

**A LIFE LONG SHADOW**



REPORT  
OF A PARTIAL INVESTIGATION  
OF  
THE CHILD PROTECTION AUTHORITY



3.

CHILD ABUSE CASTS A SHADOW THE LENGTH OF A LIFETIME  
*Herbert Ward*



## TABLE OF CONTENTS

<b>ACRONYMS AND DEFINITIONS .....</b>	<b>8</b>
<b>EXECUTIVE SUMMARY .....</b>	<b>10</b>
INTRODUCTION.....	10
ARRANGEMENT OF THIS REPORT.....	11
THE CENTRAL INTAKE TEAM.....	11
STRATAGEM TO REDUCE BACKLOGS .....	12
LACK OF RESOURCES .....	12
FAMILY SUPPORT .....	12
RESPONDING TO REPORTS OF ABUSE .....	13
RESPONDING TO CUMULATIVE HARM.....	13
WORKFORCE ISSUES.....	14
CONCLUSION.....	18
<b>BACKGROUND TO THIS INVESTIGATION.....</b>	<b>19</b>
RELUCTANCE OF THE DEPARTMENT.....	22
REACTION TO THE BOARD OF INQUIRY REPORT .....	24
<b>THE SYSTEM TO ACCESS HELP FOR THE WELLBEING OF CHILDREN .....</b>	<b>25</b>
CENTRAL INTAKE TEAM .....	25
THE INTAKE EVENT.....	30
THE DEATH OF MARLON CLANCY .....	31
<b>STRUCTURED DECISION MAKING TOOL (SDM) – COMPUTER CONTROL OF CHILDREN’S LIVES? OR AN IMPROVEMENT?.....</b>	<b>32</b>
BACKGROUND.....	32
LIMITATIONS OF SDM.....	33
DELAY AT CENTRAL INTAKE TEAM .....	35
<b>COMMUNITY EXPECTATIONS NOT MET .....</b>	<b>38</b>
‘DUMMY’ DOCUMENTS - STRATAGEM TO REDUCE BACKLOG .....	39
<i>Write Offs.....</i>	39
<i>Memoranda – Authorised ‘Dummy’ Forms.....</i>	40
<i>Who Authorised the Stratagem? .....</i>	41
<i>Keeping the Minister in the Dark .....</i>	42
<i>Action Taken by the Department .....</i>	46
RISKS TO UNBORN CHILDREN .....	46
<i>Marlon Clancy – History of family before his birth.....</i>	47
<i>Amanda VINCENTS: Born 7 April 1993 (Fictitious Name).....</i>	49
PATIENT ASSISTANCE TRAVEL SCHEME.....	51
CONSECUTIVE CHILD PROTECTION REPORTS.....	52
TIMELY RESPONSES TO NOTIFICATIONS .....	53
THE THIRD REPORT RULE .....	55
<b>THE POWER OF THE CHILD PROTECTION AUTHORITY TO MAKE ENQUIRIES.....</b>	<b>59</b>
ITS NOT EASY FOR PEOPLE TO MAKE REPORTS .....	61
<i>A NEW TELEPHONE SYSTEM.....</i>	61
<i>ADMINISTRATIVE OFFICERS .....</i>	63
<i>PROFESSIONALS’ PERCEPTION OF BEING UNSUPPORTED .....</i>	65
<i>EMAIL SYSTEM .....</i>	68
<i>DEDICATED EMAIL SERVICE FOR POLICE REPORTS .....</i>	69
<b>POORLY EXECUTED INVESTIGATION .....</b>	<b>71</b>
<b>DATA QUALITY.....</b>	<b>72</b>
THE IMPORTANCE OF COMPLETE AND ACCURATE INFORMATION.....	73
<i>Inadequate training in use of information technology.....</i>	77
<i>INCOMPLETE INTAKE EVENTS.....</i>	78
<b>WORKFORCE ISSUES.....</b>	<b>79</b>

IMPLICATIONS OF INEXPERIENCED WORKERS .....	79
<i>Vacancies at CIT</i> .....	79
INADEQUATE SUPERVISION OF STAFF .....	80
STAFF CLIMATE SURVEY .....	81
<i>Background</i> .....	81
<i>Key Findings</i> .....	81
BULLYING AND HARASSMENT .....	82
GOVERNMENT INITIATIVES TO IMPROVE STAFFING LEVELS .....	84
LACK OF INFORMATION PROVIDED TO PROFESSIONAL REPORTERS .....	86
OUTPOSTED INTAKE WORKER AT RDH .....	90
<b>FAMILY SUPPORT SERVICES – ‘ONE OF THESE MYSTERY PROGRAMS’ .....</b>	<b>92</b>
FAMILY SUPPORT SERVICES POLICY .....	93
ALICE YOUTH BEDS – A STEP FORWARD .....	96
TARGETED FAMILY SUPPORT SERVICES (TFSS) .....	97
<i>Has the differential response of TFSS been effective?</i> .....	98
<i>Community Child Protection Workers</i> .....	100
<i>NEED FOR A FURTHER EVALUATION OF TFSS</i> .....	104
<b>NON ATTENDANCE AT SCHOOL .....</b>	<b>105</b>
<b>WHAT IS REALLY HAPPENING TO THE CHILDREN? .....</b>	<b>106</b>
<b>TIMELY PROVISION OF INFORMATION .....</b>	<b>108</b>
<b>METHODOLOGY .....</b>	<b>109</b>
OPERATION OF MANUALS .....	109
<b>THE CHILDREN’S LIVES AS RECORDED BY THE CPA.....</b>	<b>111</b>
ABUSE/NEGLECT UNSUBSTANTIATED.....	114
NORTON FAMILY .....	115
<i>Jarrold NORTON: Born May 1999</i> .....	115
<i>Nicholas NORTON: Born October 1995</i> .....	121
RAYMOND / SMITH FAMILY .....	125
<i>Mary SMITH (aka Mary RAYMOND): Born July 2005</i> .....	125
<i>Donald SMITH: Born January 2009</i> .....	130
BERL/LISTER/HATFELD FAMILY .....	133
<i>Francesca HATFELD: Born January 2004</i> .....	133
<i>Jasper KYTE-HATFELD: Born November 1999</i> .....	139
<i>Marlon BERL (D’ced): Born August 2009</i> .....	140
ROYLSTON FAMILY .....	142
<i>Gillian ROYLSTON: Born May 2003</i> .....	142
KATIE WINSTON (REEVES) FAMILY .....	145
<i>Katie Winston: Born August 1979</i> .....	145
SMYTH/WINSTON/REEDMAN/DUNFIELD FAMILY .....	149
<i>Kim SMYTH: Born February 2002</i> .....	149
<i>Ronald WINSTON-SMYTH – Born March 2004</i> .....	152
<i>Jack REEDMAN: Born February 2006</i> .....	158
<i>Darren REEDMAN: Born December 2008</i> .....	160
<i>Craig REEDMAN: Born October 2007</i> .....	162
<i>Sam DUNFIELD: Born August 1996</i> .....	163
WALLER / CLIFTON FAMILY .....	169
<i>Tabatha WALLER / CLIFTON: Born October 2004</i> .....	169
BRIGDIN / WORLSEY FAMILY .....	173
<i>Talia BRIGDIN: Born November 1996</i> .....	173
<i>Karl BRIGDIN: Born December 2001</i> .....	175
<i>Ian WORLSEY: Born January 2007</i> .....	178
<i>Edward WORLSEY: Born February 2009</i> .....	179
LINSON FAMILY .....	181
<i>Desmond LINSON: Born March 2009</i> .....	181
<i>Tony LINSON: Born March 2006</i> .....	184
WATSON FAMILY .....	186
<i>Laura WATSON: Born September 2009</i> .....	186
PORTMAN FAMILY .....	189

<i>Emma PORTMAN: Born Jan 2009</i> .....	189
MAWLEY / FENWICK FAMILY .....	193
<i>George MAWLEY: Born June 1992</i> .....	193
<i>Jayden MAWLEY: Born May 2001</i> .....	202
<i>Derrick MAWLEY: Born July 2009</i> .....	206
ADAMS FAMILY .....	209
<i>Carla Adams: Born July 1998</i> .....	209
BRINKLE/ SAMPSON FAMILY .....	211
<i>Cassandra BRINKLE: Born July 2002</i> .....	211
<i>Phillip BRINKLE: Born February 2004</i> .....	214
<i>Ashlea SAMPSON: Born August 2006</i> .....	214
<b>RECOMMENDATIONS</b> .....	<b>217</b>
ATTACHMENT A - METHODOLOGY .....	222
ATTACHMENT B - INFORMATION GATHERING GUIDE FOR INTAKE.....	226
ATTACHMENT C - STRUCTURED DECISION MAKING TOOL.....	227
ATTACHMENT D - RESPONSE OF CPA ON FAMILY SUPPORT SERVICES 24 <sup>TH</sup> JUNE 2011 .....	231

## ACRONYMS AND DEFINITIONS

Throughout this report the 'Department' refers to what is now called the Department of Health. It was formerly called the Department of Health and Families and prior to that the Department of Health and Community Services. Prior to 1 January 2011 what was previously known as Family and Community Services (FACS) or (NTFC) Northern Territory Families and Children was a division of the Department of Health. After 1 January 2011 the Department of Children and Families was administratively created as a separate department. Throughout this report FACS, NTFC and the Department of Children and Families are referred to as the 'Child Protection Authority' (CPA). The other entities' names or acronyms are used when quoting or reproducing records.

This report also refers to the terms 'notifications' and 'intakes'. Both those terms mean a report to the Central Intake Team of the Child Protection Authority providing information that the person reporting believes on reasonable grounds that harm or potential harm to a child has occurred and/or is likely to occur.

Phrase/meaning	Acronym
Aboriginal Health Worker	AHW
Aboriginal Island Education Worker	AIEW
Aboriginal Liaison Officer	ALO
Accident and Emergency	A&E
Apprehended Violence Order	AVO
Alcohol and Other Drugs	A&OD
Acting Officer In Charge	A/OIC
Attention Deficit and Hyperactivity Disorder	ADHD
Board of Inquiry An inquiry under the <i>Inquiries Act</i> into child protection in the Northern Territory chaired by Ms Muriel Bamblett, Dr R Rosebery and Dr Howard Bath	BI
<i>Care and Protection of Children Act (2007)</i>	CPC Act
A document created by the CPA for the Ombudsman that summarised the history of contact between a child and the CPA and a summary of a child's family as at 23/12/09	CCIS File Review
Central Intake Team	CIT
Chief Executive Officer	CEO
Child Abuse Taskforce	CAT
Child Protection Authority	CPA
Child Protection Intake	CP Intake
Child Protection Investigations	CP Investigations
Child Protection Reports	CP Reports
Child Protection Team Report	CPTR
Community Care Information System	CCIS (The CPA's electronic record system)



Computerised Tomography Scan	CT Scan
Darwin Aboriginal and Islander Women's Shelter	DAIWS
Date of Birth	DOB
Department of Children and Families	DCF
Department of Health and Community Services	DHCS
Department of Health and Families	DHF
Differential Response Framework	DRF
Domestic Violence Unit	DVU
Domestic Violence Order	DVO
Estimated Time of Arrival	ETA
Failure to Thrive	FTT
Family and Community Services	FACS
Family Support / Family Support - Parenting Support	FS / FSPS
Foetal Alcohol Syndrome	FAS
Full Danger Assessment	FDA
Identification	ID
Initial Danger Assessment	IDA
A computer report that provides a list of children's names, the dates of intakes for a child and the status of an intake, eg. 'closed', 'referred'.	Intake Search Results
Intravenous	IV
Local Police Office	LPO
Manager of Child Abuse Taskforce and Central Intake	Manager of CIT
North Australian Aboriginal Justice Agency	NAAJA
Non-Government Organisation	NGO
Northern Territory	NT
Northern Territory Families and Children	NTFC
Ombudsman	Omb
Protective Assessment	PA
Royal Darwin Hospital	RDH
Sexual Assault Referral Centre	SARC
Special Care Nursery	SCN
Structured Decision Making Tool – a computer based template with rigid formulas to assess harm	SDM
The report of the Board of Inquiry entitled 'Growing Them Strong Together'	The Board's Report
When 3 notifications about children living in the same household are received in a 12 month timeframe the third report about any such child should automatically proceed to investigation.	Third Report Rule

## EXECUTIVE SUMMARY

### *Introduction*

The '*Growing Them Strong Together Report*' in October 2010 and the earlier report '*Little Children are Sacred*' together with several reports of the Northern Territory Coroner into the deaths of children have described exploitation, neglect and harm of children occurring in the Northern Territory. Those reports have analysed the underlying causes and the contributing influences. They have made recommendations about how to improve both the plight of children and the operation of the services and organisations in place to promote the wellbeing of children. Those reports have also given insight into the extent of harm, and the number of children affected.

This report was born prematurely. Like Macduff, it was '*from its mother's womb untimely ripped*'<sup>1</sup>. It was in its infancy when the *Ombudsman Act 2009* and the *Care and Protection of Children Act* were amended in the March 2011 sittings of the Legislative Assembly. Those amendments remove the power of the Ombudsman to investigate complaints about *vulnerable children* as defined in the *Care and Protection of Children Act*. Those amendments will come into force on 1 July 2011 and thereafter the Children's Commissioner will take over the role of managing complaints involving services to vulnerable children, excepting police services. I have not completed an investigation of a number of matters nor verified sufficient information to be able to report on aspects of the services to protect and promote the wellbeing of vulnerable children that I had intended.

The contents of this report do bring home that foreshadowed reforms happening as fast as is consistent with high standards must be speedy as in the meantime consequences to children at risk of harm continue unabated. Reforms so far have tended to focus on technical solutions – increasing rules, more detailed procedures, more use of decision making tools, more reviewing and monitoring more restructuring of governance with less attention to fostering the skills of frontline workers to engage with families to develop their expertise to bring about enduring improvements and to provide a working environment that respects workers for their dedication in the face of daily contact with the heart rendering sadness of the lives of many of the children they see.

It was evident throughout my investigation that there are a dedicated group of child protection workers who strive to achieve positive outcomes for children. The current shortcomings of the system should not be seen to reflect on the many dedicated staff working under difficult circumstances.

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<sup>1</sup> William Shakespeare '*Macbeth*'

## ***Arrangement of this Report***

The first part of this report is about various aspects of the child protection services. It is negative and at times critical. I am not sure whether or not it presents a balanced view between the good that is achieved and the flaws where children have slipped between the gaps. It does show some of the mistakes of the past but does so in order to throw light on the way forward. Given more time I may have been able to report on some of the strengths.

*It is easier to perceive error than to find truth, for the former lies on the surface and is easily seen, while the latter lies in the depth, where few are willing to search for it.*

J.W.Von Goethe

The second part of the report is made up of the stories of the lives of children and families and their interaction with the child protection service which is the gateway to all other services. We can consider these children as those that seem to have fallen through the gaps that have been created by underlying factors of alcohol and drug abuse, gambling, poverty, lack of education, social marginalisation, unemployment, discrimination and exacerbated by a system that was overloaded, under resourced, and concentrating on responding to reports of harm rather than early intervention to prevent it. It would not be unfair to say, as *Kenny Guinn* has

*..children who are victims of neglect, abuse, or abandonment must not also be victims of bureaucracy.*

## ***The Central Intake Team***

This section of the child protection services determines whether or not any child who is brought to the attention of the CIT will be accepted for help or investigation. I found it has been understaffed for years and still is. It did not have a modern telephone system that enables a message to be left, records conversations or has a queuing function to tell both callers and workers how many calls are waiting and how long they might still have to wait. I was informed by the CPA in response to a draft of this report that since December 2010 callers can leave a message and there is a queuing function but no recording function as yet.

Until December 2010 persons wanting to report a child who they believed might be suffering harm could send a facsimile, an email or telephone report. Now a report of harm can only be made by telephone except by police. There are two phones which ring. There are on average 6000 notifications recorded each year. There is good reason to believe the number is higher and not all reports are recorded.

A worker who answers the phone, after taking details of the report, leaves the phone – goes offline – and does not return to answer the phone until all the information required is entered into the computer system. That task averages about 30 minutes but on occasion can be much longer. If the other worker answers a phone and receives a report before the other worker goes on line, there is no-one to answer the phone.

In response to the draft of this report the CPA advised that during the day at CIT there will be five staff at CIT. If there are only five and one is a manager, one is a team leader, one is an administrative worker, that still only leaves two people to answer the phone.

NT Police notify the Intake Team daily of all cases of violence where children were present. Witnessing violence is defined as *harm* in the *Care and Protection of Children Act 'CPC Act'*. Many hundreds of these reports by NT Police are not entered into the computer system at CIT.

Recording is a key social work task and its centrality to the protection of children cannot be underestimated. Several reports to CIT about a child, especially from different people, indicate neglect or cumulative harm. Reports about siblings or children in the same residence must be at the fingertips of the worker who receives a report that a child might be in danger or at risk of harm and a decision must be made about whether to send someone to investigate or not.

The Child Protection Authority had a rule that if there are three reports about a child or children in the same household within 12 months then there must be an investigation. Someone must at least go and see whether the child(ren) are safe. There were numerous instances where this rule was not complied with. There are no longer any breaches of the rule because the rule was revoked in July 2010.

### ***Stratagem to Reduce Backlogs***

By the end of 2008 not only was there a backlog of cases awaiting investigation there was a backlog of reports about children believed to have been harmed or likely to be harmed awaiting a danger assessment.

To remove the backlog a process was authorised whereby, blank danger assessments were created, reports about children not followed up, and information not entered into the computer system for reference if a later report was made about children in the same family.

The potential risk of children falling through the gaps was greatly increased by this dummy document process. It was not until March 2011 that the records that had been written off were corrected and audited for the quality of the decisions made. It was discovered that reports which had been assessed as indicating no risk of harm to a child had been inappropriately assessed. The new Department of Families and Children have taken the necessary action to mitigate the potential risk to children arising from the dummy documents about which the Minister at the time was given misleading information.

### ***Lack of Resources***

The introduction of the CPC Act meant that lower thresholds for risk of harm were to occur. It was predicted by the Department that as a result of this more reports would be received. The Department did not increase the resources or capabilities of CIT to meet this increased demand. This in my opinion was one of the great failings of the Department. The reasons for the lack of support by the Department to the CIT team that was already under immense pressure I have not reported on because others have.

### ***Family support***

Family support is an umbrella term referring to services provided to children and families that are not investigative or statutory in nature or provided by non-government organisations and include assistance such as parent education, home visiting, financial support or housing assistance. When making a submission to me on the draft of this report Senior Executives of the CPA informed me that in the past intake workers would inappropriately enter as an

outcome of a report 'referred to family support'. That was code for 'take no action' as there was not any realistic expectation that family support services could be or would be provided.

The most glaring deficiency was that despite the aspirational objectives of the *Care and Protection of Children Act* there was not a corresponding increase in the resourcing establishment and development of Family Support Services either within Government or by arrangement for the delivery of services through other non-governmental organisations (NGOs).

### ***Responding to reports of abuse***

It appears that the drive to meet performance measures influences the risk threshold tolerated by the Department. This became glaringly obvious from the notifications reviewed by my investigators. When the CPC Act was about to become operative in December 2008 managers at CIT recorded in a memo that even though the new legislation provided lower thresholds for harm requiring action the intake service would continue using the same thresholds and the gap between the expectation of the public and what the intake team would deliver would widen further.

### ***Responding to cumulative harm***

In my view, the measures used by the Department require reconsideration to ensure that they encourage a more comprehensive approach to investigating reports in relation to cumulative harm.

It was intended that with the introduction of the CPC Act that cumulative harm would be more readily addressed. Unfortunately this has not occurred and my investigation identified several barriers for the Department when responding to and identifying cumulative harm:

- Assumptions are made that the problems identified in previous notifications are resolved at closure when in fact in many instances they remain ongoing. Further, matters are closed and outcomes recorded as "unsubstantiated" which tends to suggest that the notification was investigated and no child care protection concerns found, when in fact the matter was closed as the children or carer could not be located to conduct an investigation.
- CCIS provides a summary of previous notifications and in an overworked, demanding and stressful environment, there is a tendency not to read individual notifications.
- A review of the history of notifications made about a particular child is undertaken by administrative workers who do not have the expertise to identify a thread of similar minor events that could equate to cumulative harm.
- Introduction of a new category called 'the intake event'. This has meant that the Third Report Rule which is a procedural requirement that the Department must respond to any third report about a child when two previous reports were not responded to. The Third Report Rule was designed to identify cumulative harm, however with the introduction of the intake event the Third Report Rule has become diluted. A similar indicator of multiple notifications as showing a need for an investigation has been included in the computerised Structured Decision Making Tool. The Third Report Rule was revoked in July 2010. There is now no mandatory investigation regardless of how many notifications are made about a child.

## ***Workforce issues***

Survey results conducted with past and present CIT staff revealed that inadequate supervision is occurring. Supervision is the cornerstone to achieving quality assurance. If there are deficiencies in the supervision that is being provided it jeopardises the Department's ability to adequately monitor the services being provided to children and families considered to be at risk. The survey also indicated that the workforce at CIT were dissatisfied about a number of aspects of their working environment.

It is well known the Department has experienced dilemmas in recruiting and retaining staff, this has meant that frontline child protection work is increasingly being undertaken by the least experienced staff. Consequently it is imperative that supervision is provided and prioritised to allow these workers to have the best possible support available to perform their roles to the best of their abilities. Anything less will place children and their families at risk.

There has been emerging evidence of the unintended consequences of new decision making tools and guidance in that frontline staff feel that this has been at the compromise of their own professional judgment. Some workers have informed my investigators that their professional judgment is not seen as a significant aspect of the social work task; it is no longer an activity which is valued, developed, rewarded or motivated in the system of child protection.

Decisions about possible harm to a child that someone believes enough in to approach CIT and report are made by a formula in a computer on indicators of risk of harm given predetermined scores. The rationale is that it achieves consistency of decisions. It may well do so. The question is, are the decisions 'consistently good' to foster the wellbeing of children or consistently rigid so that children will consistently fall through the gaps.

Senior management defend the SDM and insist that it is a guide only, an aid for considering all issues and risk indicators. I can see value in the tool if that were so. The workers who use it have either not received adequate communication about the expectations of senior management or need further training in use of the SDM. Those who actually use it see it not as a useful servant but as a slave master constraining their flexibility and professional judgment. The fact that Senior Executives view it so differently indicates a need to close the divide.

This investigation saw cases of 'buck passing'. Notifications about a child were assessed as a 'police problem' or a 'school problem' even though the information provided would seem to warrant some type of response by the CPA, at the very least, a child concern investigation. Notifications were assessed as 'no further action' as it was determined that the concerns raised were not the Department's concern. My investigators were unable to locate correspondence or any other type of communication where a referral had been made to the Department believed to be responsible to enable the Department to follow up on the concerns that had been communicated to CIT.

One boy's history is indicative of how the child protection system reacted to harm that I consider is contrary to public expectation about what should be done to protect children from neglect.

- 14 notifications were made about Jarrod Norton. Of those 14 notifications 7 were made by police raising concerns about Jarrod being involved in criminal activities and his mother's ignorance of her 8 year old son's whereabouts. The details of the information provided by police and the subsequent response by the Department are outlined below.
  - 8 years old – *Jarrod located in a suburb ... in the company of two older children at 2230hrs ... other children's mother asked that Jarrod and the other child be returned home. Jarrod explained to Police that he had been at school but would not specify when he and the other children had left school. When Jarrod was returned home, his mother said that she had seen him at 1600hrs after school and that she didn't know his whereabouts after this. She didn't see why Police needed to be involved as she knew Jarrod would come home when he wanted. She had told Jarrod to be home by sunset.*

The assessment was: *this Child Protection Report was not investigated due to the allegation not constituting harm.*

[Ombudsman Comment: A child under ten is not capable of committing a criminal offence and there is no role for police.]

- 8 years & 4 months old – *Jarrod had been suspended from school but continued to go to school to steal bikes. He was staying out late at night, was implicated in disturbances and rock throwing incidents involving buses and was actively encouraging younger children to commit offences. Police asked for Jarrod to be classified as a child not under effective control of an adult.*

The assessment was: ***this was police business and not FACS business and no further action was required.***

- 8 years & 10 months old – *Jarrod was with other male juveniles at a local club and was taken home by police and left in the care of family members. No-one seemed to be concerned for his welfare. When questioned as to whether they knew where Jarrod had been all night, no person spoken to knew or cared.*

The assessment was: *Child Concern Response.*

The outcome was: *The matter was investigated and **neglect unsubstantiated with the child considered conditionally safe in the family home**<sup>2</sup>.*

- 9 years & 9 months old – *Jarrod had been arrested that morning at 0900hrs. He was found with several other juveniles breaking into a local sports facility and stealing liquor unsuccessfully. Jarrod had been out with the boys all night. Police had been trying to locate Jarrod's mother all day. The house was locked and no-one was home when police visited twice. CPA provided the address of an aunt. However, Jarrod said the aunt had moved interstate. The mother had attended the police station to report Jarrod missing.*

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<sup>2</sup> Child in unsafe situation but protective factors exist for the present time

The outcome was: *The matter was investigated and **neglect unsubstantiated** with the child considered **conditionally safe in the family home**.*

- 10 years old – *On 2 March 2009 police had responded to a call about juveniles creating a disturbance at a local service station. Police attended and found Jarrod with a number of other juveniles. The juveniles had been causing a disturbance prior to police arrival. Jarrod was returned home to the care of his mother. She was advised of the occurrence and told that CPA would be notified. At approx 1800 hrs on 5 May 2009 police responded to a call regarding juveniles attempting to assault a security guard at a local shopping centre. Jarrod was identified as one of the culprits. Police located Jarrod at a local take away food shop, where he attempted to flee from them. However, police were able to apprehend Jarrod and convey him home to his mother, who was advised of the incident and told that CPA would also be notified.*

The assessment was: *This matter not proceed to investigation as the allegations did not constitute harm; **this was a police matter and no role for NTFC**.*

- 10 years old – *On 18 May 2009 Jarrod was with three other boys. At about 10pm they went to a house in the suburbs and tried to break in. They were startled by the occupant and fled. One of the boys was caught. The three other boys then went to a local Sporting Club and tried to break in before climbing up onto the roof. They were apprehended by Police. Jarrod was conveyed home and left with his mother, who had not known of his whereabouts and did not care when he was dropped off by police.*

The assessment was: *This matter proceeds to investigation as a Child Concern Matter. However, the Manager overruled this assessment on the basis that the concerns identified were **juvenile justice issues, not issues of protection** and therefore the matter should not proceed.*

The remaining two notifications were assessed as Child Concern Response which required that an investigation commence within 5 days and be completed within 28 days. One investigation had not been commenced 7 months later while the other a period of 5 months had elapsed.

When Jarrod was 10 years old a notification from a police officer was made about his older brother Nicholas aged 13. The police officer raised concerns of inappropriate sexual activity involving Nicholas and Jarrod and an adult female who was named.

By the time this notification was received there had already been notifications on 19 May and 21 May 2009 for Jarrod.

6 days later another notification was received from a police officer about Nicholas physical relationship with a 28 year old woman.



- Sam Dunfield is another example where it was determined that there was no role for CPA.

Sam was born with Foetal Alcohol Syndrome as a result of his mother's abuse of alcohol during his gestation. Sam's mother had also been abused when she was younger.

From the age of 2 until 10 years old there had been eleven notifications to the Child Protection Authority for Sam. The fifth notification for Sam was made by a doctor who raised concerns about Sam's sexually charged and unpredictable behaviour. Sam told the doctor of an alleged sexual assault on him by three other boys two years previously. He said the boys threatened him and forced him to perform oral and anal sex and that they would kill him if he told anyone. The assessment made was that *the context of the sexual abuse was uncertain and his aunt and uncle were committed to his care and accessing the appropriate services to assist him with his behaviours there was no role for CPA at this time.* Sam was aged five at the time of this notification.

- Ten notifications were made about George Mawley. Of these 4 notifications were made by school personnel including the Principal of George's school. Of the remaining six notifications two other notifications raised concerns about school behavioural problems such as non attendance and an assault against a teacher. In one notification the assessment made was that:

***School absences were a school related matter rather than a CPA issue.***

The pain and suffering endured by these children is intolerable and shocking. Carla Adams and Mary Raymond are just a few who have endured unbearable pain and suffering which until reading the notifications of these children was largely unimaginable.

Carla Adams was brought into a remote health clinic with third degree burns five days after falling into a fire. It was recorded that Carla had received no pain relief following the incident and the wound had turned septic and was infected with maggots. The father had delayed seeking medical treatment as he did not 'get along' with one of the staff members at the clinic.

At the tender age of two years old a carer for Mary contacted CPA and explained that Mary's vagina 'looks stretched'. A medical examination was undertaken which indicated a previous hymeneal injury; that healing had produced scarring which accounted for the lack of movement in that part of the hymeneal edge and the penetration would have been by an object with a diameter greater than the hymeneal opening, being 1.0-1.2 cm and that the injury had occurred approximately 6 weeks ago. This was the sixth notification to the CPA for Mary. None of the earlier ones had resulted in an investigation proceeding.

The information in this report was given to the CPA and to the Department when it was in draft form. The CPA and the Department are entitled to be made aware of any adverse comment that I propose making and to have an opportunity to make a submission to me. I am then required to include in the report a fair summary of a submission. The submissions made addressed many matters that were not adverse comments by me. In doing so, however, more recent information was provided and, where relevant, I have included it.

Where I accepted the submission I amended the report. On reading the submission and comparing it to information received from witnesses and derived from documents, what has struck me the most is that on several issues there is disparity between Senior Executives about what is intended to happen at the frontline and what actually happens according to the frontline workers. I make this observation without any judgment on it in the hope that the lines of communication can be unclogged.

### ***Conclusion***

The stories of the children's circumstances need no comment or conclusion from the Ombudsman. They speak for themselves. The task facing the Child Protection Authority and the Department of Education and Training, the NT Police, the Department of Health, the Aboriginal Peak Body, the NGO service providers and NT Housing is huge. To find solutions the beginning lies in studying the intricacies of why the children, whose stories I describe, have so often fallen through the safety nets that exist.

## **BACKGROUND TO THIS INVESTIGATION**

In late September 2009 the Office of the Ombudsman was approached by several experienced health workers who had concerns about the operation of the Child Protection Authority and the response of the Child Protection Authority to notifications made by the health workers about children they believed were at risk of harm. Several approaches were made and the identities of 17 children disclosed. The sources wished to remain anonymous. The information was credible and the content disturbing. These approaches were during the conduct of the Northern Territory Coroner of an inquest into the death of Deborah Melville. It was apparent that what happened to Deborah Melville could easily happen again if the information provided to my office was correct.

