the Coroner's Office in order to ascertain a cause of death.

Coronial records

The Courts Administration Authority (CAA) is the controlling agency for coronial records in South Australia. Records from 2002 are held at the Coroner's Office, while those before 2002 are controlled by CAA and stored in archives maintained by State Records of South Australia.

Coronial records for a reportable death may include a police report to the coroner, a burial order signed by the coroner (permitting burial when an inquest was deemed unnecessary or completed) and an inquest file (when an inquest was held).

SRSA provided information on references for coronial records for more than 500 names on the Inquiry's list. The Coroner's Office was consulted on additional cases and where further information was required. Coronial records were requested for 458 deaths, after the elimination of cases where the child had died after being released from State care and the cause of death available from departmental sources did not suggest criminal conduct linked to the period in care.

However the process of gaining coronial files was not straightforward. The historical records management system used at the Coroner's Office has limitations, which make it difficult to locate references for records. A central database has been used since 1997, which was made consistent with the National Coroners Information System (NCIS) in 1999. A spreadsheet program is used to locate coronial records for deaths between 1966 and 1997. However, the spreadsheet does not record all the necessary information (e.g. date of death, inquest file reference) because it is based on various historical documents that may overlap in date range, span only a discrete period, cover only specific geographical areas and vary in administrative function.

The Coroner's Office uses several, incomplete historical documents to locate references for matters before 1966. For example, the office only holds an index to records of inquests from 1931 (inquest files from 1877 to 1930 were destroyed during World War II) and to coronial reports from 1936 so it is difficult to determine whether the records existed before those dates. As a result, the Inquiry manually searched records at SRSA. Also, there was no index for archived burial orders between 1955 and 1971 (contained in 13 boxes at SRSA), which are stored according to the year in which they were signed by the coroner rather than the year in which the death occurred. In a manual search of the boxes, Inquiry staff found burial orders for 18. Two of these orders were the only coronial record of the deaths.

8 From 1966, if a State child died, the person who had immediate care of the child and the person in possession of the child's body had to immediately notify the DCW director. Licensees of children's homes and foster parents had to notify the director in writing within 24 hours of the child's death, giving the name, date of death and cause of death 'so far as known': see Regulations 32, 70, 75 under the *Social Welfare Act 1926–65*. This was the first time the regulations stipulated that the notification include cause of death, however the provisions were revoked in 1972.

9 From 1896–1927, officers in charge of institutions, foster-parents and licensed foster mothers were required to give notice of a death of a child in their care to the SCC secretary: see Regulations 22, 53 and 87 under *State Children Act 1895*, s. 67; from 1927, officers in charge of institutions had to report the death of a child to the CWPRB. Parents, foster parents and licensed foster mothers were required to give the chairman notice of the death: see Regulations 92, 122 and 145 under the *Maintenance Act 1926–37*. The start of these regulations in 1927 corresponds with the first entry in the Mortality Record Book. From July 1960 every licensee of a lying-in home was required to notify the board of the death of an illegitimate child born in the home within 24 hours: see Regulation 143 under the *Maintenance Act 1926–58*. These provisions were revoked in 1966. From 1972–83, the person having the immediate care of a child in State care, approved foster parents and the person in charge of a licensed children's home had to immediately notify the DCW director-general of the child's death: see Regulations 32, 35 and 47 under the *Community Welfare Act 1972*. From 1983, the person having the immediate care of a child under the guardianship of the Minister or placed by the director-general pursuant to an order of the Children's Court, approved foster parents and the person in charge of a licensed children's home had to immediately notify the director-general of the death of the child. These provisions were revoked in 1996: see Regulations 22, 33 and 38 under the *Community Welfare Act 1972–81*.

In some cases the Coroner's Office was unable to find any reference for coronial records but Inquiry staff subsequently located references or records in the Index to Certificates of Burial 1933–1953, which is held at SRSA[10] (despite finding the references using the index, the actual coronial records could not be found).

In several cases, coronial records obtained by the Inquiry indicated the existence of other coronial records for which the Coroner's Office had no reference. For example, in the case of the 1970 death of a youth in State care in a motor vehicle accident, which involved the theft of the car, the burial order refers to the receipt of a police report to the coroner setting out the circumstances of the death, but the Coroner's Office had no reference for this report and it could not be located.

There were several cases where the Coroner's Office located a reference to coronial files, which could not be located, including:

- the death from criminal conduct of a 14-year old girl in State care in 1944. SRSA found a police report to the coroner that contained a notation concerning an inquest into the matter. The Coroner's Office confirmed the existence of an inquest file, however the office could not find the file and had no record of it being archived.[11]
- an alleged homicide in 1974. The Inquiry requested the police report to the coroner, however the Coroner's Office said that its records showed it had requested the file from SRSA in 1985. The file had not been returned to SRSA, however the office was unable to find it and there is no evidence to suggest it was destroyed. The Inquiry later determined that the deceased was not in State care and the matter was not pursued.
- a 1982 death by criminal conduct of a youth who had been in State care. The Coroner's Office found references for both coronial and inquest files. The office recorded that the coronial file was transferred to archives, however SRSA advised the Inquiry that the coronial file could not be located and there was no record the file had ever been transferred.

[10] SRSA GRG 1/92.

[11] SRSA staff advised of gaps in the archival records from 1931–76.

As a result of these difficulties, the Inquiry also searched records at BDM for information on State children's causes of death.

Office of Births, Deaths and Marriages

BDM registers deaths from 1842 in a variety of formats including microfiche, microfilm and electronic database. In this report 'death certificate' denotes certificates of registered deaths taken from historical registers at the BDM or printouts of information from a database of registered deaths maintained by BDM since the early 1990s. With the assistance of BDM staff, the Inquiry located and retrieved 364 death certificates. Death certificates contain information that was generally not recorded in departmental records, notably a cause and location of death. For example, several children were found to have died at the Edwardstown Industrial School in the early 20th century, but this information was not on any of the children's SWICs.

Deaths after release from State care

Of the 479 children in State care whose deaths required further investigation, the Inquiry found that 85 had died after they were released from State care. In relation to one additional person, the Inquiry was not able to verify his death, however, available records suggest that if he has died, his death occurred after he was released from State care. The Inquiry therefore proceeded on the basis that 86 out of the 479 children who had been in State care died after they had been released from State care.

Suicides

Of the 86 children who died outside State care, 22 committed suicide. The Inquiry has not tried to make a definitive finding about the reason for suicide, but has sought to determine whether any criminal conduct occurred while the person was a child in State care and if this was linked to the suicide.

Three people committed suicide within a year of being released from State care. In two cases, family violence and allegations of sexual abuse precipitated the child's placement in State care. Each child had extensive interaction with the department, which focused on addressing serial offending, substance abuse and expressions of suicidal thinking.

The third case involved a youth under a guardianship order that was made in 1993 and ran for two years, or until his 16th birthday. The department incorrectly calculated his age and released him on his 15th birthday. The two years expired early the following year and the youth hanged himself six months later. At the time he was living with family members in a private arrangement that was not organised by the department. The department wrote to the youth shortly after the premature expiration of the guardianship order, noting that the order had ended because the youth had turned 16 (which was not the case): 'We believe you are now living with relatives at [name of town] and are well settled'.[12] The youth hanged himself after an altercation with family members who had attempted to curb his drug use.

Five people committed suicide from one to five years after their release from State care. In one case, departmental files record a discussion between the departmental worker and a foster carer of a sexual abuse allegation, however no information could be found in the files to indicate whether the child made the allegation himself or whether it was investigated. Another child experienced sexual abuse, family instability, substance abuse and offending preceding the period in State care. Her extensive interaction with the department involved alternative and secure care. She was living interstate at the time of her death. Another suicide victim had experienced family violence as a child and was taken into foster care. The child absconded from foster care, became involved in substance abuse and spent time in secure care as a result of offending. One person committed suicide in an adult prison.

In another case, records suggest one factor (among many, including alcohol) in the youth's suicide may have been something he had experienced or witnessed during a period in secure care. He committed suicide at the age of 19 in 1998, having first been placed at the Magill Training Centre for three months in 1993 for offending. In 1995 he was again sent to the centre for offending. Two statements from friends provided to the coroner said the youth told them he hated jail and never wanted to go back to it again. A former employer made a statement that the youth had said 'some pretty bad things happened in prison'. Log books for the Magill Training Centre in 1993 indicate visits to the centre by two suspected perpetrators of child sexual abuse during that time, though not to the victim. The logs also indicate that the centre was full and there were standover tactics between inmates, bullying, theft and intimidation. The youth's father said at his son's inquest that his son's

> *... desire was not to get back into trouble with the law at all, but, realising that potentially that's where he's going to end up … he wasn't going to have that, and decided to take things in his own hands, if I can use that expression. That's just my thoughts on the matter.*[13]

[12] Social worker, letter to client, departmental client file.

[13] Coroner's inquest, file —/1998, p. 201.

Six people committed suicide 5–10 years after their period in State care had ended. One had made allegations of familial sexual abuse while a child, before being placed in State care. There are no records of any sexual abuse while in State care. The child expressed suicidal ideas during the period in State care. In another case, the child came into State care because of familial physical abuse but no records of criminal conduct were found during the child's time in State care. Again, the child's time in care was marked by suicidal thoughts.

Five people committed suicide 10–15 years after they had been in State care. A friend of one of these people gave evidence to the Inquiry that the person's extensive period in foster care and alternative care as a child was allegedly linked to the suicide. Departmental records showed a history of family violence and that the child's period in care involved substance abuse and suicidal thinking. Two of these people had spent periods in secure care for offending and records show that both suicides occurred after significant alcohol use. In the other two cases the suicides seem to have been linked to relationship breakdowns.

The Inquiry received information on the suicide of one person about 15 years after release from State care. He had been in State care for a brief period on juvenile justice matters. Investigations revealed no evidence of criminal conduct while in State care.

Two people had committed suicide about 20 years after their period in State care had expired. One death appeared to have been linked to a relationship breakdown and the other was the result of an acute drug overdose. The latter death appeared to be directly linked to sexual abuse. The woman had taken court action against the State regarding sexual abuse. The court found that the sexual abuse occurred after she had been adopted, not while she was in State care, and that the State was not liable for its involvement in the adoption. The woman died eight days after the court delivered its judgment.

The names of five males alleged to have committed suicide were given to the Inquiry by the Special Investigations Unit of the department on the basis that at some stage, as youths, they had all been in the care of a youth worker who was the subject of sexual assault allegations by other youths. The Inquiry was to investigate whether there was any link between their contact with the youth worker and subsequent suicides. The Inquiry obtained the five men's departmental and coronial files. The deaths occurred in 1994 (age 21), 1995 (age 20), 1998 (age 20), 2000 (age 23) and 2004 (age 33). The Inquiry determined that the 1995 death was not due to suicide but to an accident at a train station. In relation to the 2004 death, the Inquiry was unable to find any recorded contact between the deceased and the youth worker.

The Inquiry found that the remaining three deaths were the result of suicide and in each case there was contact between the youth and the youth worker. Concerning the 1994 death, the files record that contact was in 1989, however the youth worker was named as the person who collected the youth's clothes from the police station after his death. In relation to the deaths in 1998 and 2000, the last recorded contact between the two youths and the youth worker was in 1993. There was no record of any allegation of sexual abuse made by the three youths against the youth worker. From the records, the Inquiry was unable to substantiate any link between the youth worker and the three youths who committed suicide.

Substance abuse

Seven people died outside State care from substance abuse, including one from sniffing petrol.

One Aboriginal male died from petrol sniffing one month after his release from State care. He had been placed in State care at the age of three weeks by court order and had several placements in foster care and departmental institutions. According to department files, he was assessed as severely emotionally disturbed at an early age, attributed in part to his placement in departmental care and

fostering. The child's case management involved debate about whether he should be placed with white foster parents or reunited with his mother, who had a history of alcohol abuse. The child was returned to his mother, but she then abandoned him. The department's records indicate that the child first sniffed petrol at 14 and three times in the next two years the departmental reviews noted efforts to combat the sniffing. The department was unable to locate him when he was 17 even though he had been charged with attempting to steal petrol and ordered to reside where directed and be under departmental supervision. The department planned to release the child from guardianship once he was located, as he was deemed 'an independent person of independent means'. He was not located before he died.

Homicides

Five people died as a result of homicide. Two were aged 18, two 17 and one 15. Four had previously been placed in foster or secure care and one child had been placed under the care and control of the Minister, his term expiring a year before his death.

One girl, 17, was murdered by a family member. She had been placed under the guardianship of the Minister for a month in 1987 and then spent some time in detention on remand for criminal offences. A month before her death in 1988, she had been placed on a court-ordered bond, which required her to be under the supervision of a departmental officer. She went to live with the family member who, one month later, murdered her. There is a recorded note that she had chosen to live with the family member against the advice of the departmental officer. She also previously alleged that the family member had raped her. Two days before her death, she advised the officer that she had found a new place to live and told the officer not to tell the family member. Her body was found near a railway line. The family member was convicted of her murder.

Deaths in State care

The Inquiry determined that 391 children died while in State care. It was unable to verify a further two deaths that allegedly occurred in institutions. In one case, it was not possible to determine that the child existed or died in the alleged circumstances. In the other case, the police investigation concluded that no such death occurred. Table 3 shows the number of children who died from each cause of death while in State care, including the two additional deaths that could not be verified.

Cause of death	Number of children who died while in State care
Natural causes: infectious disease	128
Natural causes: medical condition	108
Accident	85
Malnutrition	24
Undetermined	20[14]
Allegations of criminal conduct	15[15]
Suicide	11
Substance abuse including petrol	2
TOTAL	393

Table 3 Causes of death of children in State care

The Inquiry uses the term 'medical condition' to refer to deaths of children from congenital medical conditions or those arising during their lifetime, for example, heart disease, epilepsy, cancer, asthma and rickets. The records show that a death was categorised as due to a medical condition even when the main cause of death was an infectious disease, such as pneumonia, if the child suffered from a serious underlying medical condition that made the child more susceptible. This was to distinguish between otherwise healthy children who died purely as the result of

[14] Includes the death where investigations were unable to determine whether the child existed or died in the circumstances alleged: see 'Deaths in State care, Deaths in institutional care – undetermined'.

[15] Includes the alleged death caused by criminal conduct in which a police investigation concluded that no such death occurred: see 'Deaths in State care, Deaths in institutional care – allegations of criminal conduct'.

an infectious disease. The predominant infectious diseases, particularly in historical cases between 1908 and 1930, were gastroenteritis, meningitis, pneumonia and tuberculosis.

The Inquiry placed 20 deaths in an 'undetermined' category to cover three circumstances:

- a coronial record of the cause of death as 'undetermined'
- insufficient records to determine the circumstances of the death
- few records available and containing conflicting information that could not be resolved.

Deaths in institutional care

Medical conditions and infectious diseases

Of 171 children in State care who died while placed in institutions, 67 were caused by medical conditions, 67 from infectious disease and 21 from malnutrition, referred to in historical records as marasmus or asthenia.[16] Sixteen of the malnutrition deaths occurred between 1908 and 1914.

Before the prescription of penicillin in the late 1930s, there was a high risk of infectious disease, particularly gastrointestinal illnesses, due to crowded, unsanitary housing. In South Australia the risk was exacerbated by a dry, hot climate. Dehydration during summer was common, as was contamination of milk and foodstuffs, which contributed to the spread of bacterial infections in babies and children.[17]

The SCC reported on the issue of infant and child mortality. In 1911 the death of 11 State children, nine in institutions, moved the council to comment on the 'dangers of institutional life for infants'. In addition to the need for hygiene and clean air, the council noted that infants in institutions lacked attention compared to those placed in homes. 'Infants appear to be unable to live without love … no matter how good the nurse.' The council noted that the statistics 'display the facts'.[18] At a council meeting in 1914 the secretary presented statistics on the death rate of 'Supervised infants, which the Council did not think it wise to publish'.

