

## **CORONERS FINDINGS AND COMMENTS**

This is the inquest into the death and circumstances of death of **Alvin Naidu**.

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I must deliver my findings pursuant to the provisions of the Coroners Act 2003. I do so, reserving the right to revise these reasons should the need of the necessity arise.

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The purpose of this inquest, as of any inquest, is to establish, as far as practicable –

- Whether or not a death happened;
- The identity of the deceased person;
- How the person died;
- When the person died;
- Where the person died, and
- What caused the person to die. [Section 45 (1) and (2)]

3

It should be kept firmly in mind that an inquest is a fact finding exercise and not a method of apportioning guilt. A Coroner must not include in the findings any statement that a person is, or may be guilty of an offence or civilly liable for something. [Section 45(5)]

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The procedure and rules of evidence suitable for a criminal trial are not suitable for an inquest. The Coroners Court is not bound by the rules of evidence and may inform itself in any way it considers appropriate. [Section 37]

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In an inquest there are no parties; there is no charge; there is no prosecution; there is no defence; there is no trial. An inquest is simply an attempt to establish facts. It is an inquisitorial process, a process of investigation: These observations were confirmed by Justice Toohey in *Anetts v McCann* ALJR at 175.

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A Coroner's inquest is an investigation by inquisition. It is not inclusive of adversary litigation. Nevertheless, the rules of natural justice and procedural fairness are applicable. Application of these rules will depend on the particular circumstances of the case in question.

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A Coroner may, whenever appropriate, comment on anything connected with the death that relates to-

- a) Public health or safety, or
- b) The administration of justice, or
- c) Ways to prevent deaths from happening in similar circumstances in the future. [Section 46 (1)]

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If, from information obtained while investigating a death, a coroner reasonably suspects a person has committed an offence the coroner must give the information to-

- a) for an indictable offence – the Director Public Prosecutions, or
- b) for any other offence – the chief executive of the department in which the legislation creating the offence is administered.

9

A Coroner may give information about a person's conduct in a profession or trade, obtained while investigating a death, to a disciplinary body for the person's profession or trade if the coroner reasonably believes the information might cause the body to inquire into, or take steps in relation to, the conduct.

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All proceedings before this Court are sad proceedings. At this stage I express my sympathy and condolences, and that of the court, to the family of the deceased in their sad loss, in the tragic death of Alvin Naidu.

#### **SUMMARY EVIDENCE:**

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Alvin Naidu was fifteen years old and had been living with his family members at the time of his death on 18 November 2004. He was attending the local high school at Sunnybank. On 10 November 2004 his family became aware for the first time that he had been missing days from school. Mrs Naidu received a phone call from the absenteeism officer, Ms Olive Borovsky, (a teacher aid) at the Sunnybank High School. She recalls being told that her son had not been at school for two weeks. She expressed her surprise and concern over the completely unexpected news. Ms Borovsky recalls that she indicated she expected Alvin's father to be angry, whereas Mrs Naidu recounts that she said her husband would speak with her son about this issue. I do not draw any particular inference from these differences in recollection.

12

What is clear was that Alvin came home about 2.30 pm that day, as if returning from school after sport. His mother asked him where he had been and he indicated he had been at school. She challenged him and told him that she had been speaking with the school and she knew that he had not been at school. It was necessary that Mrs Naidu go out at that time in relation to children she cared for. She told her son they would talk when she returned.

13

Mrs Naidu came home about ten past three that afternoon and discovered her son to be hanging in the garage area. Immediate efforts were made to help Alvin and he was taken to hospital. He was resuscitated but tragically he had suffered such severe hypoxic brain damage that he died on 18 November 2005. His family consented to organ donation.

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The background to this tragedy developed in the months leading up to Alvin's death although the situation was not clear to anyone at the time. Alvin was facing a series of events that apparently overwhelmed him and led to his tragic death.

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At the outset it must be recorded that the evidence was clear that Alvin had a strong and supportive family unit who never-the-less were completely unaware that Alvin was struggling. The parents became aware that their son had a friendship with a girl called Amina when they saw the girl's name marked into the skin of Alvin's left forearm. The lettering was able to be seen and Alvin indicated to his father that he had done this with a pointy knife so that a marking was evident. His father discussed the issue with Alvin, and Alvin acknowledged that he was infatuated with the girl, but that the friendship had ended. Alvin told his father he now thought that it was a 'mistake' to have cut her name in his arm and he wanted it removed. Father and son went to the family general practitioner, Dr Randall Jackson.