At least two of the persons who approached my Office reported what they considered to be harassment and reprisals for their actions in speaking out both to the Children's Commissioner and to their employer about what they saw as serious deficiencies in responses to notifications of children believed to be at risk of harm. Notification at the time concerned was mandatory under the *Care and Protection of Children Act* and the health workers complained that their employer was discouraging and hindering them from making reports to the CPA.

The Opposition Party in the Northern Territory Legislative Assembly was calling on the Government to institute an enquiry into the Child Protection Authority as a result of the disclosures surrounding the death of Deborah Melville. Public announcements by the Government were to the effect that no such enquiry would be instituted. As a result of urgings to me by interested parties I decided to undertake an investigation on my own motion to protect the identity of the complainants.

On 2 November 2009 I served a Notice of Investigation on the Chief Executive Officer of the Department and on the Minister for Families and Children as required by Section 47 of the *Ombudsman Act 2009*. The contents of that Notice of Investigation are reproduced hereafter:

### **NOTICE OF INVESTIGATION**

Pursuant to Section 47 of the *Ombudsman Act 2009* notice is hereby given that it is my intention to conduct an investigation into administrative actions of the Department of Health and Families and its predecessor the Department of Health and Community Services including the sections of that public authority known as Family and Children's Services and NT Family and Children's Services (called from hereon 'Child Protection Authority' which expression includes the Department of Health and Families)

I intend to also investigate the administrative actions of the Royal Darwin Hospital (RDH) Social Work Unit, social workers employed at RDH and the policies and practices of RDH with respect to notifications to the Child Protection Authority of children who were believed to have suffered or were likely to suffer harm.

I intend also to investigate the administrative actions of Dr Howard Bath, Children's Commissioner, in connection with any report made to him, or of which he became aware during 2009, alleging that the Child Protection Authority had failed to take

adequate action after receiving a notification that a child had or was likely to suffer harm.

The administrative actions I intend to investigate include the policies, practices, systems, guidelines and actions of the Child Protection Authority for managing and responding to notifications of a child having suffered or likely to suffer harm (as defined in the *Care and Protection of Children Act* from hereon called 'the CPC Act') and without limiting that general description will include:

1. The administrative actions, as defined in the *Ombudsman Act 2009*, of the Child Protection Authority and anyone performing functions or administrative actions on behalf of the Child Protection Authority from 1 January 2007 in connection with assessing, investigating, intervening, reviewing, applying to a Court as a result of a notification to the Child Protection Authority of information to the effect that a child had been or was likely to be at risk of harm.
2. The administrative actions of the Child Protection Authority in response to notifications from the Royal Darwin Hospital (RDH) or any doctor, social worker, or other employee of RDH since 1 January 2007.
3. The systems, guidelines, policies and practice of the Child Protection Authority, the RDH and of the Children's Commissioner for the protection of persons who notified the Child Protection Authority or the Commissioner of a child believed to have been harmed or at risk of suffering harm including preventing any act of reprisal, obstruction or interference with the person so notifying or for investigating whether there had been any breach of or non compliance with Sections 27,275 or 277 of the *CPC Act* or the *Community Welfare Act*.
4. Whether any effective interagency co-operation protocols, policies systems or practice had been established and implemented with or by the Child Protection Authority for the advancement of the objects and principles underlying the *CPC Act*.
5. (1) Whether or not the Child Protection Authority since 1 January 2004 had received any recommendations from a Coroner, Dr Howard Bath or any other consultant or person whether employed by the Department of Health and Families or not in connection with reviewing, changing, improving or taking any administrative action (as defined in the *Ombudsman Act 2009*) to improve the operation, effectiveness, training, management, staffing of the Authority or to advance or improve the services for the protection of children.  
  
(2) Whether or not the Department or the Child Protection Authority had implemented any such recommendation by 29 October 2009 either wholly or partly, and in what manner.
6. The facts surrounding the health, development, physical, psychological and emotional well being of the persons identified on the attached list which is sealed and only to be disclosed to the Minister and persons authorised under Section 304 of the *CPC Act* and whether or not the Child protection Authority received notification that any child associated with, cared for by or related to the person identified was

likely to suffer harm or had suffered harm on or about the date listed or at any other time stating when.

7. Whether or not on or after 1 January 2009 any person identified on the attached list or any other child related to those persons had or was likely to suffer harm as defined in the CPC Act.
8. Whether or not any persons identified on the list or their child relatives are still likely to suffer harm and what action the Child Protection Authority has taken or intends to take to minimise that risk of harm.
9. Whether or not the RDH, or the Department has taken, or threatened any action against any person to discourage, sanction, criticise, dissuade or obstruct that person from making a notification to the Child Protection Authority, the Children's Commissioner or the Ombudsman.
10. All matters incidental or relevant to the above issues or that may arise during the investigation touching upon the purpose and object of the investigation which is to investigate whether and to what extent the Child Protection Authority is performing the functions assigned to it under the *CPC Act* and Regulations thereunder in connection with the objects and principles of that Act

Dated this 2<sup>nd</sup> day of November 2009

C A Richards

Ombudsman

Included with the notice was a list of the names of 17 children in a sealed envelope which was only given to the CEO of the Department and to the Minister. The reference to the Children's Commissioner in paragraph 3 of the Notice of Investigation and in paragraph 9 was the consequence of a report from two sources who informed me that following an approach by a health worker to the Children's Commissioner about the alleged failure of the Child Protection Authority to respond to notifications about a child the worker was subjected to harassment and unfavourable treatment in her workplace. The issue to be investigated was how the worker's employer became aware of her report to the Children's Commissioner and what processes were in place to protect persons approaching the Children's Commissioner.

Some other issues emerged during the investigation and were included in the investigation:

- Lack of information sharing between the Department and agencies such as Royal Darwin Hospital, the police and other pivotal organisations involved in the care of children.
- Inconsistencies with information provided to CIT and what was ultimately recorded in the computer system known as Community Care and Information System (CCIS).
- Notifications from professional reporters requesting assistance and intervention, not being recorded at all, or when they were recorded and assessed not being prioritised consonant with the seriousness of the risk of harm conveyed by the reporter.
- Delay in responding to a notification about risk of harm, and reports assessed as needing an investigation not acted on for many months.

After service of the notice Government announced that it was establishing a Board of Inquiry under the *Inquiries Act*. The Co-Chairs of the Board of Inquiry were Muriel Bamblett, Dr R Rosebery and Dr Howard Bath, the Children's Commissioner. In view of the fact that the administrative actions of the Children's Commissioner were the subject of a pending investigation by my office I did raise my concerns about the Children's Commissioner having a potential conflict of interest.

I was also concerned that two concurrent investigations would be wasteful and cause disruption to the operation of the Department and the CPA.

Under Section 34 of the *Ombudsman Act* if some other entity is investigating the same matters as an investigation by the Ombudsman I have a discretion to not proceed with an investigation provided I am satisfied that the other investigation will be carried out '*at a level substantially equivalent to the level at which the Ombudsman would otherwise investigate the complaint*'.

No information was given to me about the methodology to be used by the Board of Inquiry and I was not in a position to make an assessment about whether the Board of Inquiry would conduct an investigation equivalent to the level at which my Office would conduct an investigation. I sought information from the Chief Minister and from Dr Bath about the proposed Board of Inquiry, its resources, the expertise of the staff available to it and the methodology it would adopt in conducting the Inquiry. The purpose of that was to enable me to decide whether I should continue with this investigation or not. In the absence of that information being provided, three months after my notice, I commenced this investigation at the end of January 2010.

### ***Reluctance of the Department***

Initially there was some reluctance on the part of the Department and the Child Protection Authority to provide information to me. The Department obtained a legal opinion from a senior counsel at the Victorian Bar. That opinion was to the effect that I had no jurisdiction under the notice I had given to conduct the investigation.

In January 2010 I served a notice on the Department asking for production of all the records held by the Department relating to the 17 children who had been identified with the investigation notice as well as the records of their siblings. The request was for medical records as well as child protection records of any notification or contact between any of the 17 children identified or related to them. The Department replied that I did not have jurisdiction to investigate some matters set out in the notice of investigation, that the notice to produce documents was 'oppressive and invalid'. A copy of a legal opinion from a Senior Counsel from Victoria, which the Department obtained, was sent to me. I informed the Department that I did not agree with the opinion of Queens's Counsel and that if they wished to continue with their allegation that I had no jurisdiction they should take proceedings in the Supreme Court to prevent me from doing an investigation. The Minister intervened and the Department indicated that it would not pursue a challenge to my jurisdiction to conduct the investigation.

When the new CEO of the Department, Jeff Moffet, took up his position in September 2010 he directed the Department to co-operate and assist this investigation. I extend my gratitude to

him. I acknowledge that the need to provide voluminous records to me was burdensome. It was also unavoidable.

The CPA's submission to me on the draft of this report acknowledged that some of the difficulty was caused by deficiencies in the knowledge management systems of the CPA. I accept that submission. Those deficiencies ought to be remedied as a matter of priority because the adverse effect on the quality of the work of the CPA from inadequate record management will affect the welfare of children far more than it did me.

The first witness that I summonsed to give evidence to my investigation appeared with a Barrister. The witness took objection to answering questions on the ground that I lacked jurisdiction. In support of that submission she relied on the opinion of the Queen's Counsel from Victoria which had been obtained by the Department. This was despite the Barrister appearing with the witness assuring me that he was acting for the witness in her personal capacity and was not acting for the Department.

Despite the best endeavours of the CEO of the Department and the Acting Director of the Child Protection Authority, Ms Clare Gardiner-Barnes, there were occasions when difficulties were encountered in obtaining information. The *Ombudsman Act* Section 49 says that the Ombudsman may conduct an investigation in any manner which the Ombudsman thinks appropriate. I had reasons for wanting to talk direct to staff at the Intake Service rather than directing my questions to management. I had been provided with information from the Union representing staff at the CIT, CPSU. That information was that there were a number of staff who wished to provide information to this investigation but were not confident that their anonymity would be preserved and they were scared of recriminations from management within the Child Protection Authority. My investigator managed to gain the trust and confidence of the CIT workers who agreed to speak with her. Several other staff were identified as having relevant information and were sent a summons to attend at my Office and provide information.

A memo was then circulated from management advising all staff that if they were asked to provide information to the Ombudsman they should notify management and that a support person would accompany them to the Ombudsman's Office. Although the words of the memo suggested that it was an offer of support it was equally capable of amounting to a warning that staff should not voluntarily speak to the Ombudsman. I was obliged to send a letter to the authors of the notice reminding them that it was an offence under the *Ombudsman Act* to hinder or attempt to dissuade people from providing information to the Ombudsman.

On another occasion I was seeking to clarify the status and duties of a child protection worker at Royal Darwin Hospital. Inconsistent information had been given by the Department about the duties of the worker. My investigator contacted the outposted CIT worker at RDH. That worker reported that she had been told not to speak with my investigator without manager's approval obtained by the Ombudsman. I subsequently received a request from the Acting Director of the Child Protection Authority that if my investigator was to interview any staff, arrangements should be made through senior management and not by a direct approach to staff. I did not accede to this request as by that time I had doubts about the reliability of the information from management levels.

In its submission to me on the draft of this report the CPA said '*whilst acknowledging there were some occasions where this was not handled well this was not because of any intention to impede but due to uncertainty and inexperience of some staff in dealing with the Ombudsman*'.

I served a summons on the Children's Commissioner to produce records relating to an approach to him by the witness who alleged that she had been harassed as a consequence of her approaching the Children's Commissioner. The Children's Commissioner objected, on various grounds, to producing any records and quoted in his objection the opinion of Queen's Counsel to the Department. It was unusual that privileged advice to the Department was made known to an employee who was personally represented and also to the Children's Commissioner, an independent statutory officer not part of the Department. I had intended to follow up with the witness at a later date and also to follow up with the Children's Commissioner my requests for documents and information but had not done so when, in February 2011, I was informed by the Minister for Child Protection that legislation was about to be passed to remove my powers to investigate matters relating to child protection unless they involved a complaint about a police officer.

By way of response to the draft of this report the CPA submitted that '*it was appropriate to provide that [legal] advice to the legal practitioners representing individuals*'. I do not accept that submission. The CPA submission went on to say that it would have been inappropriate not to waive privilege and release the advice. I also do not accept that submission. It was privileged advice to a Crown agency paid for by taxpayers money. It had been considered by the Solicitor General and not acted on by the Minister. Release of the opinion to private individuals to challenge my jurisdiction may not have breached the letter of the Minister's undertaking to me that there would be no Court challenge to my jurisdiction on the basis of the opinion of the Victorian Counsel, it did, in my mind, breach the spirit. I do not suggest that the Minister was made aware that the opinion was given to and relied on by others.

Upon being informed of the amendments to the *Care and Protection of Children Act* removing the Ombudsman's jurisdiction I ceased any further investigation and concentrated on analysing the information collected and on writing this report so that it could be completed before the amendments took effect on 1 July 2011. There are many matters that I have not yet explored and throughout this report I have indicated what those matters are. It will be up to the CPA, the Children's Commissioner or the External Monitoring Committee to decide whether any further investigation is undertaken of the matters that have come to my attention which, in my view, need further examination to ensure that the mistakes of the past are not repeated.

### ***Reaction to the Board of Inquiry Report***

On 18 October 2010 the Northern Territory Government accepted the Board of Inquiry recommendations in its Report. The Chief Minister announced that a new agency dedicated to child safety and wellbeing would be established. The Board's report emphasised the need for early intervention to avoid the Child Protection Authority having ultimately to intervene and perform its investigative and forensic function which unfairly has come to be known in some circles by the derogatory term '*child snatcher*'.

The Board's report made numerous recommendations about improving the work processes at the Child Protection Authority and specifically approved the introduction of what is called a



structured decision making tool (SDM). After reading the Board's report and its recommendations for a transformation of the operation of the Child Protection Authority in the Northern Territory I pondered whether or not any report by me on my investigation could contribute anything worthwhile.

If the recommendations of the Board's report are implemented and the commitment of the government to do what is necessary to achieve that is maintained, a report about the way things operated before 2010 could be detrimental to the process of change. However, after release of the Board's report I was approached by a number of people who had information to provide about the Child Protection Authority and who wished to make that information more widely known. They expressed disappointment that enquiries had not been made of them by the Board of Inquiry. The Board of Inquiry's process invited people to make submissions to the Inquiry and to speak out. The people concerned thought their information ought to be aired in public and were unaware that they could have asked to provide information to the Board verbally and in confidence with an assurance from the Chief Minister that there would be no recriminations.

One witness explained:

*There was a strong reluctance to approach the Ombudsman expressed by my staff: fear of recriminations, fear of disciplinary action fear of losing their jobs.*

Such was the level of concern of these people, who were, and had been, involved in child protection services, either as workers, professionals dealing with the Child Protection Authority, or other people who personally or through their families had interaction with the Child Protection Authority that I decided to deliver this report. It describes the seriousness of consequences to children who are unable to protect themselves or look after their own wellbeing if their family, society and public agencies are unable to do it adequately.

## **THE SYSTEM TO ACCESS HELP FOR THE WELLBEING OF CHILDREN**

### ***Central Intake Team***

The central intake service is the **sole** point of access for the receipt of reports of suspected child abuse and neglect. The intention is that a team of highly trained workers make all intake decisions. The advantages of such a service is to ensure that local issues such as resourcing do not impact on the threshold for accepting a case. It has been argued that a central intake service is a means of standardising service responses and increasing accountability and evaluation of performance.

My investigation found that these benefits were not being realised. Witnesses informed my Office that decisions concerning family support referrals were influenced by the reality that such services were unlikely to be provided in a timely or effective manner and therefore were not offered or, in many cases, were not assessed and recorded as needed for a family. Instead of centralisation improving access to child protection services or family support services, CIT became a gatekeeper, almost impenetrable and certainly secretive, factors which drove health and child protection workers to approach the Ombudsman.

This report is predominantly about the Central Intake Team. The Central Intake Team is the **only** pathway to access such services as are available to achieve the objects of the *Care and Protection of Children Act*. The object of that legislation is:

To promote the wellbeing of children

Under Section 26 of the *Care and Protection of Children Act* any person who has reason to believe that a child may be at risk of harm is required under sanction of criminal penalty to notify either the police or the Child Protection Authority. One exception to the CIT as the only entry point for services is a Court. A Court may refer a child for protective assessment. The Child Protection Authority however is not required and cannot be ordered by the Court to accept a referral or to provide any services. I saw correspondence from a regional office of the CPA to a Magistrate telling the Court that it could not provide an assessment of a juvenile's circumstances because it was overloaded with work. The same office was so under staffed that it would leave its phone off the hook for hours at a time.

The Central Intake Team is located with the Child Abuse Task Force and the CAT consists of NT Police and the Manager of CIT. Unless the Central Intake Team assesses a notification by a member of the public, by a health professional, by police, or by anybody else as amounting to a child protection report no action will be taken in response to a notification. If notifications are assessed as amounting to a child protection report there are three possible responses with timeframes. These are:

Category 1 - Child in Danger:

Child is in immediate danger of harm from physical, sexual emotional abuse or neglect. Child Protection Investigation will commence within 24 hours.

Category 2 - Child at Risk:

Child is at high or moderate risk of significant harm. Child Protection Investigation will commence within 3 days.

Category 3 - Child Concern:

High, complex, ongoing needs in family yet low level of harm to child in short term, although may be long-term harmful implications. Child Protection Investigation will commence within 5 days.<sup>3</sup>

The CIT Operations Manual stipulates that once an investigation response has been identified, the investigation needs to be started within the above timeframes and completed within 28 days.

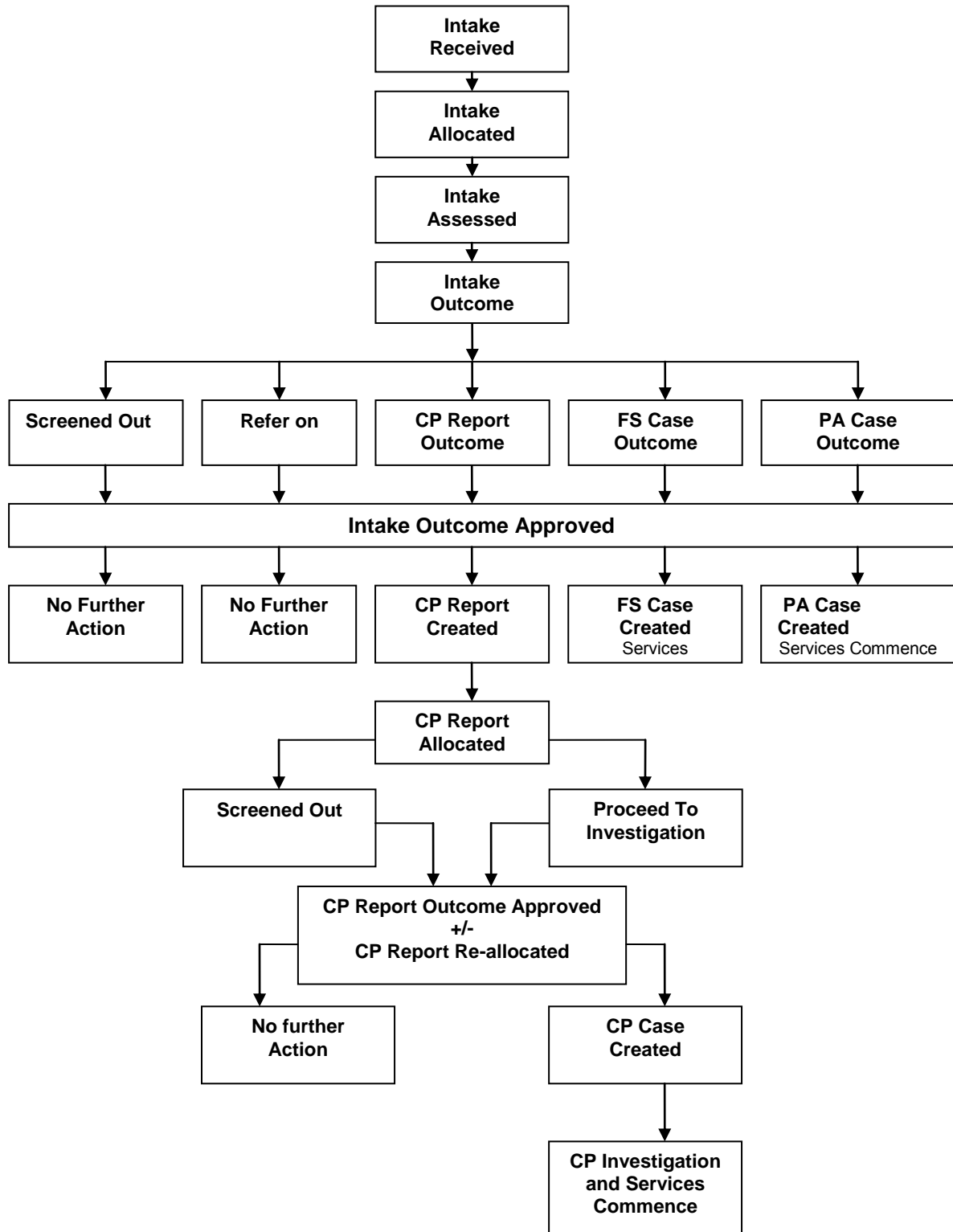
There are two other possible outcomes of a notification, namely, referral to Family Support Services or a Protective Assessment. For the purposes of this chapter I concentrate on notifications that are assessed as child protection reports.

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<sup>3</sup> Manual 2 at 7.9

The Board's Report included, as Appendix 7.1, an intake event flow chart. That chart is reproduced below. The processes outlined in the flow chart have been those in operation since 1 July 2009. For members of the public reading this report the chart needs some explanation.

### CENTRAL INTAKE FLOW CHART AFTER 1 JULY 2009<sup>4</sup>



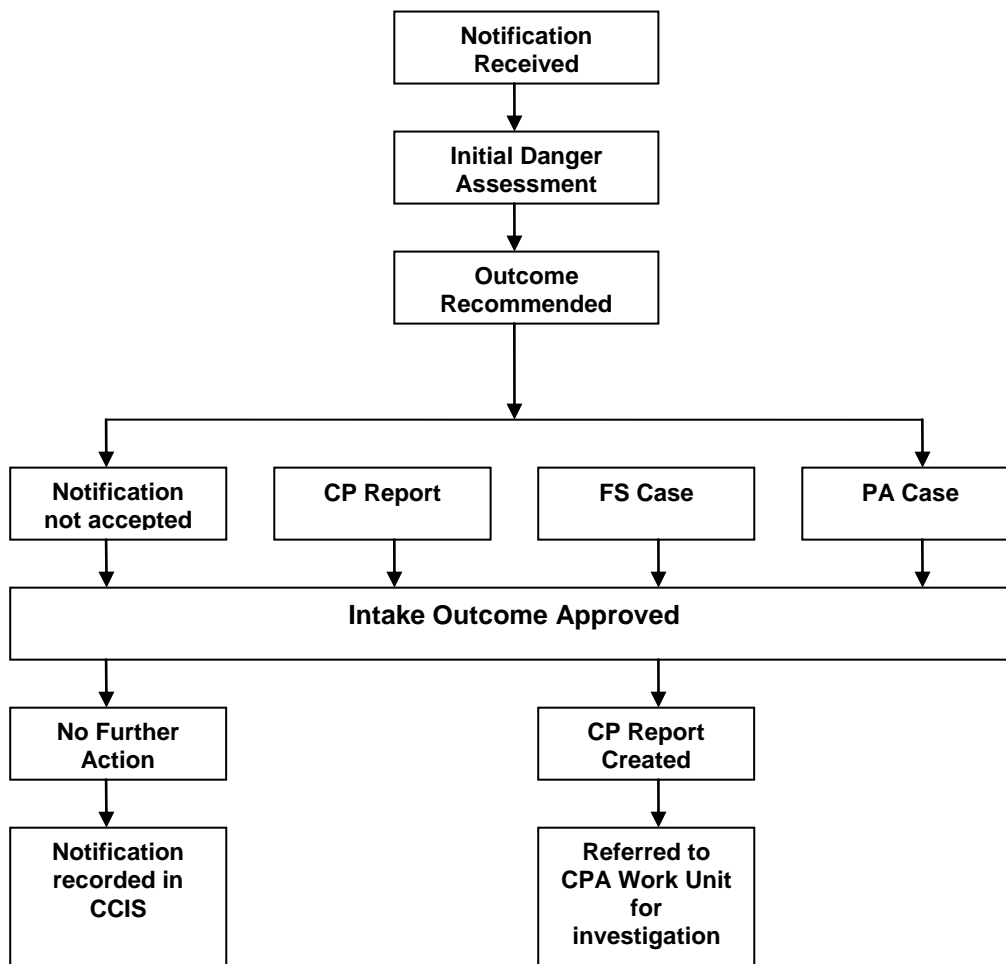
<sup>4</sup> Schedule 7.0.4 of the Growing them Strong Together Report

'Intake received' means that a notification is received by the CIT through its central phone number. This investigation discovered that there were discrepancies between how CIT was meant to operate according to policies and procedures set down in its Operations Manual and how it actually operated. The chart represents the prescribed procedure.

'Screened Out' means the information was not retained and accessed by intake workers who receive subsequent notifications.

The next chart is a flow chart showing the prescribed procedure at the Central Intake Team prior to 1 July 2009.

### CENTRAL INTAKE FLOW CHART BEFORE 1 JULY 2009



The features to be noted looking at this chart is that for all notifications received an initial danger assessment was created and documented.

The advantage of this was that even if there was no intervention and a child protection report or referral was not created the details of the danger assessment were recorded in the computer system and accessible to any worker who might receive a subsequent notification involving the same child or a sibling. By recording every single notification it meant that statistics were available of the number of notifications that were being received. Because of a

growing number of notifications coming to CIT there was also another category which is not shown in this flowchart and details of which are not contained anywhere within the records of the Child Protection Authority or the Department. These were what are known as general enquiries.

The information provided by the Child Protection Authority is that enquiries were matters that did not amount to someone reporting that a child was at risk of harm but someone seeking information about how to make a notification, what the criteria were, what the processes were and where a person could go for a particular matter. Advice was usually given to the caller. The manual refers to enquiries as:

### **General Inquiry**

*General inquiries may include:*

- *Consultations about reporter concerns where information is provided by the caller and the information does not indicate any concerns for the care and protection of a child/children.*
- *Requests for a referral to another agency for financial or accommodation assistance.*
- *Requests for information from files including subpoenas and requests from interstate authorities for Child Protection History searches.*

*Where these requests are made and there is no history of previous or current departmental involvement; a letter advising of the same is sent to the referring agency and no further action is taken. If there is previous departmental involvement, a Family Support case is created and referred to the Work Unit in the area where the client currently resides and that Work Unit is responsible for responding to the request. If there is current departmental involvement, the Work Unit holding the open case is informed of the request and of their responsibility for responding to the request.*

*Once a Primary Intake Reason is selected intake information can be entered into the Intake Event.*

As no records about the enquiries were produced and no quality assurance process in place it is not known how many times reported concerns were assessed as not indicating concerns for the care or protection of a child. Nor is any evaluation of the quality of the assessment possible. In my opinion very brief records should be kept of all inquiries as is the practice in my office. At the very least a record of enquiries is an indicator of what information should be publicly available. A number of enquiries about the same issue should result in public education by inclusion on a website or distribution of a pamphlet. One example of an enquiry would be 'The child next door, who is 8, never seems to go to school, who do I report it to?' The caller would be told to ring the Department of Education and no information entered. I discuss non attendance at school later at page 105. If no records are kept of what a worker deems to be only an enquiry no one at a senior level can review the accuracy of the decision, its quality or the time workers devote to enquiries.

In response to the draft of this report the CPA submitted that details of all enquiries are kept. I do not accept that submission. I served summonses and made informal requests for all

records of CIT relevant to the operation of the CIT. No records of enquiries were produced. My investigator sat with workers at CIT for about 5 days in all. The submission is contrary to her own observations as well as to information from CIT workers.

On receipt of a notification either by telephone, email or facsimile, the person receiving the notification, either themselves or by allocation to another staff member assesses the information obtained, searches the computer records in CCIS and completes an Initial Danger Assessment. This document should take account of all factors and information about earlier notifications for the same family. On occasions an enquiry was made of police about the children or family named in the notification. Once this information was obtained a decision was made whether to accept the notification for action as a child protection report. If it was accepted as a child protection report it was then classified either as a Child in Danger - investigation within 24 hours; a Child at Risk - investigation within 3 days; or Child Concern - investigation within 5 days.

The essential differences after 1 July 2009 are:

- The introduction of a concept called an Intake Event.
- The removal of the initial danger assessment step from July 2010.
- The introduction of the structured decision making tool in July 2010.
- The addition of a response 'Screened Out'

In my view these changes together with revoking the Third Report Rule have a risk of being a retrograde step.

### ***The Intake Event***

One change introduced on 1 July 2009 at CIT is the 'intake event'. On my examination of the records the re-classification of a 'notification' to an intake event is not just semantics. The ability to label a report from a person who believes that a child is suffering harm, or potentially may suffer harm, diminishes accountability and responsibility for taking no action. 'Intake events' distort the statistics about the number of notifications and undermines the efficacy of the Third Report Rule for a year before the rule was revoked by avoiding an obligatory investigation when a third report within 12 months is received about a child or another child in the same family.

The Department provided the following information concerning the Intake Event on 20 October 2010:

*The introduction of the Intake event on 1 July 2009 was a change in CCIS functionality. The Intake Event changed the way intakes were documented on CCIS. Prior to 1 July 2009 calls to Central Intake had to be classified as a child protection report, family support referral (including protective assessment) or miscellaneous event prior to inputting into CCIS. Each of the above was a different function in CCIS. The intake event allows all intakes to be input as an intake event and the decision about which category of intake is made at the assessment and out coming stage. The category of intake (CP, FS or PA) is able to be changed if further information is revealed through enquiries right up to the final out coming point.*

Prior to the implementation of the Intake Event, initial referrals/notifications to CPA were recorded in specific system streams. The two stream options were referred to as 'Referral In' and 'Child Protection Report'. Decisions regarding the appropriate stream were made through assessment and decision processes not recorded in CCIS.

Jay Tolhurst in his report of June 2009 said of the impending introduction of the intake event *'There are clearly significant problems with the current configuration of CCIS for the Intake Process. He also said '..... detailed field testing of the Intake Event product has not occurred. There are lingering suspicions that [it] might have some unintended consequences in actual application'.*

To illustrate the effect of the re-classification of a report to an intake event I refer to the report of the Coroner on an inquest into the death of Marlon Clancy. [2011] NTMC 90.