At the Edwardstown Industrial School, 23 children died from infectious diseases or malnutrition from 1908–17, with death from infectious disease being prevalent from 1908–12. Many children passed through the school, some of whom were ill on admittance. The SCC was aware of the risk of infectious disease due to crowding at the school. In its annual report for the year ending 30 June 1910, the council noted the difficulty in finding homes for young children and that a high number of babies in the school is 'always prejudicial to the health of such children no matter how carefully they are managed'.[19] In 1911, the council reported its concern that six infants had died at the school, all of whom were ill on admission. Its report for 1912 noted the 'serious mortality' among infants at the school and the council's decision to request assistance from the children's hospital in the care of children with non-notifiable illnesses. The 'heavy death rate' was attributed to the 'influx of diseased and ailing infants', who were placed in the same institution as the healthy. In addition, the council noted it was seeking out children in need of care and that the condition in which many infants were found made 'their early decease almost a certainty'.[20] In 1914 a minute notes that the council would 'consider the isolation of infectious cases among the children at the Industrial School when the Council visits the School'.[21] A special meeting on the subject was convened in November 1916, the minutes recording discussion of 'the limited room in the IS, the number of children of all ages accommodated there, the

[16] Marasmus is severe malnutrition caused by caloric and nutrient deficiency, sometimes by diseases such as dysentery. It is characterised by poor growth, muscle atrophy and apathy. See <http://www.nlm.nih.gov/medlineplus/mplusdictionary.html>

[17] H Jones, *In her own name: a history of women in South Australia since 1836*, Wakefield Press, Adelaide, 1994, pp. 37–38.

[18] SCC annual report 1910–11, p. 12.

[19] ibid., 1909–10, p. 8.

[20] ibid., 1911–12, pp. 5, 7, 11.

[21] SRSA GRG 29/124/4, minutes SCC (minute 445), docket ref 546/14.

possibility of importing infectious diseases … Its unsuitability for delicate children … the open drains at the IS, the flies … the risk of importing marasmus and gastro enteritis.'[22] Measures were taken to prevent infection, for example, in October 1917 the council resolved that 'in view of the number of children in the IS and as a preventive to sickness a McKenzie Disinfecting Spray Pump be provided'.[23] In January 1918 the council resolved that the school's matron should submit regular reports on the numbers of infectious disease cases at the industrial school and that instruction in 'new methods of disinfection' be obtained.[24]

It is a risk to make assumptions about the circumstances of a death simply from a description of the cause of death as infectious disease. For example, the Inquiry obtained records about the deaths of two girls through 'infectious disease'. However records reveal that their deaths cannot be put down simply to overcrowding or lack of antibiotics.

In 1907, a nine-year-old girl was charged as having unfit guardianship and placed in State care by court order until she turned 18. The order was later changed to age 20. At 19, in December 1916, she was recorded as having died after one month of heart disease and 14 days of pneumonia.

Departmental records indicate that while she was in State care, the girl was repeatedly placed in service—out to homes as a domestic servant—despite a history of serious illness. Between September 1910 and her death in 1916, she was admitted to hospitals 12 times for ailments including rheumatic fever, measles, heart trouble, appendicitis and tonsillitis. The department received doctor's advice in May 1911 that the 'condition of girl's health is serious'. Despite this the department transferred her among institutions and service placements in metropolitan and rural areas 13 times from June 1907 to April 1913. During a rural placement in March 1913, the local doctor advised the department that the girl should be transferred to Adelaide for effective medical care. She collapsed at the railway station and was admitted to a rural hospital. The doctor advised the State Children's Council secretary that 'on the face of it, it would appear that either her being sent to Adelaide was too long delayed, or she should have remained in [the boarding-out] home'.[25] At another rural placement in November 1913, where the child worked as a maid, the female employer requested her removal as her illness limited her ability to work.[26] The department's secretary wrote, 'I regret that you have had so much trouble in the matter, but it was quite unforeseen, as the doctor here had passed her as quite well before she went to [the placement]'.[27] Again, a local doctor sent a telegram to the department recommending that the child 'be removed as soon as possible suggest [a local] Hospital'.[28]

In October 1916 the girl was transferred to the Edwardstown Industrial School. The records indicate that she had been sent from the school in October to visit her aunt, collapsing on arrival at the State Children's Department, where the two were to meet. Reference was also made to her expectorating blood in the weeks before her death. Correspondence from 1916 shows that the doctor attending the Industrial School 'has never thought her fit to go to a situation'.[29]

In November 1916, an anonymous card alleging ill-treatment of the girl by the acting matron of the Industrial School was sent to the secretary of the State Children's Department. The card, written in what appears to be a child's hand, stated that the acting matron's treatment

[22] ibid., (minute 456), docket ref 1258/14.
[23] ibid., (minute 546), 12 Nov. 1917.
[24] ibid., (minute 549), 10 Dec. 10 1917; (minute 550), 7 Jan. 1918.
[25] SRSA GRG 27/1/31, correspondence 669/1913.
[26] ibid., correspondence 1622/1913.
[27] ibid.
[28] ibid.
[29] SRSA GRG 27/1/41, file 1509/1916.

> *... ought to be seen into. I wish you would call at the hospital and [the girl] would explain. It's a disgrace to any institution (sic) the poor girl was that frightened to tell the sister how ill she was because if she dropped dead at her feet she would kick her and tell her to get up it was all shame hope you will see into it.*[30]

The acting matron denied the allegations and identified the girl as the likely author of the card, suggesting that she had been influenced to write it. She cited her excellent care and attention to the girl and argued that 'every consideration' had been given by the doctor visiting the Industrial School, including the prescription of 10 drops of Easton's Syrup before each meal.[31] She claimed to have no knowledge that the girl had expectorated blood. She denied that the girl could have been too frightened to speak with her and suggested that because the girl was

> *... mentally depressed, I really do not think [the girl] at all times realises what she says. … I have always been very fond of the children down here and it worries me very much to learn that I have had such a complaint laid against me in this way, which I cannot possibly understand.*[32]

The records do not show whether the council took any further action.

Sixteen months after the girl's death, however, the council received information that the same acting matron had slapped the faces of several children at the Industrial School. Under regulations in force since 1909, permission would have to be sought from the SCC secretary before inflicting any punishment on residents. The council took no action in response to the information about slapping. However, two further complaints were received about ill-treatment of residents, including physical abuse and stripping, by the acting matron. In July 1918 the council resolved that the acting matron should be suspended pending further enquiry. Evidence was taken from several children, which is contained in the departmental correspondence docket. The council requested that the acting matron resign and resolved that she was not to be transferred to any other State institution. She resigned in July 1918.

In 1939, a 14-year-old girl was placed in State care and committed to the Salvation Army Girls Home, Fullarton, after a court found that she was uncontrollable. Her SWIC records that she died from toxaemia in 1941, however records obtained by the Inquiry reveal that the girl's death was not simply the result of an infectious disease. Her death was not recorded in the Mortality Record Book.

The girl's SWIC shows that she absconded from the home after 2½ months to live with her mother. Her mother was told by the department that she was in breach of section 185 of the Maintenance Act for harbouring absconders and the girl returned to the school four days later. She wrote to the secretary of the CWPRB about 10 months later, asking to go home to her mother rather than be placed out in a situation. The board advised that the application for release was 'deferred for the present'.

The child wrote again three months later, asking when she could be released: 'I have learnt all the work now … I hope you say I can go home this month … I have been here a year and six months and I haven't ran away for a long time'. The secretary wrote back, saying the board was not prepared to let her go home, but telling her to 'keep learning as much as you can in regard to housework, cooking etc in order that something may be done for you at the earliest possible date'.

Two months later the child wrote again: 'Please … would you let me go home'. The secretary responded: 'I am sorry that this request cannot be granted. I want you to try and learn all you can while in the Institution so that when an opportunity arises Matron will be able to give me a good

[30] ibid.

[31] Easton's Syrup was a thick syrup containing phosphates of iron, quinine and strychnine administered orally as a nerve tonic.

[32] SRSA GRG 27/1/41.

report and recommend you for placing out in a situation. I hope you will have a very happy Christmas'.[33]

The child died in hospital about three weeks later.

Departmental records include a report from the CWPRB's secretary to its chief secretary after the death, which notes that in October 1940 the matron had called a doctor after she noticed that the child had a bad cough. The doctor advised that the child would recover in a few days. The cold did not improve so the matron gave the child 'local remedies', which included a herbal treatment called white pine. The doctor saw the child again in late November and a further 10 times during the next month. A report from the doctor after the death indicates that he thought the child seemed well on Christmas Eve, so he had decided he would only attend the institution if called. As he was not called, he assumed that the child's condition was satisfactory.

According to a departmental report on the death, the child advised the matron six days before her death that she was not feeling well, suffering pain in her right side. Children from the school were to be taken to the beach that day. The matron wrote in her report that she took the child along to the beach, thinking it would do her good, taking rugs and aspirin to 'make her more comfortable'. She did not take the child's temperature beforehand as she thought it unnecessary. At the beach, the child's mother approached the matron and asked to see her daughter. Her daughter cried upon seeing her mother and the matron told the mother that the doctor would see her child the next day. The mother left and returned with a police officer. The matron advised the police officer that the child was a 'State ward' and receiving the best possible care. The mother then returned with a doctor, who ordered the child be sent to hospital, where she was diagnosed with pneumonia and died six days later.

Correspondence from the hospital indicates that the child had an early pneumonia when she was admitted to hospital.[34] The post-mortem revealed evidence of tuberculosis in both lungs, with pyo-pneumothorax on the right side. Toxaemia from that condition caused the death. The doctor who had seen the child at the school reported to the board after her death that she may have had some 'deep seated quiescent old lesion in the lung which lighted up suddenly and manifested itself on the morning' at the beach.

A member of the public sent a letter of complaint to the department five months after the child died. The writer referred to the 'callous treatment to a poor girl who had been a very sick girl'. She alleged that the child was 'made to work right up to the time that she went to Hospital', that she was 'yelled and screamed at and threatened to be punished', that she was being called 'lazy in front of the other girls, would say that she went about as though she was half dying, the girl would say that she didn't feel well enough to work'. She alleged that the child was made to scrub the floor of the dormitory when she had stayed in bed, made to eat her meals even though others were permitted to leave their food and then, a week or two before her death, was made to do ironing/laundry work. She alleged that before they left for the beach that morning, the child had a 'very bad turn', had to leave the breakfast table to vomit but was then 'made' to go on a picnic to the beach. The complainant stated that this was 'a terrible affair' that 'should be brought before the Public'. The department responded to the effect that it was aware of the facts and that 'suitable action has been taken'.[35] There is a record that the secretary of the CWPRB had seen the girl working at the institution eight days before she died. A few weeks after the child died, a board minute in relation to the death noted that a report to the chief secretary had been read to the board and a letter from the matron received, which talked about 'precautions taken in connection with bed-clothes'. The minute also noted that a report in relation to the use of thermometers in all institutions was received and 'it was decided to discuss matters connected therewith at the next meeting of the Board'. No further records about the girl's death were located.

[33] SRSA GRG 29/121/ 66; SRSA GRG 29/123/78.
[34] SRSA GRG 29/121/66.
[35] SRSA GRG 29/123/78.

Accidents

Eight children died from accidents while in an institution, and all their departmental files contain some information about the circumstances.

The Inquiry found that two girls died at Seaforth Home in strikingly similar circumstances, although their deaths were 22 years apart. Each demonstrates a significantly different approach taken by the department following the deaths. The departmental records indicate little effort was made to determine the circumstances of the earlier death, however its records of the later accident contain statements of relevant witnesses.

In 1923 a court placed a seven-year-old girl in State care until the age of 18, for reason of unfit guardianship. She had Aboriginal heritage and was described on her SWIC as 'half-caste'. She was placed with various foster carers in the community, once being removed because she was 'unsuitable'. Her first time in Seaforth Home was because the subsidy to her foster parent of five years had expired. Over six months in 1929–30 she was returned to Seaforth Home from foster placements three times, the reasons given being 'did not like girl being half-caste' and 'on account of color'. After living at Seaforth Home for a year, she died, aged 16. Her SWIC states the cause of death as 'result of burning accident, heart failure following severe burns'.

Coronial records include statements from people who had been at Seaforth Home at the time of the girl's death. One child witness stated that the girl was working in the laundry at Seaforth Home at 8am. She was seen to enter the laundry and stand near the copper, which was enclosed with bricks and contained a wood fire. The witness stated that the girl took hot water from the copper and stood next to it, washing her clothing. The witness next heard a scream and saw that the girl's clothing, made of cotton and flannel, had caught fire. The child witness ran out and called 'fire'. A nurse and others put out the flames with blankets. The records indicate that the girl had burns to her chest and arms. After a doctor saw her, she was transferred to Adelaide Hospital. Her condition deteriorated and she died three days later. In a statement, the home's nurse said: 'I have warned the inmates from time to time, including the deceased, about standing near the copper when washing clothes'.

The child's departmental file included a report from the matron to the secretary of the board on the morning of the accident, stating that the girl was standing in front of the copper getting a bucket of hot water when her clothes caught on fire. The report stated that the girl 'was not a laundry girl she had no right in the laundry'.

A report from the matron three days later said five staff members had been on duty, but did not say where they were at the time. The matron also said: 'The copper is well built in and not at all dangerous to anyone working there unless of course they stand in front when a flame is likely to escape'. The next note is that the child died. The board did not conduct an investigation, and the questions of why the girl was in the laundry and whether the copper door had been opened were not answered.

In 1943 a five-year-old girl was placed in State care until the age of 18, the court finding that she was neglected and had unfit guardianship. She was committed to Seaforth Home and placed out with foster parents at least eight times in the next decade. She died at Seaforth Home in 1953 when she was 14; the cause of death on her SWIC and in the Mortality Record Book was 'Toxaemia from burns'.

Coronial records contained statements from people at Seaforth Home on the day the girl died. The laundress's statement said the child entered the laundry with some tea towels about 8.45am. She was told to put them in a basket by the door. The laundress then left to get some soap, leaving the child standing by the copper. She then heard screaming, but ignored it thinking that it was from girls playing. After hearing a girl yell her name, she then saw the

child, on fire, in the yard and another staff member smother her in a blanket. The records indicate that the child was transferred to hospital and died 10 days later. The laundress said the door to the copper was shut when she left the laundry but open after the incident. There was paper missing from a bucket in the laundry.

The departmental file contained a certified copy of the registration of death (rarely seen by the Inquiry on departmental files). It also contained a report from the CWPRB chairman to its chief secretary, and statements from witnesses, including the girl's sister, who stated that the girl resisted her help. It was assumed that the child had been standing near the copper, possibly to warm herself, when her clothes caught alight.

Four people who were once children in State care at Seaforth Home contacted or gave evidence to the Inquiry about the death of this child.

One person gave a statement to the Inquiry saying that she was 12 at the time of the girl's death and described her as 'being like a sister'. She said there was a sauna in the laundry and the copper fire was kept going day and night for the babies' nappies and other clothes. She said the girls would often go in there to keep warm. She did not remember being specifically told they could not touch the copper fire, but she did not ever work in the laundry. She remembered playing chasey on the day the girl was burnt, running up the path into a forbidden area to hide. It was from there that she saw her friend screaming and

> *... switched off … I felt guilt as I couldn't do anything … I know now that there was nothing I could have done as I couldn't get through the cyclone fence. I didn't talk to anyone about it as I was forbidden to be where I had witnessed the incident.*

She said that she remains puzzled about why the girl opened the copper fire door, saying it did not make sense because the girls would warm themselves in the sauna. She said that until coming to the Inquiry she had never really talked about what she saw and her friend's death. 'This is really good for me.'

Another witness to the Inquiry also described the girl as one of her best friends. She said she was a service girl and that the schoolgirls mixed with the service girls in the laundry, where they dried the clothes. She saw the girl was very badly burnt that day.

Another witness who alleged she was sexually abused during her placement at Seaforth Home said she remembered seeing the girl's sister trying to help her, but the girl wouldn't let her. The witness stated: 'She wanted out, it was more or less a suicide'. She said she was told as a child that the girl had poured cleaning fluid over herself and set herself alight because she couldn't stand living there any longer.