16

Dr Jackson gave evidence that Alvin and his father came to see him on 11 October 2004. The doctor recalls discussing the issue with Alvin, and that Alvin acknowledged that marking himself in this way wasn't a good thing. The marking was inspected by the doctor and he considered that there were no signs of infection and that the mark would fade in time without any further treatment being required.

17

The doctor spoke with Alvin with his father present. The doctor made some cursory notes, but he specifically recalls that he did consider whether this was an incident that needed to be referred to a counsellor or on to a psychiatrist. However, the impression of Alvin was that there were no signs of any concern, either physical or mental. Alvin was not demonstrating any sign to indicate that he was depressed, unduly distressed or unstable.

Nor did his father indicate that he had observed anything to suggest there was a significant problem. Dr Jackson made the decision that it was appropriate for him to talk with the boy and leave the issue at that. I cannot see any reason to suggest that this was an inadequate response given the information that was available at the time.

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I note in particular that the family were unaware that Alvin had missed time from school - nor was that fact known to the doctor.

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By the time of Alvin's subsequent hospitalisation, it became known to the family that Alvin had also marked the girl's name on his chest. This fact also was not known to the general practitioner at the time of his first or subsequent consultation with Alvin.

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The second consultation with the doctor was on 1 November 2004. Alvin's mother recalls that this attendance was prompted by Alvin being self conscious about his acne, which had been increasing according to his mother's observations. However, again there was nothing to indicate to either parent or the doctor that at the time of this second consultation, he was suffering depression or considering self harm

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The doctor discussed the skin condition with Alvin and a prescription was issued for an antibiotic, (Vibra-Tabs). It was clarified that the antibiotic was a well tried and reliable antibiotic (as distinct from a particular medication that has been known to be associated with the onset or exacerbation of depression in adolescents.)

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Again the doctor's notes are perfunctory, but I accept his evidence that his recollection is that there was no indication that anything was amiss with Alvin. He remembers clearly thinking that he seemed "good" in terms of his general outlook and demeanour.

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This is consistent with the parents' observation, that they had no reason to suspect their son was in anyway suffering or concerned at this time.

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The real issue for this inquest has focused on the communication between the Sunnybank High school and the Alvin's parents.

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I accept the evidence from the school that Alvin was away from school, without satisfactory explanation or authorisation on the following dates:

- 24 June 2004           entire day    Thursday ( \*end of school term )
- 25 June 2004           entire day    Friday\* (\* end of school term period)
- 27 July 2004           entire day    Tuesday
  
- 14 Sept 2004           entire day    Tuesday
- 15 Sept 2004           morning      unexplained, Wednesday
- 16 Sept 2004           entire day    Wednesday
- 17 Sept 2004           entire day    Thursday  
Interview with Acting Deputy Principal, Alvin
  
- 27 Oct 2004           entire day    Wednesday
- 28 Oct 2004           entire day    Thursday
- 29 Oct 2004           entire day    Friday

Alvin returns to school Monday 1 November and is asked to bring a note. He does not return to school.

- 2 Nov 2004           entire day    Tuesday
- 3 Nov 2004           entire day    Wednesday
- 4 Nov 2004           entire day    Thursday
- 5 Nov 2004           entire day    Friday
- 8 Nov 2004           entire day    Monday
- 9 Nov 2004           entire day    Tuesday
- 10 Nov 2004           entire day    Wednesday

On 10 November 2004 Ms Borovsky telephones Mrs Naidu and informs her that Alvin has not been at school. She undertakes to inform Mrs Naidu if Alvin is absent on the following day.

Mr Naidu phoned the school on 11 November 2004 indicating that Alvin was critically ill, in hospital.

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The school presented evidence concerning the system in place at the time regarding the management of absenteeism. All students had to attend a roll mark period at 9.05am until 9.15 every day. The purpose of that period was for the designated "roll mark" teacher to record any absences and to read out any messages. The information of which students were absent, (identified by their student number), was then given to the absenteeism officer, Ms Borovsky, who was a teacher aid. Her responsibility each day was to first attend to recording of students who were "late". Then she would record the data regarding absent students into the school's computer system.