### ***The death of Marlon Clancy***

When Marlon Clancy was born a report by the hospital staff that his wellbeing was believed to be at risk because of the known extent to which his siblings had been subjected to a violence ridden family life; with a mother who abused alcohol and other illicit substances, gambled regularly and was not likely to care adequately for her baby, was classified as an intake event. Before Marlon's birth nine people, including professional health workers, police and neighbours notified the CPA of concerns about neglect and harm to Marlon's five year old sister and a brother, 9 years old. The report by the hospital nurses and Paediatrician when Marlon was born was treated by CIT as an intake event. It was not recorded as a report about a child potentially at risk.

If he had been born before 1 July 2009 that report from the hospital would have resulted in an investigation into the living circumstances of both Marlon and his sister as it was the 3<sup>rd</sup> report within 12 months. The necessity to do an investigation was avoided because of the introduction of the new classification. If there was need to have a new classification there is no explanation either provided to me by the CPA or that I can conceive to explain why the Third Report Rule was not changed so that there was an obligatory investigation after 3 notifications **or** intake events within 12 months. The capacity to identify cumulative harm to a child will be reduced by the 'screening out' of information and the classification of a report as an intake event.

The CPA submitted in its response to the draft report that it was not open to me to imply that the acts or omissions of the CPA in any way contributed to the death of Marlon because the Coroner did not find that. I am in no way contradicting the Coroner, but complementing his findings with the information I provide in this report. During the last few days of the hearing of the inquest I was made aware of the inquest. I wrote to the Coroner seeking leave to place all the information in my possession about Marlon and his family before him and to appear by Counsel at the inquest. The Coroner informed me, through Counsel assisting him, that he would not be examining the role of the CPA in the events leading to the death. He said he may decide to do that later. He pointed out that he was not in favour of further delay and that the focus of his enquiries was on the cause of death. I therefore withdrew my application. The Coroner's report refers to my investigation with no comment that it encroached on his jurisdiction. Accordingly I reject this submission of the CPA that I should remove from my report any reference to the circumstances of Marlon Clancy and his siblings. I will bring this

report to the attention of the Coroner as he has the discretion to decide whether or not to resume the inquest.

An Intake Event is still a notification by someone of a child believed to be at risk of harm. Calling it by another name and entering into a part of CCIS that is not subsequently automatically thrown up for a worker to consider on a later report of harm cannot change that fact, only conceal it. Both the introduction of the Intake Event and screening notifications out will distort the statistics. Comparison of the number of reports being received after 1 July 2009 cannot accurately and reliably be compared with statistics of notifications being received before that date.

I have been informed that since July 2010 the Third Report Rule has been revoked. It is now at the discretion of a computerised program to decide whether or not after three reports in 12 months an investigation is done. I consider that a safety net requiring some benchmark that crystallises the obligation to investigate ought to remain. The CPA submitted in response to the draft that the SDM will take it into account to assess harm. Nonetheless given the number of times when no action was taken to investigate children's circumstances even when the Rule existed, some safety net as a benchmark mandating an investigation is preferable. A reading of the children's stories later in this report is evidence enough of that.

### ***Recommendation***

I recommend that the Third Report Rule be reinstated to require an investigation after 3 notifications within 12 months about a child or children in the same household.

I recommend that the CPA amends its policy to prescribe that for the operation of the Third Report Rule 3 intake events within 12 months for a child or a member of the same household triggers an investigation. I also recommend that in calculating whether three intake events have occurred within 12 months any report by one or more persons notifying the same or similar information about the same child or household be treated as a single report not a duplicate report.

## **STRUCTURED DECISION MAKING TOOL (SDM) – COMPUTER CONTROL OF CHILDREN'S LIVES? OR AN IMPROVEMENT?**

### ***Background***

In November 2007, Dr Howard Bath, of the Thomas Wright Institute, provided a report to the Minister which was subsequently endorsed by Cabinet. The *Northern Territory Community Services High Risk Audit Report* contained 30 recommendations, Recommendation 1 related specifically to reviewing CPA tools and processes.

As part of responding to that recommendation the Structured Decision Making (SDM) and Screening and Priority tools were implemented in Central Intake from 1 July 2010. The tools are forms or templates that prompt a CIT worker receiving a notification about a child to consider all the factors and information that the template prompts the worker to collect and consider. Some of the information will be requested of the notifier, some will come from information already known to DFC and some from NT Police. The screening tools are supposed to take into account the accumulation of experience and the cumulative effect on



children of repeated incidents. It is understood that the tools are supposed to be used only as an aid to assess and integrate historical data relating to the child subject of the notification and any siblings, family background including previous reports/notifications, as well as caregiver risk factors. The screening tools are designed to capture parental risk factors associated with chronic neglect and cumulative harm. No form can cater for all complexities of human beings or social and family dynamics. CIT workers still need in each case to exercise professional judgement when 'ticking the boxes' of the tool. The tool, however, does not always cater for all exigencies and there is a big gap between how workers believe they must use it and how Senior Executives of the CPA expect it will be used.

### ***Limitations of SDM***

Staff explained that in order for a particular notification to be accepted it needed to satisfy a particular definition provided for in the SDM. For example to substantiate physical abuse it must be that:

*the parent or caregiver's behaviour toward the child is/was violent and raving, explosive or out of control (e.g wildly and repeatedly punching or kicking the child) and this behaviour did cause or was likely to cause serious physical injury.<sup>5</sup>*

The use of the SDM in some cases constrains the exercise of professional judgement and limits the ability of CIT workers to record matters they consider to be significant. A comparison that the public would be familiar with is a menu on a phone system when calling a bank or phone carrier. The menu items don't always fit what you are ringing about. There is a risk with the tool that experienced workers' professional judgement will be stifled and junior staff will rely on the tool only and not develop professional judgement.

The SDM tool has a discretionary override which allows team leaders to override a response assessment made by SDM. Staff explained that this facility was seldom used and team leaders were discouraged from exercising their own judgment in preference to the SDM tool. Senior Executives and the CPA submission in response to the draft of this report have impressed on me that if a worker can justify using an overriding discretion that will be respected. The workers have informed me that there are many assessments that ought to be overridden in their opinion. Recommendations to over ride the SDM are frowned on and team leaders do not readily accept recommendations. The tool itself also specifies some circumstances that justify an override (see Attachment C, page 233).

Staff members experienced with this tool explained it in interviews, the transcript of which is below:

**Staff Member:** .... In the first part of the SDM there's two parts to it, the first part you look to see whether it meets the threshold.

**Investigating Officer:** Mm, and if it meets the threshold then does it proceed to the next step?

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<sup>5</sup> NT Families and Children SDM Response Priority Definitions pg 30.

**Staff Member:** Yes then you go on to the second screening tool. As soon as its screened in you go to the second screen tool which is called the Response Priority Tool, that is when it gives you the level whether it's a 24 hour, 3 day or 5 day.

**Investigating Officer:** Are you saying sometimes you're having difficulties where your professional judgement is that the notification should be screened in for an investigation?

**Staff Member:** Yep.

**Investigating Officer:** However, when you're doing the SDM tool it's not actually allowing you to screen it in?

**Staff Member:** Yep.

**Investigating Officer:** Can you give me some examples?

**Staff Member:** An example that I struggle with is physical abuse. Physical abuse, if its extreme, and the category off the top of my head, the first part of it is, was it violent and out of control and it gives an example and the example is ranting and raving and wouldn't stop hitting. So if a child gets a couple of whacks around the head.

**Investigating Officer:** Or one single hard whack?

**Staff Member:** It can be one particular, it can be one extremely violent incident but if a child gets hit, say, four times across the face some people's definition is that is not extreme violent ranting out of control.

**Investigating Officer:** So it's quite subjective as to how people interpret the definitions provided for in the SDM tools?

**Staff Member:** It all depends on who you are talking to.

Experienced staff who spoke to my investigating officer about SDM explained that in order to achieve a decision that accords with their professional judgement they sometimes have to manipulate information to avoid the SDM undermining their judgement:

*I look at some information and it does not screen in for an investigation and I struggle to understand how that happened. I have put intakes through myself when I've written them up. We're not allowed to make the intake for the SDM. I find that very difficult not to do sometimes so I will hunt around and if you write it up the right way, because I know that it*

*should be investigated, and it worries me that I have to write the intake up in a manner to make sure it gets through.*

Staff told my investigating officers of an example of when this was done:

*A notification was received about a 10 year old girl who was in the fulltime care of her grandmother. One day this girl went to visit her mother who lived nearby. The grandmother was not aware that she had left. Upon arriving at her mother's house she found that her mother was not there but the mother's boyfriend was. He offered the girl a lift and she subsequently got into the car. At some point the boyfriend pulled over and sexually assaulted the girl.*

Staff explained that they felt conflicted about this notification. On the one hand it was extra familial but on the other hand they wanted this information to be recorded into the system as a child protection report for future consideration should the mother regain care of the child, rather than record the information as an intake event only. Consequently in order to have it accepted by SDM the alleged perpetrator was recorded as the grandmother as a failure to adequately supervise the child despite intake workers feeling that she had not failed in her supervision.

To explain how staff are required to interpret the structured decision making tool I have attached several pages from the guidelines for the use of the SDM tool<sup>6</sup>. Consideration of these guidelines:

- demonstrates that exposure to dangerous drugs paraphernalia
- exposed electrical wires
- evidence of human or animal excrement in the living quarters
- substances or objects are accessible to the child that endanger health/safety
- a current parent/care giver has previously had a substantiated report for serious abuse or neglect of a child in his/her household
- there have been three or more prior non-malicious child protection reports AND a new child has been born

are all examples of harm. Throughout the investigation there were examples that fitted these categories but which were not assessed as requiring any action by the CPA. This will be apparent on reading the stories of the children which are related in the second part of this report.

Senior managers at the CPA view the SDM as a guide only. Intake workers that spoke to the Ombudsman's Office see it as a constraint. This division of opinion needs to be addressed as there appears to be a chasm between those at the top and those using the tool.

### ***Delay at Central Intake Team***

The Board of Inquiry has reported on the extent to which timeframes for commencing investigations within 24 hours, 3 days and 5 days were not met. The Board of Inquiry has further reported that even once the matter had been referred for a child protection report to

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<sup>6</sup> Figures 4 & 5 Structured Decision Making Model, California Family Risk Assessment at Attachment C.

a CPA work unit or regional office there was a backlog in the order of some 800 cases at the time the Board of Inquiry collected its information. The Coroner's report on the inquest into the death of Marlon Clancy referred to a backlog of cases awaiting investigation and the CEO of the CPA has confirmed that although 870 cases had been completed by 29 May 2011 the backlog was still 290 outstanding investigations.

My investigators, on perusing what statistics were available and the records, discovered that compliance with the timeframes was the exception rather than the rule. In many cases the response time was months rather than days outside of the benchmarks.

The Child Protection Authority management and staff were aware of its inability to respond in a timely manner to notifications. The Department commissioned a consultant expert in child protection, Mr J. Tolhurst, to prepare a report relating to the Intake Service and how it could be improved. The Tolhurst Report was delivered to the Department in June 2009 but up until the end of 2010 very few of its recommendations had been implemented. The Tolhurst Report refers to how dire the situation was at CIT with respect to entering notifications into CCIS. The Tolhurst report identified nearly every problem with CIT that I have reported on and has pointed out solutions for many of them.

Implementation of recommendations in a report commissioned from Dr Howard Bath, then of the Wright Institute dated November 2007 have also not been achieved. The reports of Tolhurst and Dr Bath are written in terminology appropriate to consultants advising the Child Protection Authority on processes and procedures and assumes the recipient of the report has professional experience of child protection and of an intake service specifically.

To others not so familiar with the system what is not apparent is how the defects those reports describe were affecting protection and the wellbeing of children. It is understandable that those reports do not go into detail about specific cases. They did not need to. I have decided to disclose details of a number of cases. Without describing the human dimension, discussions about Family Strengths and Needs Assessment Tools, Targeted Family Support Services, the Differential Response Framework, or Structured Decision Making Tools do not have immediacy or inform the general public how in reality these technicalities affect children and families in the real world.

### **WHAT IS HARM? – THE CARE AND PROTECTION OF CHILDREN ACT**

The *Care and Protection of Children Act* came into operation in December 2008. The objects of the Act are set out in Section 4 as follows:

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

These objects created a new threshold for providing services and responding to notifications from people about children in the Northern Territory. The principal object is to promote the wellbeing of children. The concentration to date and prior to the Act was overwhelmingly on the object:

‘4(a)(i) to protect children from harm and exploitation.’

Little effort has been given to promoting the welfare of children or to maximising the opportunities for children to realise their full potential or assisting families to achieve those objects. The Board’s Report has outlined a blue print to move the focus to promoting welfare and away from the narrower object.

The *Care and Protection of Children Act* did introduce lower thresholds for providing services and responding to notifications. The CPC Act also expanded the obligation to notify the CPA or police if there was a belief that a child was at risk of harm. The *Care and Protection of Children Act* relevantly states:

### **26 Reporting obligations**

(1) *A person is guilty of an offence if the person:*

(a) *believes, on reasonable grounds, any of the following:*

(i) *a child **has** suffered or **is likely to suffer harm** or exploitation;*

(ii) *a child aged less than 14 years has been or is likely to be a victim of a sexual offence;*

(iii) *a child has been or is likely to be a victim of an offence against section 128 of the Criminal Code; and*

(b) *does not, as soon as possible after forming that belief, report (orally or in writing) to the CEO or a police officer:*

(i) *that belief; and*

(ii) *any knowledge of the person forming the grounds for that belief; and*

(iii) *any factual circumstances on which that knowledge is based.*

*Maximum penalty: 200 penalty units.*

The lower threshold prescribed by the *Care and Protection of Children Act* has not been applied by the Child Protection Authority since the Act came into operation.

The definition of ‘harm’ in the *Care and Protection of Children Act* is:

(1) *Harm to a child is any **significant detrimental effect** caused by any act, omission or circumstance on:*

(a) *the physical, psychological or emotional wellbeing of the child; or*

(b) *the physical, psychological or emotional development of the child.*

(2) *Without limiting subsection (1), harm can be caused by the following:*

(a) *physical, psychological or emotional **abuse or neglect** of the child;*

(b) *sexual abuse or other exploitation of the child;*

(c) ***exposure of the child to physical violence.***

*Example: A child **witnessing violence** between the child's parents at home.*

## **COMMUNITY EXPECTATIONS NOT MET**

In late 2008, staff meetings were held at CIT in which the pending introduction of the *Care and Protection of Children Act* was discussed. Lower thresholds for deciding if a child was at risk of harm were to be introduced by the CPC Act. A note prepared for a management meeting scheduled for 29 October 2008 from the two senior managers at CIT contained the following:

### **Issues impacting or likely to impact on CI**

#### **1. New legislation**

- The broadening of the definition – from maltreatment involving a parent/caregiver to, harm and wellbeing without the prerequisite of parent/carer involvement.

#### **Issues**

- Likely increase in reporting, particularly by agencies such as Police, Child Care Centres, Schools and Clinics.
- **NTFC thresholds for CP investigations to remain the same, thus the disparity between what the community will expect NTFC to do and what will actually be done will likely increase further.**

It is not surprising that the lower thresholds for accepting a notification as a child protection report were not acted on by the Child Protection Authority. The staff at the CIT were inundated with notifications prompted by the expectations of those notifying that some action would be taken. No greater resourcing or staffing, training or enhanced systems were provided to respond to what was predictably a large increase in notifications following the introduction of the CPC Act. The *Community Welfare Act* did have provisions requiring mandatory notification but the type of harm to be notified was considerably less than the potential risk of harm to a child defined in the *Care and Protection of Children Act*. The note describing the disparity between community expectation and CIT's capacity was written **before** the introduction of the CPC Act. No explanation has been discovered to explain why the senior managers were stating that the thresholds would remain as before. In other words, why the intention of CIT was to not implement the legislation.

The most glaring deficiency was that despite the aspirational objects of the *Care and Protection of Children Act* there was not a corresponding increase in the resourcing establishment and development of Family Support Services either within Government or by arrangement for the delivery of services through other non-governmental organisations (NGOs). The Board's Report has emphasised the need for early intervention support services

and my investigation confirms that development of such services is urgent and critical but not progressing with any urgency.<sup>7</sup>

On 24 June 2011 the CPA submitted in response to this comment by me in the draft report that *'At the current time [June 2011] the Department does not have an evidence based framework to guide future investment in the non-government sector'*. The CPA expects to complete a Strategic Investment Framework in 2011. It went on to say:

*'The Framework will:*

1. *establish the Department's service footprint*
2. *help identify critical service groups*
3. *facilitate development of an investment in end-to-end services that meet clients needs across the life cycle; and*
4. *build capacity across the sector to partner in delivery an expanded range of prevention and early intervention services.*

*The Framework will be implemented over the coming 18 months.'*

I have included the whole of this submission as Attachment D. I quote again Kenny Guinn *'... children who are victims of neglect, abuse or abandonment must not also be the victims of bureaucracy'*. I have not altered the comment I made in response to the CPA's submission because the submission does not convince me that even yet there are established family support services. In fact the submission confirms that they, at the very least, are 18 months away.

### ***'DUMMY' DOCUMENTS - STRATAGEM TO REDUCE BACKLOG***

To demonstrate how overtaxed and inundated the Child Protection Authority was in late 2008 and early 2009 I report the following stratagem adopted by the Central Intake Service to reduce the known backlog of notifications about children that had not been recorded on CCIS which is the knowledge management computer system for the CPA. These are reports of harm to children, in addition to the backlog of 800 investigations.

#### ***Write Offs***

When a notification is received and assessed by an intake worker it is entered into a spreadsheet on a computer which is referred to as the Whiteboard to indicate that the intake is ready to be reviewed by team leaders. No action was taken on a CP report until the initially recommended response had been approved by a team leader.

From 2008 onwards the whiteboard began to have a 'backlog' of cases that had not been finalised by the team leaders at CIT. They had also not been recorded in CCIS, hence were not accessible to other workers. The Department advised *it is likely that this was contributed to by the fact that a 68% increase in reports was experienced during the 2008/2009 period* and low staffing levels. However, this backlog existed before the lower threshold and definition of harm in the CPC Act and extended mandatory reporting had come into operation.

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<sup>7</sup> Report on six month's progress – Child Protection Reform: Progress Report Volume 1, April 2011, and attachment D – page 233 of the report

Often intakes that were initially assessed as not requiring an immediate response remained on the whiteboard for long periods of time; some were there for months. My investigation discovered that approximately 400 were written off between 24 October 2008 and 31 December 2009. Cases were 'written off' and a 'dummy intake' completed for the notifications received in order for these notifications to be shown as 'closed'. The matters 'written off' were not reviewed by a team leader to check that the initial assessment of 'no immediate response' was appropriate.

The CPA submitted in its submission on this draft report that they were checked by a team leader. I do not accept that. It is contrary to the information provided to me by the (then) Acting Director of CPA and contrary to the report of Jay Tolhurst, June 2009, pages 34-35.

The Department gave me a report on the number of notifications that were written off with dummy documents:

- a) During the period 01/09/2008 – 30/03/2009. **238 CP Reports/referrals** were managed according to the memos dated 24<sup>th</sup> October 2008 or 5<sup>th</sup> January 2009. This is a count of reports not children.
- b) During the period 01/09/2008 – 30/03/2009, **367 Distinct Children** were subject children within a CP Report or Referral that was managed according to the memos dated 24<sup>th</sup> October 2008 or 5<sup>th</sup> January 2009.
- c) **343** 'children in reports' were subject to a previous or later notification. \*note: this is a count of children in reports, this may result in individual children being counted more than once.
- d) **287** 'children in reports' had siblings that were subject to a previous or later notification. \*note: this is a count of children in reports, this may result in individual children being counted more than once.
- e) **1** child named on an existing OMB notice has a CP Report or Referral managed according to the memos dated 24<sup>th</sup> October 2008 or 5<sup>th</sup> January 2009.
- f) The intake history of every person (and sibling) subject to a CP Report or Referral managed according to the memos dated 24<sup>th</sup> October 2008 or 5<sup>th</sup> January 2009 has been printed and stored in hard file for future reference (238 records).<sup>8</sup>

### ***Memoranda – Authorised 'Dummy' Forms***

While reviewing intake records my investigating officer found blank assessment of risk forms with the notation 'Refer to Memo sent to Senior Manager, Darwin Urban 05/01/2009'. The memo of 05/01/2009 was an extension of an earlier memo of 24 October 2008 about writing off notifications with dummy forms.

There were 388 reports of children believed to be at risk of harm, details of which had not been entered in the computer record system as at 24 October 2008. The great majority of those had been notified prior to 1 October 2008 and had not been approved by a team leader or any action taken. A number dated back to June 2008.

The relevant part of the memorandum of 24 October 2008 which initiated this stratagem is reproduced below:

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<sup>8</sup> These are past notifications. See page 46 'Action taken by the Department'



**MEMORANDUM****TO:** SENIOR MANAGER, DARWIN URBAN AND NT WIDE SERVICES**FROM:** MANAGER, CHILD ABUSE TASK FORCE AND CENTRAL INTAKE**DATE:** 24 OCTOBER 2008**RE:** BACK LOG IN CENTRAL INTAKE

*Due to the current and on going staff shortage in Central Intake which has seen the number of reports yet to be entered on CCIS rise to 388 as of COB 17:00 on 23 October, it is requested that you sanction the following actions:*

*All matters currently on the CI 'whiteboard' that were first reported prior to 01 October and have been initially assessed as to not proceed, are to be dealt with in the following manner:*

- 1. A CP /PA/ FS report will be created against the relevant client.*
- 2. The first page of the CCIS CP /PA/ FS report will be completed, including notifier's ID and a brief description of the allegation eg 'possible DV'.*
- 3. A **dummy Intake form** will be added to the CP report. There will be a statement already on this form advising any reader to refer to a memo (with TRIM Ref No) from you supporting the actions described here.*
- 4. No IDA will be completed. [IDA – Initial Danger Assessment].*
- 5. The report will then be outcomed by either the Intake Team Leader or the CAT Manager as 'insufficient information' or 'Not Accepted - other' in respect of an FS with the comment 'No NTFC response possible at this time'.*

**Who Authorised the Stratagem?**

Because I considered that the stratagem of using dummy reports to clear a backlog was a serious departure from good practice and was risk prone for the welfare of the children concerned I summonsed two witnesses who were in management positions at the CPA in October 2008 and January 2009. Records indicated that these witnesses ought to know who authorised this departure from accepted standards. The memo of 24 October 2008 was to the Senior Manager, Darwin Urban and NT Wide Services from the Manager, Child Abuse Task Force and Central Intake. I asked the Child Protection Authority who held those positions on 24 October 2008.

In order to give me that information the Authority provided me with the leave records of several of their officers. There were numerous periods of absences on leave and people in acting positions. The person identified as the Senior Manager of Darwin Urban and NT Wide Services on 24 October 2008 was summonsed and asked about the memorandum. It was clear that someone authorised the process of using dummy documents but the Senior Manager to whom the memo is addressed denied on oath that she had authorised it. She had no memory of receiving the memo and said that if she had received it, because it was a departure from accepted procedure, she would have referred it 'up the line'. She was unable to name a person to whom she would have referred it.

I made an enquiry of the Child Protection Authority to produce any email or other document recording who had authorised the use of the dummy procedures and I was told that there was no access to emails at that time in the archives because of a change within the Northern Territory Government from using Lotus Notes as the platform for messaging to Microsoft

Outlook. I do not accept that explanation as my office also changed its messaging system from Lotus Notes to Outlook and has been able to retrieve old email messages within minutes. I also note that the authorising memo was supposed to be in TRIM, in other words, in the permanent database for records not just in the email system.

The Manager, Child Abuse Task Force and Central Intake at the time had left the Child Protection Authority and was interstate. Being out of the Northern Territory jurisdiction I was unable to summons that manager to provide me with information. However, the Manager voluntarily provided information by email in which he stated that the adoption of the dummy procedure was specifically authorised by the Minister and that he had seen the memo from the Minister with the Minister's approval on it. This was not the truth at all. The Minister only noted what the CPA told her, which itself was not the whole truth.

### ***Keeping the Minister in the Dark***

I then sent a summons to the Child Protection Authority to produce all Ministerials passing between the Child Protection Authority, the Department and the Minister that might relate to this topic. I was provided with a memo to the Minister dated 13 January 2009. My interpretation of this document was that the Minister was not adequately informed by the Department as to what was occurring.

The Minister, in December 2008, had asked for a briefing about the CIT process and backlog. On 13 January a seven page briefing was sent to her. The relevant parts of that briefing were:

*'A centralised NT wide Intake team was created to enhance practice quality and consistency in receiving and decision making relating to child protection notifications.'*

*'The Central Intake Process:*

*Reporters can make notifications to CI team via:*

- *freecall number:* 1800 700 250
- *generic email account:* FACS [intake@nt.gov.au](mailto:intake@nt.gov.au)
- *facsimile:* 8922 3766'

*'Intake workers can make further enquiries in order to make an informed assessment of the child's safety. Information can be sourced from anyone, however further contacts are typically directed towards professional sources eg the child's school, health centres or Police.*

***All** notifications are assessed using an Initial Child Danger Assessment, which is a professional tool that assists staff to make informed judgements about:' ...*

*'The CI Team Leader and/or Manager read **all** notifications, because it is an NTFC policy requirement that these positions review notification outcomes including the response priority and date and time of the outcome decision. Based on the information that has been collected, and the preliminary assessment of the intake worker, these positions make a professional decision on the final outcome to be allocated to each notification. A notification receives one of two outcomes, either:*

- a) *proceed to a child protection investigation; or*
- b) *do not proceed to a statutory investigation.*

Those notifications that proceed to investigation are then allocated a prioritisation rating as follows:

- *Child in Danger – investigation to be commenced within 24 hours;*
- *Child at Risk – investigation to be commenced with 2-3 days; and*
- *Child Concern – investigation to be commenced within 5 days.*

*All child protection notifications allocated a Proceed to Investigation outcome, are then forwarded to the NTFC Work Unit.'*

*'Notifications that do not proceed to investigation are allocated this outcome for one of the following reasons:*

- *Allegations would not constitute maltreatment;*
- *Child / family moved interstate;*
- *False allegation; and*
- *Insufficient information.'*

*'NTFC has a policy that if within a twelve month period there have been two prior notifications about the same child that did not proceed to investigation the third notification will receive a proceed to investigation response.*

*All notifications are recorded on the Community Care Information System (CCIS). This serves to ensure that there is a chronology of the concerns about a child over time. Where a notification does not proceed to investigation, there is essential information to assess whether there are any emerging patterns regarding the risk of harm to the child over time.'*

***Backlog of low risk notifications:***

*There is a current backlog in the order of 380 notifications that have yet to be formally outcomed and entered onto CCIS. These notifications have had a preliminary assessment by the receiving worker that they do not require a proceed to investigation outcome.*

*All notifications not outcomed immediately are recorded on a spreadsheet to track workflow.*

*The NTFC Service System Improvement Unit conduct monthly quality audits of the CI Teams compliance with approving the outcome of the notifications within 24 hours..... The November 2008 audit sampled 296 **notifications**.<sup>9</sup>*

*and revealed that:*

- *100 percent of Child in Danger notifications were outcomed within 24 hours*
- *58.8 percent of Child at Risk notifications within 24 hours; and*
- *9.7 percent of Child Concern notifications within 24 hours.'*

*Activities being undertaken to reduce the backlog:*

*Planned strategies to reduce the current backlog of notifications are discussed at Attachment A.*

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<sup>9</sup> *Ombudsman Note: Not the 380 that only had handwritten notes and not entered into CCIS*

*A new Quality Auditing system across child protection and out of home care services commenced in April 2008 and has produced eight audit reports to date..... Low compliance against the eight standards has been reported in most work units each month.'*

**Attachment A**

**Shorthand recording of notifications:**

**Target:** *All outstanding child protection notifications received up to 31 December 2008 are outcomed and finalised on CCIS.*

**Strategy:** *A time-limited strategy to be applied throughout January 2009, which involves the **shorthand data entry of these notifications into CCIS.** (My emphasis.)*

*This is a time-limited approach to dealing with the volume of notifications which are **a month old** have been assessed as not proceeding to investigation and not yet entered on to CCIS.*

[Ombudsman Note: Many were 3-5 months old.]

*Given the **absolute requirement** that these notifications are recorded for future reference, these notifications are being entered into CCIS in '**shorthand**'. This still ensures that the details of the notification date, the client, the notifier, an abbreviated summary of the concerns and the outcome of the notification are recorded on the core CCIS panels. However, the action to record these details longhand into a separate Intake document is not occurring for this **sample** of notifications. (My emphasis.)*

*This methodology is strictly limited to those notifications assessed as not proceeding to investigation. This practice ensures that should further reports about the same child come in, the previous report can still be factored in to the risk assessment and enables the functionality of the third report to remain active.'*

The information given to the Minister could not be described as accurate.

- The describing of entering blank dummy documents into the records as 'shorthand' was misleading.
- The effect of the dummy documents meant that a number of other statements were misleading. For the 380 notifications that were the backlog in January 2009 the 'shorthand' had consequences that were obfuscated and masked. The statements concerned that did not apply to the 'shorthand' matters were:

(1) **All** notifications are assessed using an Initial Child Danger Assessment.

(2) *Intake workers make further enquiries – typically directed towards professional sources, eg, the child's school, health centres or police. **No** further enquiries were made for the shorthand cases.*

- (3) *The CI Team leader and/or Manager read all notifications ..... these positions make a professional decision on the final outcome to be allocated to **each** notification.* This did not happen.
- (4) ***All** notifications are recorded on the Community Care Information System ..... Where a notification does not proceed to investigation there is essential information to assess whether there are emerging patterns regarding the risk of harm to the child over time.*
- (5) 'The November 2008 audit sampled 296 notifications and revealed.....'  
The figures are misleading as there were over 380 notifications not entered into CCIS and a random audit of a sample in March 2011 revealed that not all of them should have been assessed as 'not to proceed'.
- (6) *The 'shorthand' entry into CCIS for future reference 'still ensures that the details of the notification date, the client, **the notifier** an **abbreviated summary of the concerns** are recorded.*
- [Ombudsman Note: Summaries and the notifier were not entered on many of the cases produced to the Ombudsman. Only a small sample of these dummy forms had been examined at the time this investigation ceased. **There were twelve archive boxes of handwritten records not entered in March 2011.**]
- (7) In Attachment A the matters being treated by the 'shorthand' method are referred to as '*this **sample** of notifications*'. The number involved was not aptly called a 'sample'.
- (8) The Minister was not informed that in all such cases no referral would be made for family support services and the records marked '*No response possible at this time*'.
- (9) The Minister was told this strategy would be applied throughout January 2009 when in fact it had been applied since October 2008.