Another witness said about Seaforth Home:

> *Well, there wasn't a day that went by that somebody wasn't crying for their mother or crying because they'd gotten punished or crying for something ... There was just crying all the time.*

She said she remembered seeing what happened to the girl from her window next to her bed. As a child, she said, she was angry with the girl for dying because 'death was one way of escaping'.

Other records received by the Inquiry stated that four boys allegedly died as a result of drowning while placed at various institutions. Departmental files on two of the deaths did not contain any information about the circumstances. However, the Inquiry was able to determine the circumstances of all four deaths from coronial records.

In 1961 an 11-year-old boy was placed in State care after a court found he was neglected and had unfit guardianship. His SWIC recorded his death at 15 as 'released – died'. The Mortality Record Book noted the cause of death as 'drowned'. At the time of his death, he was placed at Struan Farm School, Naracoorte, and had been there for five months. Departmental files obtained by the Inquiry contained no details about the circumstances of his death.

According to statements on his coronial file, the boy was given permission in the afternoon to go to the pools at Mosquito Creek, which were about 160 metres from the school. Three other boys were there when he arrived. One of the boys stated that he last saw him swinging from a rope suspended from a tree over the pool. Another boy said he slipped on the bank and fell on his back. No inquest was held.

A man who gave evidence to the Inquiry was in State care at Struan Farm when the boy died. He said the boy had been abused; he had 'all these whip marks on his back'. He could not give any detail about who may have abused the boy or when it occurred.

A three-year-old boy was placed in State care in 1950 after a court found he was neglected. His SWIC stated he was eventually transferred to Minda Home, Brighton, to have 'psychiatric treatment', and stayed there for seven years. He died aged 14 on an outing for Minda children to Gorge Park.

The departmental files contained insufficient information about the circumstances of the death. The file contained a note that 'the Chairman reported that [name of boy], aged 14 years 6 months, had died by drowning at the Torrens Gorge on [date] 1961. Noted with regret'. Four days later, the CWPRB secretary wrote to the boy's parents advising them of the death, stating that it occurred as the result of a 'drowning accident' and extending the board's condolences. A letter on file (in response to a letter from the parents requesting assistance with funeral expenses) stated that the department was unable to assist.

Coronial records indicate that a group of about 40, with two Minda Home staff supervising them, went to the park. The children ate a large lunch and then went for a swim in the river approximately 45 minutes later. The boy jumped into the river and was seen to go under, surface with his arms in the air and then submerge again. Neither of the two staff supervisors could swim and had to go for help. Two bystanders entered the river but the child's body was not located until after police arrived. The post-mortem findings revealed that the boy's lungs were congested and had excess fluid – 'his stomach was distended by an enormous meal'. A letter was sent from the State Coroner's Office to the secretary of Minda Home commenting on the inadequate supervision due to the child's mental disability and questioning the wisdom of letting children swim soon after a large meal. However, it said, 'an inquest would probably do more harm than good'. A letter in response disputed the comments, stating that having one attendant in charge of 12 boys was adequate and that the boy did not go swimming for at least 30 minutes after eating and 'in all probability the time was considerably in excess of that period'.

Departmental records relating to the following two deaths by drowning did contain information about the circumstances of the deaths.

An 11-year-old boy was placed in care in 1948 after a court found he was neglected and had unfit guardianship. He was eventually placed at Kumanka Boys Hostel and, according to his SWIC, had been there for about six months before his death in 1951.

Departmental and coronial records show that the superintendent gave six boys permission to go swimming in the Torrens River near the weir one evening. They swam for about one hour before the boy who had been put in charge left the group to go into the city. According to the statements of the remaining boys, they heard a cry for help. One boy went into the water, as did some men who were nearby, but the missing boy could not be located. His body was found the next day.

An inquest was held. The post-mortem revealed the boy did not die from drowning, but from 'vagal shock'.[36] The pathologist said this was caused by the sudden immersion of a person with distended stomach (but there was no suggestion of a recent meal) and an enlarged thymus, 100 per cent larger than it should be for the boy's age. There were spots on the lungs indicating asphyxia, but the cause

could not be found and there were no blockages in the airways. The pathologist suggested the boy might have inhaled some water in trying to surface, which shut off the airway, and then fought against the spasm and lost consciousness. The pathologist believed this would occur in heavy drinkers or smokers. (While the boy was known to smoke, he was only 14.) The death was ruled a 'misadventure'.

Vagal inhibition is cardiac arrest brought on by the impact of cold water on the larynx. It is an atypical but not uncommon form of drowning. Contributing factors include entering the water feet-first and duck-diving. Loss of consciousness is instantaneous and death occurs within minutes.

The departmental files show that the superintendent conducted his own investigation, which included interviewing the boys. He stated that the boy in charge 'did not do the job I gave him'. The CWPRB decided to forward a letter of sympathy and expression of confidence in his work to the superintendent.

A 16 year-old boy drowned at the Salvation Army Boys Home, Eden Park, at Mount Barker in 1930. He was placed in State care aged 12, after committing larceny. An Education Department psychologist assessed him as having a mental age of six or seven. He was transferred to Eden Park in 1928 after a placement in service.

Coronial records showed that the child drowned in a watering hole on school property. A group of nine children went swimming, accompanied by an attendant. While the children were undressing, the boy jumped into a 2.4-metre stock-watering hole next to the bathing hole. This was off-limits to the children. He surfaced, but disappeared again and could not be recovered. One of the boys told police that he had asked the boy whether he could swim. He had replied that he could not, but 'I will have a try'. The coroner deemed an inquest unnecessary.

According to departmental records, the attendant reported that the boy 'did not cry out or give any alarm'. The CWPRB secretary reported that: 'The next thing they knew was the lad crying for help'. The school superintendent's report to the CWPRB stated that the youth jumped into the water 'while the officer was temporarily engaged otherwise'. The board secretary reported that the child jumped 'while the attention of the attendant was on the other boys'. The board's chairman reported that the child jumped 'directly [the assistant's] back was turned'. Each report presents a different account of the events. The attendant's statement to the police made no mention of having left the group unattended. After reviewing the events, the chairman wrote: 'I am satisfied that every effort was made to rescue [the youth] and that he deliberately disobeyed orders in entering the Water-hole'. The report concluded that 'no blame is attachable to the staff'.[37]

There was sufficient information on departmental files to determine the circumstances of the death of a boy who died in an unusual accident at the Boys Reformatory, Magill. The boy, 16, was placed in State care by order of a court for offences of breaking, entering and stealing in 1928. He was placed on probation to his father but later the police brought him to Adelaide and he was sent to the reformatory in early 1929. He died two months later, the cause of death stated on his SWIC as 'Injuries, gored by a bull'. One department file contained a copy of the police report, which was forwarded to the department by the Inquirer of Police. The boy was sent to the bull yard by the superintendent to keep watch at the gate while another boy repaired the enclosure. They were told not to go into the pen or feed the bull. According to witness statements, the boy left the gate to speak to another boy at the far side of the enclosure, both having their backs to the enclosure. The bull charged and pinned the boy. No inquest was held.

[36] The vagus nerves are cranial nerves that supply internal organs with autonomic sensory and motor fibres.

[37] SRSA GRG 27/1/62 file __/1925, police report to the coroner.

A coronial inquest found that the death of a 14-year-old youth in custody at the McNally Training Centre[38] in 1975 was an accident rather than suicide. His SWIC records 'released – died'. In 1972, when he was 11, the boy was placed in State care until he turned 18 for breaking, entering and stealing. He was placed in Windana Remand Home and Brookway Park but re-offended on the two occasions when he was on probation living with relatives. He absconded from subsequent placements at Kali Hostel, Windana and Brookway Park.

The coronial inquest found that the boy was placed alone in a cabin at McNally at 5.10pm in an area known as 'the Block'. Inside the cabin was a foam rubber mattress with vinyl covering and blankets. A call button had been removed from the cell three years earlier as the boys had continually broken it. At 5.35pm, a residential care worker wanted to place four other boys in the cabins. He noticed that the peep-hole of the boy's cabin was black. When the door was opened, smoke and soot billowed out. The Coroner's Court found that the fire probably started from a match or cigarette, although none was found. The coroner found the boy could have had matches and criticised the fact that he was not searched before being placed in the cabin. It would have taken a couple of minutes for the boy to be overcome by the toxic fumes. Also, even if he had thumped on the door, it was considered unlikely that it would have been heard, as the nearest staff member was 60 metres away. The coroner commended the subsequent actions of the supervisor in ensuring fireproof mattresses, self-opening/closing doors, specific instructions about searching boys beforehand, a larger window in the wall of each cabin for surveillance and an alarm system in each cabin.

Five people gave evidence to the Inquiry about the death of the boy. Two stated there was a rumour that a match had been slipped into the cell and it smouldered, the fumes killing the boy while he was asleep. One person stated that he was in the Block at the time and that there was banging coming from a cell for about an hour but he could not understand why nobody was answering. He said the other boys joined in when they could smell smoke. He said nobody came for a couple of hours. A staff member at the time gave evidence that there had been a few fires in rooms because the boys

> *... discovered that if you get a bit of foam out of a mattress and light it, that it makes a terrific pall of black smoke, which was great fun in a dormitory, but this kid did it in a small room with no decent ventilation.*

Suicides

Two children committed suicide while placed in institutions. The inquiry found that in one case the department failed to record anything about the circumstances of the death. In the other it was praised by the coroner for conducting an internal investigation.

In 1918 a one-year-old girl was placed in State care until the age of 18, a court finding she was destitute. During her life she had various placements in subsidy homes and with foster parents, several times being found to be 'unsuitable'. She spent long periods at Seaforth Home, where she committed suicide at the age of 19 in 1937.

The CWPRB extended her care order twice, until she was 20, considering it 'in her best interests'. A letter written to her by the board in March 1936 advising of the second extension stated:

> *You know you have not been as good as you might have been, and I hope for your own sake you will make your mind up to do better when you are again placed out.*

The only information about the circumstances of her death on the departmental files was 'Died 17.1.37 … Cause of Death?' then a pencilled note 'Picric Acid Poisoning'. The file noted that about a month before her death, the latest

[38] Children in State Care (CISC) Commission of Inquiry, Interim report, p. 109.

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foster parents said they were going to return the girl because she is 'so moody and will not do as she is told, will do things her way'.[39]

The Inquiry obtained the circumstances of the death from coronial records, in particular a police report to the coroner and an inquest file. According to the records, the girl was caught trying to abscond from Seaforth Home to visit her grandmother. The staff took her clothes from her and she became hysterical. After a few hours, a doctor was called and prescribed morphia. The next day she was observed wandering around, hysterical. The following day she told a child at the home: 'I have taken poison and I am serious about it. Don't tell anyone.' The child told a nurse who then spoke to the girl, who confirmed she had taken picric acid, which was kept on a shelf in the unlocked surgery. The matron contacted a doctor who gave instructions for treatment, which were followed. However, the girl's condition deteriorated that evening and she was found dead by the matron. In finding that the girl died from the self-administration of picric acid, the coroner noted that 'no blame whatsoever is attachable to the Matron, nurses or other Officers of the Home'. The secretary of the CWPRB told the inquest that Seaforth

> *... is used as an industrial school for neglected destitute and some uncontrollable girls, and boys under 6 years of age. It is not a disciplinary home. It is not for convicted children or incorrigible children. A small percentage of girls are difficult. Some girls are difficult. It is merely used as a depot in the process of the boarding out system.*

In relation to the girl he stated:

> *We regarded her as of rather low mentality. She was backward in schooling and somewhat unsatisfactory in the different homes she was in. She was morose and melancholy. She had been in various positions and was usually sent back from those positions. She did not keep positions long. There is a grandmother living in the suburbs but no record of father and mother.*[40]

In complete contrast, the department conducted a thorough investigation of a youth's suicide at Cavan in 1994. The youth, who had turned 18 one week before his death, was in secure care serving a Youth Court sentence for an offence committed while he was a juvenile. His involvement with the department, which started when he was 12, spanned periods in community residential care, secure care and Intensive Neighbourhood Care, along with various adolescent support programs. His first serious offence occurred when he was 13. He lived on the streets for a brief period when he was 14 and was reportedly in contact with a known paedophile. A coronial inquest found that he had an extensive history of substance abuse and had attempted suicide twice, in 1990 and 1993. While in secure care he made statements to family members indicating a desire to commit suicide. After the death, the department conducted an internal review. The coroner commended the

> *... professional and dispassionate way in which this investigation was conducted, and for the fact that the department has taken such an open and self-critical approach to these events in an attempt to avoid a similar tragedy in the future.*

Allegations of criminal conduct

Three witnesses to the Inquiry made allegations that the deaths of three children at institutions were the result of criminal conduct. The Inquiry could not substantiate the allegations.

One witness gave evidence about a child alleged to have been murdered at St Stanislaus House at Royal Park in the 1960s.[41] The witness gave evidence that when he was about 10 or 11, a nun elbowed a boy who was standing in front of him in a line. He said that the force of the blow knocked the boy to the ground and that he did not get up. The boy's eyes were open but glazed. The witness never saw the boy again. He said that another nun told him later that night that the boy had been taken by a foster family. He said that the boy had previously been the victim of this nun's physical abuse.

39 SRSA GRG 29/123/183

40 ibid.

41 Children in State Care Commission of Inquiry, Interim report, p. 109

The witness had reported the allegations to police in 2003, which started an investigation. The allegations were also raised in State Parliament. The alleged perpetrator died more than 20 years ago. The police narrowed the time frame down to the six months between December 1968 and May 1969. The police obtained a book of boarders from the Professional Standards Office of the Catholic Church, which contained the names of 105 boys who were at the home during the relevant time. The book was forensically tested and found to be an authentic record. After extensive and exhaustive enquiries, the police were able to account for all 105 children. The police spoke to 15 males who had been present at the home, none of whom recalled an incident as described by the witness. The police took a statement from the only surviving nun, who was alleged to have told the witness that the boy had been taken into foster care. The nun had no recollection of such an incident as described by the witness. The allegations were found not to be substantiated.

In 1986, aged 14, a girl was placed in State care until the age of 18 after a court found she was in need of care. According to her SWIC, she spent the following 14 months in foster care and a shelter. During the next few months she was charged with assault and hindering police, and spent some time in the South Australian Youth Remand and Assessment Centre (SAYRAC). Her SWIC records that she spent about seven months in 1987–88 at Glenside Hospital and was then placed at various regional admission units. A witness at the Inquiry alleged that the girl was the victim of homicide in 1988.

Department files contained several memoranda to the Minister following the death of the girl. They note that she was placed on several 21-day detention orders at Glenside Hospital in the year before her death. She had significant drug and alcohol issues, on one occasion taking an overdose. After the second detention order, she stayed at Glenside Hospital voluntarily and then had several short-term placements before going to live at St Stephens youth shelter. At 16, she spent six weeks living with a boy at his parents' home. She became pregnant and returned to live at St Stephens. After a violent episode, she was detained at Glenside, but was staying there voluntarily at the time of her death.

The coronial records contained several witness statements arising from a police investigation into the death, but an inquest was not held. On the day she died, the girl had left Glenside Hospital in the morning and was due to return at 4pm. About 5.40pm, witnesses heard screams coming from a park and saw a girl engulfed in flames. One man tried to smother the flames with his jacket while his wife ran to call an ambulance. Another man came with a heavier jacket, which they used to try to put out the flames. The first man's wife then returned with a blanket and they were able to extinguish the flames.

One of the men then spoke to the girl, who said: 'Help me'. He asked who did it. She said: 'I did it to myself to get out of this world'. He asked her why she had done it. She replied: 'I haven't got anybody, I've never hurt anybody'. She said: 'Help me, do I have to stay here forever?' Another witness overheard her say: 'I don't want to stay in this world'.

Police and ambulance officers arrived and she was transferred to the Royal Adelaide Hospital, where she died the next day. About 20 metres from where she had been lying in the park, police found a lighter, methylated spirits and a black cloth bag. One of the witnesses, who lived nearby, said he did not see anyone else when he first heard the screams and saw the girl in flames from his window. No suicide note was found at the scene. The cause of death was: '1. suppurative bronchitis and intravascular coagulation complicating 2. shock due to burns'. The body was found to have 92 per cent burns, with no other external signs of recent trauma. The girl was about six months pregnant, the foetus dying soon after the burning incident.