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During the day, (and in the days following), she would receive information via notes or telephone calls to explain and thus “authorise” an absence. [An absence might be authorised by, for example, a telephone call with the parent who confirmed the student was ill, or the receipt of information from a teacher that a student was away from school at an authorised function, perhaps a sports event.] The information could come from a teacher, from a parent, or from a student if Ms Borovsky thought it appropriate to accept that information as reliable. It could be verbal, by phone, or written.

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Her last task each Friday afternoon was to compile information taking into account the absences that had subsequently been authorised to then produce a record of “unauthorised absences”. That information was then put into the designated “teacher manager’s” pigeon hole late on Friday afternoon, or possibly early in the following week.

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In that following week the teacher manager was to follow up with the parent or student in accordance with the behaviour management policy, depending on the total number of unauthorised absent days the student had accrued that year.

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The School Principal, Ms Farwell gave evidence. She told the court that the school policy at the time required a phone call to a parent after the third “unauthorised” absence, together with a follow up letter to be issued. A similar response was supposed to occur after a fourth unauthorised absence. On the fifth such absence, the parent should again be contacted and an automatic after school detention was imposed. After five, and before ten absences, a parent interview including the student was required. A student was then in the position of having to show cause why the Deputy Principal should not be called upon to suspend the student for three days. If truancy occurred after this stage, the Deputy Principal managed the situation directly with penalty suspensions and ultimate exclusion from school.

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In Alvin’s case, Ms Farwell’s evidence was that Alvin had been counselled on September 14 when he was spoken to by the acting deputy principal. There was then the phone call to the family by Ms Borovsky on 10 November 2004, the day that Alvin subsequently attempted to hang himself.

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Ms Farwell’s answers to Mr Isdale’s question revealed the latitude within the policy and guidelines. At first reading of the behaviour and management consequences document it appears that a parent could expect to be telephoned after the third consecutive absence. But this did not occur on Monday 1 November 2004 when Alvin returned to school having missed three consecutive days from 27 October to 29 October 2004.

One might have expected that if Alvin did not front with a note explaining his absence on the day, that his parents would have received a phone call- not so. Instead, Ms Farwell explained it as an area of a “judgement call “ by a teacher to then allow Alvin the opportunity to present a note.

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But Alvin did not attend for the rest of that week, nor the following week and there was no contact made with his family by the school. The “truancy“ policy ( in addition to the behaviour management guidelines which should have been triggered by three days unauthorised absence,) indicated that the school would notify the parents when a student was absent on a fourth consecutive day. There was no contact from the roll mark teacher, Ms Schloss, who was the same person as the teacher manager in this case.

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Nor did the deputy principal, (who had the responsibility of following up that this call had been made for their respective year level,) make contact with the family at this time.

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It was not until the Wednesday of the following week, November 10th that contact was initiated by the school with the family. By this stage, Alvin had missed seven consecutive school days (with an intervening weekend.) Preceding that period of absence, Alvin had been in attendance for one day (1 November) and before that, had missed another three consecutive days between 27 and 29 October.

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The role of a “teacher manager” was integral to this system. A teacher manager was responsible for student behaviour issues and overall “welfare” issues of individual students. The responsibility might be for a group of up to eighty students. At the beginning of each school year the teacher manager would have the opportunity to meet each student and a parent. School policy information was available to the parent at this time, including information about student behaviour management and the school’s truancy / absenteeism policy.

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In Alvin’s case, there had been a change in his teacher manager from the beginning of July 2004 when the previous teacher manager left the school. Ms Kerry Schloss took over the responsibility.

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She was also Alvin’s roll mark teacher. Because she took over during the course of the year she, and Alvin’s parents and Alvin, did not have the opportunity to participate in the interview / meeting process that occurred only at the start of the school year. Her evidence indicated that she really did not know Alvin very well. She had not noticed any change in his demeanour or presentation during her period of responsibility for Alvin.

As his teacher manager, she had not received any adverse reports about Alvin's behaviour. It was Ms Schloss who recorded that fact that Alvin had been away for three days from 27 October, before attending school on 1 November. But instead of contacting his parents at this time, she accepted what Alvin allegedly told her, (that he had been ill,) and that he would bring a note the next day.

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Ms Schloss' explanation was that she was new to her role as a departmental head and very busy. She did not think there was anything amiss with Alvin and simply had not made time to make contact with the parents, although she recognised that she should have.