The information bolded above was in my view likely to hide the true situation from the Minister. A reasonable person considering the Briefing as a whole would assume that the statements about 'all notifications' applied equally to the 'shorthand' notifications. The terms of 'Attachment A' did not disclose how and to what extent the dummy records could increase the risk of harm to the children.

One of the functions of the Ombudsman is to address inappropriate administrative actions of agencies. I can think of nothing more inappropriate in public administration than an agency providing misleading information to it's Minister. Such an action undermines the operation of democratic government, the Public Service Code of Conduct and proper public administration. Even if the information provided was inaccurate unintentionally the result was the same. The Minister was deprived of the opportunity to know all the facts and to act.

In case the Minister wishes to follow up this issue the Ministerial Reference is 2009/0020 MBM.

In its submission on the draft of this report the CPA referred to the report of the Children's Commissioner on the intake service delivered in December 2009. The Commissioner's report referred to the practice and said it was not good practice. His report explained the reasons why it occurred. The CPA infers that he justified the practice. I do not accept that as the correct interpretation of his report. The CPA further submitted that the terms of the memo are suggestive of poor expression of an intent honestly conveyed. I leave that issue to the Minister.

Despite efforts to find out who approved the stratagem I was unable to do so. A similar memo on 5 January 2009 extended the period for which the dummy records could be created up until the end of January 2009. I note, however, that write offs and dummy documents appear in the records right up until December 2009.

I also found it of interest that when the Manager for the Child Abuse Task Force and Central Intake and the Senior Manager of Darwin Urban and NT Wide Services came in response to a summons to answer questions they were accompanied by a Barrister who was retained by the Child Protection Authority. When asking information from the Manager who had moved interstate he also advised me that he would not be responding until he had had an opportunity to obtain advice from the Barrister who had been retained by the Child Protection Authority at its cost to represent any staff who requested advice or legal representation.

### **Action Taken by the Department**

A greater issue than calling to account the people responsible for the departure from all accepted standards was correcting the records.

At my request the Acting CEO of the Child Protection Authority, Clare Gardiner-Barnes, in early 2011 undertook an audit of a sample of these dummy intakes to *identify whether an appropriate initial assessment of these reports had been made*. I was informed:

*In March 2011 thirty 'written off intakes were randomly audited using interval sampling methodology. A summary of notified concerns was recorded on the electronic client information system for each of these thirty clients as part of the audit process. This will ensure that a full history of reported concerns will form part of any assessment of risk if future contact with these clients occurs. The audit identified some quality errors in process and in the accuracy of assessments, and as a result the Department will thoroughly review all 'written off' intakes.*

I was informed that there were twelve boxes of handwritten notes which contained the **only** records of hundreds of notifications written off. That information only confirmed the inaccuracy of the information provided to the Minister. I commend Ms Clare Gardiner-Barnes for taking the steps to ameliorate the risk to the children involved.

### **Risks to unborn children**

Another example of the Department not adhering to its own policy is in relation to the steps to be undertaken when information is received about an unborn child believed to be potentially at risk of harm.

The CPA Operations Manual 2 (December 2008) provided that:

*Reports made before the birth of a child that identify risks to the child after their birth should be recorded on CCIS and referred to an NTFC work unit for follow up if appropriate. The purpose of recording these reports is to allow assistance and support to be provided to the family to reduce the likelihood of the child of being harmed when born. The work unit may need to plan Child Protection action in advance of the birth and liaise with maternity services.*

*The unborn child can be created as a 'person' i.e. 'baby of parent on CCIS but not a 'client' or 'case' as essential information about gender and date of birth are not yet available. Therefore the only possible outcome is 'Forward On'. If this option is pursued it is important to include a search of, baby of for Child Protection Reports involving young children.*

A similar provision is contained in the current manual, September 2010, although not as prescriptive. In the current manual there is no reference to organising a child protection plan or liaising with maternity services.

The consequence of non-compliance with the policy may have been a factor leading to the death of 8 weeks old, Marlon Clancy in October 2009. The Coroner reported on the inquest into the death of this child on 13 May 2011. This is the background shown in the CPA records:

### ***Marlon Clancy – History of family before his birth***

In May 2009 a neighbour reported to CIT information about a five year old girl, Marlon's sister to be, Francesca:

- *'The child has seen her mother have the crap bashed out of her'.*
- *For the last 4 weeks, the child's mother has been 'non-stop drinking and smoking marijuana'.*
- *The child's mother has been so intoxicated recently that she has shit herself and continued to sit in it.*
- *The mother has been asking people for money to buy more drugs and when they say no, she has been getting abusive towards people.*
- *The place the child and her mother live in is supposed to be alcohol free, as there is a Govt sign stating this.*
- ***The child's mother is also 5-6 months pregnant.***
- *The mother's partner (the one that beat her up) is now out of jail and living back with her and the child.*
- *The mother often has sex with random men and when she does so, she's really noisy-cries out loud.*

- *The child's mother is also actively seeking sexual partners when her child is with her.*
- *The mother also talks dirty in front of Francesca saying things like 'f\*\*ck, f\*\*ck, f\*\*ck' and 'stick your cock in my arse.' The mother talks about 'f\*\*cking in front of Francesca and in detail'. The mother's attitude is that the child is going to grow up one day.*
- *The child's mother is gambling too – she will go missing for a few days after payday.*
- *The child has lost weight in the past couple of weeks but is clothed.*
- *Most nights the child plays in the car park until about 8pm.*
- *The mother's partner has recently been caught prowling around people's places and looking in bathroom windows.*
- *The child's mother owes everyone money.*

Although the notification outlined that the mother was pregnant and despite there being 8 earlier notifications about Francesca and another 4 notifications including a substantiated report of abuse about a son 4 years older than Francesca no information was recorded in CCIS regarding the impending birth of Marlon. Consequently no information was forwarded to a work unit so that a child protection plan could be considered in consultation with maternity services. This notification resulted in a child concern assessment and was sent to a work unit for investigation.

Four months later another notification was received when Marlon was born. The notification was made by a nurse on the direction of a Paediatrician about concerns regarding the mother's abuse of alcohol and illicit drugs and her lack of capacity to care for the newborn child. On 8 September the Acting Manager of CIT in an email to the Acting Manager at the Casuarina office wrote:

*Please note this information is in addition to Intake #17718 - a current Child Concern Report allocated to your office. The new information has been recorded as an Intake Event only.<sup>10</sup>*

Essentially the Acting Manager was referring the information received regarding Marlon to be added as information to the report made about Francesca on 22 May 2009. 56 days after this referral was made Marlon died. Seven days elapsed before any referral was made. The Department advised my office that:

*An Intake Event is recorded if the report does not contain any information to indicate that a child is in need of protection and if it does not indicate that a Family Support or Protective Assessment case should be created.<sup>11</sup>*

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<sup>10</sup> The intake number recorded in this email was incorrect.

<sup>11</sup> Response provided by the department dated 12 July 2010 in response to my investigators writing to the department on 9 July asking in what circumstances a notification will be recorded as an intake event.



It is disturbing that despite 12 notifications received by CIT regarding Marlon's siblings combined with the notification from the doctor when Marlon was born, that the Acting Manager authorized the information to be recorded as an *intake event only*. It is questionable as to how the Acting Manager of CIT did not identify any information to indicate that a child was in need of protection or that a Family support case might be required.

It is also noted that the email from the Acting Manager of CIT gave the wrong intake number and did not provide additional details such as the child's name, client ID and the intake number. A witness with over 10 years experience in child protection told my office these details should have been provided in the referring email and in their opinion a response classification of child in danger given to the notification about Marlon at the time of his birth. At the very least family support services ought to have been offered. If this did not meet the CPA's threshold to activate an enquiry into the wellbeing of children it is hard to imagine one that would.

Another disturbing discovery that my investigator found was, that when the notification reporting Marlon's death was made in October 2009, the facts reported on 22 May 2009 still had not been investigated 158 days after it had been assessed a child of concern report requiring an investigation within 5 days to be completed within 28 days. Even more concerning is the fact that a CIT Intake Search Results Report records that as at 17 September 2010 the notification dated 22 May 2009; some 483 days later still had no outcome recorded against that notification.

During the hearing of the inquest in February 2011 the Acting Manager of the Casuarina work unit was asked by the Coroner, if a similar situation occurred today whether a more timely response would occur. The Acting Manager responded that it would not.

The Manual lists as an indicator of maltreatment 'a carer under 20 years of age at birth of a first child'. One such story follows:

***Amanda VINCENTS: Born April 1993 (Fictitious Name)***

### ***FAMILY HISTORY***

As a young 15 year old girl from a remote community, Amanda presented at the hospital's antenatal clinic 39 weeks pregnant and due to give birth within a few days. Amanda (legally still a child) declined to give the age or identity of the father of her child, who was believed to be still living in the community. She stated she would keep the baby with support from her family members and would return to school after the birth. A medical record indicated that the girl (who had a long history of medical conditions) had arranged to terminate the pregnancy 4 months earlier, which apparently did not occur. It was not known who Amanda's own father was and her mother had a long history of contact with police. The case was not investigated due to strong family support being available and insufficient information to suggest harm.

## **NOTIFICATION HISTORY**

### **February 2009 - One**

A social worker from RDH reported that a 15 year old girl had presented at the hospital 39 weeks pregnant. The social worker also provided the following information:

- Amanda was no longer in a relationship with the father.
- Amanda's mother would also help with the care of the baby to allow Amanda to return to school.
- Amanda indicated her intention to keep the baby.
- Amanda had strong family support.

### **ASSESSMENT:**

Recommended that this matter not proceed as there is insufficient information to suggest harm to the child.

Intake Search Results Report shows outcome as Allegations Would Not Constitute Maltreatment

### **Other Information:**

The medical records indicate that Amanda tested positive to gonorrhoea on 6 October 2008.

The Board's Report made the following recommendation:

*That the Act be amended to provide that Northern Territory Families and Children can accept a notification of concern about an unborn child and make provision for the immediate care and protection of the child when born.<sup>12</sup>*

I support this recommendation to enshrine that ability in legislation. I see no reason, why the Board's recommendation could not be acted on immediately by amending the CPA's manual. I note the report recommended that this amendment occur within 18 months. I propose that the Manual be amended to reflect the earlier version (Manual 2) which prescribed that maternity services be involved in a child protection plan for the impending birth of the child where appropriate.

## **RECOMMENDATION**

I recommend an immediate change to the Operations Manual from:

*'the work unit **may** need to plan Child Protection action in advance of the birth and liaise with maternity services '*

to

*'the work unit **must** plan a child protection action in advance and **must** liaise with maternity services when there is a foreseeable risk to the wellbeing of an unborn child'.*

There needs to be co-operation between RDH and CIT to establish a mechanism whereby when a baby is born there is immediate monitoring and support for a family whose history of

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<sup>12</sup> Recommendation 10.33

caring for children or lifestyle factors known to the CPA indicate a risk to the wellbeing of the unborn.

### ***Patient Assistance Travel Scheme***

The birth of a child also has unique features in the Northern Territory due to the many occasions that women must travel from a regional area to Darwin for a birth.

On examining the records relating to a comparatively small number of children it became apparent that on at least six occasions a mother from an outlying community had come to Royal Darwin Hospital to have a child. Usually the child was premature. Under those circumstances the child needs to be kept in the special care nursery. This becomes a problem for a mother from an outlying community. The Patient Assistance Travel Scheme (PATS) pays for the travel to the Royal Darwin Hospital and home again but only once. If the child needs to stay in the special care nursery or the hospital for weeks or months, unless the mother has family in Darwin she has a dilemma. There were several instances where children were left in the hospital long after they were ready to go home, on a couple of occasions for several months. This was because to return to collect the child and then go back to the community the mother had to find the money, usually from her Centrelink payment, to pay for the travel.

I wrote to the Minister about this issue on 13 November 2009 and suggested that the Patient Assistance Travel Scheme be amended so that where a child has been born prematurely and the mother needs to return to her community, two return fares will be provided.

The Minister replied, most likely on the advice of his Department, that there was accommodation on the grounds of RDH and there was a hostel to which women in this situation could go. What the Minister did not address is that a mother may very well have two or three other children at home and not be able to bring them to Darwin to stay in the on-site accommodation. The stay at the on-site accommodation is limited to 2 weeks. If she had to go to the hostel there is a curfew at the hostel and it is approximately three kilometres return trip to the hospital. Taxi fares are not provided. If a mother needs to attend the hospital to breast feed on three occasions per day she will have to walk at least nine kilometres shortly after having given birth to a baby. One of those trips, if not two, would almost certainly be in the dark and there is a safety issue. It costs a minimum of \$1,000 per day to keep a patient in hospital. There is not likely to be many places to which a return airfare exceeds \$1,000. The social cost of even a mother not bonding with her child will surely be much greater than an airfare. One example of this dilemma for mothers is the family history of Desmond Linson.

### ***RECOMMENDATION***

I recommend that the guidelines for eligibility for PATS be altered so that where it is necessary for a mother from a community to travel twice to RDH in connection with the birth of a child then two return airfares be provided. As I pointed out to the Minister the cost of a return airfare within the Northern Territory cannot possibly exceed the cost of keeping a child in hospital for even one day.

### ***Consecutive Child Protection Reports***

On some occasions a work unit may receive two or more consecutive Child Protection Reports about an individual child. The following table outlines how these consecutive reports were to be recorded:

<p><b>Manual 1 February 1999</b></p>	<p>On some occasions a work unit may receive two or more consecutive Child Protection Reports about an individual child. <b>If a subsequent Child Protection Report is received from a different referral source</b> before an investigation outcome decision on the first report had been made and approved by the Casework Supervisor, <b>the two reports may be investigated concurrently</b>. Caseworkers must clearly explain to the family that two allegations of maltreatment are being investigated. <b>Each child protection report must be recorded in CCIS</b> and if approved to proceed to investigation, CT cases must be created to <b>record the investigation outcome for each report</b>. Although the investigation activity has occurred concurrently, the details need to be recorded against each case.</p>
<p><b>Manual 2 December 2008 and Manual 3 July 2009</b></p>	<p>A new Child Protection Report cannot be recorded against an existing Child Protection Report, investigation or assessment. <b>Each Child Protection Report must be recorded separately in CCIS</b>. If approved to proceed to investigation, the work unit must create Child Protection cases to record the investigation outcome for each report. Where two or more consecutive Child Protection Reports are received about an individual child prior to an investigation outcome decision on the first report being approved by the work unit Team Leader, the subsequent reports may be investigated concurrently with the first. Although the investigation activity has occurred concurrently, the details need to be recorded against each case.</p>

A notification about Marlon Clancy at his birth in September 2009 was assessed as ‘an intake event’ and information about it was entered as a progress note on the record of a child protection report about his sister. That action would not have been consistent with the Manual directive about consecutive reports were it not for the introduction of the intake event. I discussed earlier the real effect on responding to reports about children’s wellbeing by the stroke of the pen that created ‘an intake event’.

<p><b>Manual 4 July 2010 and Manual 5 September 2010</b></p>	<p>Each Child Protection Report must be recorded separately in CCIS. A new Child Protection Report cannot be recorded against an existing Child Protection Report, investigation or assessment or case unless it is a duplicate report (see 7.11.3 Duplicate Reports). If approved to proceed to investigation, the work unit must create Child Protection cases to record the investigation outcome for each report. Where two or more consecutive Child Protection Reports are received about an individual child prior to an investigation outcome decision on the first report being approved by the work unit Team Leader, the subsequent reports may be investigated concurrently with the first. Although the investigation activity has occurred concurrently, the details need to be recorded against each case.</p>
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In Manuals 4 and 5 a duplicate report is defined as:

A report made by the same or a different person in which the information is virtually identical to that contained in an earlier report.<sup>13</sup> A report is considered to be a duplicate report when no new information is reported regarding the nature of the harm or risk of harm, the location, the date(s) or the victim. A duplicate report may be added to an existing Child Protection Report as a Progress Note.<sup>14</sup>

My investigating officer often found three reports were recorded as one notification although each notification outlined separate and distinct concerns. The importance of recording separate reports is that cumulative harm can be identified and the Third Report Rule complied with. It also has consequences for obtaining more accurate statistics.

One of the indicators of cumulative harm is multiple sources alleging similar problems.<sup>15</sup> My office had intended conducting further analysis to determine the unintended consequences of the change to the policy on Consecutive Reports. My investigators found a number of incidents where people had made notifications at a later stage about similar issues but that this had not been recorded as an intake but rather as a progress note. If a second notification is only recorded in progress notes for child A, and a report comes in about a sibling or child in the same household it will not be accessible or cross referenced to assess whether or not the report about a sibling is the third for that **household**. If it is, an investigation must be done. I stress that the Operations Manual, the Third Report Rule and the intake event are not just procedures. Compliance and especially non compliance has a human consequence for children.

A question that needs to be answered is how statistically these duplicate notifications will be captured and counted for statistical and evaluation purposes. Comparison with the number of notifications prior to this change would be comparing apples to pears. More importantly, if a notification is recorded in progress notes for a case, that information will not be available to the CIT nor entered into the SDM tool. The assessment made about a child notified as being at risk of harm after the progress note or 'intake event' will not be made on all available relevant information.

### ***Timely responses to notifications***

My investigation confirmed, what is already common knowledge, that there are many notifications which are not receiving a timely response.

The May 2009 investigation of the report about Marlon Clancy's sister had not started for 158 days.

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<sup>13</sup> Manual 5 at page 26

<sup>14</sup> Manual 5 at page 38

<sup>15</sup> Bromfield, L.M., & Gillingham, P. (2007). Cumulative Harm and Chronic Child Maltreatment. *Developing Practice*, 19 34-42.

Another notification took over 5 months for an investigation of harm to be substantiated. This shows not just the statistics but what the delays and backlogs mean in reality for the children.

My investigator was told of caseworkers who had in excess of 50 cases to manage. One particular example provided was a caseworker who in one week was expected to complete 6 affidavits as well as respond to daily emergencies with a caseload of 58. In order to be able to complete the affidavits the caseworker needed to go 'offline' which meant that she had no client contact for that week.

## **RECOMMENDATION**

The CPA ought to disclose in its annual report the number of notifications allocated to a work unit, the cases which are opened and closed, the time from receipt until closure and break this down into regional areas. Apart from the annual report I would expect senior management to capture this data and use it to manage workflow and rosters. In the past the CPA has reported as a section of the Department's Annual Report. There is no legislative requirement for the CPA to deliver an Annual Report.

Several of the senior staff members interviewed in my investigation spoke about the pressure to prematurely close cases. A CIT staff member stated:

*'There has been pressure to close an intake where you know it is not going to get a response in a very long time or if it is out bush you know remote community and no-one is going to be available to go out there and investigate it further.'*

The workload pressure and delay at CIT weighed heavily on the workers. One worker gave the following example:

*... a notification had come in by fax or email at 1pm about a baby who had been swung by the arms and then scolded with hot water. The baby was on a community. The intake had been printed off and put in a Team Leader's intray. The Team Leader was leaving the office early at 3.30pm and read the notification. She passed it to another Team Leader... who read it and took it to ...the Manager of CIT. The manager told the team leader to give it to the Afterhours Team Leader.... who read it and at 4.30 pm passed it to me. I read it and could not believe that it had not been responded to immediately as a child in danger. Four management staff members had read it and nobody had done a thing! I contacted police and health personnel on community by phone (5 minutes) and organised a safety plan for the baby overnight. I did the intake which had to be sent back to ...the Manager of CIT to outcome as we were no longer permitted to outcome. What happened from there is that the next day it went back to an intake worker to get a police check on the alleged perpetrator. That intake worker recommended a child concern response because I had actioned an immediate response overnight. I understand that the notification then sat on the whiteboard for some days. **6 days later** I came to work at 4pm and took a call from the Manager of the remote office who informed me that she was travelling back from the community after responding to the notification. She stated that the intake had only arrived at her office that morning as a child concern. She knew instantly that it was much more than a child concern and actioned it immediately.*

## **THE THIRD REPORT RULE**

The Third Report Rule is a procedural requirement that NTFC must respond to any third report about a child when two previous reports were not approved for Departmental action within a 12-month period. The third report shall proceed as an investigation. In the Third Report Rule, **reports are counted by household**, that is, any reports about any child known to be living at the same residential address.

In some instances reports are made within a conflictual context e.g. due to Family Law dispute or a conflict between family members or neighbours. The Third Report Rule must be investigated irrespective of the nature and substance of the notification.

Should further reports and previous contact with the child and family reveal that the concerns are malicious, unfounded or unsubstantiated the Manager of CIT may waive the requirement of investigating further reports received within the 12-month time frame.

The reasons for waiving the Third Report Rule requirement must be clearly documented on CCIS.<sup>16</sup>

The Third Report Rule was revoked on introduction of the Structured Decision Making Tool in July 2010. The SDM treats three reports within twelve months as an indicator of harm but the obligation to do an investigation after three reports no longer exists. I consider that change to increase the risk to children. When the Third Report Rule existed there were many occasions where it was not complied with and subsequent reports disclosed children at risk of harm which might have been picked up earlier if the Rule had been complied with. Without the safety net of an obligatory investigation after three reports in 12 months if the CPA once again is placed under stress, and I believe it still is, children's circumstances may not be investigated until their wellbeing is severely affected.

On 1 July 2009 the CPA introduced the 'Intake event'. This was not classified as a notification or a report. The result has been to avoid compliance with the Third Report Rule. The sections that follow demonstrate how.

The Ombudsman, apart from this investigation, also receives complaints about the Department and the CPA.

On 28 April 2010 a complaint that had been made to the Ombudsman about alleged inaction by the CPA was referred to the Department. A response was requested by 24 May 2010. -The complaint details provided to the Department were:

*The complainant is concerned about the risk and conditions' his daughter is living in with her mother and has made approximately 7 complaints to FACS dating back 2007 with the*

<sup>16</sup> Manual 3 ( July 2009) version 2.0

most recent being Jan/Feb 2010. The complainant advised that his complaints have related to the following concerns:

- Child allegedly being bitten by a dog at the premises on several occasions (one occasion required being rushed to hospital and obtaining stitches).
- Mother's partner being an alleged intravenous drug user
- Child allegedly picking up a syringe left on the floor at home.
- Other drugs allegedly being dropped on the floor for the child to pick up.

The complainant alleges that he is not aware of any enquiries being made into his complaints nor has he received any response and is extremely concerned for the safety and wellbeing of his daughter.

On 3 June 2010 my office received information about 3 reports to CIT. These three notifications were all within 12 months but because of the creation of the category 'intake event' the Third Report Rule was not activated.

### **Notification One – 22 April 2009**

A report was made by a father that the mother of his child was sharing her house with her brother who was an IV drug user. The father was concerned that the brother sometimes leaves drugs lying around the house and that his daughter may one day pick up and eat the drugs. The father had spoken to the child's mother, however was not convinced that she shared the same level of concern.

The intake worker's assessment was that there was:

*insufficient information to constitute maltreatment. Concerns that child may access drugs left lying around the house. At this stage there have been no incidents where the child has accessed the drugs. Concerns have been brought to the mother's attention by the notifier.*

On 9 June 2010 my office wrote to the Department with the following queries:

1. What enquiries were undertaken to assess the risk to the child? Had a police check been undertaken on the brother of the mother? Had a hospital check been undertaken on the brother of the mother? Was the brother of the mother questioned? Were enquiries made with Alcohol and Other Drugs Services to establish if the brother of the mother and/or the mother were known to them?
2. If none of the above enquiries were made how did the intake worker conclude *Insufficient information to constitute maltreatment*.
3. Given the concerns raised by the father was risk to the child a consideration? How was the risk assessed?

On 23 June 2010 the Department responded as follows:

*The NTFC Care and Protection Policy and Procedure Manual (Version 2.0 — version at the time this Intake was recorded) states that inquiries are only made (1) after a departmental history check has been completed; (2) when it is not possible to make a*



*decision about the appropriate response to a report; (3) when it is likely that a Child Protection Report will be recorded. In assessing this information, Departmental (CCIS) checks were undertaken, revealing no previous history with NT Families and Children (NTFC). No other inquiries were undertaken.<sup>17</sup>*

I consider it unsound that it is only when a child protection report at first glimpse is likely to be recorded that inquiries are undertaken to see if there is need for a child protection report. The reasoning in the response of 23/6/10 is reminiscent of the book 'Catch 22'. Enquiries ought to be conducted to ascertain whether a child protection report should proceed either to investigation, the offer of FS or a PA. The policy the Department referred to means that initial inquiries are only conducted in the most serious of cases where the initial information provided to the Department indicates that it is likely that a child protection report will be recorded. The judgement is made before the facts are known. Unfortunately after examining hundreds of CIT's records it appears that the CPA has so far operated under 'Catch 22'. If this is the threshold against which a mandatory report is measured there will most likely be many children at risk of harm who fall through the gap.

### **Notification Two – 19 March 2010**

A report was made by the father that the child had been bitten by the mother's dog when the child was 2 ½ years old and again approximately 6 weeks ago when the child was 4 years old. The father informed CIT that the child was scared of the dog and that he wanted the mother to remove the dog from the premises but the mother was not agreeable to this. The father requested assistance to help him in this regard.

The assessment of this intake was that:

*There is no information to suggest the child has been harmed because of an act or omission of a parent. Context of the report seems to be marital dispute and custody of child. It is recommended the matter be recorded as an intake event given that there are no allegations of harm.*

On 9 June 2010 my office wrote to the Department to determine what inquiries had been undertaken to determine who was taking care of the child when the dog biting incident occurred. My office also asked why the assessment only focused on the parent's act or omission given there was prior knowledge from the earlier notification that the brother of the mother was also a resident at the home with the child.

The Department responded that:

*No inquiries were made in relation to this intake. Child Protection Reports are any reports that give the Intake worker reasonable grounds to believe that a child is in need of protection. Section 20 of the Care and Protection of Children Act 2007 defines 'in need of protection' as being when:*

- a) The child has suffered or is likely to suffer harm or exploitation because of an act or omission of a parent of the child; or*

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<sup>17</sup> I note that the manual the department refers to is dated July 2009, some three months after this complaint was received so it is questionable that this was the applicable policy at the time.

- b) *The child is abandoned and no family member of the child is willing and able to care for the child; or*
- c) *The parents of the child are dead or unable or unwilling to care for the children and no other family member of the child is able and willing to do so; or*
- d) *The child is not under the control of any person and is engaged in conduct that causes or is likely to cause harm to the child or other persons.*

*Pursuant to Section 20(a) of the legislation, the information was assessed as not indicating the child was in need of protection, therefore recorded as an Intake Event — No Further Action.*

### **Notification Three – 6 April 2010**

There were continued allegations of the child living with drug users, being exposed to pornography that was being watched by the uncle and inadequate supervision. My office asked the Department why no details regarding the uncle were recorded on the intake form and whether any inquiries were made with Alcohol and Other Drugs Services to establish if the brother of the mother and/or the mother were known to them.

The Department informed my office that no inquiries were undertaken on the mother's brother as *'he was not referenced in the intake report and so it cannot be assumed that he is still residing at the child's home'*. However, the respective Intake Report under Current Situation stated the child *'went in to the lounge room late at night'* and saw *'boys and girls playing with their pees'* on the television. Her uncle was watching the television. Information obtained from the complainant during this intake report did in fact reference the mother's brother.

The outcome of the report stated *'marital dispute'* and *'not to proceed to investigation due to insufficient information.'*

This notification was the third report within a 12 month period.

My office asked the Department why this notification did not proceed to investigation in accordance with the Third Report Rule. The Department explained on 8 July 2010 that:

*The NTFC Care and Protection Policy and Procedures Manual states that Child Protection Reports are subject to the Third Report Rule. The Intake received on 19 March 2010 was recorded as an Intake Event with no further action, therefore the Third Report Rule does not apply.*

My office informed the Department that enquiries had established that the brother mentioned in the notifications has a criminal history which includes drugs, firearms and other offensive weapons.

No enquiries were made by CIT in relation to the brother. The true risk to the child could not have been appropriately assessed. The current policy is that police checks must be undertaken for all reports related to, domestic violence, serious physical assault and allegations of sexual abuse.<sup>18</sup>

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<sup>18</sup> Manual 5 (September 2010) at 7.5.3

The first notification for the child highlights how the worker's emphasis appeared to be on the fact that the child had at the time of the report not accessed the drugs rather than consider the likelihood of this occurring. The assessment seemed to focus on whether actual harm had occurred rather than the risk or potential that harm may occur.

Any allegation that a child is in an environment that may possibly involve exposure to illicit drugs or pornography should be investigated or reported to police. There is no record that CIT passed on information to the police. This 4/5 year child reported '**girls and boys** playing with their pees'. It could well have been child pornography that was being viewed. Getting a person's criminal history is not time consuming especially as CIT is co-located with the CAT at Peter McAulay Centre.

My investigation also identified a tendency to dismiss reports as insufficient information when the report being made was in the context of a family break-up or family law dispute. Although extra care is needed in that context, as there may be some motivation to obtain support and evidence for one party's Court submissions, the fact of a notification made in that context ought to consider the child first, not the motivation of the notifier.

## **THE POWER OF THE CHILD PROTECTION AUTHORITY TO MAKE ENQUIRIES**

Section 32(1) of *the Act* states the CEO may make inquiries about a child if the CEO receives information **that raises concerns about a child's wellbeing**. A child's wellbeing is defined in *the Act* by Section 14 and includes the child's physical, psychological and emotional wellbeing.

Section 34 of *the Act* gives authority to the CPA to request information about the child from specified persons. Section 34 outlines that the request for information has to be **about the child**. Therefore it is arguable that if a request is made to a service provider, such as Alcohol, Drugs and Other Services about the nature and duration of the agency's contact with a parent and the history and extent of abuse of alcohol & other drugs or their effect on parenting skills this request could be denied as it is not directly **about the child**.

## **RECOMMENDATION**

I recommend that Section 34 of the Act be amended to extend the authority of the CPA to request information:

'that may be relevant in connection with or incidental to a child's wellbeing', or  
'relevant to information received about a child'.

Further, I recommend that a provision is inserted into Section 34 to allow the CEO:

*'to make those inquiries of any other persons who may reasonably be expected to have information about a child'.*

The current policy states that:

*inquiries should be made at Intake if it is not possible to make a decision about the response to a report, and the Inquiry may enable a decision to be made about the response.*<sup>19</sup>

That policy is at odds with the terms of the Department's response to me of 23 June 2010 (see pages 41 - 42).