Two people gave evidence to the Inquiry about the girl's death. One person stated that she knew the girl had set fire to herself, that she was pregnant and that she had been

sexually abused. The other stated that she believed the girl was murdered and not burnt because when she saw her after her death, she had bruises to her face but no burns. She also referred to a suicide note at the hospital, which she believed was not in the girl's handwriting.

The Inquiry was unable to find any support for the allegation that the girl died as a result of criminal conduct and that she was not burnt. There was no reason to doubt the post-mortem report, which was written by a highly regarded pathologist in South Australia. A copy of the note referred to by the witness was obtained. It is not evident that it can be categorised as a suicide note. Rather, it appears to be a note written by the girl about several things. Initially she writes about thinking that she was being followed and thinking that it was the Holy Ghost, but later suggests she was thinking about death.

A 16-year-old boy was placed in detention in 1988 for an offence of break, enter and stealing, according to his SWIC. He had spent significant periods in detention for similar criminal offending since 1985. He died in 1988 at the South Australian Youth Training Centre (SAYTC) when he was 17, after almost 3½ months in detention.

A witness gave evidence to the Inquiry regarding his own abuse while in care. He also said he had been in custody when an Aboriginal youth died in an institution. He alleged that to break up a fight between the youth and another inmate, a staff member rendered the youth unconscious by holding him in a headlock while suspending him in the air. He said he then saw staff strip the unconscious youth and drag him to an isolation cell, where he was locked inside.

The Inquiry referred the matter for police investigation. The police spoke to the witness the next day. He then returned to the Inquiry and retracted what he had said regarding staff involvement in the youth's death, stating that he had confused the incident with another. He said the police had let him look at the statement he made at the time as well as other documents and that he was definitely wrong.[42] Police investigations revealed that the witness had not been present when the fight erupted, nor had the workers he said were involved. Police concluded that the youth had committed suicide, no third party was involved and there were no suspicious circumstances.

The Inquiry obtained the youth's files from the department and the coroner. An inquest, conducted in 1988, found that the youth had been playing soccer in the SAYTC gym in the hours before his death. A fight erupted between him and another inmate, which was broken up by staff, one of whom escorted the youth to his cell. About 30 minutes later, when a worker and another inmate went to the cell to deliver dinner, he was found hanging from an air-conditioning grille by a torn sheet. The coroner found that the youth committed suicide by hanging himself and died from asphyxia. He ruled that there was no criminal conduct and no suspicious circumstances surrounding his death. He said he was concerned about the length of time the youth was left alone. As a result, SAYTC surveillance frequency increased and a new monitoring system and ventilator grille were installed.

In 2006, another witness gave evidence to the Inquiry about the death. His recall of events differed slightly from the police and coronial findings but still suggested that the youth committed suicide and that no third party was involved in the death. He stated that he and another inmate were in the gym when the fight started and he saw the youth being escorted out after the fight. He said that he saw the youth being held around the neck by someone with his feet still touching the ground. He next saw the youth about 10 minutes later, standing in his cell and tearing up the bed sheets. He did not advise staff as he thought the youth was simply destroying the sheets in anger. He said no staff went to the cell until dinner was served, about one hour later.

[42] ibid., p. 108.

Undetermined causes

The cause of death could not be determined in three cases.

One girl, aged 15, came under a care and protection order against her will in December 1995. She had given birth a month earlier. She died in January 1996 at St Joseph's Refuge, Fullarton. The Coroner's Court found that the cause of death was undetermined. The inquest heard several expert opinions. Toxic shock syndrome was considered unlikely but could not be discounted. Another possibility was an asthma attack. The cause most favoured was an epileptic fit. There were no injuries or markings on her body to indicate the involvement of another person.

In 1958 an eight-year-old girl was placed on remand at Seaforth Home on a charge of being neglected and illegitimate. After six weeks, the charge was withdrawn and a note on her SWIC recorded 'child certified and admitted to Mental Hospital Parkside'. Her departmental file indicated confusion about her status as a State child. A note on the file in 1963 from a social worker stated that the girl was ready for placing out and that from 'reading the file of her mother suggests that [the girl] is a State Ward or she has a brother or sister who is'. Another note stated that she is 'Not a State Ward' and that the child was placed in the hospital through the department, who sent the mother papers to sign. No such papers were on the file. Correspondence about who should place the child followed. A former worker at the hospital who gave evidence to the Inquiry thought the child was a State child. It is not possible to finally determine her status as a State child.

The files show the girl spent most of her life in Parkside or Hillcrest hospitals. She absconded in 1962 when she was 12 and was sexually assaulted; the perpetrator was convicted and sentenced to three years' jail. Records leading up to her death in May 1968 indicate that she was very aggressive and was often locked up as a result. Recorded incidents include 'threatening to break glass and injure herself; ripped sheet and wrapped it around throat' and 'acutely disturbed because she did not receive immediate attention from the nurse'.

The Inquiry obtained information about the circumstances of the death from the coronial records. At Hillcrest Hospital she was placed in a secluded room after burning a mattress in her room. In the afternoon she wanted to talk to one of the nurses and when he refused she verbally abused him. He returned half an hour later and saw her sitting on the floor in her room with her back to the door. He returned five minutes later and when he touched her, she fell over. There was a piece of her nightdress tied in a slipknot around her neck. She died five days later in hospital.

The Hillcrest patient file referred to the girl being admitted unconscious to the Royal Adelaide Hospital with a rope around her neck. She regained consciousness but could not move her body. This was defined as further cerebral damage due to strangulation. The final diagnosis on the RAH notes was 'Strangulation, Epilepsy, Severe Behaviour Problem'. The post-mortem report had the cause of death as 'cerebral oedema arising from long-standing effects of meningitis'. The coroner's burial order agreed with the post-mortem, deeming an inquest unnecessary 'because the death was natural'.

To add to the unsatisfactory and conflicting nature of the records, a witness to the Inquiry said she thought the girl had hanged herself because of some inappropriate attention from a worker at Hillcrest.

A witness to the Inquiry gave evidence about the death of a child at Vaughan House, Enfield. On her first day at Vaughan House in 1972, aged 11, she went to the shower block and 'saw a girl that had hung herself, and she was about 15, and it was like, a sheet'. She said the girl was a 'white girl'. She said that when she told the staff, 'they just said, "Off you go" ... no-one pulled me aside and comforted me and explained to me'. Records obtained by the Inquiry, however, stated that the witness first arrived at Vaughan House in January 1975. The matter was referred to the police. As part of the police investigation, a former staff member was spoken to and denied there had been any such hanging or any deaths at Vaughan House. The police investigation is continuing.

Deaths in foster care/other placements

One hundred and twenty-four children died while in foster care or apprenticed.

Thirty-one children died from medical conditions, some of whom had been born with significant disabilities, reducing life expectancy.

Infectious diseases

The Inquiry found that 51 children died from infectious diseases, although sometimes the only information on the cause of death was on the death certificate, not from department or coronial files.

For example, a one-month-old baby was committed to Seaforth Home until she turned 18, after a court found she was neglected. She died 13 months later, in 1971, at her third foster placement. Her SWIC recorded that she 'died' but says nothing about a cause of death. The Mortality Record Book has a question mark in the cause of death column. Both the department and Coroner's Office advised the Inquiry they had no files relating to the child. Her death certificate lists the cause as gastroenteritis of three weeks' duration.

The Inquiry found that the circumstances surrounding the death of one child in foster care exemplified the danger of assuming death by 'infectious disease' to be clear-cut.

A six-year-old child was placed in State care in 1905 after a court found she was 'illegitimate' and her mother was unable to maintain her. She died in a foster placement, aged 16, in 1916, her SWIC recording 'died, consumption'. Her death certificate stated the cause of death as 'tuberculosis of lungs'.

Departmental files contained several letters concerning the child's death. A letter from a departmental inspector of foster placements to the secretary of the State Children's Department, written while the girl was in hospital, stated that she was in service with her last foster parent for eight months and had a bad cough most of that time. She was visited by a departmental inspector once in that period. The inspector ordered a mustard poultice and said if the cold was not better soon she was to be taken to a doctor.

Her cold worsened but she was not taken to a doctor until four months later. Records show she was buying remedies out of her minimal wages. The inspector noted:

> *The Matron [Adelaide Hospital] said she cannot understand how she had any strength to work at all & it appears as if through ignorance and thoughtlessness this poor child, who has always been a weakling, has been grossly neglected & suffered greatly ...*

Following that visit, there was a letter from the secretary of the State Children's Council to the foster parent stating that she had neglected the child and that it was disgraceful that the child paid for the elixirs. A letter in response from the foster parent denied neglect, stating she paid for the remedies and cared for the child. After the death, there was another letter from the secretary to the foster parent, advising that the girl had died and so 'it is useless to prolong any correspondence with regard to the past'.

Accidents

Twenty-five children died as a result of accidents while placed in foster care or apprenticed.

The discretionary nature of the department's record-keeping of the circumstances of children's deaths is illustrated by the death of a 17-year-old youth in 1967. The boy was placed in State care in 1951 at the age of two, after being found by a court to be neglected and under unfit guardianship. His SWIC stated 'released – died' and the Mortality Record Book listed 'result of fall from a roof'. The coronial records stated that there were no suspicious circumstances, but did not record any of the circumstances. The circumstances of death were not found in a departmental file relating to the deceased boy, but in a report titled 'Workmen's Compensation for Foster Parents'[43]. A report to the director of Social Welfare advised that the boy had fallen from a roof of a house while working for a plumber. Another letter stated that he fell from a scaffold while working for a building contractor.

Records obtained by the Inquiry in relation to another accidental death demonstrate the department's

[43] SRSA GRS 6629/1/8, file 95/1967. Workmen's compensation for foster parents.

acceptance of an employer's word as to the circumstances, despite later allegations putting that word into doubt.

In 1912, a 14-year-old boy was placed in State care after a court found he was uncontrollable. He was then sent to Snowtown to be a farmer's labourer. His SWIC recorded 'died – tetanus'.

Departmental records revealed that the hospital, not the employer, advised the department of his admittance and death. The SCC secretary wrote to the employer asking:

> *When the accident happened, and why it was not reported to me, what was the character of the boy's injuries, and what was done to help the lad while he was sick, how the injuries were treated, whether a doctor was in attendance or not, and if not, why not?*[44]

The employer responded that no doubt the secretary had seen the results of the coronial inquiry. The secretary replied:

> *Your letter … does not give the particulars necessary ... you mention the enquiry. I have seen nothing of it nor have I heard anything. Will you please send me a copy of the newspaper in which it appeared – if it was so published. Will you please also answer the questions I put to you in my letter.*

The employer wrote back to show 'how quick [the child] was taken'. According to the employer, the child had been thrown from a horse and cut his face. His employer cleaned the wound but did not send for a doctor. The next day, the child could not close his mouth, but apparently refused to see a doctor. Soon, he reported feeling better and his wound healed. After complaining of pain and stiffness a week later, the boy was taken to the doctor and admitted to hospital, where he died. The employer noted: 'We did not report the fall because it seemed not very bad at the time'. He stated that hospital staff had advised him that the secretary had already wired for an inquiry to be held. 'However, I was told afterwards that there was no enquiry or inquest' as a doctor certified the cause of death. He claimed to have asked hospital staff to contact the secretary: 'It was not any neglect or carelessness that it was not reported'. The secretary thanked the employer for the report and said: 'The boy's death would appear from it to have been quite accidental'.

The department's records also contained an anonymous note received after the death. It read:

> *In view of the circumstances surrounding the death of a State boy named [child's name] and in view of the fact that he did not receive medical attention till 12 days after meeting with a nasty accident don't you think people like [employer's name] should be debarred from having State children under their control.*

There was no departmental response on file.

Despite the employer's failure to obtain medical attention for the boy and his subsequent death, the SCC continued to place children on the farm. The Inquiry obtained other files that indicated there were subsequent problems with the employer and no action was taken by the SCC. In 1913, a girl wrote to the SCC, asking to leave the farm: 'They think because you are a state child they [can] say just what they like'. The employer complained about another girl in 1914. Of one girl who asked twice to be removed, the employer wrote in 1916: 'I do not take any notice of her sulky fits now I have got so used to them'. The employer complained about another girl in 1917. In 1918, when asked why another child had absconded from his farm, he said: 'I am not sorry she left, as she would not be a bit of use on a farm'. In 1925, the employer sent another child back, saying he was 'too lazy, a real failure' and 'I told him he ought to be ashamed of himself'.

In relation to a child's death in 2004, the department decided an internal review was not needed. A boy aged 19 months was fatally injured while his parents, foster carer and departmental staff were meeting to review his case. The boy came to the department's attention in 2003 before he was a month old, due to parental neglect. After several child protection notifications, the child's parents authorised

[44] SRSA GRG 27/1/35, file 151/1914; file 850/1914; file 840/1914.

his placement in short-term foster care. On the day of his death, a day before the agreement expired, a meeting was held at a local health centre to determine his care. The foster carer removed the boy from the meeting as he was being noisy and took him to a neighbour's house, before returning to the meeting. The neighbour left the child unsupervised for a short time in the yard and later backed over him with a utility. The neighbour drove him to the same health centre at which his care meeting was being held for treatment. The child died later of head injuries. The coroner found that the death was accidental, but commented on the department's delay in finding suitable care for the boy and the neighbour's negligence, noting that the neighbour's own children had been the subject of neglect notifications. From the records, it is evident that the carer had not planned for the child's care during the meeting and his placement with the neighbour was a spur of the moment decision. The departmental supervisor at the meeting said he saw the boy being removed but did not know where he had been taken until the carer's return. While the boy was still receiving medical attention at the health centre, the departmental workers who had been present at the centre left to return to their office. The boy died two hours later. The department deemed the death a 'tragic accident' that did not warrant internal review.

A former departmental worker alerted the Inquiry to another death in foster care. The coronial file notes that a 20-month-old boy was found face-down in a swimming pool at his foster parents' home. His foster father told police that the boy had gone outside to play and he checked up on him after 30 minutes. The foster parents retrieved the body and attempted resuscitation, but the boy was pronounced dead in hospital. His autopsy summarised the cause of death as 'apparently victim of fresh water drowning'.[45]

The foster parents' file indicated that the child had been placed in several foster care placements as his mother had been unable to manage his care—the last two placements were to the home where he drowned. A report by the boys' social worker indicates that the child's parent was 'extremely angry' about the accident and was considering taking up the issue. The report concluded: 'There is no question of negligence on the part of the foster parents (both were home at the time)'. The report does not refer to whether the child was left unattended for 30 minutes and, if so, why. It contains a discrepancy about how the child gained access to the pool. There is no record of interview between the department and the foster parents about the accident.

Suicides

Three children committed suicide while in foster placements. The departmental records contained information about the circumstances of the deaths. In one case of an 11-year-old boy, the recorded cause of death as intentional suicide rather than accident, however, was questioned by the department.

A nine-year-old boy was placed in State care in 1912 due to unfit guardianship and spent two months in the Edwardstown Industrial School. During the next 4½ years he was placed in four separate foster homes. His SWIC recorded 'died from gunshot wound'. Coroner's records stated that an inquest found he had died from 'a bullet fired from a rifle self inflicted while temporarily insane'. The boy was 15 and had been in the foster placement for one year. He shot himself in his bedroom, using a rifle kept in the house for shooting rabbits. The coroner's report noted that a letter in the boy's handwriting was found, which stated: 'I have tried to do my best but I can't there is more than one liar in this world'. The departmental files also contained information on the death. A letter from the chief prosecuting officer to the SCC secretary stated that the officer had spoken to the foster parents and

> *... from the Constable and others I am convinced this boy had an exceedingly good home … I have formed the opinion that this boy had made up his mind to leave the home, probably to abscond. I do not think the note he left was written on the morning of his decease. And some incident upsetting the*

[45] SRSA GRG 1/44, police report to the coroner on this file.

boy, he in a moment of moodiness, to which he seemed subject, took the gun and shot himself.