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The school attendance officer, Ms Borovsky, gave evidence that she struggled from time to time to complete the necessary data entry within the stipulated time frame. She acknowledged that in the time immediately before Alvin's death she had not completed the list by the Friday 5 November 2004.

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It was not until Wednesday 10 November that Ms Schloss went to see Ms Borovsky to inquire whether a note authorising his absence had been produced. Alvin was still absent from school without satisfactory explanation, and had been continuously absent on seven consecutive school days after Monday 1 November. There was an intervening weekend during this period.

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Ms Borovsky's evidence, (which I accept) was that she told Ms Schloss that she would make the phone call to the parent to make inquiry (even though the responsibility had by this time passed to the teacher manager, Ms Schloss.) She undertook to do this because she had failed to get the list out in time by the preceding Friday.

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The phone call then occurred with Mrs Naidu, who expressed her surprise and concern over her son's absence and indicated that her husband would speak with her son. She wanted to be informed if her son was absent again. Tragically, Alvin attempted to hang himself later that day. When he was not at school on 11 November, Ms Borovsky telephoned and was told that Alvin was in hospital.

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There were problems with this system, even if it was followed to the letter, which clearly it was not in this case. If a student was absent for a number of days at the beginning of the week it would not be actioned by any contact with the family until the following week. This is hardly a satisfactory situation.

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Since Alvin's death, the school principal, Ms Vicki Farwell states that she oversees the printouts of absenteeism. Ms Farwell stated that if a teacher could or did not follow the policy then that was to be advised to the manager, and in turn to the deputy and then on to the principal.

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Ms Farwell, explained that the policy and its implementation have been constantly under review. The present system (which, interestingly, the evidence indicated exceeds the current Queensland Education standard), uses a software package.

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Information of absence is collected at the beginning of each day. At noon, 1.00pm and 2.00pm that day an automated SMS message is sent to the parent of any absent student. The SMS message requires a response acknowledging the student's absence and asking for explanation. It was explained that this still required a human follow up to check SMS / telephoned responses, or the lack thereof. ***However good the software package, the critical factor will be the importance that is placed on follow up and communication with parents by the school staff. This cannot be simply a question of a policy and procedures that appear to address absenteeism. The safety of students requires leadership to enforce compliance with the system and an automated audit system backed up with appropriate action from the Principal.***

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Ms Farwell's evidence was that she now monitors the reports that are generated. The system still operates on generating a letter to the family after a three day period of absence. The attendance officer provides a report directly to the principal of the three day letters sent out.

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There is of course still a potential gap in communication where the software is unable to operate if a family does not have a mobile telephone, said to be about twenty percent of the school family population. The attendance officer is expected now to make these calls to landlines where possible.

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There is still a reliance on the teacher manager following up with the contact with parents. I would draw to the attention of Ms Farwell two passages of evidence; the first from Ms Schloss at the bottom pages 54 and page 55. This is to be contrasted with the passage of evidence from Mr Molloy on page 81. Mr Molloy is confident that the new system means teachers would reliably be in contact with a parent before the second week if a student was absent for more than three days. He is assuming that teacher managers will be proactive in checking the system to seek out information for this to happen. There does not seem to be any real mechanism in place to make sure that this occurs.

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However, the positive outcome so far is that the school is reporting a reduced number of unauthorised absences.

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After Alvin's death there was some contact between the school and the family, particularly the principal and deputy principal.

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What is clear from all of the evidence is that neither Alvin's parents nor any of the teachers, who had varying degrees of contact with him, nor his general practitioner, noticed anything significantly amiss with him to suggest that he was at risk of self harm. The school had in place resources to assist students, including a guidance officer, school nurse and chaplain. The principal was aware that certain behaviours which could be identified as self harming would be referred to the Child Protection authority, but nothing came to the attention of either teachers, parents or doctor's to trigger alarm.

**I AM SATISFIED ON THE BALANCE OF PROBABILITY AND FIND ACCORDINGLY THAT:**

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Alvin Naidu attempted to hang himself at his home on 10 November 2004. At the time his family had just been informed by the school that Alvin had been absent from school for seven consecutive school days. The last occasion he had attended school was 1 November 2004. Before that he had missed three days from 27 to 29 October 2004.

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His family had been unaware of his absence from school and there was concern on their part. I infer that there was also extreme anxiety on Alvin's part when it was discovered that he had been absent.