The current policy is not as narrowly defined as previous policies in relation to when enquiries should be made however my investigation found enquiries were seldom conducted.

Unless the information from a notifier clearly outlined unquestionable abuse the outcome recorded was often *insufficient information*. This is regrettable as inquiries may identify problems within the family that can be addressed by early intervention. One of the decision categories for a notification is *no further action*. My investigation found that as a result of this categorisation inquiries rarely occurred as it was always possible to reach a decision of *no further action* as a result of *insufficient information*.

It is not reasonable to make decisions out of wilful blindness if a few phone calls, emails or computer searches could provide information. The information needed is to allow an initial assessment of possible risk to a child. It does not need to be beyond reasonable doubt. If there is an indication of risk factors present the investigation is to determine if the report of risk is substantiated or not. If the report of neglect or abuse is substantiated and the last resort is to remove a child to safe care the evidence will have to be presented to a Court. The evidence will have to be collected, preserved and sufficiently cogent to persuade a Court that the plan for the care of a child at risk is in the child's best interest and the least intrusive alternative consistent with preventing potential harm and preserving the family.

## **RECOMMENDATION**

I recommend that:

- A direction be issued to CIT staff to reiterate the importance of conducting further inquiries to clarify information at every opportunity where a notification is made about alleged risk of harm. To achieve this CIT needs to have a full complement of professional qualified staff. Intake workers interviewed told my office of their dilemmas in wanting to pursue more lines of inquiry but simply not having the capacity to do so because of workload issues.
- Quarterly audits of a sample of notifications that have been assessed as *no further action* as a result of *insufficient information* to determine the quality of those decisions.
- The Manual be amended so that it mandates enquiries be undertaken to clarify initial information where those enquiries can be made by the intake worker. At the very least an intake worker is to inform the notifier of what further information would assist.

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<sup>19</sup> Manual 5 (September 2010) at 7.5

## **ITS NOT EASY FOR PEOPLE TO MAKE REPORTS**

The facility to notify the CPA by email or facsimile has been removed. The justification for removing that facility even for professionals is that if the notification is taken by phone the intake worker will have the skill and knowledge to ask all relevant questions at the outset. That will mean that an assessment about any risk can be promptly made. There may be occasions when the notifier has insufficient information. In that event an outcome of insufficient information is legitimate. The frequency with which reports have been not acted on in the past due to insufficient information indicates lack of staff in CIT. Accepting only verbal reports may be a good idea but it has not been implemented to achieve the stated objective. There are not many businesses today that do not have a facility on the internet for customers to order goods or services, make complaints, register for membership and such like. With appropriate security CIT could have a site with a report form. That way a person wanting to report can be prompted to give the precise information that CIT needs. Guidance can be provided by instructions on how to complete the form on the CPA's policies and guidelines so that the CPA not only provides its 'customers' with a method of fulfilling their obligations under Section 26 of the CPC Act, the form can elicit the needed information.

## **A NEW TELEPHONE SYSTEM**

The need for a new telephone system was recommended by a review conducted by Jay Tolhurst in March to June 2009. The review identified that one of the advantages of a new modern telephone system is:

*It can tape conversations which can be useful to defend workers who are falsely accused of having said, or not said, things by callers who later complain. This taping facility enhances and extends the ability of supervisors to monitor how workers are actually dealing with cases rather than relying in supervision on indirect accounts of how these conversations with clients went.*

*Queuing systems are possible so that callers can be directed via phone prompts to particular services (eg administrative, after hours etc). Sophisticated tape messaging systems can deliver a variety of messages to callers waiting on hold, including things like the need to ring Emergency Services if the matter is a life-or-death situation, rather than waiting for Intake to answer. Or the need to have accurate case details (names addresses, dates of birth etc) to hand to help the worker to process the report effectively.<sup>20</sup>*

Unfortunately the implied benefits that the Jay Tolhurst review identified have not been realised as the recording function for the new telephone system has not been activated. Since December 2010 it has a queuing facility and callers can leave a message. I was informed of this by the submission of the CPA on the draft of this report.

On 9 June 2010, the Acting Executive Director of NT Families and Children, provided me with a briefing. I was informed that a new telephone system would be operational in July 2010. On

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<sup>20</sup> Jay Tolhurst, Review Report of NTFC Intake Service June 2009, pg 37

17 December 2010 the Department advised my office that the telephone system was implemented on 19 August 2010.<sup>21</sup> The Department also explained with:

*The introduction of the new telephone system within Intake Services, the service has commenced the 'one-piece workflow' model. That is, upon the Intake worker receiving an intake:*

- *the worker logs out of the telephone system;*
- *the intake is entered onto CCIS*
- *inquiries, as necessary, are undertaken;*
- *the information is assessed;*
- *the SDM tools are applied if relevant;*
- *a recommendation is made.*<sup>22</sup>

*When the recommendation is completed, or no further action can be undertaken at that time due to waiting on further information via inquiries, the Intake worker logs back onto the telephone system to be available for further intake calls.*

In its submission in response to this draft the CPA said that during the day there will be 5 workers at CIT who will operate the call lines. I agree that for 2 phones that is the minimum required.

CIT staff informed my office that they generally agreed that with a full complement of staff, they could appreciate the benefits of the new telephone system however they explained that these benefits were not being realised due to staff shortages. This was confirmed by Maureen Armstrong in the, Extension of Review Report DCF Intake Service, January 2011 where it was noted:

*This workflow model has been in place since late November 2010 and has received mixed reactions from staff. Some report improved job satisfaction as they are able to complete work whilst others still feel the pressure caused by the queue of calls. There is still a backlog in addition to the processing of new work.*

*However, with staff vacancies at a high level, intake staff are constantly aware of the queue of calls backing up and feel a strong sense of professional responsibility to keep taking incoming calls. This in turn creates data backlog pressures and on some days intake staff leave knowing that some work is still not outcomed. It should be noted though that a Child in Danger report is actioned immediately however this requires the intake worker removing themselves from the Intake lines which in turn adds additional pressure on an already understaffed service.*<sup>23</sup>

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<sup>21</sup> Email from A/Complaints, Sentinel Events & Coronials Coordinator  
Office of the CE Department of Health and Families

<sup>22</sup> Email from A/Complaints, Sentinel Events & Coronials Coordinator  
Office of the CE Department of Health and Families

<sup>23</sup> Extension of Review Report DCF Intake Service by Maureen Armstrong, pg 6.

To summarise:

Until December 2010 people wanting to report suspected harm to a child could do so by telephone, email or facsimile. Now, a person is restricted to a telephone call. There are still only 2 phones allocated to answer calls to the intake number. Those two phones were answered by two rostered workers until April 2011. After receiving one call a worker does not answer another call until after collecting information in CCIS about any prior notifications, completing the information to be entered into the Structured Decision Making Tool and recording an Assessment. Initial enquiries, when made, occur before the worker returns to the phone. In its submission on the draft report the CPA advised that they accept that there must be 5 workers available to cover the two phones. I have not had time since 24 June 2011 to find out if in fact there are 5 people available at CIT.

The unsatisfactory service caused by workers leaving the telephone lines combined with inadequate staff levels is evident from information about unqualified staff being rostered to answer the phone. The justification for only taking reports by phone is that the report will be received by a professionally trained person, usually a social worker who can ask the right questions. On occasions the phones are answered by administrative workers who also receive the emails from NT Police. This is not in accord with the justification described in the Tolhurst Report.

### **ADMINISTRATIVE OFFICERS**

My investigation found that administrative workers were tasked with completing the details of the notifier, subject children of the notification and the background section of the intake form. The background section is a summary of the prior notifications made about a child. Once this information was completed the administrative workers then provided this notification to intake workers to assess the priority of response for the notification. This process requires the administrative worker to review past notifications for the subject child and then summarise information into the new notification. A number of intake workers told my investigator that they did not agree with administrative workers performing this task. They firmly believe that administrative workers do not have the requisite experience to identify the information from past notifications which is pertinent to the current notification, or the expertise to identify minor pieces of information from several notifications which suggest that there is cumulative harm occurring.

As a result of this intake workers said that they often felt they needed to repeat the process of reviewing the previous notifications to ensure all relevant information was considered and documented. In addition intake workers said if information was not assessed accurately it was their professional integrity that would be questioned in the event of a child's death or serious harm.

Witnesses said administrative workers had also been asked to answer the phones and take down information about a notification. This is a dangerous practice for several reasons:

1. Vital information may need to be obtained from the notifier to accurately assess a notification. An administrative worker does not have the professional expertise to understand what questions should be asked to glean additional, relevant information for an accurate assessment to occur.

2. It places an unnecessary burden on the administrative workers who are not equipped with the necessary qualifications to handle sensitive and highly charged emotional matters.
3. The notifier may feel that their concerns are not being addressed in a manner expected from a professional and become frustrated by what is perceived as an inadequate response.

A witness explained her concerns about administrative workers as follows:

*The concerns I have is that we've got someone who has no qualification in social work or psychology writing up the history, ... taking into consideration when people are doing an assessment on care and protection concerns for a child quite often a lot of the investigations are unsubstantiated. If you look at them the unsubstantiated it can be anything from it could not locate the child, a mother has been long grassing with the children and they have serious concerns and they close the case down because the children couldn't be located. So when the history's been written its got neglect, unsubstantiated. **That is a huge concern to me because unsubstantiated where I come from means is that it was investigated and there were no care and protection concerns found and the children are safe. That does not mean this in the Territory. When you've got people coming in to Intake like we do, who, especially, we've had new recruits and new to the Territory, straight out of University and given to us to do intake work that's not been, cannot be picked up if they're not going back and actually knowing what they're looking for.***

Administrative workers are primarily utilised to input information from email notifications which, from December 2010, come only from police. Print outs are provided to the administrative officers to complete. This places the administrative officer in an unenviable position of triaging notifications.

One case of an administrative officer receiving an email notification is as follows:

*On Friday 28 January 2011 police sent an email notification to CIT detailing concerns that **a toddler**, aged 2 years and 7 months, was being neglected by the mother. The officers pulled over a vehicle at midnight as a result of observing a toddler in the front seat of a car. The child was sitting on the mother's lap and the mother appeared to be under the influence of alcohol. When asked by police where they were going the mother responded 'to the casino'. The police instructed the mother to restrain the child in the back seat. Later that same night at approximately 4am police again observed the mother carrying the child along a highway. The police made a report stating:*

*Members believe mother is neglecting care of her child by taking him out around town in early hours of the morning while she is under the influence.*

An administrative worker received this report from police by email on Friday 28 January 2011. It was not entered into CCIS until 1 February 2011 some 4 days later. A professional witness told my office that she was approached on 2 February 2011 by a *frantic* administrative worker. The witness explained that the administrative worker had been trying to speak to someone about this notification but that everyone had been too busy to talk to her. The witness reviewed the background information that the administrative worker had completed for the



subject child. That history included seven previous notifications for the child and a sibling in the same household:

- 21/11/2010 No Further Action – Child said to have witnessed the father assaulted her mother.
- 26/01/2010 Child Protection Report - Emotional - **Substantiated** - Child was in the arms of her mother when the father assaulted the mother.
- 23/07/2009 Child Protection Report - Emotional & Neglect - Insufficient Information - The child's mother received injuries after being physically assaulted by a maternal uncle, child witnessed the incident.
- 09/04/2009 Child Protection Report - Neglect - Insufficient Information – Mother breast fed the baby whilst she was intoxicated.

The administrative worker had also completed the child's siblings' past notification history:

- 17/09/2010 Child Protection Report - Neglect - No Abuse or Neglect Found - Concerns of inadequate supervision provided to the children and significant risk of neglect as the result of the parents fluent alcohol used.
- 25/02/2002 Child Protection Report - Neglect - No Abuse or Neglect Found – Child continues to FTT.
- 27/11/2001 Child Protection Report Neglect - No Abuse or Neglect Found - Child has history of FTT.

The witness explained that the administrative worker was seeking guidance as to whether this matter needed to be escalated and asking what acronyms such as FTT meant [Failure to Thrive].

The witness said that as a result of her extensive professional experience she was able to immediately assess the matter as a Child at Risk which requires an investigation within 3 days. The witness immediately took steps to finalise the intake. Her name was shown as the intake worker. The witness felt uncomfortable that she was now associated with this notification as it appeared as if it had taken her 5 days to outcome a notification that required a 3 day response. Her dedication and concern for the child overrode her self interest and she is to be applauded for that. It is a situation that should not have arisen and ought not to occur again.

In its submission on the draft of this report the CPA agreed that administrative officers should not perform the tasks I have described. The submission stated '*It is not the intention of the CPA to allow administrative staff to play any decision making role. This will occur from 1 July 2011*'.

### **PROFESSIONALS' PERCEPTION OF BEING UNSUPPORTED**

On 27 February 2011 correspondence was sent from an intake worker to a manager at CIT regarding administrative workers completing notifications:

*I am a little confused still regarding why it's OK for Admin staff to be undertaking the beginning of a notification. I know you term it as data entry but I disagree with this. So I have two questions.*

*1 Are they authorised officers to undertake take these duties under the act?*

*2 Is that one of the duties outline in their duty statement that they were recruited to and they currently should have? Is their duty statement been re jessed?*

This correspondence was forwarded to the Senior Manager Child Protection Authority Darwin Urban who provided the following response on 5 March 2011:

*As we discussed last Friday data entry by AO staff is legitimate and if there is a problem with the data entry then it is up to T/L's to address in the first instance (as part of their T/L's responsibilities) and if this does not occur or resolve the issue then it is escalated to the manager / senior manager. (T/Ls – Team Leaders)*

A witness with 14 years experience in child protection informed my office that they sent correspondence to the Strategic Reform and Accountability Team who was in charge of the review for the restructure of CIT. The correspondence detailed the following:

....

*I have been wanting to let you know of some issues that people have come to me with over the last few weeks.*

*Mainly to do with the email system and the system of getting A stream workers to put information on CCIS.*

*There have been some serious mistakes made and in the last few weeks when I have come on shift workers ... have come to me to help get them sorted. I have happily done this but I am pointing out the risk that we are putting A stream workers in along with the children who the emails then pertain to. This relates to at least 4 to 5 cases. Happy to point in individual cases but I guess I am looking at and talking about the bigger picture of this.*

*I can only suggest that the best way to resolve this situation would be not to have A stream workers doing this type of thing.*

This witness said she was then reprimanded for the stance she took. The witness said that in her interview with her supervisor:

*I explained my concerns about administrative workers doing part of the notification. Then when I had my supervision I got into trouble. You bring a person in to do a review and are suppose to be open and transparent but if you don't talk about what upper management wants you to you get into trouble. After I sent that email I was told in my subsequent supervision that I didn't follow line management and it was not the right thing to do.*

A witness explained that once the administrative officer had completed part of the notification, the intake worker needed to remove the administrative officer's name as the 'receiving officer' and place their name in this section. Below is an excerpt from that interview:

**Ombudsman Officer:** Were there any reasons provided by management or team leaders as to why they believed the notification shouldn't be in an AO's name?

**Witness:** Because an unqualified person can't be doing a CP report.

**Ombudsman Officer:** Did you feel comfortable that you could express your concerns about this?

**Witness:** Em, they were never listened to.

I am concerned that management does not appear to appreciate the implications of using administrative officers to receive notifications and then recording that a professional intake worker was responsible. I consider this to be unfair to a professional as well as concealing the truth in a record.

### ***RECOMMENDATION***

I recommend that the Quality Assurance Unit review the logs of calls to the CIT and compare them to the rosters of staff and the leave records of CIT to determine how often an administrative officer has received/recorded notifications as opposed to mere entry into CCIS information created by a professional intake worker. The log will identify which phone received the call and identify the person to whom that phone was allocated.

I further recommend that administrative staff do not perform the function of reviewing previous history from CCIS. When an administrative officer performs a task, that should be recorded on the intake form.

A similar concern about inexperienced staff performing duties beyond their capabilities was expressed by staff at RDH. .

Information given to the Ombudsman was that in December 2009 a trainee social worker was tasked by the Allied Health Director at RDH to draft assessment tools for use by social workers at RDH to identify risk to children prior to a referral by RDH social workers to CIT. Professionals said they were annoyed that this requirement was going to be imposed and more annoyed that the task had been given to a trainee. They believed the paperwork involved was lengthy and not conducive for RDH personnel to complete given the time and poor environment in which the personnel operated. The notification document that RDH social workers had to complete was a six page document. There had been no implementation policy regarding the use of this report. Staff explained the draft notification documentation used occupation specific terms that only a trained social worker would understand such as 'protective factors' and 'risk factors'.

I have not yet found out whether the proposed assessment tools have become obligatory at RDH. Major objections to the procedure by experienced social workers were:

1. The procedure was inconsistent with the mandatory notification requirements of the CPC Act, and

2. It was not in the best interests of children because it would cause delay and undermine compliance with a social workers' Code of Conduct.

## **EMAIL SYSTEM**

Professional reporters told investigators that they made their reports via email for evidentiary purposes. The professional reporters said there were a number of times that they had made verbal notifications, only to ring CIT at a later stage to provide additional information and been told that there was no record of their notification.

The Jay Tolhurst Report also confirmed this:

*There is a concern that not every phone call received at Intake, where a record should be produced on CCIS actually produces such a record.<sup>24</sup>*

The Department explained in an email to my office on 17 December 2010:

*Intake Services is terminating the generic email account that is currently managed by the Central Intake Team. NT Families and Children encourages reports of child abuse and harm to occur, in the first instance, via verbal contact (ie. phone or face-to-face) to enable valuable information gathering and assessment. This provides the opportunity for the Reporter to discuss the reported concerns, provide additional contextual and identifying information in relation to the subject children and family and receive feedback in relation to the information provided. The Intake Worker, at the time of the Report, will provide a direct email address or facsimile number to the Reporter to provide any additional written information that may be required, pursuant to Section 26 of the Care and Protection on Children Act 2007. This action is supported in the NTFC Intake Services Review (dated June 2009) undertaken by Jay Tolhurst, specifically Recommendation Four which states that 'NTFC explore ways in which it can reduce the proportion of written (email or faxed) reports received at CIT and increase the proportion of telephoned reports received'.*

Although the Department has taken steps to implement this recommendation of the Tolhurst report it has done so at the expense of recommendation 12, of the same report which recommended an improved telephone system with the capability to tape conversations. By introduction of a work flow process workers answering the two telephone lines are also taken off answering phones to complete the paperwork before taking another call. Unless there are four workers available to answer the phone, reaching CIT will be even harder for callers. The CIT must be readily accessible. All indications are that it is not.

## **RECOMMENDATION**

I recommend that:

- A recording capability for the telephone system is implemented.
- That the full capabilities of the new telephone system be explored to determine whether it is possible for a reference to be provided to callers and this number married with the individual notification input into CCIS. This would alleviate the

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<sup>24</sup> Review Report of NTFC Intake Service June 2009 page 37.

concerns raised by professional reporters. The Telecommunications Ombudsman has such a facility.

- The Children's Commissioner be provided with auditing powers to review phone calls made and corresponding notifications completed. This would require a change in legislation and funding to achieve this.
- The ability to delete or edit recorded messages be restricted to authorised personnel with management responsibility.
- The recordings be kept for two months at least and during that time the Quality Assurance Unit audits how the recorded notifications or messages have been actioned and within what timeframes.

### ***DEDICATED EMAIL SERVICE FOR POLICE REPORTS***

In late 2010 the Department set up a dedicated email line accessible only to police. Upon reviewing the police files provided to my office my investigation found that there were a number of police notifications which had not been entered into CCIS. During an interview with a police officer I was informed that officers who attended a scene of reported domestic violence were required by a General Order to notify the CPA of all cases of DV when a child was present. The CPC Act has legislated specifically that a child witnessing domestic violence is a category of harm. The officer concerned reported to me that in a 2 year period at Katherine there were probably about 3,000 reports to the CPA about children witnessing violence.

There is a facility that exists whereby police can automatically transmit to CIT what is called a BRIO. This enables the police to inform the CPA of all incidents of domestic violence in which a child might be involved. The process is fully automated. Key words in police reports automatically generate a report. Key words include '*child at violent scene*', '*child assault*' and '*child welfare*'. The following is a copy of part of a BRIO report about the family into which Marlon Clancy was born. The first part of the report sets out a list of previous police contact with a child or children in the same household. The second part is a more detailed report of an incident of violence on the day of the BRIO report. These reports are given routinely on a daily basis so that CPA is made aware of any incident in which a child is present at the scene of domestic violence or otherwise at risk. A sample follows:

**CASUARINA Police District****PERSON Id: 827333 HATFELD, FRANCESCA****Gender: Female****Race:****Date of Birth: 2004****Incident location:****Report date of latest incident: 06/01/2008 04:12****Involvements:**

Created	Type	PROMIS No.
18/06/08 06:10	FAMILY VIOLENCE CHILD	3964487
31/05/07 04:58	FAMILY VIOLENCE CHILD	3635033
14/04/07 15:32	FAMILY VIOLENCE CHILD	3587212
13/02/07 04:49	FAMILY VIOLENCE VICTIM	3526091
13/10/06 12:54	JUVENILE WELFARE CONCERN	3426877
23/11/05 19:59	JUVENILE WELFARE CONCERN	1606574
02/10/04 20:34	FAMILY VIOLENCE CHILD	1168012
05/09/04 16:22	FAMILY VIOLENCE CHILD	1142405
27/03/04 18:37	FAMILY VIOLENCE CHILD	876831

Only one of these incidents had been recorded on the child's records within CCIS, that of 14 April 2007. If they had been there would have been an obligatory investigation under the third report rule on the notification dated 14 April 2007.

I have been informed that when a child abuse report is received by CIT it cannot be attached to CCIS and the information must be typed into CCIS manually. The printed copy of the original police report is put on a paper file. This flaw in CCIS I consider must be remedied as a matter of urgency.

Another example where CIT had not taken any action or even entered information in CCIS about a child believed to be at risk of abuse is set out below.

CPA provided a summary to our office of all the notifications made for one family. It was recorded in this summary that there was nil history of departmental involvement for Blake.

However, records obtained from police indicated that a child abuse report form was completed for Blake in relation to an incident that occurred at 5am on 5 September 2008. The description of the incident outlined the following information:

*Child was not present at the DV incident. However members are extremely concerned about the living conditions of the Child. There are currently two dogs living in the unit with above persons. The unit is extremely dirty covered in dog waste and food and totally unfit for a 16month old to live in. Requesting follow up. Child normally resides at residence however spent night with grandfather.*

## ***Police History***

Police records indicated there had been five involvements with Blake's mother between March 2005 and October 2009. Records further indicated there had been four involvements with Blake's father for domestic violence.

I had proposed to gain feedback from the police to determine what their view was on how CPA responded to their reports and whether the dedicated email system had improved the lines of communication. I had intended to examine whether there has been any improvement at CIT.

## ***RECOMMENDATION***

I recommend that this email service account be extended to professional RDH, Alice Springs, Tennant Creek, Nhulunbuy, Katherine Hospitals and all medical clinics.

## ***POORLY EXECUTED INVESTIGATION***

A number of departmental files were reviewed by my investigators and they seldom found evidence of thoroughly planned and comprehensive investigations. In many instances obvious lines of enquiry were not followed up. It appears that the Department continues to have problems with conducting robust investigations as was seen in a recent complaint to my office.

The question arises of whether or not decisions not to investigate are overly influenced by a bias against persons involved in Court disputes.

## ***COMPLAINT TO OMBUDSMAN***

Complainant contacted this office regarding the welfare of her children. Complainant advised that her daughter Gabriella (3 years) made allegations against her father to the doctor. Complainant advised that when Gabriella, and 2 year old brother Jeremy returned from a visit with their father she started complaining of having a sore vagina. The complainant made an appointment with their local GP, and this was when Gabriella made the allegation that her father had touched her vagina.

Complainant stated that CPA investigated the matter, and although they have advised her that they have strong suspicions, they are unable to prove whether or not the child was groomed to say this. Therefore they are unable to proceed further with their investigation against the father.

Complainant advised that she has a current AVO against her former partner. However she is concerned that the children's father is making an application through the Family Court to gain access to the children.

Complainant stated that she cannot understand why FACS can advise that they have suspicions regarding the alleged incident, and yet cannot take further steps to protect her children.

This complaint was referred to the Department in the first instance for a response in accordance with Section 33 (c) of *the Ombudsman Act*. On 9 December 2010 the Chief Executive wrote to my office to advise that in response to the complaint a review of the child protection investigation was undertaken by the A/Senior Manager of the Quality Unit. The Chief Executive wrote:

*This review has resulted in a determination that the original outcome of the investigation to not substantiate harm was unsound.*

## DATA QUALITY

There is some doubt about the reliability of data and statistics from the Department.

In 2008, Jodeen Carney, MLA, Opposition spokesperson for Children and Families requested data from the Department regarding children at risk.

The Department corresponded with the Department of the Chief Minister to provide the information. A letter from the Department to the Department of the Chief Minister stated:

....  
***Re Abuse in Care Data*** - *we had done this for estimates, and so we are pulling this out and reformatting for her. But I've been told the report that is run without validation, has errors because staff miscode things when they enter the child protection report context (they tick a code that says something like in care, which when checked does not always show as the child being in care at the time, so people clearly use the code wrongly). So the report has to be manually checked, which is what we did for the Estimates process.*

A review of the implementation of the CCIS Intake Event reported that '*an unknown number of clients brought to the attention of NTFC have no record of the referral report recorded in CCIS if the matter raised was screened out at first contact.*'<sup>25</sup>

It is therefore probable that there have been more notifications received about risks to children but that this information is not recorded because it was 'screened out'. One example could be a notification from a school that the child was not attending. If the notifier was referred to the truancy line as was observed by my investigators when they attended Central Intake Team no record would be available for later retrieval or reference.

The Jay Tolhurst Review revealed:

*that there exists significant unease about the accuracy of the CP data upon which NTFC has had to rely in attempting to monitor and manage this CP demand issue. It relates to a concern that not every phone call received at Intake, where a record should be produced on CCIS, actually produces such a record.*<sup>26</sup>

This is consistent with reports from health professionals at RDH that when they made verbal reports CIT had no record on later enquiry by the reporter.

<sup>25</sup> Review of 'The Implementation of the CCIS Intake Event Function for NT Families and Children' at pg 2 dated May 2010.

<sup>26</sup> Jay Tolhurst report, Review Report of NTFC Intake Service June 2009, pg 38.



My investigators were unable to identify one intake record out of approximately 250 that we closely examined which did not have discrepancies or errors in it.

### **THE IMPORTANCE OF COMPLETE AND ACCURATE INFORMATION**

Following the death of Deborah Melville the CPA conducted an internal review of the CPA system. It was broader than a review of just CIT. A reviewing team made a recommendation – [24] on 20 August 2007:

*‘As a matter of urgency FACS undertake a more comprehensive review of current record management practices..... and develop and implement record management standards and guidelines’.*

By July 2010 the standards and guidelines had been reviewed and included in the Procedures Manual. They are included here as Attachment B. However, within the CIT the guidelines and standards were not complied with. If they had been, information requested by the Ombudsman ought to have been readily retrievable and it was not.

The record that captures information and is the basis for any action by the CPA is the Intake Form. The significance of not capturing earlier notifications or history relating to a child, that child’s siblings or family carers is that a later notification will not take into account relevant information which, when looked at cumulatively, would tend to suggest that a child’s circumstances ought to be assessed or investigated even though assessment of a single event has insufficient indicators to examine the child’s circumstances. This is particularly important if the potential for harm or neglect can be predicted from a series of reports about a matter that, on its own, may not raise alarm bells. The case of Derrick Mawley is an example:

#### **Family history<sup>27</sup>**

Derrick was born prematurely at RDH in July 2009. His mother died in hospital a few days later. Nothing is known of his father. He had a brother aged 17 and an 8 year old half brother. Both had special needs. The family experienced significant stress even before the death of the mother. All three children were cared for by their uncle, after the mother’s death. He alleged that the Grandmother was aggressive and had smacked the other two children, while in her care. Derrick’s two brothers were already the subject of numerous notifications of suspected neglect and emotional abuse over a number of years. At 2 months of age Derrick returned to hospital.

Medical examinations showed that Derrick had a head injury, multiple fractures to his limbs and other serious medical conditions that required medical treatment, monitoring, rehabilitation and follow up. These injuries were considered to be non-accidental.

Derrick remained in the care of RDH. An investigation began and police were notified. A joint investigation was undertaken by police and NTFC. Derrick was taken in to the protective care of the CEO of the Department and subsequently placed in Foster Care. He will have lifelong severe disabilities.

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<sup>27</sup> The full history of the family’s involvement with the CPA is related at Page... 195 et seq.

### **Police History**

Derrick had two police involvements recorded as a **victim and child welfare**. His mother had 22 recorded involvements with police, which included 13 incidents of domestic argument and family violence. It was also noted that the children's uncle between 1999 and 2007 was a family violence offender on seven occasions and on eight occasions he had been the subject of a warrant or a Court order. He was also known to use an alias. He had been convicted of breaching a restraining order and of assault occasioning bodily harm.

### **Notification History**

5 August 2009 (No intake form completed for this notification by CIT)

An allied health professional at RDH made an email notification about Derrick. The following information was provided:

- Derrick was a premature baby, an inpatient at RDH since birth and was a 'child at risk'.
- Derrick's mother became gravely ill after giving birth to him and was in Intensive Care Unit at RDH, in a coma and on life support in hospital.
- A relative was presently caring for Derrick's two other siblings aged 17 and 8 who both had disabilities and the uncle also had his own medical problems.
- The Grandmother also offered to care for the children but due to her age and language concerns, required support.
- The notifier advised that although they were working with the family to find support services for the family they requested CPA involvement to assess the family's situation and provide additional family support.

### **Assessment:**

The assessment decision/outcome for this notification is unknown because no record of it was disclosed by the Department in response to a summons requiring production of all of the Child Protection Authority's records for this child.

### **Ombudsman yet to investigate:**

Why was this email notification not entered into CCIS?

Why has the information requested not been provided to the Ombudsman?

### **7 August 2009**

An email was sent by an allied health professional stating that a family meeting had been held to discuss who would be able to take care of the children. The Allied Health Professional stated: *'I would appreciate your urgent response to this matter, with the view to your **assessment of the family** situation, and alternative care options available to the family, should the uncle decide that he can no longer care for the children'*.

### **Assessment:**

There was an extended family willing to care for the boys and the family had been linked/referred to other service providers for ongoing assistance. At that point in time there was no role for CPA. In consideration of the risk and protective factors for these children, it was recommended that the CP report not proceed to investigation.