In 1972 a one-year-old boy was placed in State care until the age of 18. He was placed in Seaforth Home and later with foster parents. At nine, the child exhibited concerning behaviour, including arson and theft. The department arranged for a psychiatric assessment, which showed the child had above-average intelligence but was emotionally immature. The records suggested a strong maternal attachment, yet only intermittent contact between the boy and his mother. His mother committed suicide when he was 10. When the boy turned 11 he was placed with maternal relatives in Western Australia with a view to moving there permanently. He died in that home when he was 11. The department's files recorded correspondence between the South Australian and WA departments for community welfare about the death. A WA department worker advised that the child had been playing in the family home and had been found in the bathroom by his aunt with a belt around his neck. His feet were on the floor and he was considered to have accidentally hanged himself. The post-mortem revealed the cause of death to be inhalation of gastric contents. Correspondence from the WA departmental worker stated that the coronial inquest found that the child died of 'asphyxiation caused by the inhalation of gastric contents as a result of hanging himself with the intention of taking his own life'. The SA department expressed surprise at the inquest finding and requested a basis for it. In further correspondence, the WA worker noted that general surprise was expressed at the finding, including from the police. There were no coroner's documents on the file, only correspondence referring to the coronial process. The WA worker reported that the child had never shown any tendency to self-harm and had not appeared upset. The SA department closed the file after the foster parents said they did not want to pursue the matter.

The Inquiry's research into other general sexual abuse matters, rather than the department's lists, brought to light the suicide of a 17-year-old girl who was in State care at the time of her death and who was the victim of criminal conduct during her time in care. The child came to the department's attention in 1989, at the age of 15, after disclosure of parental sexual abuse of her sister. Departmental workers assessed the girl's safety and consulted her school counsellor, who stated that the child appeared well-adjusted. The records do not show the girl was interviewed. The file was closed as there appeared to be no evidence of abuse other than to the sibling. The following year, at 16, the child disclosed that she had also been sexually abused since she was eight. The offender was subsequently charged, convicted and jailed. The child was initially placed under a temporary guardianship order, then placed under the guardianship of the Minister until the age of 18. The department's case management addressed the child's multiple suicide attempts, drug use, family breakdown and habitual absconding from placements and programs. The girl spent several periods living on the streets. She was raped in August 1990 after absconding from a psychiatric counselling program. Departmental staff liaised with the hospital and police. She was raped again in April 1991, after she absconded from a care placement. Information about the department's role here was missing as the child's files were partially destroyed by fire. At the time of her suicide, she was living in a friend's home and had plans to obtain her own housing with the department's assistance. The child shot herself at this home in an apparent suicide pact, and died in hospital.

Departmental files showed that before the death, the girl's mother had threatened to sue the department, claiming it had separated the family and caused her daughter to live on the streets and use drugs. The files noted that the child acknowledged the considerable efforts of her many caseworkers to provide accommodation, support and counselling. After the death, the girl's social workers reported her case history to the department's chief

executive. The files also contained a copy of the registration of death, a level of documentation rarely seen on client files.

Malnutrition

Three children died from malnutrition while in foster care. Two died between 1908–15 and the third as recently as 1973, when he was two years old.

The boy who died in 1973 had been placed in State care at birth in 1970, after a court finding that he was 'neglected'. His SWIC recorded 'released – died', however the Mortality Record Book contained no information other than his name.

Department and Coroner's Office files showed that the department received a phone call from the foster mother saying 'we've got problems' a week before the child died, however the department was unable to visit. Four days later the foster mother was admitted to hospital after taking an overdose. The next day, a worker from the department went to the home and saw that the boy looked unwell—'his face had an extreme pallor and his eyes appeared sunken with dark circles'. The worker considered taking the child away but did not in case this was interpreted by the foster mother as a 'lack of confidence in her ability'. The next day, the worker went to the foster house and was informed that the child had died. A post-mortem revealed that the boy was very thin, extremely dehydrated and covered in small bruises. He had been with the foster parents for four months. A doctor gave an opinion after the death that the foster parents were not fit parents. From information provided to the Inquiry by the police, it seems there were no criminal charges laid against the foster parents.

The Inquiry obtained the department's files relating to the foster parents. About five years after the death, there was a record of a meeting held to discuss whether the foster parents should be reapproved to take other children. Central Mission Child Care Services, a private foster care provider, recommended to the department that they be approved. A departmental check showed no previous record and they were approved. However, it appeared that the death of the child later came to the department's attention. A letter on the foster parents' file reads:

> *... some months later ... the old file was discovered and the circumstances surrounding [the foster mother's] admission to Glenside 4 years ago came to light. At this time a retarded child was in … [their] care and he unfortunately died from dehydration; had this been known at the time of their reapplication, Department for Community Welfare would not under any circumstances have given approval. The current situation is that … [they] are fostering 4 children ... and we are very satisfied with the quality of care.*

Undetermined causes

Nine children died in foster care where a cause of death could not be determined because of lack of records or conflicting information from records.

One of the record discrepancies related to the death of a girl who was placed in State care aged one and died aged 12, in 1909. Her SWIC and the 1909 annual report of the SCC listed asthma as the cause of death. However, the microfilm print of her death certificate lists the cause of death as 'nephritis, coma'. (Nephritis is acute kidney inflammation). Her departmental files contained no information about her death. The Inquiry was advised that a coronial file could not be located.

A boy placed in State care in 1914, when he was almost one, died at the age of two from gastroenteritis and meningitis, according to his SWIC. However his death certificate listed general tuberculosis. There were no files available from the Coroner's Office or the department.

A 15-month-old girl was placed in State care in 1920, a court finding her illegitimate, and died in foster care eight months later. Her SWIC recorded her death as 'from effect of swallowing caustic soda' and her death certificate as due to collapse after the accidental drinking of caustic

soda. As there was no information on the death in departmental files and the Coroner's Office could not locate any records about the death, the Inquiry could not assess the circumstances of the poisoning, including whether there was any criminal conduct.

There is no record of the circumstances of the 'accidental' death of a 17-year-old boy in State care in 1922. He had been placed in State care at the age of 10 for truancy and absconded several times from his many placements during the next seven years. His SWIC recorded his death as 'perforation of bowels – result of accident' and the death certificate as 'laceration of small intestine, 2 days duration, peritonitis'. His departmental files contained no information about the circumstances of his death and the Coroner's Office was unable to locate a file reference for the death.

A five-year-old girl placed in State care in 1914, after a court found she was destitute, died in 1923 of pulmonary tuberculosis – secondary cause exhaustion, according to her SWIC. The State Coroner's Office was unable to find any file reference.

A nine-year-old boy died in State care in 1924, his SWIC listing the cause of death as gastroenteritis. He had been placed in State care when three months old, a court finding him destitute. His death certificate listed the causes of death as otitis media (infection of the middle ear) and chronic mastoiditis, both of some years' duration, and a cerebral abscess of nine days' duration. The inconsistency could not be investigated as the child's departmental files contained no information about his death and the Coroner's Office could not locate any records.

A one-month-old girl placed in State care died when almost two years old in 1925. Her SWIC listed uraemia (accumulation in the blood of toxins normally excreted from the body) and chronic nephritis (acute kidney inflammation). It also listed 'paralysis of the brain', but these words are struck through. The death certificate listed 'cerebral tumour 3 days duration?, paralysis'.

Correspondence on the departmental files included a letter from the foster parent advising the department of the death, citing the cause as paralysis of the brain. The department noted that this was not the case and requested further information by writing a letter to an undertaker. The undertaker replied that he was unable to communicate the cause of death as the treating doctor had left Jamestown and advised the department to contact BDM. This letter is not from the undertaker who actually performed the funeral and the records do not clarify why this undertaker was writing the letter. There was a note added to the undertaker's letter listing chronic nephritis uraemia 'vide Registrar General of Births Deaths etc'. It is not possible to determine how the child died from the confusion in the records.

No record of the circumstances of a baby boy's suffocation in 1951 could be found. The baby had been placed in State care by order of a court when he was one month old and died four months later. His SWIC recorded 'released died, suffocation' and his department files noted that he died and included correspondence regarding payment of his burial account. No file reference could be found at the State Coroner's Office. His death certificate stated 'suffocation'. The CWPRB minutes noted that the child died of suffocation while in the care of foster parents, however that there were no suspicious circumstances and an inquest was not held. The minutes noted that the board received reports relating to the matter, but these could not be located.[46]

Another baby died aged six months while in foster care. He had been placed in State care from birth in 2000. A coronial inquest could not determine the cause of death, however noted that it was consistent with sudden infant death syndrome (SIDS), with no evidence of any third-party involvement.

[46] SRSA GRG 29/124/19, CWPRB minutes (minute 1658), 1958–60.

Allegations of criminal conduct

The Inquiry received evidence of possible criminal conduct in relation to the deaths of two children while in foster care.

The Inquiry received an allegation of possible criminal conduct resulting in the death of a baby who was placed in foster care in 2004.[47] The girl was born in 2003. It was a traumatic birth for both mother and baby. The mother told the Inquiry that her baby had some possible seizures after the birth. About seven months after the birth the mother asked the department to care for her baby while she moved into a new home and regained her health. By voluntary agreement with the mother, the department placed the baby in foster care. One foster parent became ill and the baby was moved to another foster placement, where she died eight days later.

On the morning of her baby's death, the mother had made several phone calls to the department, complaining that she was not receiving enough information about her daughter. She was told that the manager would make inquiries and respond to her. The manager did not return her call. The baby died less than three hours later. Both police and departmental employees went to the foster parents' home. Despite this, the maternal grandmother was not advised of the death until nine hours later. The mother was advised the next morning.

The Inquiry received evidence from the mother about her ongoing efforts to obtain information about the circumstances of her baby's death. She gave evidence that a departmental employee turned up at her house and said her baby had died, that she had just gone to sleep. She said that the police stated it was a tragic accident, however the following day she received information that her baby was found wrapped and lying face-down in a cot. She considered that this did not make sense—the baby could not roll if she was wrapped. She then received information that the baby had been put on a pillow and had a bottle propped in her mouth while the foster parent folded up the washing.

The post-mortem found that the baby died from the combined effects of asphyxia and inhalation of gastric contents. The baby was unable to free herself once she had vomited when in a face-down position. The pathologist reported information received that the baby was found 2½ hours after being left by the carer face-down in a U-shaped pillow, which appeared wet, and there was an empty bottle in the cot.

The mother told the Inquiry about her relentless efforts to have a coronial inquiry into the death of her baby. An inquest started in late 2006, almost 2½ years after the death. The mother also told the Inquiry about needing to have legal representation at the inquest and the distress involved in the potential costs.

The foster parents' file was requested and received from the department. The file contained forms approving the registration of the parents as foster carers over a number of years. The Inquiry became aware that two other foster children made complaints in relation to the foster parents two years before the death of the baby, however there was no information on the file about those complaints. There was an approval form for their registration postdating those complaints. Similarly, there was another approval form for the registration of the foster parents that postdated the death of the baby. There was no information on the foster parents' file about the death of the baby.

It was at this stage that the coroner decided an inquest would be held into the baby's death. The coroner delivered his findings in September 2007. He found that the baby died as a result of the combined effects of asphyxia and inhalation of gastric contents. He also found that the baby's previous possible history of seizures was minor and did not play a role in her tragic death, but rather 'the most likely situation was that the U-shaped pillow restricted her ability to breathe freely once she had wriggled into a position in which her face was obstructed by the pillow itself'. He found that there was no formal training available to foster carers for the care of children under the age of two and the

[47] CISC Inquiry, Interim report, p. 109.

recent introduction of such training 'is an implicit acknowledgement of a deficiency in the system as it existed prior to [the baby's] death' and that 'had such training been available for [this foster carer], it is possible that she may not have placed [the baby] in a cot with a U-shaped pillow [which] … may have prevented what was, in all probability, an avoidable death'. In the course of his decision, the coroner noted evidence from Families SA that it had no central computerised record keeping system that would enable the agency to keep track of complaints made against foster carers, but said that had been addressed since 2004.

The Inquiry received evidence about a girl who committed suicide in 2002. It was suggested to the Inquiry that her allegations of sexual abuse by her foster father were connected to her death. In 1993, at the age of eight, she was placed under the guardianship of the Minister until she was 18 years old. In July 2001, she complained to the police that her foster father had sexually abused her. She had been living in that foster placement since December 1998. She gave a statement to the police that he had regularly sexually abused her since she began living at the home. Six charges of unlawful sexual intercourse were laid in the Magistrates Court in May 2002. The girl died on 9 June 2002 after taking an overdose of Panadol.[48]

Seven people gave evidence to the Inquiry about the girl's death, three of whom came specifically to speak on that topic. In particular, one witness told the Inquiry that she believed the girl had fabricated the sexual allegations and that she had been pressured by the department and the Office of the Director of Public Prosecutions (DPP) to proceed. The Inquiry obtained files from the department and the DPP relating to the girl. There was no suggestion in the files that the department or the DPP had pressured her. To the contrary, they contained notes of conversations with her, in which she was recorded as saying that her family and people she called family were putting pressure on her to withdraw the charges. The files contained two letters from family members stating that she was a liar and that she would not see one of them again if she proceeded.

In January 2008, the coroner delivered his findings following an inquest into the girl's death. He found that the girl died 'as a result of raised intracranial pressure due to hepatic encephalopathy related cerebral oedema'. The coroner found that the girl made allegations of sexual abuse perpetrated by her foster father and that it was not the function of his inquest to determine the truth of those allegations. He received evidence from some witnesses that the girl was subjected to pressure by the department, the SA Police and the DPP officers to proceed with the charges, which those witnesses said were false. The coroner found that no pressure was brought to bear upon the girl by the departmental workers, the police or the DPP officers and that

> *... no criticism should be directed at any of the [departmental] workers … for failing to predict that [the girl] might have a suicidal intent. In my opinion, [the girl] obtained a considerable amount of support from all of the workers involved.*

He observed that 'there is no doubt however that she felt immense pressure from family members and others to withdraw the allegations'. He decided that the girl felt a great deal of pressure in relation to her allegations and 'it appears that she was ultimately unable to cope with this pressure and sought release by taking an overdose of paracetamol'.

Deaths of children who had absconded from State care

Twenty-one children died after absconding from their placements. The SWICs recorded the fact that they had run away. However, the Inquiry generally found that there was little, if any, information on departmental files concerning the circumstances of their deaths. It was often necessary to obtain coronial records to find the information.

[48] ibid.

Accidents

Eleven children absconded and then died as a result of accidents. The Inquiry found that several children died when they ran away from their placements, stole cars and crashed them.

In 1968, a 16-year-old boy absconded from McNally Training Centre with another boy. According to his SWIC he was 'released – died'. The Mortality Record Book recorded 'asphyxia'. The department was unable to locate any files to provide information about how he died.[49]

The Inquiry obtained information about the circumstances of the death from coronial records. The two boys stole a car and rolled it in the Adelaide Hills. They both survived the crash, however the 16-year-old complained to the other boy about his health for the next few days. The two boys were eventually located by police four days later but did not advise them about the boy's ill-health. On return to Adelaide under police escort, the boy fell to the floor, convulsing. A doctor was called but the boy died. His cause of death was asphyxia occurring during an epileptic fit, probably sustained as a result of the accident.

In 1970 a 16-year-old boy absconded from Brookway Park one month after being placed there by court order due to a criminal offence of break, enter and larceny. His SWIC recorded 'released – died' and the Mortality Record Book recorded 'road accident'. The department was unable to locate any files relating to the boy.

The only coronial reference was to a burial order, which the Inquiry found after a manual search. It listed the cause of death as cerebral injuries sustained in a traffic accident. A memorandum attached to the burial order recorded that the boy ran away with another boy and stole a car on the same day. The other boy was driving the car when it crashed into a monument. The driver survived.

In 1971 a 17-year-old boy absconded from McNally Training Centre after two months. At 15 he had been placed in State care for criminal offences until he turned 18. He was then permitted to live with his parents but he committed further offences and, at 16, was sent to McNally for illegal use of a motor vehicle. There is no cause of death on his SWIC, but the Mortality Record Book listed 'car accident'. The department could not locate any relevant files.