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The background situation included a relationship between Alvin and a girl at school which had broken down. Alvin had etched the girl's name in his forearm. When they discovered this, his parents had taken him to the doctor and the matter was discussed. It was considered that Alvin was coping with the situation and was not depressed or at risk of self harm. There were no indicators observed by his family, his doctor or any school personnel to indicate that Alvin was depressed or considering self harm.

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After his admission to hospital it was discovered that Alvin had also marked the girl's name into his chest. He died on 18 November 2004. An external post mortem examination was performed upon the body of the deceased, (Exhibit 4) The medical history of treatment was referred to. Dr Guy Lampe conducted the examination on 19 November 2004 at the John Tonge Centre, Coopers Plains.

He expressed the opinion that the medical cause of death was; Hypoxic Ischaemic brain injury, due to hanging on 10 November 2004.

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Alvin had attended the Sunnybank High School as a student. The school had established policies and guidelines which, in 2004, required the school to:

- a) Make telephone contact with a parent if a student was absent for three consecutive days;
- b) Send a letter to parents if a student was absent for three consecutive days.
- c) If there were further absences, contact was required with the parent and was to involve meetings.
- d) Further absences were to be dealt with by the Deputy Principal and were to attract detention, exclusions and ultimate exclusion from the school as well as referral to police.

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The school's practices in applying the school policy took considerable time so that even if the policy were adhered to there may be significant delay in any notification reaching the parent of the absence of a student.

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In Alvin's case the policy was not adhered to and it was not until 10 November that the school communicated with the family to advise them of Alvin's continuous absence since 2 November after last attending on 1 November 2004.

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I make the following formal findings-

- i. The identity of the deceased was Alvin Naidu.
- ii. His date of birth was 23 May 1989.
- iii. His address was 30 Estoril Street Robertson.
- iv. At the time of death his occupation was student.
- v. The date of death was 18 November 2004.
- vi. The place of death was Queen Elizabeth II Hospital
- vii. The formal cause of death was hypoxic ischaemic brain injury, due to hanging.

## COMMENTS

61

Mr Isdale, appearing to assist the coroner, emphasized the continuing concern over the communication between the school and parents over a student's absence from school. Even with the improvement of the automated SMS generated message to eighty per cent of parents who have mobile phones, there remains an element of uncertainty about the reliability of the follow up system to inform parents if students are repeatedly absent.

62

It was also remarked that the SMS system in place at Sunnybank High School exceeded the standard required by Queensland Education. The SMS system of notification on the day of initial absence appears to be a worthy initiative.

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Mr Kent, appearing for the Naidu family, followed on from Mr Isdale. He invited the Education Department to investigate the possibility of a software product to help monitor whether a human response has been taken to communicate with parents about a student's absenteeism.

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Ms Maloney appearing for the Education Department noted that for the twenty per cent of parents who do not have a mobile phone, there was a system of direct phone contact. She also noted the evidence of the efforts taken to constantly review and improve the system.

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Pursuant to Section 46 of the Act, the following comments are made.

- a) That Queensland Education review the minimum requirements to communicate with parents of students on each day that a student is absent from school. Qld Education consider making it compulsory to use software options generating automated SMS messages to parents indicating a student is absent.
- b) That Queensland Education assists Sunnybank High school to consider an independent or external audit of its absenteeism / truancy management communication system with parents. The audit should include a focus on whether there is sufficient feedback (both up and down the hierarchical chain within the school) to ensure that each consequential step is being taken in accordance with the school policy.
- c) That Queensland Education reviews all Queensland school's communication requirements with parents concerning the issue of truancy in light of the evidence in this inquest.

Copies of these comments are to be forwarded to:

- i. The State Coroner
- ii. The Children's Commissioner
- iii. The Minister for Education
- iv. The Chief Executive Officer for Department of Queensland Education [Section 46 (2)]
- v. Professor, Diego De Lio, Australian Institute for Suicide Research and Prevention Griffith University, Mt Gravatt Campus, Brisbane.Qld 4111.

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It is to be hoped that the family's efforts in pursuing recommendations for change will improve communications and help to reduce the chances of another similar tragedy. Alvin's death was difficult to have anticipated and a tragic loss to his family. Their efforts in assisting the research into the deaths of other young people are commended.

**Christine Clements**  
**Deputy State Coroner**

[Attachment, pages 54, 55 and 81 from transcript.]