**Ombudsman yet to investigate:**

Why was it recorded in the intake form under the heading 'Background' that '*there have been 4 previous notifications for this family but that the allegations have been vague and not sufficient to warrant investigation*' when in fact there had been 12 previous notifications about both **George** and **Jayden** and the family situation? It was recorded that the older brother liked to pick the other one up and throw him to the ground. Why was this information not taken into account by CIT when assessing the notification?

**17 August 2009**

An Intake form was completed on 20/8/09 by the intake worker following receipt of an email from the social worker dated 17/8/09, querying why she had not received any further contact from CPA following a previous notification requesting CPA assistance, intervention and family support for the family.

**Assessment:**

The A/Child Abuse Taskforce and Central Intake Manager made the following assessment:

*as discussed the information provided to date in relation to this family is not sufficient to proceed to investigation.'* Assessment states '*There were nil child protection or child well-being concerns raised by the notifier in regards to the subject child. Therefore it is recommended that this matter be recorded only as an Intake Event.*

**Outcome:**

No action. (ie, no action and not even recorded as a child protection notification for later reference.)

At this point of time the reporting social worker from RDH was not aware that there had been previous reports to the CPA about the baby's siblings. She was not aware of the aggressive behaviour of the two siblings or of their disabilities. She was not aware of the Police History of the uncle. Her professional opinion, without that knowledge, was that there was a very serious risk of harm if the child left the RDH to be cared for by the uncle. She made two email notifications and three phone calls to explain her reasons. She was ignored. The CIT did not do any police check on the uncle. The social worker requested her manager to write to the Minister about the failure of the CPA to take action to no avail. Eventually her conscience and concern caused her to go to the Children's Commissioner. She was reprimanded by her superiors and at RDH for approaching the Children's Commissioner. Her name was Susan Mansfield. The CPA was informed that the uncle was applying to Court to obtain an order placing the child in his care. The Minister is on public record as saying that the decision to place the child in the care of the uncle was made by a Court. That is correct. **The CPA, however, did not provide to the Court any information about the concerns notified by the RDH social worker, or the history of contact between the CPA and the family. No relevant information was given to the Court other than what was given by the carer.**

**Notification Four: 27 September 2009**

A doctor provided the following information:

- Derrick was brought to RDH by his primary carer on 25 September 2009. He was generally unwell and his symptoms first suggested meningitis;
- He tested negatively for meningitis but his condition deteriorated;

- He had a CT scan which determined that the child had an inter-cranial haemorrhage;
- This haemorrhage being described as a 'significant bleed' with doctors uncertain of the cause;
- The presentation of the bleed was indicative of a non accidental injury;
- His carer could offer no explanation for the bleed;
- He remained in hospital and had a full examination for non accidental injury;
- The child's medical condition was described as 'very unwell';
- He had been cared for by his carer since his mother passed away shortly after his birth;
- He was born pre-maturely at 34 weeks;
- His carer also cares for his two siblings. The notes indicated that both these siblings had special needs.

**Assessment:**

The assessment stated that this notification warranted a child in danger response . A CP Report was allocated to Casuarina CPA to investigate and to CAT North police. Neglect was substantiated.

An affidavit of an investigator was later prepared the investigation that had been undertaken by the Department. The relevant parts are:

*The carer was asked to explain the lead up to Derrick being admitted to RDH on 25 September 2009.*

*The carer stated that he left Derrick in the care of his older siblings in the late afternoon of Sunday 20 September 2009 so that he could buy nappies and toilet paper from Coles. He completed this journey on foot and said it took less than an hour. The carer said he left Derrick asleep on his bed, wrapped up and placed in between two pillows. On his return, the carer said that the older child met him at the door and told him the middle child had 'dropped Derrick'. The carer then went to his bedroom and found Derrick unwrapped and on the outside of the pillows. The carer said Derrick was not crying and had no marks.*

*The carer stated he left Derrick asleep on a mattress on the floor of the lounge room. At the time he left the residence, the two older boys were watching a wrestling video. The carer said that it was common for the boys to act out wrestling moves, especially the middle child.*

*The carer stated that Derrick was unwell for the next three to four days. He said that from Sunday night to Thursday morning Derrick was not waking up for his feeds and was very quiet all the time.*

*The carer stated that on the morning of Thursday 24 September 2009, Derrick began crying out again when he was hungry and his nappy needed changing.*

*The carer stated the early morning of Friday 25th September 2009, he realised Derrick was 'burning up'.*

*The carer stated that when the nurse checked Derrick at Casuarina Community Care she advised him that Derrick was 'really crook' and that he needed to take him to the Emergency Department immediately. The carer then caught a taxi to RDH.*

*The carer stated that he was feeling 'seriously mentally burnt out' over this period. He said he had very little sleep and was very forgetful. He said there were lots of things going on and his 'brain was not working'.*

*When NTFC workers asked why he had not sought medical-advice-or-treatment-for-Derrick after he had been-dropped and when his behaviours changed, he said it 'didn't trigger: there was anything wrong'.*

A report from the Casuarina Community Care Centre explained the involvements with the carer as follows:

*Immunisations- Appointment 25th September 2009. Not given child acutely ill. Appearance when child sighted-Universal Home visit 03/09/2009- baby check all within normal limits.*

*No further assessment achieved.*

*Clinic visit 25/09/2009- brought to clinic by carer (uncle) after another phone reminder that appointment made for the am had not been kept. Child had fever; carer reported had it on and off for over week, had not seen doctor, had been feeding less over last few days and not interested in feeding, weak cry and carer stated had not heard him cry for past 2 days.*

*Appointments- several attempts to make contact with family prior to presentation on 25th Sept.*

Between 7 September or 24 September clinic staff had been attempting to contact the child's carer. They made six phone calls, called at the house 4 times and left a message for the carer to call. He did not attend an appointment on the morning of 25 September.

### ***Inadequate training in use of information technology***

Intake workers use a computer system known as the Community Care Information System (CCIS). Witnesses informed my investigators that their training for CCIS was completely inadequate. Witnesses said that the only CCIS training they received was when they attended a whole of Department orientation day at RDH.

The bulk of this training was not specific to the phases required for an intake notification. One witness explained the training she received as follows:

*I went to the hospital where we had, I think, one hour training for the first session and that included all the nursing staff and other people within the department that had arrived...to do the various jobs here. But to be honest if you asked me, after that first session I probably came back with the same amount of knowledge as I started with because it wasn't focussed on... intake, so it was just a general overview of...the CCIS itself, so I found that training wasn't... sufficient enough for me to actually start the job.*

*If I was given an Intake to do after that training and I can honestly say I wouldn't have been able to...use CCIS because it wasn't Intake orientated it was just a general overview provided of CCIS.*

My investigator made enquiries of the Director of the Community Care Information System about the capabilities of CCIS. He said that there are individual tailored training modules specific for intake workers. These training modules are competency based. The Director explained that when large groups of personnel are recruited training sessions are held. Witnesses told my investigators that no tailored intake CCIS training was provided to them; rather training occurred 'on the job.' All the witnesses said that the orientation they received was inadequate and did not place them in the position to confidently perform their duties for which competency in using CCIS was critical.

I have been unable to examine the induction process of intake workers further. I had intended to conduct further interviews with the new recruits and obtain all relevant orientation material.

I refer, however, to the Jay Tolhurst report of June 2009. At page 39 of his report he described how the Initial Danger Assessment was not helpful and did not assist to do assessments. He pointed out that the IDA was a CPA adaption of a tool used elsewhere for a different purpose. He recommended that when the SDM was introduced to replace the IDA training would need to take account of the compromised local reputation of such tools because of the experience with the IDA.

### **RECOMMENDATION**

I recommend that a review of the adequacy of orientation training is pursued by the CPA to identify training needs for intake workers so that they have the capability to use CCIS effectively.

### **INCOMPLETE INTAKE EVENTS**

An exception data report known as the, **Incomplete Intake Events for a Work Unit' Report'** identifies intakes that are incomplete. Incomplete means that an investigation has not been done so that the outcome of a notification can be recorded. If a report of harm is substantiated a course of action to decide how to protect a child would then be decided.

This exception report is scheduled to go to the CAT North Work Unit on a nightly basis and to the remainder of the CIT work units on a fortnightly basis. This report identifies all uncompleted cases that were referred to an allocated work unit and therefore requires some action by the work unit to 'complete' the event.

In 2010 CIT provided feedback that the schedule is considered too frequent and is not useful due to the volume of exceptions occurring. CIT staff said their preference would be for this report to be produced on a weekly basis. CIT has indicated that this particular report will be become more valuable and useful, when the Whiteboard is no longer used.<sup>28</sup>

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<sup>28</sup> CCIS Review of, 'The Implementation of the CCIS Intake Event Function for NT Families and Children', Version 1 May 2010.

It can be deduced from this information that the Department, the CPA and all work units were well aware of backlogs. It took public exposure by the Board of Inquiry for action to be taken.

## **WORKFORCE ISSUES**

### ***Implications of inexperienced workers***

#### Vacancies at CIT

*CIT has experienced a high turnover of intake staff and has never experienced an extended period of time when it was fully staffed. Recently more staff have resigned and this service is again operating well below capacity.<sup>29</sup>*

As a result of this staff turnover, workers from other areas were asked to come and work at CIT on a short term basis. A witness interviewed by my office said:

*Management sent out an SOS around December 2010 to other agencies to come and help us because we had no staff. It had a detrimental effect though because each day you had these workers showing up, some only for a couple of hours here and there and then going. It made it even more difficult because they were only there for a short while and with little notice given that they were coming. It meant IT couldn't give them access to our computer systems which meant there were all these pieces of scrap paper floating around with information on them that hadn't been entered into the system.*

The witness explained that this had been occurring since December 2010 through to February 2011 when I stopped investigating.

A witness provided my office with a print out of a notification completed by a recently recruited worker assigned to CIT as a result of the SOS. The notification referred to a call received from a teacher with concerns about a slap mark on a child's face that the mother had allegedly inflicted. The child at the time of the notification was living with the father. The notification was made on 27 January 2011. The intake recorded the following:

*The alleged perpetrator is the mother, however the child resides with his father and the primary responsibility of the child care is with the father. The father is willing and able to protect the child from the mother. Therefore, pursuant to Section 20(a) of the Care and Protection of Children Act, 2007 the information received has identified as 'the child has suffered or is likely to suffer harm or exploitation because of an act or omission of a parent of the child'. As per SDM Screening Tool the incident has been screened in as the child concern and requires a response within 5 calendar days.*

The use of the SDM tool resulted in an assessment of a Child of Concern. The tool is only capable of assessing the information put in. The 'SOS' worker could not access CCIS and the risk of a false result from use of the SDM in the circumstances was predictable and avoidable because the decision maker did not have access to any previous history of the child's interaction with the CPA.

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<sup>29</sup> Extension of Review Report DCF Intake Service by Maureen Armstrong pg 5 – dated May 2010.

Six days later a team leader went to outcome this matter and recognised that it was recorded in CCIS that the father was a convicted child sex offender.

An additional assessment was undertaken by the team leader and the new assessment was recorded as follows:

*The notifier contacted Central Intake on the 27.01.2011 to advise that the child had been slapped on the face by his mother ... however, he was safe in the care of his father ... Departmental records indicated that the father was convicted for child sex offences in 2008 and NT Police intelligence has confirmed that this information is accurate.*

*The content of the allegation regarding both ... parents.. and the concerns regarding the father have both been screened into the SDM tool to determine whether (child) is in need of care and protection from either or both parents.*

*The physical assault on ...the child by his mother has been screened into the SDM assessment tool under the category of Physical Abuse, using the criteria of 'excess discipline'. The SDM response criteria has screened the contents of the allegation as a child concern requiring a 5 day response.*

*However, due to the identification of (the father's), criminal history and (child) residing in the home with his father, the above 5 day response priority identified has been superseded by the risks associated with Sexual Abuse, and criteria of the child being at 'significant risk of sexual abuse'. The SDM response priority has screened this information as a 'child at risk' requiring a 3 day response.*

By the time this assessment was done the child had lived with a sex offender for six days.

### ***Inadequate supervision of staff***

A commonly reported comment by CIT workers interviewed by my office was that there was no or very little supervision. One interviewee informed my office that no supervision had been provided in the past nine months. Another said that 2 years had lapsed since her last supervision occasion.

Manual 3 stipulates that:

Professional supervision is an essential component of the provision of services. All workers providing NTFC services have a right to receive regular formal supervision.

In the survey conducted by my office, intake workers were asked whether they agreed with the statement:

*My manager/supervisor regularly provides me with constructive feedback on my performance and the results he or she expects.*



67% disagreed with this statement.

The Board's Report made several recommendations relating to supervision and training and I endorse these recommendations – 12.8 – 12.14.

## **STAFF CLIMATE SURVEY**

### **Background**

Many staff interviewed expressed their concerns about extended work hours and the impact this has on their own wellbeing and that of the clients they are servicing. The after hours service and its restructure is but one instance of CIT workers complaining that communication by management about changes and policy was poor and management did not consult with the workers most affected by management's decision.

One of the recommendations of the Board of Inquiry was that the Department organise an independently conducted morale survey of the staff at the Child Protection Authority (Recommendation 128). The urgency applied by the Board of Inquiry to that was within 18 months of October 2010. The Commissioner for Public Employment conducted such a survey of all staff in the Northern Territory Public Service early in 2010. The findings for staff in the Child Protection Authority could not be isolated from those of the whole Department.

In view of the number of approaches to me by staff of the Department and the Child Protection Authority expressing dissatisfaction about their work climate, I conducted a survey.

The survey was of past and present intake workers at CIT. The primary aim of the survey was to measure the staff climate. My office obtained from the Department contact details for the past and present employees of CIT from January 2009 to December 2010. The contact information for 48 individuals was provided. We were unable to confirm the whereabouts of 8 of these people, so 40 surveys were sent. From this 30 responses were received. There were 26 questions and the responses were anonymous. I have provided to the Director of the Department of Children and Families and to the participants a full copy of the survey but I mention some of the interesting findings. The survey was conducted in April 2011.

Respondents were asked to give their answers stating whether they strongly disagreed with a statement, disagreed, agreed, strongly agreed or neither.

### **Key Findings**

- Only 24 percent felt they would **not** suffer any negative consequences if they lodged a grievance.
- 57 percent of respondees either strongly disagreed or disagreed with the statement that  
*'my organisation has good procedures and processes for selecting employees'*.

27 percent provided no opinion.

- In answer to the statement

*'my workplace selects people with the right knowledge, skills and abilities to fill job vacancies'*

80 percent either did not agree or strongly disagreed and 7% had no opinion.

- 74 percent believed that change is not managed well at CIT, with no opinion from 13 percent.

For an organisation that is going through significant change and has been for the last 18 months this is a most significant finding if indicative of staff currently employed and should be followed up immediately by the Child Protection Authority.

- 63 percent reported little confidence in the formal processes used to resolve employee grievances. Just 17% felt confident that the processes to resolve employee grievances were fair. 64% did not feel comfortable approaching their manager to discuss a workplace grievance or dispute.
- Only 30% of the intake workers agreed that  
*'good work performance is acknowledged'*  
and only 20% agreed that the  
*'workplace promotes equity and fairness in employment'*.
- A significant majority of employees reported that gender, age or cultural background is not a barrier to their status at CIT and that confidentiality was taken seriously.
- 70 percent did not feel that their manager/supervisor is good at managing people.
- Just 17 percent agreed that leadership at CIT is of a high standard.
- Only 20 percent believed that *favouritism is not a factor in decisions about hours of duty, permanent appointment or promotion of employees* at CIT.
- A minority (16 percent) felt that opportunities for part-time work are available if they wanted to work part time. Only 16 percent agreed that their workplace proactively supports people to achieve good work life balance.

### ***Bullying and Harassment***

Three questions were asked about workplace bullying, harassment or unfavourable treatment and the results were so significant that they are reported here.

- In answer to the statement:  
*'My workplace is free of bullying and/or harassment **of employees to each other**'*  
37 percent disagreed or strongly disagreed. 20 percent had no opinion

- In answer to the statement:  
*'My workplace is free of bullying and/or harassment of employees **by their manager/supervisor**'*  
41 percent strongly disagreed, 24 percent disagreed, 14 percent had no opinion.
- In answer to the statement:  
*'Bullying and harassment is not tolerated in my workplace'*  
57 percent disagreed, 13 percent had no opinion

On 16 June 2011 I discussed this survey with a Senior Project Officer from CPA. He submitted to me that I delete the survey from this report because a person in it was identifiable and I should give the person concerned an opportunity to comment on any implications against that person. I am required by the *Ombudsman Act* if I propose to make an adverse comment about a person to give that person an opportunity to make a submission. I had no evidence to identify any person to whom the survey referred. There were 48 people identified as working at CIT during the period covered by the survey. Some would have been team leaders, supervisors and managers. The survey was done anonymously. I did not agree that the *Ombudsman Act* obliged me to write to all 48 participants and invite them to make a submission to me if they considered they had been identified and I had made an adverse comment. I wrote to the Project Officer and asked him to contact the person he thought was identifiable and invite that person to make a submission. I received no submission from anyone. The CPA submitted that I remove the whole survey and instead send it to the Office of the Commissioner for Public Employment for him to follow up. I do not have permission from the participants to do that and the CPA can do it if it wishes.

Of the 40 surveys sent managers and supervisors were included. That staff felt trepidation about speaking to my investigator was apparent. Workers at the Child Protection Authority did not approach my Office until late 2010, shortly after one social worker, Susan Mansfield, spoke out publicly on the Four Corners Program and after release of the Board's Report. A number of people phoned my Office without giving their name and indicated they wished to speak to the Ombudsman but were fearful of disclosing their identity because of fear of reprisals. An approach was also made by the Union representing the workers at CIT who passed on the same information, namely, that workers had come to the Union with relevant information about the Intake Service and would like information imparted to the Ombudsman but were afraid.

I did receive a report from a CPSU representative which is partly reproduced below:

*I have been employed in the role of Field Organiser with the CPSU Darwin Office since January 2010 and am responsible for the Department of Health and Families, NT-wide as part of my portfolio allocation. Throughout 2010, the majority of all member issues and grievances raised with me originated from within the Peter McAulay Centre. [ie. The Intake Team]*

*The issues raised with me by members focused on elements such as:*

- *Lack of management support and direction*
- *Bullying and harassment*
- *Inexperience of management and team leaders*

- *Intimidatory management practices*
- *Rostering changes without consultation*
- *OHS (physical and psychosocial) concerns*
- *Significant workplace change without consultation*
- *Stress*
- *Workloads and work/life balance*

*I was informed of most member issues through the nominated CPSU Workplace Delegate, with conversations regarding member concerns taking place almost weekly from approximately mid June 2010 to mid December 2010. In addition, I sourced information from members at scheduled meetings that took place on 17<sup>th</sup> February, 18<sup>th</sup> June, 20<sup>th</sup> July, 21<sup>st</sup> September, 15<sup>th</sup> October (hook up), 25<sup>th</sup> October, 26<sup>th</sup> November (hook up) and the 7<sup>th</sup> December.*

The proposed restructuring of the AHS has been recommended by a consultant, Maureen Armstrong, after a review of the intake service. The review report explained well the changes and the reasons for them. It would appear that some workers have not been made aware of the review. That may be because they only work at night. The dissatisfaction expressed and how to manage it is best decided by a human resources professional at the CPA.

### **GOVERNMENT INITIATIVES TO IMPROVE STAFFING LEVELS**

On 3 December 2010 it was reported in the ABC News that the Northern Territory Government had announced a \$6 million package of incentives for child protection workers. It was reported that the package was designed to recruit new workers to the Territory and retain current staff. The ABC asked how many workers had left the Department this year but Mr Vatskalis' spokeswoman said that figure was not readily available. However, she did comment that there were more staff than there were at the start of the year.

CPA recorded a 32 percent increase in staffing resources in the 2009-10 financial year, represented by an increase in the average Full Time Equivalent staffing from 315.2 positions in 2008-09 to 414.9 positions in 2009-10<sup>30</sup>.

On 7 November 2010 the Hon Minister for Children and Families explained in a media release that:

*The Government is committed to reducing the backlog of investigations, and in order to address this as urgently as possible, child protection frontline workers from Tasmania and New Zealand will be arriving in the Northern Territory within the next month,' Children and Families Minister Kon Vatskalis said today.*

*'This is in addition to the work already being carried out by the Department to address this backlog, including seconding trained staff from departments interstate and redirecting our own staff to the frontline to get through the backlog.*

*'We can confirm 8 from New Zealand and 6 from Tasmania have accepted the NT's request for workers to tackle the backlog – exceeding the 10 workers announced as part of the blitz last month.*

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<sup>30</sup> Department of Health and Families Annual Report Page 99

*'I am also pleased to confirm that two recent recruitment drives in the UK and Canada have found 41 suitable candidates for permanent frontline positions.'*

Despite the increases in staffing levels it appears from information provided to my office by staff that this had not filtered into the CIT area.

This is evidenced by correspondence from CIT Workplace Delegate to Union dated 2 February 2011.

*I am writing to you regarding concerns here at DCF CIT/AHS two people have come to me tonight as workplace delegate and advised me that there have only been 2 staff on during today and a team leader and admin.*

*The admin worker has been putting emails on the system and doing background checks.*

*The team leader is so snowed under that she is not able to keep up.*

*They have had some relief staff in but they don't know what they are doing and one of them has created a child in danger as a child concern as such. Thus the team leader is busy trying to fix those mistakes.*

*The CIT day time team is not functioning at all 'children's lives are at risk as a result of this' it appears that the sole responsibilities for the children in the NT are being placed on 2 staff members taking calls 1 admin worker and a team leader. There is no experienced staff during the day here.*

*I have to go as there are lots of calls coming in please call me tomorrow.*

### ***Lack of Information Provided to Professional Reporters***

A sample of 17 children files revealed the following:

- 21 notifications had been made by Professional Reporters about those 17 children.
- 52 percent of these notifications had been assessed as not meeting the threshold for an investigation.
- 62 percent of the Professional reporters did not receive a response to their notification.

The following is outlined in Manual 2 (2008) at 7.3.4:

Reporters who are making a report in their professional capacity are entitled to receive a call back or written confirmation from the Intake worker of the following:

- whether or not the report has been accepted for investigation
- the response classification rating and
- the office to which it has been referred

Feedback can be provided either at the time of first contact with the reporter if an immediate decision is possible, or by return phone call, or in writing if further assessment is required.

Written confirmation may be provided on an Outcome of Report in Regard to Allegations.

Manual 2 and the current manual have no significant differences with regard to this policy.

Professional reporters interviewed told my office that they were never informed by CIT that they were entitled to receive a response in relation to the notifications. The professional reporters said that it was often the case that they had to continually follow up CIT to determine what the outcome was from their notification. Some professional reporters said that as a result of doing a follow up phone call they were told by CIT staff that there was no record of their notification. It was a result of this that some professional reporters began sending emails to ensure that there was evidence of their notification. Professional reporters explained that because feedback was not provided they had to keep reporting the family or try some other course of action.

A professional witness with 22 years experience in the child protection area said that in 2009 she made approximately 80 notifications to CIT and only received 4 responses.

A witness explained:

***There appears to be a veil of secrecy drawn over NTFC: information flow is only ever one way and getting information from them is very difficult. I have spoken with police often at RDH and they have had the same experience. This lack of information sharing makes it difficult for RDH social worker to assess safety of children when discharge planning.***

*Likewise, no information on previous NTCF involvement leads to a shallow history of psycho-social issues that would otherwise be the case...*

A former manager of an Allied Health Service within Royal Darwin Hospital (RDH) told my office that meetings had been convened with the Manager of CIT in 2009 to discuss the lack of responses provided to professional reporters about their notifications. The manager said that despite these meetings, professional reporters continued:

*making applications to a black hole and having to ring up and try and track and get feedback so we knew what we should or could be doing further with the kids, you know, here at the hospital.*

In February 2010 the Children's Commissioner in a report on the Intake Service made the following recommendation and indicated that it should be actioned as a matter of urgency:

*That NTCF policies and guidelines be amended to reflect the principle that the opinions of health and allied professionals who have worked directly with infants and young children and their caregivers, should be afforded special consideration in assessing the risk status and wellbeing of children.<sup>31</sup>*

Although the Department was aware of the lack of response to notifications since 2009 through meetings with a manager from an allied health service and the recommendation from the Children's Commissioner in February 2010, no significant changes occurred within the Department's policy and procedures until the implementation of Manual 4 (July 2010) when the following section was inserted at 7.3.5:

#### **Reports from Medical Personnel**

The opinions of medical and allied personnel (registered health practitioners) who have worked directly with infants and young children and their caregivers, should be afforded 'special consideration' in assessing a child protection report. All reports received from medical and allied personnel (registered health practitioners) are to be recorded as Child Protection Reports. Registered Health practitioners include Aboriginal health workers, chiropractors, dentists; dental hygienists; dental prosthetists, dental specialists; dental therapists, medical practitioners; midwives; registered nurses authorised to practise midwifery; registered and enrolled nurses, occupational therapists; optometrists; osteopaths; pharmacists; physiotherapists, psychologists and radiographers.

It is to be noted that social workers were not included.

However, this section was removed from Manual 5 in September 2010.

<sup>31</sup> A Report Relating to a Child Protection Notification made to Northern Territory Families and Children in Respect of Baby BM.

On 2 November 2010, the following practice direction was issued:

All reports received from Health and Allied Health Professionals (Government and Non-Government) are to be recorded as a Child Protection Report. You will need to apply the Screening Tool and Priority Tool (if Screened In) as per usual process. During the call, you need to determine the intention of the Reporter and note this within the intake notes (ie. is the Reporter intending to make a CP Report/Notification?).

The term 'Allied health Professionals' usually includes social workers.

However, in December 2010, the facility for professionals to notify by email or facsimile was removed. They must now queue on the telephones which are not answered when CIT workers are completing data entry before returning to the phone.

I wrote to the Department and the CPA to clarify who were treated by CIT as professionals. I received the following information:

*Categories included in the 'All professionals' aggregate are hospital/health centre, medical practitioner, other health personnel, **social worker**, school personnel, childcare personnel, police, departmental officer and non-government organisation.*

*Section 19 and 20 of the Care & Protection of Children Act 2007 gives a broad indication of which reports would be considered 'professional' and in our current NTFC Care and Protection Policy and Procedures Manual S7.3.4 professional reported are indicated to be 'Reports who are involved in service provision for the child and/or family...'*

## **RECOMMENDATION**

That for the sake of clarity 'social worker' be included as a professional reporter in the Operations Manual not just in a practice direction.

A manager interviewed by my office said that the Department had taken some steps to make medical personnel authorised officers in accordance with the CPC Act so as to enable the medical personnel to take a child into provisional protection. Section 52 of the *CPC Act* allows an authorised officer to:

- Arrange for a medical examination of the child; and
- Arrange for the provision of other medical services for the child; and
- Make other arrangements for the care and protection of the child; and

Further examination is required to determine whether this initiative has been implemented and if so whether training has been provided to the medical personnel to undertake this role. Consideration should also be given to whether other professionals such as social workers, nurses and other allied health professionals also become authorised officers. Their authorisation could be limited to exercising the power under Section 5.



The Child Abuse Taskforce Intake Minutes dated 9 December 2009 recorded that:

*NTFC are looking at developing their relationships with Paediatrician's who have been around a long time, and would be a valuable resource in relation to topics like STI's in children, and Failure to Thrive.*

On 30 November 2010 the Manager of CIT issued the following practice direction:

*If the person making the report believes that a child is being harmed or exploited or is likely to be harmed or exploited, the information must be recorded as a Child Protection Report. The exception to this are reports where a Child is Not under Control, is engaged in conduct that is likely to cause harm to themselves and where there are no allegations of parental abuse or neglect (S20(d)). These are recorded as Protective Assessments (see chapter 10 Protective Assessments).*

*The Intake worker must establish the belief of the caller. In order to establish the belief of the caller, the Intake Worker may ask:*

- *Do you believe that the child is being harmed, likely to be harmed or living in a harmful environment?*
- *Do you believe that that the harm is caused by their parent/caregiver or that the parent/caregiver is not protecting the child?*
- *An Intake Outcome other than 'Child Protection Report' may only be chosen where: it is not the intention of the person providing the information to make a report of harm to a child where the harm reported is not believed to have been caused by an act or omission of the parent.*

*This Practice Direction will be included in the new Policy and Procedures Manual, which is expected to be finalised in the near future.*

The second dot point of this Practice Direction is contrary to the terms of the CPC Act. It confuses the concepts of “a child in need of protection” set out in Section 20 of the CPC Act with harm to a child set out in Section 26 of the CPC Act. There is an obligation created by Section 26 to report when a person believes on reasonable grounds that a child:

- (a) (i) has been or is likely to be a victim of a sexual offence, or*
- (ii) otherwise has suffered or is likely to suffer harm or exploitation.*

There is no requirement for a notifier to believe that the harm or sexual offence has been caused by an act or omission of a parent. That requirement only appears in Section 20 of the CPC Act. Workers acting on the practice direction are likely to discourage notifiers, and result in non acceptance or ‘screening out’ of valuable information. The direction in the first dot point is entirely unnecessary. If anyone has taken the trouble to ring CIT and make a report it is obvious that they believe a child is likely to be harmed or have been harmed or are living in a harmful environment. The asking of this question is disrespectful to the notifier.

Since 2 November 2010 CIT has kept a register of the notifications made by professional reporters which are not accepted. I commend the Department for taking this step. It had been my intention to do the following:

Obtain a copy of the register and review the notifications which were not accepted.

Interview the professional reporters who made these notifications.

Arrange for an expert and for the Children's Commissioner to review and discuss a sample of these reports to understand the reasons why the report was made and the reasons that it was determined that the report should not be accepted.

### ***RECOMMENDATION***

I recommend that further analysis is undertaken so that there can be a more complete understanding of the different perspectives of CIT and health professionals about how notifications are assessed by CIT, the criteria applied and the threshold for any action on a report.

There is a wealth of experience in both agencies and it is essential that both areas are working in unison to achieve the best results for children at risk and their families. More effective interagency collaboration needs to occur. Part of achieving this is enhancing the relationship between CIT, RDH and other hospitals and this can be achieved in part by regular meetings between these organisations. It is important that these meetings do not just occur between the upper echelons of management but also between the workers who are directly involved with the care of children on a daily basis, for example, a representative from the CIT intake workers and representatives from the allied health area, such as social workers and nurses.

### ***RECOMMENDATION***

I recommend that RDH and other hospitals keep a register of notifications made to CIT. I recommend that the Quality Assurance Unit do a three monthly comparison of the hospitals' register and CIT's register to assess outcomes and convergence or differences between reports made and CIT's assessments. The information gleaned should be used to develop education programs.