The Inquiry obtained the circumstances of his death from coronial records. On the evening of his 17th birthday, the boy absconded and lost control of a stolen car, colliding with a brick fence. The boy was taken to hospital, where he was found to have 0.14 per cent alcohol in his blood, and died soon after his arrival. His three passengers were arrested and charged with illegal use of a motor vehicle.

In 1993 a 16-year-old boy in State care had left his placement and was living on the streets. Two years earlier a court had placed him in State care after several unsuccessful placements arising from his being 'unmanageable' at home and in trouble with the police.

The departmental files obtained by the Inquiry contained concerns from workers about his involvement in crime and 'being on the fringe of the Adelaide street culture'. About three months before his death, community residential care workers raised concerns that he 'still might be associating with known paedophiles'. The boy had been living on the streets for approximately three weeks before his death, having left community residential care.

The coronial records contained detailed circumstances of his death. The boy moved out of a hostel several weeks before his death and had been living on the streets. He was friendly with a group of youths who stole cars to 'engage in hot pursuit, as a form of exciting recreation'.

[49] The department advised the Inquiry that from 1970–85, it allowed the destruction of up to 95 per cent of client files, with only 5 per cent retained as 'samples'. The department did not record what material was archived at SRSA. Therefore the department was unable to advise whether, in this case, there were no departmental files or whether they had been destroyed.

On the night of his death, he was driving a stolen car at high speed, at one stage being involved in a police chase. He went through red lights, hit a median strip and then slid sideways into a tree. The coroner found that his driving was reckless and that the police actions did not contribute to the way the boy drove the car.

Two people gave evidence to the Inquiry about the boy's death. One confirmed that the boy had been living on the streets before his death.

In 1953 a 13-year-old boy absconded from the Glandore (formerly Edwardstown) Industrial School after three weeks. He had been placed in State care about 10 years earlier due to unfit guardianship and neglect, and had been in various foster placements since. His father applied for his release when he was 11, but was declined. His SWIC and the Mortality Record Book recorded the cause of death as 'motor vehicle accident'. The State Coroner's Office had no record of a file on the death.

The departmental file contained a copy of the death certificate, as well as a memorandum stating that the boy absconded with another boy who was on remand on the evening of 1 October 1953 'and who was undoubtedly the ringleader'. The memo stated that:

> *Information from the Police shows that [the other boy] was driving. He will not be charged in relation to the death … but will be charged with the "Illegal use of a Motor Vehicle". It seems unlikely that there will be an inquest, and [the other boy's] only injury was a broken thumb.*

Other children died as a result of other types of accidents. Again there was generally little, if any, information on departmental client files concerning the nature of the accidents. The first two examples are exceptions.

In 1921 a two-year-old boy was placed in State care until the age of 18 for being illegitimate. When he was 14, he absconded twice from subsidy placements and, at 15, from the Edwardstown Industrial School. He died 11 months later in Victoria in 1936. His SWIC recorded 'died' and the Mortality Record Book 'sudden – poison'. No coronial files were held in South Australia because the death occurred interstate.

The Inquiry obtained department files relating to the boy. One file[50] contained a report on absconding from the superintendent of the industrial school, which said the boy absconded in February 1935. The police were notified and a warrant issued. Eleven months later, the department received information from the police regarding an unnamed person dying from poisoning in Mildura. According to an informant, the person had given himself a different name but stated that he had come from an Adelaide orphanage. He told the informant that he had twice previously escaped from the orphanage and that he had no intention of returning to SA until he turned 18. Fingerprints taken from the deceased matched those of someone with a different name again. A photo was then sent to the department, which identified the boy. It appears he had used at least two false names after he had absconded. A newspaper article on the file refers to the circumstances of the death. The boy had been camping on the River Murray with two other youths. He wandered onto an island and what happened next was not known, but later the boy came running from trees and collapsed, saying, 'I am dying'. He died 'in agony almost immediately at [the boys'] feet'. The article said that a swiftly acting poison caused the boy's death. The file contained no official documents following up the circumstances of the boy's death.

A 15-year-old boy absconded in 1939 from the Boys Reformatory, Magill, and the department discovered from a funeral notice in the newspaper that he had died. According to his SWIC, he had been placed in State care at 12 after committing an offence of unlawful possession. He absconded from the reformatory after 15 months and was then placed with his mother. However, three months later he was charged with breaking, entering and stealing and sent back to the reformatory. He absconded after five weeks but was returned on the same day. After six months, he absconded again and a warrant was issued for his arrest. The department did not know where he was for almost three months.

[50] SRSA GRG 29/6/31, file 51/1933, superintendent, Edwardstown Industrial School, Report on absconding.

Both his SWIC and the Mortality Record Book recorded drowning as the cause of death. The files showed the department found out about the death from the funeral notice. The secretary then wrote to police asking for confirmation of identity and the circumstances of the death. A police report to the coroner stated that the boy had been staying with his brother for a few weeks and was found dead in a tank, having gone swimming after dinner. His cause of death was given as drowning, there were no signs of violence on his body and an inquest was deemed not necessary.

A youth, aged 18, drowned after running away with another boy from the Northfield Mental Hospital in 1964. He had been placed in State care at 14 until he turned 18 after a court found him to be neglected and under unfit guardianship. The order was extended to the age of 19. Both his SWIC and the Mortality Record Book recorded his cause of death as accidental drowning. There was no information in the departmental files about the circumstances of death. The Inquiry obtained the information from the coroner's file, which stated that the boy went swimming with the other runaway in the River Torrens the day after they absconded, and he drowned.

The department was unable to locate any files relating to a 15-year-old girl who had been placed in State care in 1969 on a larceny charge. Her SWIC stated that she was placed with her mother, but absconded in February 1971. It is not clear from the SWIC whether she returned home before her death three months later. Her SWIC registered her death two months after it occurred as simply 'released – died'. There was no record of her death in the Mortality Record Book.

Coronial records showed she died as a pillion passenger on a motorbike that collided head-on with a car. She was 17. The driver of the motorbike provided a statement to police but his whereabouts were unknown at the time of the inquest.

A 13-year-old boy was charged with larceny in 1956 and placed in State care until he turned 18. His SWIC recorded that he was placed in Kumanka in 1956–57 and repeatedly absconded over a four-month period. He was found in Victoria and placed in the Boys Reformatory, Magill. He spent some time in hospital (reason not recorded) and had a few holidays with his mother. During this time there was a note on his SWIC: 'to be seen by the psychologist as soon as possible'. He was sent back to Kumanka but absconded again. He was then placed in foster care, absconded and was sent to the Boys Reformatory. He was on holiday with his mother when he absconded for the last time. He died 12 days later, aged 17, in Broken Hill. The SWIC recorded his death as 'died' and the Mortality Record Book as a 'shooting accident'.

Because the boy died interstate, there were no coronial records in South Australia. The only information about the circumstances of his death was in a newspaper clipping on a departmental file. It stated that the boy was on a shooting trip with two friends in Broken Hill. He climbed a tree and his rifle accidentally fired, shooting a bullet into his head. His friends found him hanging by the foot from a fork of the tree. He died in hospital. There was no other information about his death in the department's file. There was no correspondence to the police or the coroner to verify the circumstances of the death.

Suicides

Two children committed suicide after absconding from their placements.

The department had no information about the death of a 16-year-old girl who absconded with another girl from Vaughan House in 1952. Her death was recorded as 'suicide' on her SWIC, but was not listed in the Mortality Record Book. The departmental file recorded that the girl had absconded and contained a note to the parents advising them of that fact. Curiously, the file recorded that

she was 'released' a day after she absconded and two days before her death. There was no information about what efforts, if any, were made to find the girl after she absconded.

Information about her death was obtained from coronial records. Three days after absconding the girl died as a result of jumping from a building on North Terrace. Witnesses saw her alone on top of the building, then she put her arms out and jumped. On the roof she left a note addressed to the police, but the records did not include any information about its contents. Information was provided to the coroner that the police became aware of the girl in 1951, when she reported that a boy had indecently assaulted her. She believed she was pregnant and took pills hoping to abort the pregnancy. Her father then reported her as missing to the police. When found, she was too afraid to go home and was placed in the Bridge Women's Rescue Home run by the Salvation Army. She returned to her parents after eight days but ran away on several occasions over the next year. On one occasion she could not be found for six weeks. In 1952 she was charged with theft and remanded in custody to Vaughan House, where she spent 12 days before absconding on the day she was due to appear in court on the theft charges.

An Aboriginal boy was placed under the guardianship of the Northern Territory Minister in 1986; an order that was later transferred to South Australia. He had been in various placements, including foster care, with relatives and then in Aboriginal supported accommodation hostels. Two months before his death he was recorded as a priority to be referred to a psychologist for urgent assessment due to depression and expressions of suicidal thoughts and mood swings. However, he then went missing a couple of times. About three weeks before his death, he contacted the Queensland Youth & Community Services Department for help with accommodation; the department then informed its South Australian counterpart, which reported him missing. He was found dead at a train station in Queensland, after hanging himself. He was 17.

The circumstances of his death were contained in a memorandum to the chief executive on his departmental funeral file. There was no record of any complaint by the boy that he had been sexually abused, however there were records of complaints by others against the boy as an alleged perpetrator of sexual abuse.

Undetermined causes

The deaths of two children who absconded from State care could not be determined.

A 17-year-old girl was placed in State care in 1987 until she was 18, after a court found she was in need of care. At the time of her death she was placed in a cottage home. She had made sexual abuse allegations against her father and was due to give evidence in court in August 1988, however her body was found at the bottom of a cliff one month earlier. Coronial records showed debate as to whether it was suicide or an accident. Records from the cottage home indicate a history of depression.[51]

A 13-year-old boy was committed to the control and custody of the CWPRB until the age of 18 for committing larceny in February 1941. The child was placed on probation to his mother in Adelaide and held jobs on various stations in remote South Australia during 1941 and 1942. He was returned to his mother in August 1942 after being convicted of an offence. In February 1943 the child left Adelaide to travel to what would be his last position, as a station stockman in South Australia's north.

In April 1943 the boy argued with the station manager over his duties as camp cook on a muster, then left the mustering camp on foot without any provisions; the station manager stated he had no intention of following the child. The camp broke that day and relocated. In May 1943 Oodnadatta police made enquiries with the station manager about the child's whereabouts. According to the coroner's file, the station manager advised police that the boy had left in a 'fury' and surmised that he had made his way to Adelaide. In December 1943, the station manager alerted the Oodnadatta police that a stockman had seen human remains in the area. The station manager did not investigate.

[51] Catholic Archdiocese of Adelaide, Professional Standards Office Records Service, casenotes, —/—/198-.

An inquest into the death was conducted in Adelaide and Oodnadatta in late 1944 and early 1945. The coroner ruled the cause of death as unknown due to the time that had elapsed between the death in April 1943 and the body being found in December 1943, although there was no evidence to suggest direct criminal conduct or violence. Evidence suggested the child had returned to the area of the mustering camp the next day, possibly expecting to be collected. The inquest heard the station manager made no effort to inform the police that the child had left his station. The coroner found the station manager guilty of 'reprehensible indifference' to the boy's fate, as 'no search of any kind was made by those at the camp as to the subsequent safety or whereabouts of the deceased'. The child was at real risk of becoming lost and dying, given his limited knowledge of the bush, a fact known to the station manager, who sent no trackers after the child. The coroner found that the child was in a 'petulant state' when he left the camp. The coroner concluded that the station manager should have 'protected him from the possible consequence of his ignorance and his youthful petulance'. The coroner found no evidence to suggest that an indictable offence had been committed.

The CWPRB secretary's evidence noted that the child was on probation in the custody of his mother, in effect that 'he was free and his mother had control of him subject to our general Dept. approval regarding employment guidance and general conduct'. The secretary recounted the child's positions of employment and his last departure from Adelaide. He concluded: 'Apart from what we heard from him through his mother, that is the last time we heard of him alive'.

The secretary's evidence revealed omissions in the department's records of the child's location and employment. Departmental files suggested he was required to notify the department on leaving each placement and that it was the practice for station managers to issue weekly reports, but no reports were on file. In May 1943, one month after the boy had walked from the muster camp, the department wrote to him to say that it expected a monthly letter from him.[52] The departmental file did not contain a report on the death nor any record of an investigation of the department's involvement with the child. The file contained an April 1944 news article pertaining to the possible exhumation of the body for a coronial inquest and news articles on the station manager's trial for mistreatment of Aboriginal station hands.

Allegations of criminal conduct

The Inquiry found that three children died, and another two allegedly died, as a result of criminal conduct while they were on the run from their placements.

Evidence was received from four people about the death of a boy aged 14 and a 15-year-old girl from Victoria in 1990. The Inquiry found that the boy was a child in State care at the time of his death, but the girl was not. The Inquiry was told the two children were found near the Victorian border and that they had been murdered. The witnesses said the two used to hang around Hindley and Bank streets in Adelaide's CBD and were considered to be street kids. One of the witnesses, a friend of the murdered boy, told the Inquiry about the effect that the deaths had on the street kids at the time and that many of them wanted to attend the funeral:

> *It was actually almost like a state funeral type thing. Lots and lots of street kids went there … the police provided buses for us to go down there, because they were worried that we were all going to steal cars to get there.*

The South Australian police confirmed the homicide of the two children at Kaniva in October 1990. The deaths were registered with the Coroner's Office in Melbourne. The murders remain unsolved.

The boy had come to the department's attention through the criminal justice system a year before his death. He was placed on bail under the supervision of the department but was remanded to the South Australian Youth Remand and

[52] SRSA GRG 29/123/190. The coronial file contained a letter from the child to his mother dated 31 Mar. 1943.

Assessment Centre (SAYRAC) after breaching his curfew and residence conditions. The department attempted several placements but he absconded from all of them and was returned by the courts to SAYRAC. He was then placed on a bond, which he breached by absconding from the Gilles Plains Unit. He was arrested and remanded to SAYTC. Records showed that he told staff he wanted to live on the streets. Five weeks before his death he received a suspended sentence with a bond to be under the supervision of the department. However, he did not live where directed, did not attend supervision appointments and was admitted to the Queen Elizabeth Hospital with a suspected drug overdose. The department recommended to the court that his bond be revoked and the court issued a warrant for his arrest. His body was found the next day.

Two girls, aged 12 and 14, were separately placed in State care in the 1970s for criminal offending. The girls spent time together at Vaughan House. The 14-year-old had various placements but stayed in only a few. She continued to contact Vaughan House, wanting to live there. However, departmental reports showed that she would not benefit from Vaughan House and she was released to live with her brother, then mother, then boarded in a flat. A department report when she was 16 stated that:

> *... every effort made by officers has failed and have suggested to [the girl] that she should contact me rather than me chasing after her. Want her to accept some responsibility for her own behaviour, manage her own affairs which may assist her to become more independent and self reliant.*

Departmental records of the girls' placements in their last months alive are deficient. The second last entry on the older girl's SWIC was a placement with her parents in 1975. The next entry was 'released – died'. Before that there is nothing on the file to indicate the girl's living arrangements or whereabouts. The departmental file recorded her death by way of a newspaper clipping from *The Advertiser*.

The second last entry on the 12-year-old girl's SWIC recorded that she absconded from Allambi Girls Hostel in August 1975. The last entry, in 1976, was 'released – died'. The child's departmental file contains an internal memo from a community welfare worker to the District Office Enfield dated three months after she died. It stated the girl 'was killed in a road accident at Barmera ... she had been living in community placement most recently with family of [the other girl] (also killed) since absconding from Allambi in October, 1975'. There was no other information about the circumstances of the child's death.

Coronial records showed that the girls were both killed in February 1976 as pedestrians, while working as fruit pickers in the Riverland. Police records stated that the driver was convicted of causing their deaths by dangerous driving and sentenced to 18 months' jail.

At the age of 14 in 1991, a girl was placed under the guardianship of the Minister until she turned 18 due to allegations of sexual abuse in the family home. She had previously alleged she had been raped by a stranger when she was four and raped by her mother's friend when she was about 11. The Inquiry became aware of her death as a result of research on other matters when reading logbooks at the SAYTC. After becoming aware of her death, the Inquiry found a record on the CIS:

> *Case closed – 6/3/96. Child died Dec 1994. Notifier stated that [girl] was murdered 4 years ago (notifier stated that not sure if this is correct but it is well known that [girl] did die 4 years ago.*

The departmental files contained a minute from the chief executive officer advising the Minister on the day of the girl's death that police had found her body and that the circumstances of her death were yet to be ascertained. A further minute summarised the girl's history in State care. After being placed in State care, she was placed in several Intensive Neighbourhood Care and foster family placements but absconded from them all. She was then briefly reunited with her mother, but began offending and

living on the streets in 1992. In the two years before her death she spent most of her time in secure care due to criminal offending. The minute stated: 'The Department does not automatically undertake a formal enquiry of such incidents (unlike a death in custody or death of a baby) unless there are some issues which clearly need to be reviewed'. The final note on the file, from the case worker in 1996, indicates that the worker was in contact with 'the Port Adelaide police for about 4 months after the girl's death to see if they have finalised their investigations but nothing definite was forthcoming'. The file was closed three weeks later. It contained no information about the circumstances of her death.

Coronial records noted the girl's body was found in 1994 at the Semaphore Esplanade. The post-mortem report stated that her wrists indicated healing wounds, consistent with self-infliction about three weeks earlier. A recent injection site was noted. Her blood contained morphine as well as flunitrazepam. The latter is the active constituent of Rohypnol tablets. The level of flunitrazepam was potentially toxic. In relation to the level of morphine, its significance depends on how long she lived after taking the drug and other circumstances of death. Her lungs showed bronchitis and extensive early patchy bronchopneumonia. The coroner recorded the cause of death as 'bronchopneumonia complicating flunitrazepam and intravenous heroin'.

Another girl who was with the dead girl gave a statement to the police. She stated that she and the girl went to a house at Mansfield Park the day before and were supplied with a cap of heroin, which they both injected. They were then supplied with three 'rollies' each. The witness fell asleep, waking the next morning to find four men in the house but not the girl. She was told that the girl had left the night before. The previous day, shortly after injecting the heroin, the victim had expressed a desire to go to the beach, as it was hot in the house. Police inquiries revealed that the girl did not use heroin until her conditional release from Magill Training Centre on 20 October 1994. It appeared as though the witness had introduced her to the drug, administering it about three times before her death. On her own admission the witness was charged with administering heroin and was convicted in 1995 in the Children's Court, with no penalty. It is not known how the dead girl came to be in the car park at Semaphore beach. The occupants of the Mansfield Park house left after the girl's death. When the police went to the girl's home they found a letter from the department dated 17 November 1994 advising her that they had information that she had breached her conditional release from the Magill Training Centre by injuring her wrists, non-attendance at meetings and the use of drugs and alcohol. They found another departmental letter requesting that she appear before the training centre board. They also found a note written by the girl talking of her unrequited feelings for someone ('a sad love story') and of suicide because 'my life … goes nowhere'. The note also mentioned that 'if the butane in his lungs kills him' then she would introduce herself to heroin and that she felt like overdosing on some. The police report said there would be another report once they had made further inquires. There was no additional report on the file.

In 1985 a 12-year-old girl was placed in State care until the age of 18 due to neglect, physical abuse and sexual abuse by family members. Departmental records showed that during the next three years she was in and out of SAYRAC and absconded constantly from placements, spending periods of time on the streets. About six weeks before her death, she was charged with breaking, entering and theft of items, and assaulting and resisting police. One week before her death in December 1988, she was given bail, to be under the department's supervision.

The girl's SWIC recorded 'released – died'. The departmental files in relation to her death contained a closing summary to the effect that the girl was in an Intensive Neighbourhood Care (INC) scheme home, broke house rules and stole from the family. She then left the home and her whereabouts were unknown. She died in hospital after inhaling fumes from correction fluid in Hindley Street.

The coronial records set out the circumstances and cause of her death as 'anoxic epileptic fit following anoxia and cardiac arrhythmia in consequence of sniffing [brand name] correction fluid (containing trichloroethane)'. She and

another girl slept in the car park by the Academy Cinema for her final two nights. They smoked cannabis together. On the day of her death, the girl was seen by the other girl, intoxicated and inhaling from a bottle of correction fluid. She was then seen to collapse on Hindley Street and died later in hospital.

Three people gave evidence to the Inquiry about her life and death.

One witness believed that the girl was murdered. She said that she and the girl and another were 'prostitutes together'.

Another witness said the girl had been chronically sexually abused. She said that over the years the girl had been in and out of SAYRAC, where a worker had sexually abused her. She said the girl was pregnant at some stage. She thought she had been given an injection in Hindley Street and kicked in the head when she died. (The post-mortem report on the coroner's file stated that there was no pregnancy and no evidence of physical abuse at the time of her death).

Another witness gave evidence that a taxi driver raped the girl and that she was the victim of sustained sexual abuse at home.

The Inquiry was unable to find any evidence to substantiate the claim that the girl was murdered.

Deaths of children on probation to family

Seventy-seven children died while under departmental supervision and having been placed on probation to their parents. The majority, 41, died as a result of accidents and, of those, 25 involved motor vehicles. Nine children died from medical conditions and 10 from infectious diseases.

Accidents

In many of the accident cases, information about the circumstances of the deaths could not be obtained from the department because its records could not be found. For example:

An 11-year-old boy placed in State care in 1966 due to a larceny charge died 10 months later while on probation to reside with his mother. His SWIC stated that he was 'released – died'. There was no record of his death in the Mortality Record Book and the department was unable to locate any relevant files. The coronial records contained the details of his death: he died at home after he was electrocuted while handling Christmas lights.

In 1955 a two-year-old boy was placed in State care until the age of 18, after a court found that he was destitute. He died aged four, having spent most of his time in State care on probation to his mother. His SWIC recorded 'either burns or prior asphyxiation' and the Mortality Record Book listed 'misadventure – either burns or prior asphyxiation'. The department was unable to locate any files relating to the child.

The coronial records contained various statements about the circumstances of the death, including that the child died under a tank stand outside a house. There was speculation that somehow he had got hold of a box of matches and lit a fire under the stand, 'although there is not evidence to support same'. There was no report from the pathologist on the file.

Suicides

Three children committed suicide while on probation to their parents. The deaths occurred in 1944, 1963 and 1991.

A 17-year-old youth was placed in State care in mid 1944 after being charged with unlawful use of a motor vehicle. He was placed on probation to his parents immediately after his committal on an 18-month order. The youth had arranged employment as a labourer in regional South Australia, but about three weeks after he started, his employer found him bleeding from a bullet wound to the chest. The 17-year-old had shot himself after a failed love affair. He had written 'sorry' in the dirt nearby. The youth died from haemorrhaging from the wound.

The youth's SWIC notes that the insurance company, which was acting in relation to the stolen motor vehicle, alerted the department to the death. It also notes that the information about the coroner's finding on the file came from the region's newspaper. The Inquiry received no files from the department so could not verify the manner in which the department recorded the death beyond the

SWIC. The coroner told the Inquiry that no records could be found. The Inquiry's staff found a reference to a coronial record at SRSA and advised the Coroner's Office, however this record could not be located.[53] All information on the youth's death came from a mortuary book maintained by the regional police station, which was located at SRSA.[54]

An 18-year-old woman committed suicide in 1963, while placed in the care of her husband. She had been remanded to Vaughan House on a charge of break, enter and steal. She was charged and committed to the custody and control of the CWPRB until 1965. The young woman was initially placed with her mother but returned to Vaughan House briefly; her SWIC noted at the time, 'needs discipline'. Two months before her death, the young woman was released to her husband. She had a history of depression and violent behaviour, which had worsened in the month before her death. While she and her husband were travelling, she ingested almost a bottle of barbiturates without his knowledge. She was pronounced dead on arrival at an Adelaide hospital. Her SWIC read, 'released – died (suicide)'. The Inquiry received no departmental files for her.

The Inquiry discovered the death of a boy in 1991 incidentally, in the course of researching secure care facility logbooks. He had first come to the department's attention in 1981, aged five, due to parental neglect. He was placed in State care in 1982, until the age of 16.

The child was placed initially in emergency foster care, then a departmental cottage home. Departmental records showed he had become depressed, aggressive and insecure after removal from the family home when he was six. From 1983, the boy resided intermittently with his family, who remained unstable and transient, and in various alternative care placements, generally refusing to attend or absconding to return to his family. He attended seven primary schools and rarely attended high school. He was drinking, abusing drugs and offending repeatedly from the age of 11.

In 1989 allegations of familial sexual abuse of the child were raised, however a departmental investigation found no evidence. The same year, the boy made allegations of sexual abuse by an adult involved in his case management. After initial police enquiries, the child said he did not want to pursue the matter.

The boy committed suicide in late 1991, aged 15. At the time he was on conditional release from detention to reside with his parents, was participating in departmental programs and was considered stable. His welfare worker last spoke with him 12 days before his death.

The departmental files contained no records about the circumstances of the death. The child's welfare worker was alerted to the death by police, who had allegedly received a report from a departmental worker. The welfare worker verified the death through a newspaper. The departmental file recorded the cause of death as shooting, while the coronial file had death by hanging; the client file was never corrected to accurately record the death as death by hanging. CIS had three different listings under two surnames for the child, none of which noted that he had died.

Undetermined causes

The Inquiry has been unable to determine the circumstances of the deaths of six children who died while placed on probation to their parents.

A 13-year-old placed in State care in 1966 as a result of a criminal offence was given permission to join the Navy just over three years later. His SWIC recorded that in 1971, at 17, he was 'released – died'. The cause of death in the Mortality Record Book was 'fell under train'. There is no record of how this happened. The department or State Coroner could not provide the Inquiry with any files.

A mother placed her 13-year-old daughter in St Vincent de Paul Orphanage, Goodwood, in 1949, after the girl had twice run away from home. She also absconded from the orphanage and was then placed in State care until 18 years of age, charged as 'destitute' as her parents were not constantly in Adelaide. The girl's mother had a fractious relationship with the department and expressed a desire to take her daughter interstate,

[53] SRSA GRG 1/92/1.

[54] SRSA, GRG 5/235/2/1, Renmark Police Station mortuary book.

thus reducing the department's involvement with her. The girl was placed in foster care but then 'rebelled against the authority and advice of her mother' and absconded to Melbourne. She was located and returned to South Australia on probation to her mother. Both mother and daughter had contact with a departmental probation officer for a short period, however they failed to maintain contact. The girl was reported as a 'missing friend' by the department and died interstate about six months later, aged 15. The only information about her death on the departmental file was an article from *The Advertiser* in 1950 reporting that she had fallen from the balcony of a Brisbane hotel, where she had been staying with her mother. A note on the file stated that 'until the paragraph appeared in *The Advertiser* today, this Department had no definite idea of the whereabouts of either the mother or daughter'. The department wrote to the Commissioner of Police to confirm the child's identity. Nothing in the records indicated that the department sought to discover the cause or circumstances of her death. Her SWIC noted 'released – died' and 'Girl and mother staying at [name of hotel] when killed'. The Mortality Record Book gave the cause of death as 'result of fall from balcony'.

A two-year-old girl was placed in State care in 1960 until 18 years of age, after a court found her to be neglected and under unfit guardianship. She was placed on probation to her mother six months later. She died when she was 14. Her SWIC recorded 'released – died' and the Mortality Record Book, 'Fell from the Gap, NSW'. There was no information about the circumstances of her death on the departmental files.

In 1968 a 15-year-old boy was placed in State care until he turned 18 after committing larceny, and was then placed with his parents. He died in 1970. His SWIC recorded 'released – died' and the Mortality Record Book, 'died'. The only information found was a burial order stating 'multiple injuries received in a motor vehicle accident'.

In 1972 a 17-year-old boy was placed in State care—on probation to his father—for 18 months as a result of committing a criminal offence. He died 14 months later. His SWIC recorded 'released – died' and the Mortality Record Book 'motor accident'. The department and the Coroner's Office were unable to provide the Inquiry with any files. The Inquiry infers but cannot confirm that the death occurred interstate.

In 1969 a 16-year-old boy was placed under the care of the Minister for two years after committing a criminal offence. He was placed on probation to his parents and died one year later. The cause of death is 'drowned' in his SWIC and the Mortality Record Book. The only reference from the Coroner's Office was for a burial order, which contained no information about the circumstances of the death. The boy's departmental files contained the following entries:

> *9/1/71 Report in Advertiser this date that [name] missing, believed drowned near Lock 5, River Murray, Renmark area.*
>
> *10/1/71 Report in Sunday Mail that [name] body recovered from the River Murray, dead.*
>
> *11/1/71 Home Visit. Offered condolences and any assistance to family.*

There was no information about the circumstances. The file was closed the day after the body was found.

Petrol sniffing

Two Aboriginal boys died from petrol sniffing while they were on probation to their parents.

One boy was placed in State care in 1974 at the age of seven, after a court found him neglected. His SWIC recorded that during the next 10 years he was regularly moved between foster care and his mother's care. Three months before his death he was charged with larceny, spent a few weeks in SAYRAC and was then released on bail to live with his mother. He was 17. His

bond and supervision file from the department contained a copy of the forensic and autopsy reports, which attributed cause of death to petroleum hydrocarbons in the lungs and liver consistent with inhalation of petrol.

The boy's SWIC did not record his death and noted on 10 January 1985, 2½ months after he had died, 'released term expired'. His name was not on any of the lists provided to the Inquiry by the department. The Inquiry learnt of his death from a member of the public.

The second boy was placed in State care in 1973 at the age of 13, a court finding he was in need of care and control. Departmental files showed he had been involved in minor offending and petrol sniffing. He was placed at Windana Remand Home and then at Amata, an Aboriginal community. He continued offending and was then placed in State care until the age of 18. In 1975 he spent two months at McNally Training Centre. A report on his departmental file raised concerns about the secure care of Aboriginal youths. It noted a 'very thin, undernourished, confused, petrified, full-blood Aboriginal boy, coming from an environment and cultural setting completely alien to European living'. The boy did not speak English. The report writer stated that he disagreed with the District Court's decision to place the boy at McNally. He was released and went to Amata. He died 14 months later in the Northern Territory, where he was living with a relative. A letter on the departmental file stated:

> *It is believed that he died as a result of petrol inhalation. This latter is a problem which is affecting quite a number of the teenage Aboriginal youths within that general area.*

A report on the file said the boy's uncle found him slumped over in a car, his head in a billycan.

Allegations of criminal conduct

Five children died as a result of criminal conduct while on probation to their parents.

A 16-year-old girl died as a result of an infection as a result of an abortion in 1944. When she was 13 she was charged as uncontrollable and placed in State care. Her father had died and her mother remarried. She was placed at Barton Vale Home for Girls on 25 August 1941 for a year and then placed on probation with her mother.

Her SWIC recorded 'released – deceased. Conduct good'. The Mortality Record Book recorded 'abortion'.

According to the coronial files, the girl told her friend she had 'slipped' and they discussed getting her 'fixed up'. He told her about a woman, Florence Tucker, who performed abortions. The girl's mother borrowed £10 from a money lender. After visiting Tucker, the girl returned home. She told her mother she had been syringed with soapy water and had been given a telephone number to call if she had complications. When the girl complained of abdominal pain, her mother called the number, reaching a nurse, who said she was unable to help. A doctor was called and admitted the girl to hospital. The girl provided a statement to police but died soon after. The inquest found that Tucker brought about the death of the girl by mechanical interference. She was committed for trial on a charge of manslaughter and was also committed to stand trial for the unlawful abortion of another woman (who survived). The Courts Administration Authority was unable to locate any records on the charge of manslaughter. However, Tucker was found guilty of the second charge and sentenced to three years' jail with hard labour.[55]

The department's supervision file for the girl indicated that her probation officer had no knowledge of the events leading to her death. The girl's employer told the officer about the death and he then visited the family home. The officer's report to the secretary of the CWPRB did not include any information about the circumstances leading to the death or details of supervision, apart from noting that the most recent visit to the girl's home had been about one month before her death. After that visit he recorded that the girl 'has been very satisfactory since her release. She

[55] SRSA GRS 3391/2/11, files 7–8, R v Mary Hughdella Cross & Florence Mary Tucker (1944).

seems to have left all her uncontrollable traits behind her.' It concludes that the girl 'was a very good girl on probation, her manner was always most pleasant, and she spoke freely about what she was doing'. The file also contained an extract from the death registration listing 'abortion' as the cause of death, a note from the probation officer that 'this girl died in the Royal Adelaide Hospital' and a newspaper clipping about the death, which stated that the police took 'dying depositions from the girl, who died three hours later'.