### ***OUTPOSTED INTAKE WORKER AT RDH***

On 3 November 2010 I wrote to the Department to clarify conflicting information provided about the newly created outposted worker position at RDH. On the one hand my office had been advised that this position was purely an educational posting and on the other hand told that the outposted worker would have the same responsibilities and functions as that of an Intake worker and could receive a notification from a doctor, nurse or allied health professional at RDH, have access to the medical records and see the child.

On 8 November 2010, the Department the responded with the following information:

- The position is currently held against the generic Advanced Practitioner role.
- The role has key components in facilitation, communication and education.
- The role of the CPA Hospital Liaison Officer includes:
- Develop networks and positive working relationships to facilitate clear information-sharing between RDH and CPA relating to children at risk of harm and/or exploitation, in accordance with legislative and policy guidelines.

- Convene and participate in case conferences and discharge planning meetings in relation to complex child welfare matters which require a multi-disciplinary approach to assessment and intervention.
- Provide a risk-assessment consultation service for hospital based professional reporters in relation to child harm/exploitation issues, including supporting RDH staff to provide high quality information to the Central Intake Team.
- Develop and deliver occupation-specific training in child harm/exploitation matters, including the identification of child harm/exploitation and mandatory reporting requirements for professionals involved with children and families.
- Participate in regular Paediatric and Allied Health meetings as required.

On 10 November 2010, I requested the duty statement for the outposted intake worker. I was sent a document eventually that was a generic document. At the same time I was told that the outposted worker was not necessarily performing those duties in the duty statement but there were other duties and her job description would be finalised in two weeks.

The Job Description for this worker states:

1. Responsible for the delivery of case work and case management services to NTFC clients, including the management of more complex cases requiring liaison with other Departments and Non Government Organisations.
2. Maintain a high level of services to NTFC clients through the provision of professional expertise and demonstrated best practice in the delivery of statutory welfare services.
3. Undertake statutory responsibilities and exercise delegations under the Care and Protection of Children Act 2007 in accordance with departmental policies and procedures.
4. Provide support, training and education to NTFC staff on program and practice issues to enhance their skills, knowledge and understanding of the NTFC program.
5. Ensure the availability of reliable data through the accurate and timely recording of information on the Department's client information and case management systems.
6. Participate in the NTFC After Hours Service.

The Department informed my office that the outposted worker was to commence on 19 July 2010 for a six month contract. My office established that the outposted worker commenced in August 2010 and finished in November 2010.

As at February 2011, the job description for this position had not been finalised. This role has been vacant since November 2010.

Staff informed my office that feedback had been provided to the Director of Allied Health that the outposted intake worker had been beneficial in creating linkages between RDH personnel and CIT. While at RDH the outposted intake worker had access to CCIS and was able to upload notifications to be outcomed by a team leader located at CCIS. This had been beneficial in supporting a quicker response time to children considered to be at risk of harm who were going to be removed from the ward.

## **FAMILY SUPPORT SERVICES – ‘ONE OF THESE MYSTERY PROGRAMS’**

These services have been called ‘*Family Preservation*’ (Wald Fogel 1998). I prefer that name as it lacks the negative connotation that is implied by ‘family support’.

A Family Support Response is designed to provide protective services to a child who is the subject of a report, but where the reported concerns are not assessed as warranting CPA forensic investigation and legal action to protect a child. Family Support Services can only be accessed or authorised by the Intake Team.

The importance of family support services has been communicated to the NT Government since 2002 when Tomison argued that observations of recent child protection history in Australia lead to the conclusion that:

*‘statutory intervention without a wider family support and preventative service network is highly unlikely to produce positive outcomes for children, families and communities’.*<sup>32</sup>

The Board’s Report reiterates the same message.

Undoubtedly the ability to provide an effective response to concerns about a child’s well being is linked to the level of family support programs and services that are available to work with families once they are identified as being at risk. The objective is to minimise the chance of a child later needing protection.

Approximately half of the reports to CPA are currently not accepted for child protection investigation because the reported facts are not assessed as meeting the threshold for undertaking a full forensic investigatory response.<sup>33</sup> My investigation found that reports frequently do not receive any other response although there are concerns identified such as a range of social, financial and health problems that could benefit from further assessment and perhaps the provision of family support services. Witnesses confirmed the findings of the Board of Inquiry that in some areas no services exist and where they do they are swamped. From 24 October 2008 until at least the end of January 2009 notifications about families that might have benefited from family support services were written off with the notation ‘*No NTFC response possible at this time*’.

On examining the intake records of over 90 children it became apparent that when a matter had been referred for family support services there were many occasions when later notifications were made to CIT. There does not appear to be any feedback to CIT on what services have been put in place or with what outcomes. It is clear that a number of referrals for family support services are ineffectual because of later notifications about harm continuing to the children. It would be sensible before assessing a matter as requiring a second family support referral that some information was obtained by CIT about whether the first referral was actually accepted by a service provider, what services were provided,

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<sup>32</sup> As cited in DHCS (2005), *A Family Support Framework for the Family and Children’s Services Program*, Department of Health and Community Services, Family and Children Services, NT Government Darwin.

<sup>33</sup> 2009 Community Child Protection Partnerships Differential Response Framework NT Families and Children pg 11.

whether or not the family accepted the services and maintained contact with the services so that if there is a lack of co-operation by the carers of children with support services another referral is not considered as an option unless other services either from a different provider of a different type or with a different intensity are available to be provided.

I have been informed that when a family is referred to an NGO for services there is a limited number of hours that will be paid for over a particular period. For instance, an NGO may be given a three month period during which twelve hours of services are to be provided. It is not uncommon with some families that contact is not made during that three month period. Three months/12 hours is not a long enough time to develop a relationship with a family and provide help. If at the end of three months the twelve hours services have not been provided the funding is not extended so that the services can be provided later.

### ***Family Support Services Policy***

There has been a real barrier within the CPA that hinders the offering of family support services as soon as it is recognised that a child or family are under strain. That barrier is of a policy of the CPA.

The DRF Report recognised that:

*Often families requiring a family assessment response would not be aware that NTFC has received a report about concern for their child's well-being. In such circumstances referral mechanisms that respect the family's right to privacy and maximise the potential for their engagement with support agencies must be used. Such families will also require proactive engagement and dedicated strategies to increase their participation in support programs (DOCS 2005).<sup>34</sup>*

Despite the DRF report clearly stating that a 'proactive approach' is required the current manual outlines three main pathways to access CPA Family Support services. These are:

1. a request by the family
2. a request made on behalf of a family by another person, with the family's knowledge of the request for assistance being made
3. a report that is not accepted as a child protection report and, when the family is aware of the report, an offer of a CPA Family Support service is made or a referral to a community service is made. Both the family and the service provider must accept the referral.

These referrals can only come through the Central Intake Team.

In the current manual there is no information provided, to direct intake workers, to consider canvassing a family support referral with a notifier if the information contained in the notification does not meet the threshold for a child protection response. In all the notifications reviewed by my office none of the notifiers had first approached the family to advise them that they were going to make a notification. Indeed there were many instances

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<sup>34</sup> 2009 Community Child Protection Partnerships Differential Response Framework NT Families and Children page 15.

identified where concerned relatives or neighbours had made notifications but stressed the need to remain anonymous. Notification 4 Kim Smyth is one such example.

In that notification an anonymous neighbour rang up to report concerns about abusive yelling by a child's mother. It would not be reasonable to expect a neighbour who does not know the family to speak to the family about family support services being requested?

Another example of a notifier's reluctance to approach the family is notification 5 for George Mawley. In that notification a carer approached a teacher at the child's school to make the notification on his behalf as he did not want to be identified as the person making the notification. Intake workers were asked by the Ombudsman's investigator how realistic it was to expect a neighbour to first approach a family of a child they considered to be at risk of harm to gain their approval to make a notification to obtain a family support service on their behalf. It was conceded that these steps were unlikely to occur. There is also an assumption that the general public is aware of the concept of family support services and are able to articulate this request when contacting CIT.

Intake workers interviewed admitted that since the change in the policy had occurred they could not recall any occasion where a notifier had rung to make a notification with the approval of the family.

The current policy may be considered to place well intentioned persons at risk by encouraging the public to approach families in an attempt to gain approval for help for the family. The policy does not place the interests of the children as paramount.

This policy assumes a struggling family will have the capacity to identify that they require assistance and the ability to take steps to obtain this assistance. Of all the files reviewed by my office there was only one example of this occurring. A mother contacted CIT and asked for support when her husband declined to care for their children any longer. She needed help to get the children from Katherine to Darwin. Her request was not approved for family support.

Manual 1 at section 7.6.3 2002 outlined a more proactive approach to identifying when family support services could be offered and is outlined below.

**Referrals that do not Warrant a Child Protection  
Response**

*There are many occasions where the concerns raised in a Child Protection Report contain insufficient information to warrant a Child Protection investigation. Although these referrals may not proceed to an investigation, the opportunity to offer other Departmental services to the family should not be lost. In these circumstances consideration should be given to responding to the family's needs through the Family Support Program.*

*Pro-actively responding and providing FACS services to notifications which do not fit into a maltreatment context, adopts one of the basic principles of Family Support; this being the provision of early intervention and support services in order to prevent a crisis from escalating to the point whereby a tertiary response is required. (Emphasis mine)*

This is an excellent policy but in reality there were two matters that meant it was only ever a policy. The first problem was that virtually no family support services existed that was capable of providing effective, sustained support at the levels needed. The second problem was that intake workers under pressure to cope with child protection reports came to inappropriately assess a notification as about FSS. Later workers receiving notifications then tended to treat earlier reports marked as FS as being of little significance.

Departmental staff interviewed were unable to answer whose responsibility it was to discuss family support options. Professional reporters interviewed reported being confused as to how and when family support services would be offered. One professional reporter said that his understanding was that an investigation needed to be on foot before a family support referral could be accepted. Another professional reporter interviewed said:

*I don't really have a good understanding of family support services. It seems to be **one of those mystery programs**. I believe that in order to get family support you have to make a child protection notification but that family support won't take on a case if it is a child protection matter. There's some sort of double bind in the system that makes it very difficult to get family support.*

When asked what their understanding was of Family Support Services another professional reporter interviewed said that:

*I suppose it's a bit like a bridge that Family Support makes sure they are connected to services. ... I did become rather disillusioned when the NTFC was saying, look, we're providing family support. And just like you, someone else said, well what is that family support, and really its just NTFC I suppose dotting their i's and crossing their t's where it had a sense of, ... we'll tell the family to go to Centrecare for counselling ... So they're not actually doing anything that's practical, its more, I suppose, a bit like pen pushing, just saying that to the family ... I actually thought that family support workers and this is my*

*own ignorance, did more hands on work with families and probably even to the extent where they might go with them to appointments and support them intensively for a period but it doesn't involve that level of monitoring, no. And so, you know, even I as a very experienced social worker was quite surprised at the limits of what NTFC offer families.*

The questions that need to be asked are:

1. How are families that need assistance able to ask for help by way of Family Support if they are not aware that it exists?
2. How has the Department communicated to the NGO's and the wider public the options available in relation to family support options?
3. Why is the only way Family Support can be obtained through CIT, which is the same phone number as the service with the image of 'baby snatcher'? For a family that is struggling it would be the last place they would go even if they had the insight to ask for help.

I refer also to Attachment D which sets out some of the plans of the CPA to improve family support services.

Recommendation 61 of the Board's Report was that the provision of intensive family support to prevent unnecessary placements be prioritised by the Northern Territory Government and that services are developed and funded accordingly. I agree wholeheartedly with this recommendation as the most crucial step to solving, in the long term, the problems of neglect and abuse of children in the Northern Territory. I understand the policy behind only offering family support services when there is agreement by the family whether express or tacit. However, such a policy does not put the interests of the children first.

### ***ALICE YOUTH BEDS – A STEP FORWARD***

On 13 April 2011 it was reported in the Northern Territory News that there would be safe beds for youths in Alice Springs. I wrote to the Chief Executive on the same day to gather further information about this initiative. The Chief Executive responded to my queries with the following information:

*...these services have been established in consultation with Police in Alice Springs focusing on young people who are at risk as a result of being on the street late at night on their own but generally not in need of protection.*

*Section 57 of the CAPCA provides for authorised officers to take children to a child home, to a safe place or they may decide the child does need to be taken into care. We have dedicated residential care houses to accommodate children / young people who need a safe place. The emergency safe place accommodation is provided for those young people where it is not safe to return them home.*

*DCF staff including a youth worker, professional officer and a team leader will work with the young person to make an assessment around the child's safety and then engage the parents with follow up programs. This may include referral to the Family Support Centre where a Family Responsibility Agreement could be entered into.*



*We have been working with Health and Police to explore a range of pathways as clearly some young people will be substance effected and will need support from health services. The Youth Hub currently accommodates the Youth at Risk Child Protection Team, the Family Responsibility Centre and the Street Outreach Service so there is lots of opportunity for better collaboration. We also have a number of NGOs wanting to move into the hub.*

*We are currently looking at data collection issues to ensure we capture individual profile and outcomes data as well as throughputs...*

I was informed that the circumstances of the youths will be triaged to identify why they have come to the facility. They will be offered health checks, bathing facilities and food. This is a very welcome initiative that hopefully will be extended to elsewhere in the Territory.

### **Targeted Family Support Services (TFSS)**

The CPA is aware of the need to proactively develop Family Support Services. A project called the Differential Response Pilot Project commenced in Alice Springs in 2009. It is referred to with praise in the Board of Inquiry Report. I made enquiries about this differential response known as the Targeted Family Support Service.

The need to have different approaches to engage families in voluntary services to identify and address their risk factors, rather than waiting until such cases are in severe crisis and warrant coercive intervention by child protection was discussed in a paper titled, *2009 Community Child Protection Partnerships, Differential Response Framework NT Families and Children* (the DRF report).

Services are offered to less seriously risk prone cases without a determination about abuse or neglect. It removes the 'blame' barrier to families accepting help.

The primary objectives of TFSS were to be:

- Creation of more support options for vulnerable families
- Diversion of families who have been referred to child protection (CPA) and prevention of further involvement with child protection services
- Engagement of external service providers in collaborative practice to keep children safe.

A Targeted Family Support Service (TFSS) receives referrals for family support from the Central Intake Team (CIT) and coordinates support services for children and their families across agencies within a regional network. A TFSS may also be involved in family assessments undertaken independently or in partnership with CPA.<sup>35</sup>

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<sup>35</sup> Community Child Protection Partnerships Differential Response Framework NT Families and Children 2009 page 4.

### ***Has the differential response of TFSS been effective?***

To examine whether the pilot of TFSS in Alice Springs, Darwin and Katherine has been successful I wrote to the Department in 2010 requesting information about TFSS including:

- what were the services provided
- the money spent for TFSS
- how many families have been identified as appropriate to be referred to TFSS
- how many of these referrals had been accepted, and copies of the written referrals
- in what areas TFSS had been implemented and the dates this had occurred.
- A copy of the service agreements for the NGOs engaged to deliver the services
- Copies of any reports about the outcomes for families as a result of receiving services.

On 8 September 2010 the Department informed me that:

57 families had been identified to be referred to TFSS.

**Alice Springs:** 42 Family Assessment Referrals and 9 Family Support Referrals

**Darwin:** 4

**Katherine:** 2

Those referrals accepted for support or assessment were:

**Alice Springs:** 37 (28 Family Assessment Referrals and 9 Family Support Referrals)

**Darwin:** 4

**Katherine:** 2

Targeted Family Support Services commenced in:

**Alice Springs:** February 2009

**Darwin:** May 2010

**Katherine:** August 2010

The Department asked for an extension until 13 September 2010 to provide the written referrals, the expenditure information and signed copies of the service agreements. I agreed to the request. The information was not received by a month later so on 13 October 2010 I served a summons on the Department to produce the information and documents under sanction of a penalty.

On 20 October 2010 information was provided in response to the summons. The information was inconsistent with information previously provided. The Department's information was that Alice Springs had 50 referrals of which 35 were accepted and 11 were not. My investigators pointed out that these figures did not add up to 50. Later that day the Department advised that there were in fact 46 family support referrals of which 35 were accepted and 11 were not.

On 22 October 2010 the following information was received from the Department:

*Due to human error, one of the referrals was overlapped on the spreadsheet when it was being created into the different parts. We have also found one additional referral that had been missed. Both referrals have been scanned for you..... The new spreadsheet indicated the additional referrals which brings the total accepted referral number to 38.*

*It was noted in the letter dated 8 September 2010, that 42 Family Assessment Referrals and 9 Family Support Referrals (51 referrals in total) however this figure has changed as Part 6 in yesterday's spreadsheet's total should have been 6 not 5, once again due to human error. The correct total figure is now 49 (as shown on the spreadsheet).*

*There may be inaccuracies in the data provided to the Ombudsman. DRF is a developing program, it is a pilot project and as a result changes haven't been made to the client data collection system (CCIS) that would enable us to accurately track TFSS referrals. These changes will be made when the pilot becomes a part of core service provision. The recording of data has been predominantly the responsibility of the Community Child Protection Worker. Due to staff changes and vacancies in this position, the recording of data has not been consistent. As a result of the potential inaccuracies detected in the data, in future we will be coordinating the data collection as part of the Strategic Projects unit support role.*

On 22 October 2010 during an interview on *Stateline* the Acting Executive Director of the CPA said:

*There's a huge role for both government and other, non-government organisations, a role for them to play in supporting and diverting families so that they never end up in the statutory system. So, teachers, doctors, nurses all play a critical role because they have contact with those families in the very early stages and can identify symptoms of neglect, and can often refer a family to a local provider, a local non-government organisation, to get the service and response that they need, as soon as they need it. At the moment, many of those reports that come in to our central intake, we have no capacity to deal with those, so we really need to beef up that secondary support system through the non-government sector and ensure that across the Territory we have a range of services available for families.*

I agree entirely with that statement which is why I wanted to examine the TFSS records to see if the initiative was effective.

The trial that has occurred, first of all in Alice Springs and later extended to Katherine and Darwin was evaluated by Charles Darwin University and a report issued 31 August 2009 entitled 'Evaluation of the Northern Territory Differential Response Pilot Project'. I include information about the pilot reported on by Charles Darwin University in that evaluation report of the Alice Springs TFSS:

## **4.2 Targeted Family Support Service**

### **4.2.1 Relationship with NTFC**

*The relation of the TFSS to NTFC was defined in the August 2008 Service Model:*

*The TFSS must work in a close collaborative partnership with NTFC. NTFC will actively support the establishment of the TFSS through the commitment of resources through the regional NTFC office and the NTFC Policy and System Support unit. The TFSS will be required to:*

- *'host' a NTFC Community Child Protection Worker (CCPW) in their agency and to integrate this worker into the agency team including to provide a workstation for this worker*

- *conduct joint work with NTFC CCPW on needs and risk assessment*
- *consult with and take advice from CCPW.*

.....

#### **4.2.2 Role of Child Protection Authority**

*The role of NTFC Child Protection Services within the TFSS is somewhat ambiguous in that, while the CCPW reports to the NTFC Child Protection Team Leader, work is allocated by the TFSS manager. According to the August 2008 Service Model:*

*The staff of the TFSS and NTFC Community Child Protection will form a team who respond to referrals from NTFC for family assessment and support. The CCPW will report to NTFC Child Protection Team Leader. Whilst located in TFSS, the CCPW will be allocated work by and be accountable to the TFSS Manager.*

#### **Community Child Protection Workers**

These workers were CPA employees who were placed with the TFSS provider. Their duties included:

- *Provide advice to the TFSS on the assessment and provision of support services to vulnerable children and their families*
- *Ensure that any statutory requirements relating to families in the TFSS are met **including outcome reports** from NTFC*
- *Develop collaborative work practices between TFSS and NTFC including by organising and attending meetings and case conferences in both agencies*
- *Attending family support network meetings to coordinate services to vulnerable families*

*In the view of the evaluators, these roles were largely fulfilled during the period from February to May 2009. However, .... **the CCPW resigned from the position in April 2009 and no further referrals were accepted before the evaluation finished in June.***

...

*Another described the function of the CCPW in these terms:*

*It's a gateway with us into [NTFC]. Instead of having to call a stranger every time there's an issue, we've got someone sitting here with access to information or a database and can essentially provide us with information there and then or if not take it back to a team leader and feed that back to us.*

#### **4.2.3 Role of the Aboriginal support worker**

*The August 2008 Service model envisaged that:*

*Aboriginal Family Support (AFS) Workers will be employed to assist in ensuring the cultural safety of services provided. The AFS Worker will not carry a caseload of families but will participate in and support assessment and ongoing case management. They will utilise the following skills in their casework practice:*

- *Active engagement of families*
- *Gathering information for risk and needs assessment*
- *Implementing a case plan by undertaking specific support tasks*

- *Provide direct practical and emotional support to adults and children*
- *Provide direct support, education and referral to improve the parenting capacity of families...*

*Based on the data collected it is clear that the role fulfilled its objectives. It is also evident that the role had other important functions including:*

- *Providing important local and cultural contextual information about clients;*
- ***Finding out who is responsible for the care of children;***
- *Identifying appropriate family/kinship connections with which to work; and*
- *Arranging family meetings for and with other case workers.*

It was originally conceived as a model that enabled a number of entry points including self-referral. This was changed so that the Central Intake Team determined whether cases could be referred to the TFSS. Between February 2009 and June 2009 services were provided to 15 families. Those services were provided by the organisations listed in the following table:

**Table 1**

<b>Organisations</b>	<b>Clients</b>
Schools	8
Congress Clinic	6
Family Meetings	4
Congress After Hours Youth Service	4
Alice Springs Women's Shelter*	3
Northern Territory Housing	3
Alice Springs Hospital	3
Centrelink	2
Grog Mob*	2
NTFC (re-notification)	2
Tangentyere Youth Team	2
Children's Services Support Program*	2
Centacare*	2
Police Domestic Violence Unit	1
Lutheran Church Playgroup	1
SEWB Counselling	1
Salvation Army Church	1
Deadly Treadlies	1
School Constable	1
Congress Child Care	1
Tara Clinic	1
Congress Male Health*	1

Guardianship Board	1
Disability Support Services	1
Children and Adolescent Mental Health	1
Safe Families	1
Reconnect	1
Arerrnte Council Solutions (employment)	1
To evaluate the TFFS those five organisations with a * were interviewed	

According to the evaluation report of CDU the services that were provided by the organisations listed in Table 1 were those listed in Table 2:

**Table 2**

<b>Services Provided</b>	<b>Total Families Supported</b>
Understanding cultural/family background	15
Outreach	14
<b>Intensive family support</b>	<b>13</b>
Case management	11
<b>Family, assessment, needs identification</b>	<b>10</b>
Linkages to school	8
Language issues	8
Work with partners/extended family	8
Linkages to health/nutrition services	7
In home support	6
Parenting skills/support	5
Child or youth focus	5
Counselling	4
Advocacy, information and advice	2
Practical support/material aid/brokerage	2
Family decision making/conferencing	2
Information and referral	2
Restraining order	2
Re-notification	2
Behaviour management support	2
Crisis intervention	1
Linkage to youth outreach	1
Linkage to employment	1
Support to move	1

Having read the service agreements the evaluation by CDU and the referrals I was still not certain exactly what was being provided that comes under the definition of *support*. The evaluation by CDU was only of a period from March to June 2009 so with respect to the remaining period during which the program has operated I asked to see the quarterly reports that were required from the TFSS service provider under the service agreement. I also wanted to see the outcomes reports that were required under the August 2008 service model to be delivered to the CPA for each family. I have not been provided with any of these documents. As I called for their production by a summons, non compliance with which carries a criminal penalty, I have to assume that none of these reports exist.

### **RECOMMENDATION**

I recommend that the External Monitoring Committee set up to oversight the implementation of the Board's Report enquire further into the efficacy of the TFSS to see whether:

- (a) it is effective; and
- (b) it is good value for the investment compared with the benefits to families and children.
- (c) why the required quarterly and outcome reports have not been done?

Information provided to me about the cost of this program follows:

**1. How much money has been spent on the initiatives outlined in the report? Please provide documentary evidence to support this financial expenditure.** Documentation regarding the Differential Response Framework and Structured Decision Making Tools initiatives relating to this question will be provided separately.

Initiative	Actual \$'s spent
Differential Response Framework (Targeted Family Support Services (TFSS))	\$1,324,322.00
Structured Decision Making Tools (SDM)	\$111,265.90 - Paid \$USD190,000 - contracted

#### **Differential Response Framework – Targeted Family Support Services (TFSS)**

The Department of Health and Families has funded three non-government organisations (NGOs) for the provision of TFSS. Actual amounts paid to these organisations are:

#### **2009/10 Financial Year Confirmation of Payments**

NGO	F/Y 0910	F/Y 1011	Total ex GST
Central Australia Aboriginal Congress (CAAC) Inc received	\$ 702,294.00	\$0*	
Larrakia received	\$ 201,833.00	\$ 86,500.00	
Wurli received	\$ 210,000.00	\$ 65,000.00	
	\$1,114,127.00	\$151,500.00	\$1,265,627.00

The Department also committed to funding out-posted workers with the NGOs as part of this initiative. There was \$105k allocated for workers being out-posted from the Katherine, Palmerston and Alice Springs Offices. The Katherine and Palmerston positions have been vacant and the Alice Springs position has only been partially filled.

Total expenditure spent on out-posted workers was \$58,695.

I have taken the total cost of TFSS as outlined by the CPA and compared it with the number of families who have received services as outlined in Table 1.

<b>Location</b>	<b>Number of Families who received TFSS</b>	<b>Total Payment \$</b>	<b>Cost per Unit \$</b>
Darwin	4	288,333	72,083
Katherine	2	275,000	137,500
Alice Springs	(09/10) 23	(09/10) 760,989	33,086

The cost of saving a child from harm, preserving its life and bringing it to adulthood fully developed and free from emotional, physical and developmental impairment cannot be counted in dollars. It is important, however, that the dollars are spent wisely, that value is obtained and the services purchased are effective. On the above figures the sum of \$130 million to be invested in Child Protection over the next five years will probably not be sufficient to achieve the aim of early intervention and the provision of adequate and efficient family support services. That sum of \$26 million per year also has to pay for increased staffing levels for the CPA to prevent the backlogs that have occurred in the past, as well as a peak Aboriginal body, more foster carers and support to them and payment to the many family members who are foster carers under family placement arrangements.

### ***NEED FOR A FURTHER EVALUATION OF TFSS***

The evaluation by CDU covered only a very short period from March to June 2009 it may have been too early to evaluate whether the results of the services were effective and the cost represented value. I would like to know what has happened to the 15 families that were evaluated by CDU in 2009. I would like to know are there now more children at school, is there less violence, is there less alcohol abuse, is there better health, have there been any further notifications of children at risk to the CPA and practical matters such as that.

### ***RECOMMENDATION***

***I recommend a repeat evaluation of the 15 families who were involved in the first evaluation by CDU. I further recommend that the External Monitoring Committee guide the terms of reference for the evaluation and review the results of the evaluation.***

I came to hear of an award program operating in the Katherine region called 'Peace at Home'. I do not have sufficient details to describe it but it is a program that works at family preservation and rehabilitation of drug and alcohol abuses. If it is successful it can be studied for others to adopt the same approach.



## **NON ATTENDANCE AT SCHOOL**

Not attending school for a school age child is probably one of the strongest indicators that a child's well being is neglected. It is also the most easily identifiable. I consider that there ought to be some link between the *Care and Protection of Children Act* and the *Education Act*. The Children's Commissioner ought to receive a copy of any notice issued to parents or to a child over 14 because of non attendance at school. The Children's Commissioner ought to have a right to attend any conference as proposed in the *Education Act* amendments.

The effects on the development and future of a child who does not receive an adequate education are life long and likely to have a consequence that the child remains marginalised in terms of employment, home ownership, good health and at risk of abusing alcohol and drugs. The non attendance at school, in my view, ought to be included in the *Care and Protection of Children Act* as a specific category of harm to children just as witnessing violence is. I would also like to see that the CPA is informed whenever under the recent amendments to the *Education Act* the Principal of a school issues a notice to parents or to a child over 14 requiring them to show a reasonable excuse why they have not attended at school. Such a notice should be treated as a notification under section 26 of the CPC Act and actioned exactly as if it was a report of physical abuse. The CPA has placed little weight on non attendance at school as an indicator of harm. The CPA's attitude is expressed in the intake records as follows:

*'School absences are a school related matter rather than a child protection issue.'*

In my view it is an issue for both. The cause of the absence may well be a child wellbeing issue and in a number of families was associated with neglect. Not attending school is listed in the Operations Manual as an indicator of harm.

## **RECOMMENDATION**

I recommend that the *Education Act* be amended as I have outlined above and that a child or person who is the subject of any notice or action under the Education Act Amendment Bill 2011 be prescribed under Section 258(2)(f) of the *Care and Protection of Children Act* so that the Children's Commissioner can consider whether or not to investigate the matter. I further recommend that Section 15(2) of the CPC Act define harm to include:

*'A child or young person of school going age habitually does not attend school without a reasonable excuse.'*

My investigator attended CIT and observed intake workers receiving notifications. While there, a notification was made regarding a child who had not attended school for the past three days. The intake worker asked the notifier if it was possible that the family had left. The notifier responded that it was possible. The notifier was then referred to school truancy line and the phone number was provided. This notification was then recorded as an intake event only.

My investigator questioned the intake worker as to how the school truancy area operated and the intake worker informed my investigator that she had no idea. The intake worker told my investigator that now the referral had been made no further collaboration occurred between CIT and the Education Department.

My investigator subsequently contacted the phone number which had been provided to the notifier. The number went to an area in the Education Department known as the School Operational Support, Strategic School Policy Development.’ The person who answered the phone told my investigator the area did not handle any truancy related matters.

My investigator was put through to the Director of School Enrolment and Attendance who informed my investigator that currently there was no official truancy line. The Director also informed my investigator that the number one complaint received from schools was the difficulties they experienced in trying to refer truancy matters to the Department.

*‘Habitually being absent from school has been identified as one of the indicators of cumulative harm. Children are kept away from school until bruising disappears’.*<sup>36</sup>

The recent manuals only briefly refer to school attendance under the Information Gathering Guide as a one bullet point reference for points for context of harm.<sup>37</sup>

## **RECOMMENDATION**

***I recommend legislative changes to add a new reporting requirement relating to non attendance at school as an indicator of cumulative harm. Provisions ought to be inserted into Section 15 (2) of the CPC Act to define harm to include when ‘the child or young person habitually does not attend school without a reasonable excuse.***

This would be consistent with the government’s policies and strategies of Closing the Gap, Everyday, Every Child and A Working Future. The Coordinator General for Remote Services in each of his four reports has emphasised the detriment to a child who does not go to school.