Six months before her death, the department's visitation report had noted: 'She has become acquainted with a young man, who has taken her to pictures and dances'.

It appears that while the girl was at Barton Vale in 1941–42 she was medically examined by a doctor at the police medical room. The departmental file recorded this examination and noted: 'vagina: admits two fingers easily. Hymen: healed hymen tags. Slight mucous discharge. Intercourse could have taken place on a number of occasions'. It is not known why the girl was examined in this way and at that time.

A 13-year-old boy was placed in State care for breaking and entering and died in 1967, aged 17, one year before his release from care. He was visited by the department in 1964 and 1965 while on probation and living with his father in Mount Gambier. There were no departmental files other than his SWIC, which recorded 'released – died'. The Mortality Record Book noted his cause of death as 'result of street fight'.

Courts Administration Authority files recorded that a 17-year-old youth pleaded guilty to manslaughter in 1967, part-way through a trial in the Supreme Court. He was fined $100, with a four-month prison term if he defaulted, on the basis that he

> *... engaged in unlawful violence in the form of a fight with this young man, which has had the quite unintended and extremely unfortunate result of this boy losing his life.*

The judge told the defendant:

> *I do not think you can blame yourself for any worse crime than indulgence in a fight that you ought to have kept out of. It was a piece of villainously bad luck that this fight should have had the fatal result that it did.*[57]

In 1967 a three-year-old girl was charged as neglected and placed under the care of the Minister until she turned 18. She was released on probation to her mother in 1970 when she was six. She died six weeks later. Her SWIC recorded 'released – died' and the Mortality Record Book 'murdered (drowned)'. The department was unable to provide any files relating to the girl.

The Coroner's Office file stated that a 16-year-old youth was charged with her murder. The girl's body was found in the River Torrens near her home. She was last seen by her mother in the backyard of her home.

Courts Administration Authority files showed that the youth was originally charged with her murder and pleaded not guilty. The charge was then replaced with manslaughter, to which he pleaded guilty. The court ordered that he be placed under the control of the Minister of Social Welfare until he turned 18, when he would be sentenced to 12 months' prison – suspended if he entered into a three-year good behaviour bond and undertook medical and psychiatric treatment. The files showed he had been placed in State care in 1968 at the age of 13, having committed larceny. According to his SWIC, he was placed under the care of the Minister until the age of 18. He was immediately released on probation to his parents. Three months later he was placed in Windana Remand Home, then Brookway Park and later Lochiel Park Boys Training Centre, when he committed a further offence of malicious damage. He absconded from Lochiel Park several times and was also released to stay with his parents a few times. During the next year he was charged with further offences: disorderly behaviour, illegal use of a motor vehicle and unlawful use of a bicycle. He was released on probation to his parents in September 1969, seven months before he killed the girl.

[57] SRSA GRS3391/00008.

The court files showed a work placement had been arranged for the youth on his release to his parents but this lasted only 1½ days. He was assessed for vocational training at St Margaret's Rehabilitation Centre for four weeks in April 1970 but was found unsuitable for training. The youth told the police that he took the girl, who lived nearby, to the shop on his bike on the day she died. She wanted another ride on his bike, but he said no and she began to call him names. She followed him down to the river. He got angry and pushed her into the river 'to teach her a lesson' and hurt her for calling him bad names. He held her down in the water and
then got a piece of corrugated iron in an attempt to hide her body.

In a report obtained for sentencing purposes on the court files, the youth said he suddenly got very angry and felt that it could happen again if someone called him bad names. He said that he did not like Lochiel Park because 'one man kept hitting them all the time' and that is why he ran away. A doctor diagnosed the youth as 'multiple minimal handicap'.

After he was sentenced, in March 1971, he was placed in the McNally Training Centre but, according to his SWIC, absconded three times during the next two years before being released in 1973. For more than a decade from the early 1980s, he committed larceny, a grossly indecent act in public, and breaking into a building and felony.

In 1963 a baby boy was placed in State care until the age of 18 after a court found him 'neglected and under unfit guardianship'. His SWIC stated that he was put on probation into his mother's care on the same day. About 14 months later, the two-year-old boy, his younger sister and their mother were found dead at their home.

The boy's SWIC recorded 'released – died, killed by mother' and the Mortality Record Book recorded 'gassed by mother (who suicided)'. The department was unable to locate any files relating to the boy.

The coroner's file showed that the mother killed herself and her two children by coal gas poisoning, using the stove jets and oven. She left a note to her eldest child (then in foster care) that was scathing of the department: '…I could not save you from the claws of murderous Welfare now they killed me and your little sister and brother'.

In 1959, a 13-year-old boy was placed in State care until the age of 18 after committing larceny. He was placed at Struan Farm School just before he turned 15 and died about six weeks later, while on a holiday with his parents. Coroner's records stated that he and three youths stole a car in Adelaide. The 15-year-old driver misjudged a turn and the car ran off the road, killing the boy. The driver was convicted and sentenced to the reformatory until he turned 18. His SWIC and the Mortality Record Book recorded his death as due to a road accident.

Other issues

Unmarked graves

Two people gave evidence to the Inquiry about the graves of their relatives – a brother and sister. Both witnesses said they believed the children were in State care and both had wanted to put headstones on the graves but had been stopped. One of the witnesses said he thought there were at least 100 unmarked graves at a particular cemetery 'and the question needs to be asked, "Which ones are related to institutional care or issues gone wrong?"'. He said that the graves can also be put into strangers' names, for example, the name of the funeral parlour. He said he would not stop until he got headstones for the two children. The other witness said she was told:

> *... that there are a fair few of FAYS' [Family and Youth Services] graves, that there's—no documents handed over to the cemeteries. They're just kind of, like, told to dig the hole and that's it, that's all they do.*

She said she would love to take over the graves of the two relatives, 'but the thing is, we're going to lose those graves because we don't own them'.

The Inquiry requested all departmental files referring to the two children.

The girl's file contained some information about the boy's death. He died when he was eight years old and had never been in State care. His grandmother paid for his funeral over 12 months, in which time the grave site lease was in the funeral director's name. Once it was paid, in 1999, the lease was transferred to the grandmother's name. The child was not buried by the department. The Inquiry concludes that if there is no headstone on the grave, the grandmother has chosen not to have one.

The files showed the girl died when she was 17. When she was three, her grandmother had been granted custody and received a guardianship allowance. She was placed in State care for brief periods. The file recorded a meeting between family members and the department following her death, at which it was decided that the mother would claim the body and arrange the funeral and the father would supply the headstone. The department paid for the funeral but the grave site lease was in the mother's name. The Inquiry concludes from the documents and the witnesses' evidence that this is also a family, not a government, issue: the father did not supply a headstone as agreed and the mother has subsequently chosen not to install one.

In relation to the issue of unmarked graves, the Inquiry received information from the department that the department's Funeral Assistance Program, which started in 1988[58], funds funerals for children in State care and families eligible to receive financial assistance. A funeral director is contracted to provide the funerals statewide and the procedures are the same regardless of whether the child was in State care or not.

Before 1 May 2006, the lease for the burial plot of financially assisted funerals was in the department's name unless the child was under five, in which case the lease was in the family's name. The family could buy leases at any time for the original price paid by the department. The department did not pay for headstones and required permission if a person wanted to erect a headstone on a department plot. If the cost of the headstone was less than a certain amount, permission was automatic. But if the headstone cost more, the department required the family to purchase the plot lease. The program was changed in May 2006 to provide financial assistance for headstones.

The department advised that it recorded the names and place of burial of all children who received funeral assistance, regardless of whether the grave had a headstone.

The Cemeteries Association of South Australia, which was formed in July 1978, advised that all cemeteries and crematoria are legally required to keep burial records, all state-funded funerals are contracted to a funeral director and the department buys burial sites from cemeteries.

In relation to unmarked graves, the association said that 'large numbers' of babies, children and adults were buried in common ground, known as pauper sites, until the 1970s. This occurred at West Terrace Cemetery and, to a lesser extent, Dudley Park, Cheltenham and various country cemeteries. Records at West Terrace generally provided the name, last known address, age, date of burial and location of the grave, with some omissions. The government funded burials for people who had no estate or identity, or whose family could not afford to pay, as well as for children in State care. The records did not note whether a deceased person was a State child. The custom was for a State-contracted funeral director to conduct a burial in the common ground, with no grant or licence issued over the grave. Therefore the Inquiry found that the issue of unmarked graves raised by the two witnesses was not particular to the burial of State children.

[58] Between 1985–88 the department provided financial assistance for burials; between 1970–85 the department was responsible for 'all burials in South Australia of persons with insufficient resources' and during the 1960s the department arranged destitute burials. See DCW annual report 1976, p. 17.

Recommendations regarding deaths

Two committees relating to the deaths of children in South Australia were established as a result of recommendations made in the 2003 Layton report. They are the Child Death and Serious Injury Review (CDSIRC) and Adverse Events (AEC) committees.

The CDSIRC was established by Part 7C of the *Children's Protection Act 1993* on 1 February 2006. It has a wide focus in that it may review the death or serious injury of any child resident in the State at the time.[59.]

It consists of up to 20 members—appointed by the Governor of South Australia—who must meet at least five times a year. It is subject to direction of, and resourced by, the Minister of Families and Communities. It must report to the Minister, who is to table its reports in Parliament.

The committee's main functions are to review cases in which children die or suffer serious injury and identify legislative or administrative ways of preventing similar cases; and to make, and monitor the implementation of, recommendations for avoiding preventable child death or serious injury.

The Children's Protection Act sets out criteria to decide whether a review should be held. For example, a review should be held if the child was, at the time of death or serious injury, under the guardianship, or in the custody, of the Minister or was in custody or detention or in the care of a government agency.

The review should be done by examination of coronial and other relevant records and reports, however the committee may engage an expert to assist. The committee can ask to be provided with documents or supplied with other written information. Information provided to the committee is confidential, unless it relates to possible criminal offences, risk of abuse or neglect, or matters relevant to a coronial inquiry, in which case it must be referred to the relevant authority.

The committee is to maintain a confidential database of child deaths and serious injuries and their circumstances and causes.

The committee met 10 times in the year 2005–06, having been operating under Cabinet Directions since April 2005. Its main tasks included the collection and analysis of deaths, the development of a database for storing information, analysis of information about the causes and circumstances of deaths, and recommendations to the Minister.[60]

The committee completed reviews of the deaths of two people who had been in contact with the department. One was the possible suicide of a child aged 10–14 and the other a youth aged 15–17 from a fatal medical condition. The committee also considered the ways in which the Adverse Events Committee could improve its review of the services that Families SA provided to children and families.[61]

The AEC was established in July 2004 and operates in the Department of Families and Communities, reporting to the chief executive. It has a narrower focus than the CDSIRC. Its purpose is to conduct internal reviews of deaths and serious injuries of children and young people who have been, or are currently involved with, the department. This includes deaths of children under the custody or guardianship of the Minister. The primary focus of the reviews is 'quality improvement' with the ultimate purpose being 'to identify and ameliorate system issues that may assist in the reduction of adverse events'.[62] By the end of 2004, the committee had determined its procedures, including that the executive director of the department be provided with an internal memo about an adverse event and that the committee meet within 14 days of being notified by the executive director. The committee would then decide whether there is to be a case review (conducted by a social worker) or the establishment of an inquiry panel.

59 *Children's Protection Act 1993*, s. 52S(2).

60 Child Death & Serious Injury Review Committee annual report 2005–06, p. 18, viewed 15 Aug. 1987 <http://www.cdsirc.sa.gov.au>

61 ibid., s. 3, pp. 37–39.

62 DFC, Adverse events – policy and procedures (interim), Dec. 2004, p. 2.

Between July and December 2004, 23 referrals were made to the committee, of which 14, including 10 deaths, were assessed as requiring review. Of these, four were conducted by inquiry panel and six by case file review. All of the children had current or previous contact with Families SA, including three guardianship and two youth justice orders.[63]

Central database

Neither the Child Death and Serious Injury Review nor Adverse Events committees has a specific provision for a database of the deaths of children in State care. However, there is a basic need for the department to establish and maintain such a database.

There was a significant amendment to the *Coroner's Act 2003* from 1 July 2005, requiring—for the first time—that the coroner be informed of the death of a child in the custody or under the guardianship of the Minister.[64] The State Coroner must hold an inquest into the death if he considers it necessary or desirable or if he is directed by the Attorney-General. Even if an inquest is not held, the coroner must make a finding on the cause of death.

Following the amendment to the Coroner's Act the department distributed an internal circular informing staff of reporting requirements concerning child deaths. However, it did not address the issue of the central recording of deaths in a database.

In *Rapid Response progress report 2007*, Families SA said it was undertaking 'a major service and practice reform through its new case management (C3MS – Connection Client and Case Management System) system'. The Inquiry recommends that as part of that reform, the department ensures that the deaths of children in State care are centrally recorded.

RECOMMENDATION 49

That the Department for Families and Communities creates a central database of children who die while in State care as part of its new C3MS.

The database should contain:

- the child's name and date of birth
- when the child was placed in the custody or under the guardianship of the Minister; or the details of the voluntary agreement
- the child's last place of care
- the name of the child's last carers
- the date of death
- the cause of death (as initially advised to the department)
- the circumstances of the death (as initially advised to the department)
- the source of initial advice about the cause and circumstances of death
- confirmation that the death was reported to the State Coroner and when
- if an inquest was not held, the cause of death as found by the coroner and when that finding was made
- if an inquest was held, the cause of death as found by the Coroner's Court and when that finding was made
- if an inquest was not held because of a criminal prosecution, the name of the investigating police officer and the outcome of the criminal prosecution.

63 DFC, Adverse Events Committee, Progress report No. 1, p. 6.

64 *Coroners Act 2003,* s 28.

Maintaining files

If the child died in State care, the Inquiry recommends that this information is also kept in a physical file relating to the child, whether in the child's client file or a separate file created for this purpose. The file should contain any correspondence related to obtaining information concerning the child's death, including copies of any coroner's or court findings. The Inquiry recommends that when a child dies in State care, the case not be 'closed' until the Minister, as guardian or custodian, has properly informed himself/herself about the child's death and made sure the death has been properly investigated.

RECOMMENDATION 50

That where a child dies in State care, the Department for Families and Communities maintains a physical file, which contains:

- information about when the child died and in what circumstances, including reference in the file to where the information has come from
- information from the State Coroner as to whether an inquest is to be held
- the coroner's finding as to cause of death
- a copy of the coroner's reasons in the event that a coronial inquest is held.

Funding for legal representation at coronial inquests

Depending on the circumstances of a death, the coroner may decide to hold an inquest. This includes a death of a child in State care. A person who, in the opinion of the court, has a sufficient interest in the subject or result of the proceedings may appear as a party in the court and have legal representation.[65] It is foreseeable that the department's interests in the proceedings may not always be the same as the interests of the birth parents in any such proceedings. There could be a potential conflict of interest. The Inquiry heard evidence from the mother of a baby who died in State care about how she persevered for almost two years for an inquest to be held into the death of her baby and the ongoing stress of legal expenses when she finally succeeded. The department had its own legal representation and the issues surrounding the death were such that the department's interests did not reflect the mother's interests. Unlike in civil proceedings, there is no provision for a person to be reimbursed for legal expenses in regard to legal representation at a coronial inquiry. Given that the death of a child in State care is now reportable, the Inquiry recommends that the State Government financially assists a family member of the dead child with legal representation, if requested, at an inquest.

RECOMMENDATION 51

That the South Australian Government provides financial assistance to a family member of any child who dies in State care to enable that family member to be legally represented at a coronial inquest into that child's death.

[65] ibid., s. 20.