## **WHAT IS REALLY HAPPENING TO THE CHILDREN?**

If a child dies as a result of abuse or neglect in unexpected circumstances the Coroner will do an investigation, an inquest and a public report. The impetus for the Board of Inquiry being established and for the changes now being introduced to the Child Protection Service was publicity surrounding the death of Deborah Melville and Kalib Peter Johnston-Borrett.

Over the years there have been a number of children who have died about whom reports were made including Baby M. There are possibly thousands of children in the Territory who are in need of care, who are being neglected and thousands of others whose wellbeing, using the words of the *Care and Protection of Children Act*, could benefit from services to:

*maximise the opportunities for them to realise their full potential and promote their wellbeing, as well as to assist families to achieve those objects.*

The conditions under which they are living and the neglect or harm they are suffering are well documented throughout the records of the Child Protection Authority. I am telling some of their stories so that they do not become the forgotten children and their deprivation is on the public record to drive the will, particularly the political will, to care for them. It is

<sup>36</sup>Department of Health and Families, ‘Reporting Child Abuse and Neglect It’s Everyone’s Responsibility, pg 8.

<sup>37</sup> Refer to Attachment B

acknowledged that it is not the Government's role, nor is the Government equipped to be a substitute parent. A number of the stories that follow indicate clearly that society, governments, the Child Protection Authority, the Department, schools and indeed everybody should be aware of the plight of some children and their families and the long term effects of not taking action to help these children.

To collect the information relating to the children and the families that follow in this section proved surprisingly difficult. At the outset I served on the Chief Executive Officer of the Department a list of the names, dates of birth and in some cases the parents of 17 children. I requested their records from any contact with the Child Protection Authority as well as their medical records, most of which were held at Royal Darwin Hospital. I had made the assumption that if a child had ever been the subject of a notification of being at risk of harm to the Child Protection Authority:

- (a) there would be a record of that notification;
- (b) there would be a record of the parents and the siblings of that child if notification had been made with respect to those siblings;
- (c) the information would be readily accessible and retrievable.

I could not have been more wrong.

What follows is a short chronology of the time it took the Department to provide information requested. Some of the information has not been received at the time of writing this report.

#### **Chronology of Department's response to summons dated 21/1/10 for production of documents**

<b>DATE</b>	<b>FROM</b>	<b>TO</b>	<b>CONTENT</b>
22/01/2010	Ombudsman	Dept – CEO Dr Ashbridge	Summons requesting records for 27 children to be provided by 26 February 2010.
18/02/2010	Dept – CEO Dr Ashbridge	Ombudsman	Enclosed an opinion from Michael Maurice QC dated 5/02/2010. Dept requested an amendment to the notice to limit information requested. An extension of 2 weeks was requested for information pertaining to subject children and 12 weeks requested for information relating to siblings of subject children.
18/02/2010	Ombudsman	Dept – CEO Dr Ashbridge	Noting disappointment that adversarial approach adopted by committing resources to obtaining legal opinion rather than focusing on obtaining information requested.
24/02/1010	Ombudsman	Legal Officer, Dept	Email – <ul style="list-style-type: none"> <li>• Ombudsman willing to allow extension if documents identified thus far are provided.</li> <li>• Suggested that a request for an</li> </ul>

			extension of time should outline the time required and the information outstanding.
24/02/2010	Legal Officer, Dept	Ombudsman	Email – confirm receipt of Omb’s mail. Advised that she would seek instructions and respond accordingly.
26/02/2010	Legal Officer, Dept	Ombudsman	Email – Documents will be delivered today. Outstanding information : <ul style="list-style-type: none"> <li>• Hospital records for two children.</li> <li>• Hospital records for all siblings.</li> <li>• No parent records provided.</li> <li>• No records regarding mental health, alcohol and other drugs, aged and disability.</li> <li>• Suggest a meeting re what records .</li> </ul>
22/06/2010	Ombudsman	A/Director CPA	Meeting to discuss information outstanding and how to obtain information.
15/09/2010	Ombudsman Investigation Officer	Complaints Coordinator, Dept	Phone call re information not yet received. All the information needs to be checked by her superiors which increased the delay . Not comfortable in disclosing the superiors concerned.
17/09/2010	Ombudsman Investigation Officer	Complaints Coordinator, Dept	Meeting with Complaints, Sentinel Events & Coronials Coordinator and Complaints Coordinator Examples provided of incomplete information still being received.

## TIMELY PROVISION OF INFORMATION

Information that should have been readily and easily accessible proved to be difficult and timely to obtain from the Department. An example of this provided for under the heading TFSS. My investigators were advised that every response needed to be ‘run past’ each of the six directors and then given to the Executive Director for final approval before the collected information was provided to my office. This process proved to be inefficient and time consuming. Often when following up responses my investigators were told that the response was still sitting in the tray of one of the directors. The CPA did not have and still does not have an efficient or effective document management program. CCIS, its operating program, does not have the facility to attach documents from other sources to the intake records. So, for instance, if a medical report or a report from NT Police is received that information cannot be simply attached to the electronic record. It remains in the paper records only. Intake workers cannot check the paper files for information and must of necessity rely on what is in the electronic record of CCIS. It is urgent and vital for the CPA to acquire an effective document and knowledge management facility that is electronic. The CPA is working to achieve this but it ought to be high priority.

In response to the draft of this report the CPA submitted that difficulties and delays in locating records for the Ombudsman may have occurred as a consequence of ineffective knowledge management systems. I accept that is so and that the CPA was not deliberately delaying to impede the Ombudsman. However the lack of adequate and effective knowledge management systems to capture and retrieve information is far more serious than delays for the Ombudsman. The CPA says it is addressing the issue.

## **METHODOLOGY**

Conduct of this investigation involved management and analysis of a very large amount of information. Attachment A describes in detail the process.

When the records of the first 17 children were provided I sent the names of those 17 children to the NT Police and asked for production of the records in relation to each of those children and families that might indicate any contact between NT Police and the children or their families. The stories that follow are collated from the police records, child protection records, medical records, as well as information provided by the Child Protection Authority by way of a CCIS file 'review'. This was a review compiled by the Department and contained some information in response to requests about what was missing from the original source documents and was a record created for me and not an official record that intake workers could access in the course of their daily duties.

Some of the information in this report is an amalgam of information from many witnesses who have not been individually recognized because the nature of the information would identify those witnesses. Witnesses spoke to our office on our undertaking that their identities would be protected. When making the request for anonymity witnesses gave as their reason fear of reprisal in their workplace.

All witnesses interviewed were assessed and questions of their motivation explored to exclude the possibility that the information given was not accurate or given in good faith. I was satisfied with the witness's credibility because of consistency among a number of witnesses and the consistency of the information with other records. There were several witnesses whose reliability was doubtful and whose information was not accepted unless corroborated by information from other sources.

## ***OPERATION OF MANUALS***

The processes, practices, criteria for action, benchmarks and for the training of workers at CIT are prescribed in a Manual. Manuals therefore need to be comprehensive, clearly identified by the date their operation commenced, and an earlier version superseded as well as clear and unambiguous. The Coroner has referred to the Manual in reports or inquests. The Inquiry used the Manual as evidence of CPA practice. An early step in my investigation was to obtain the manual and examine what was done in the CPA for compliance with its own manual.

My investigators were given inconsistent information regarding which policy and procedures manual was applicable during certain timeframes. On 11 October 2010 my investigator rang a Senior Manager to request the most up to date manual and to discuss the changes that had

occurred since 1999. The senior manager responded to my investigator *'god knows how you will understand which policy was applicable at what time because we can't even track it.'*

Detailed below are the dates that particular manuals were provided to my office. The version refers to the footnote on each page of the manual.

DATE POLICY PROVIDED TO MY OFFICE	TITLE OF MANUAL	VERSION	REFERRED TO AS
18/08/2008	Family and Children's Services Policy and Practice Manual	October 2000	Manual 1
01/07/2010	NTFC Care and Protection Policy and Procedures Manual	July 2009 version 2.0	Manual 3
28/07/2010	NTFC Care and Protection Policy and Procedures Manual	July 2010 version 3.0	Manual 4
11/10/2010	NT Families and Children Policy and Procedures Manual	December 2008	Manual 2
11/10/2010	NTFC Care and Protection Policy and Procedures Manual	September 2010 version 3.0	Manual 5

On 1 July 2010 the Director Care and Protection Policy (the Director) advised that manual 3 *'was placed on the NTFC Intranet in December 2008 to reflect the implementation of the Care and Protection of Children Act.'*<sup>38</sup> However, this is inconsistent with information provided by the Department on 4 February 2010 that there was a draft policy which still needed to be finalised and the manual provided on 18 August 2008 Manual 1 October 2000 was the manual which intake workers were still referring to.

The Director Care and Protection Policy had previously informed my investigators that the date in the footnote of the manual represented the date the policy came into effect. The footnote date in manual 3 is July 2009. Based on the initial comments by the Director this would suggest that it would not have been possible for the policy to have been implemented in December 2008. The Director stated:

*'you will note that this is slightly different from the advice I provided you earlier that the date in the footnote is the date the policy came into effect.'*<sup>39</sup>

<sup>38</sup> Email from Director, Care & Protection Policy dated 1 July 2010  
NT Families & Children | Department of Health and Families

<sup>39</sup> Email from Director Care and Protection

The Director also stated:

*Further changes will be made to the manual during this year to reflect some new initiatives as well as other changes to enhance service delivery. NTFC Operational Policy Team will ensure that you receive a new version of the manual when this occurs.*

Despite this assurance that updated versions would be provided to my office this did not occur. While conducting an interview on 4 October 2010 it became apparent that the manual had again been updated and not provided to my office.

As at March 2011 the policy on the intranet for Children and Families refers to the policy as the September 2010 version (manual 5), however it is in fact manual 4 which is on the intranet.

Good document control refers to regulation of documents by document name, version, issue date, review date and identification of approving authority. None of the Department's policies reviewed by my office exhibited these traits.

Most importantly is the effect the poor information management around which version of the manual at any point in time would have on frontline operational staff. The manual documents any and every change in policy and practice. Wherever there is a change it is essential that frontline staff are made aware of changes and trained to understand the changes and given time to implement any changes.

***Ombudsman yet to investigate:***

Whether staff experienced difficulties and uncertainties about finding the right operating manual?

Were new staff trained to follow out of date manuals?

Were staff trained/informed about changes to policies and processes when a new manual was introduced?

Were different sections or units of CPA operating in compliance with different versions?

What version of the manual(s) were considered by the Board of Inquiry? The Coroner in at least two inquest reports has referred to the manual and to compliance with it. Did he have the applicable version? Is there any significance if the Coroner or the Board of Inquiry referred to an outdated manual?

**THE CHILDREN'S LIVES AS RECORDED BY THE CPA**

In various formal summonses to the Department I requested the medical files and CPA records of 17 children whose names were made known to me. I then obtained other files for related children who were identified from the records of the first 17 children or were mentioned in police records. The CPA also provided documents and information voluntarily. I preferred to summons information that was sensitive to avoid the CPA breaching its own confidentiality requirements. By February 2011 I was examining the records for 61 children. These are the stories of part of the lives of some children as written down in the records of the CPA. Some of these stories self evidently demonstrate that the expectations of many people about what is harm to a child do not match the benchmarks of harm pertaining in the Department and the Child Protection Authority.

What follows about the children is but a two dimensional snap shot. What is disturbing is: not knowing the quality of their daily lives; whether they are suffering harm or whether in their future as adults they will overcome the damage occurring in their young lives; whether their emotional and mental health; their self esteem and their capacity for caring, parenting their own children and leading fulfilled lives will be impaired.

Every effort has been made to de-identify the information so as not to impinge on the privacy of any particular family or child. A separate report has been given to the Child Protection Authority in which the families and the children are identified so that action can be taken to correct and follow up the children and families who it appears may not have received the services that would benefit them and, in some cases, appear to be urgently needed.

The number of reports about children considered by those who notified the CPA to be at risk has been:

- 2007/2008                    3668
- 2008/2009                    6189
- 2009/2010                    6584

Approximately a half of those reports are substantiated. The sadness of these children's condition is inexpressible; the solution to their predicament complex; and the obligation to help them undeniable. I tell their stories and I expect to be criticised for doing so in certain quarters. I am content to let the children judge me and to condemn me if telling their stories has harmed rather than helped them.

In response to this draft the CPA submitted that I should remove this section of the report about the children and families. It was submitted that making these stories public could impede current and ongoing activities with respect to the families and children named. I do not accept this submission. None of the families are identifiable except for those already in the public arena. If there are ongoing activities by the CPA with respect to those children and families perhaps the workers concerned will refer to the histories of these families and the unanswered questions about past notifications I have raised and use the information to make decisions about what will help the children and families whose stories are reported.

The other submission made by the CPA on the draft was that these stories be referred to the Children's Commissioner for follow up. I have stated throughout the report that it is my hope that either the CPA or the Children's Commissioner will follow up. If the Children's Commissioner requests I will give him the real identities of the families and children.

The stories also show what CPA workers on the front line have to face in their daily work. Their responsibility is high. An error of misjudgement could have tragic consequences. They have to face the suffering and neglect of the children, and they often confront hostility. Their strength and resilience to withstand the emotional trauma they must suffer is admirable.

These stories, but a few of the cases we examined, encapsulate the risks in the lives of these children as well as a child protection service that is overwhelmed.



These stories ought to be understood against the CPA's manual which describes indicators of maltreatment and includes:

- history of previous maltreatment to the child and/or a sibling
- social or geographical isolation, including lack of access to extended family
- history of family violence including injury to children
- carers maltreatment of alcohol or other drugs affects their ability to care for the child
- carer is experiencing significant problems in managing the child's behaviour
- prior substantiated abuse reports
- escalating concern/pattern of contact with FACS statutory services
- child under 2 years
- premature, disabled or chronically ill child
- born underweight or drug dependent

#### **Carer**

- under 20 years at birth of first child
- history of their own maltreatment as a child
- family is socially isolated or fragmented
- history of family violence, including previous harm to children
- repeated presentation of child to health/other services with injuries, ingestions or minor complaints
- appears unconcerned about the child's condition
- refuses to present child for school or health care appointments

#### **Carer's History of Violence**

- has physically abused child (past or present)
- is perpetrator of family violence
- family history of violence including previous harm to children
- perpetrator of other violent behaviour
- carer has unrealistic expectations of age appropriate behaviour in the child
- is habitually absent from school (child may be kept at home until evidence of abuse has disappeared)
- until proven otherwise the presence of an STD in a preadolescent means sexual abuse

#### **Physical Indicators of Neglect**

- being consistently without adequate supervision and at risk of injury or harm
- being consistently hungry, tired and listless
- abandonment
- failure to thrive

#### **Behavioural Indicators of Neglect**

- begging or stealing of food
- engaging in delinquent acts – vandalism, drug and alcohol abuse
- poor or irregular school attendance
- extended stays at school, public places and other homes

## **ABUSE/NEGLECT UNSUBSTANTIATED**

On reading these records I found it hard to understand how so many reports of what appeared to be from a credible, independent, often professional source reporting facts they knew from their own observations, but which had an outcome recorded as *'abuse/neglect not substantiated'*. I made the assumption that those words meant that the report had been investigated, relevant witnesses had been interviewed, the child had been sighted and spoken to and that the CPA had satisfied itself that the child was safe and not at risk of harm.

*'Abuse/neglect not substantiated'* does not mean that at all. If no contact is made with the family, the family might be living in the long grass or returned to a Community from Darwin or Katherine, or if a message is left on a phone or in a letter box and there is no response, if a witness is away on leave or holidays, the report's outcome is recorded *'unsubstantiated'*. As I did, a later worker who is from out of the Territory may read the records and assume that the CPA had excluded that there was a risk to the child.

## **RECOMMENDATION**

I recommend that the CPA only records an outcome as *'harm/abuse/neglect/unsubstantiated'* if the CPA has carried out sufficient investigation to be positively satisfied that the child, the subject of the report, is not at risk of harm or neglect or abuse.

This same recommendation was made in June 2009 by Jay Tolhurst in his report. He stated:

*'..... closure decisions need to be very clear about the difference between a clinical decision that a case does not need a "proper" investigation because the protective issues have abated and a capacity based decision which recognises that more profound protective interventions are indeed required but regrettably cannot be delivered'*

*'Workers make entries in the file which would suggest to a critical reader that the child was seen by the worker to be "safe enough" based on the superficial checks made'*

*'A more defensible case record would acknowledge the unresolved risk and that ..... the case was closed on capacity grounds without full standards compliance'*.

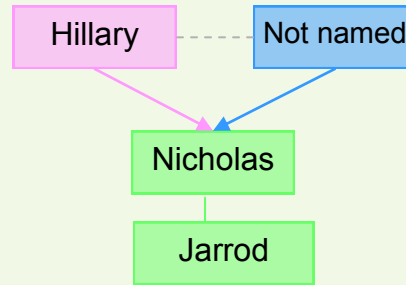
It is two years on since the Tolhurst report and his recommendations have not yet been implemented although the CPA in its submission on this draft agreed that cases should not be closed as *'unsubstantiated'* if it was being closed for other reasons.

**Norton Family****Legend**

Children

Mother

Father

**Jarrod NORTON: Born May 1999****Family History:**

Jarrod was born in late May 1999. Little is known of the father, believed to be deceased. His mother was reported to have a long history of mental health problems, diagnosed with Schizophrenia and exacerbated by negative experiences from close family members. Jarrod and his mother had a long history of contact with police. CPA records showed there were 14 child protections report received from 2002 to 2009. Reports included concerns about the safety and welfare of Jarrod, the mother's capacity to provide adequate care for him as well as reports of Jarrod being found roaming the streets late at night unsupervised, engaging in unruly behaviour, assaults, stealing and being picked up by police, begging for food in the city and once being found unconscious on a bus.

**Notification History****25 February 2002 – First** (2 years 9 months old)

No intake form was provided for this notification.

*'A Child Protection Report was received outlining the following concerns:*

- *The subject child's mother was reported to suffer mental health problems and has been in Cowdy Ward a couple of times.*
- *The mother was reported to suffer from Schizophrenia but was not on medication.*
- *The mother's brother hung himself recently and the funeral was a week before the notification was made.*
- *Mother was believed to have been drinking since the funeral — the mother's mental health deteriorates when she is drinking.*
- *The mother's mental health issues became apparent after her husband was killed 6-7 years ago.*
- *It was alleged at the time the mother's husband died, the mother took subject child's-sibling-Nicholas into the bush and they both nearly died.*
- *The mother had recently taken out a restraining order against the subject child's grandfather and a Leader of the family's people, as she believed that they would kill her and her children.*
- *The mother fled from her house and was suspected to be staying at ... hostel.*
- *The mother appeared as if she had not slept for a week.*

- *There was no direct information about the subject child and his sibling's overall well being.*
- *It was noted that Nicholas, the subject child's sibling, was not attending school.*
- *NTFC staff made contact with Police and Police confirmed that they had also received concerns and that it appeared no one had been home for a day or two.*
- *It was confirmed on 27/02/2002 that the family was residing at ... hostel and were doing well'*

**Outcome:**

This Child Protection Report was not accepted because *the allegations did not constitute harm, as there had been no direct concerns raised about the children and their care.*

**4 March 2002 – Second**

The CCIS File Review indicated:

*A Child Protection Report was received outlining the following concerns:*

- *Mother presented at Territory Housing wanting to move houses.*
- *The mother presented as being paranoid about people attacking her and had stated that she could not return to her house in the Palmerston area.*
- *It was noted that the mother tends to move around due to her paranoia.*
- *Tamarind Centre was reported to be involved with the mother but the mother's whereabouts was unknown.*
- *The mother had been involved with the Tamarind Centre since 1996, as she had been diagnosed with Schizophrenia. The mother was well known for refusing to take her medication.*
- *The mother was reported to not be abusing any substances.*
- *The mother was reported to not to be violent and show no suicidal behaviour.*

**Outcome:**

This Child Protection Report was not accepted because *the allegations did not constitute harm, as there had been no direct concerns raised about the children and their care.*

**20 June 2006 – Third**

There was no intake form provided for this notification. A Family Support Referral was received outlining :

- *The mother requested assistance from NTFC regarding the subject child and his sibling, **Nicholas**.*
- *The mother reported that she was having 'a really hard time all the time' with the children.*
- *The mother reported that she didn't have family support available.*

**Assessment:**

NTFC provided community support services information to the mother.

**Outcome:**

The request by the mother for Family Support Referral was not accepted.

**12 March 2007 – Fourth**

There was no intake form provided for this notification.

*A Child Protection Report was received outlining the following concerns:*

- *The subject child and his sibling, Nicholas, had been harassing and assaulting two younger boys whilst at school and on their way home from school.*
- *Police and the school were notified.*
- *The child and his brother had been seen roaming the streets late at night and have been involved in delinquent behaviour, such as throwing rocks at passing buses and into people's pools.*
- *Notifier was aggressive and threatening towards NTFC staff and said that he would be lodging a complaint about NTFC and NT Police*
- *Contact was made with the children's previous primary school and it was noted that the school believed that the mother was unhappy with the school's discipline of the children.*
- *School also noted that the children had attendance and behavioural problems.*
- *Mother was noted as keeping the children from school using 'poor' excuses, such as it was raining, they had no car, no clean clothes, etc.*

**Outcome:**

The CCIS File Review recorded that this Child Protection Report was not investigated as the allegations did not constitute harm and there was little information available in regards to the children roaming the streets. The boys were aged 8 and 12.

**3 May 2007 – Fifth**

No intake form available for this notification. The CCIS File Review indicated:

*A Child Protection Report was received outlining the following concerns:*

- *NT Police reported that the subject child, as located in a suburb ... in the company of two older children at 2230hrs.*
- *Police had been flagged down by one of the ... other children's mother so that Jarrod and the other child would be returned home.*
- *Jarrod explained to Police that he had been in attendance at school but would not specify when he and the other children had left school.*
- *When Jarrod was returned home, his mother reported to Police that she had seen him at 1600hrs after school and that she didn't know his whereabouts after this.*
- *The mother further stated to Police that she didn't see why Police needed to be involved as she knew Jarrod would come home when he wanted.*
- *The mother added that she had told Jarrod to be home by sunset.*

**Outcome:**

This Child Protection Report was not investigated due to the allegations not constituting harm.

**18 September 2007 – Sixth** (Child 8 years 4 months)

A notification from police was received stating that on 8 September 2007 Jarrod had been suspended from school due to his unruly behaviour and continued to go to school to steal

bikes. It is alleged Jarrod showed total disregard for staff at the school and was increasingly coming to police attention. He was staying out late at night, was implicated in disturbances and rock throwing incidents involving buses and was actively encouraging younger children to commit offences. Police believed Jarrod should be classified as a child not under effective control of an adult and be considered for further assessment under this criteria.

**Assessment:**

The Assessment stated that **this was police business and not FACS business** and no further action was required.

**17 March 2008 – Seventh**

Police reported that 3 male juveniles were found at a local Club and were taken home and left in the care of family members. The person with whom the children were left did not seem to be in the least bit concerned for the welfare of the children. When questioned as to whether they knew where the children had been all night, no person spoken to knew or cared.

**Assessment:**

Child Concern response.

**Outcome:**

The matter was investigated and **neglect unsubstantiated** with the child considered **conditionally safe in the family home.**

**26 August 2008 - Eighth** (Child 9 years 3 months old.)

A night patrol worker contacted CPA and reported that on at least 3 recent occasions she had observed Jarrod, his brother Nicholas, and two other boys on the streets of the CBD late at night/early in the morning. They all said they were hungry, their mother was on '*ganja*' and they came into town seeking food. She reported that the boys would beg for food at a local takeaway food shop and the owner would sometimes provide a meal, as did patrons. The notifier stated she had also seen the boys at a local Shopping Centre begging for food. The previous night the notifier took the boys to her own home for a sleep and a feed. The notifier was very concerned for the boys' safety.

**Assessment:**

Child of Concern response.

**Outcome:**

The matter was investigated and **neglect unsubstantiated with the child considered conditionally safe in the family home.**

**12 February 2009 – Ninth**

Another notification was received from police stating that Jarrod had been arrested that morning at 0900hrs. He was found with several other juveniles breaking into a local sports facility and stealing liquor. Jarrod acknowledged that he was involved and was out with the boys all night. Police had been trying to locate Jarrod's mother all day and had been unsuccessful. Police had visited the home twice that day but the house was locked and no one was home. CPA provided the address of an aunt. However, Police said they had spoken to Jarrod about the aunt and he advised she had moved interstate. Police later telephoned to

advise that the mother had attended the police station to report Jarrod missing. Police stated they would return him to his mother.

**Assessment:**

A Child Concern Response to be investigated concurrently with two other current investigations into similar incidents.

**Outcome:**

The matter was investigated and **neglect unsubstantiated** with the child considered **conditionally safe in the family home**.

**12 March 2009 – Tenth** (Child 9 years 10 months old.)

A notification was made to NTFC that Jarrod had been admitted to RDH after being found unconscious on a bus. He was alone at the time. It was unknown whether he was unconscious as a result of alcohol, drugs or volatile substance use. His mother was not aware of the incident and it was believed that Jarrod may not have been missed. Jarrod was often reported as a truant from school and was well known to police.

**Assessment:**

A Child Concern response.

**Outcome:**

The matter was investigated and **neglect unsubstantiated with the child considered conditionally safe** in the family home.

**4 May 2009 – Eleventh** (Child 10 years old)

A notification was made by police stating that on 2 March 2009 they had responded to a call about juveniles creating a disturbance at a local service station. Police attended and found Jarrod with a number of other juveniles. The juveniles had been causing a disturbance prior to police arrival. Jarrod was returned home to the care of his mother. She was advised of the occurrence and told that CPA would be notified. At approx. 1800 hrs on 5 May 2009 police responded to a call regarding juveniles attempting to assault a security guard at a local shopping centre. Jarrod was identified as one of the culprits. Police located Jarrod at a local take away food shop, where he attempted to flee from them. However, police were able to apprehend Jarrod and convey him home to his mother, who was advised of the incident and told that CPA would also be notified.

**Assessment:**

This matter not proceed to investigation as the allegations did not constitute harm; **this was a police matter and no role for NTFC**.

**19 May 2009 – Twelfth**

A police notification was received stating that on 18 May 2009 Jarrod was with three other boys. At about 10pm they went to a house in the suburbs and tried to break in. They were startled by the occupant and fled. One of the boys was caught. The three other boys then went to a local Sporting Club and tried to break in before climbing up onto the roof. They were apprehended by Police. Jarrod was conveyed home and left with his mother, who had not known of his whereabouts and did not care when he was dropped off by police.

**Assessment:**

The case worker's assessment was that this matter proceed to investigation as a Child Concern matter. However, the Manager overruled this assessment on the basis that the concerns identified were juvenile justice issues, not issues of protection and therefore the matter should not proceed.

**21 May 2009 – Thirteenth**

A police notification stated that police attended in relation to reports that 10 children were involved in incidents in the suburbs. The first incident related to a group of youths throwing rocks at a nursing home. The second incident related to a group of youths being seen in a stairwell of a property acting suspiciously. These youths were picked up by police and taken to the police station and also reported to CPA. Jarrod was one of these youths. Police conveyed Jarrod to his mother's house and she reportedly stated she did not have real concerns for the child and was disinterested in police explaining what had happened.

**Assessment:**

In accordance with the Third Report Rule this matter should proceed as a Child Concern investigation within 5 days.

**Outcome:**

No investigation had commenced 7 months later.

**27 July 2009 – Fourteenth**

Another police notification stated that Jarrod was currently at the police station. He had been picked up for stealing with a group of juveniles who were taking part in these behaviours. He was out at night without his mother's knowledge. The mother had previously admitted to police that she could not control him. Police had not contacted the mother at this time. The notifier requested CPA become involved that night, believing he would run away from the mother again. Jarrod was on a parental agreement, responsibility agreement and had settled down initially with agreement. He had been on the agreement for 1 month. Prior to the agreement Police came to transport the mother and Jarrod for an Interview. However, the mother hid in the house with Jarrod to prevent the Police from transporting them to the station. Police believe the mother may have mental health issues.

**Assessment:**

Proceed to investigation as a Child Concern response.

**Outcome:**

The matter was allocated for an investigation which had not commenced 5 months later.

**Police History**

Jarrod had an extensive history of 95 involvements with police recorded against him between 2006 and 2009 when he was 10 years old. This included being a person of interest, offender, suspect, juvenile welfare concern and missing person. His mother also had an extensive history of 90 involvements with police recorded about her, which included, family violence as a participant and a victim.

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**Nicholas NORTON: Born October 1995****Family History**

Nicholas was born in late October 1995 into a family consisting of a mother, a grandmother, a grandfather, 2 aunts and 6 cousins. The mother was reported to have a long history of mental health problems, diagnosed with Schizophrenia and exacerbated by negative experiences from close family members and her husband's death impacting on her. Nicholas, his brother and mother also had a history of contact with police. CPA records showed that there were 11 approaches made to CPA between 1999 to 2009, comprising child protection reports, family support referrals and protective assessments. Notifications made included concerns about the child's safety and welfare, the mother's capacity to provide adequate care for him, the child being found roaming the streets late at night unsupervised, the child engaging in unruly behaviour, assaults, stealing and being picked up by police, begging for food in the city, drinking alcohol, and allegedly being involved in having a sexual relationship (at 13 years of age) with a 27 year old mother of 6 children, who was also allegedly having sexual relations with other boys. Of these 11 approaches, 3 were accepted, 2 were not accepted, 4 were that the allegations did not constitute harm, 1 of unsubstantiated neglect and 1 where an investigation had been assessed as necessary but was still in the backlog.

**Notification History****29 June 1999 – First**

There was no Intake Form available for this notification.

**Assessment:**

Unknown.

**Outcome:**

The CCIS File Review briefly records outcome as a Family Support-Family Preservation case accepted.

**7 June 2000 – Second**

There is no Intake Form available for this notification.

**Outcome:**

The CCIS File Review briefly recorded this as a Family Support-Family Preservation case with an outcome of accepted.

**25 February 2002 – Third**

When Nicholas was not yet 3 years old his grandfather contacted CPA and raised concerns about:

- The mother's mental health problems (Schizophrenia) and lack of ability to care for his two grandchildren.
- the mother's drinking and her state of mind after attending the funeral of her brother who had hung himself and following the death of her husband who had been killed.

The reporter also stated that the mother had taken Nicholas into the bush with her where they nearly died, and the mother subsequently being admitted to Cowdy Ward. The grandfather also stated that the mother believed that the leader and members of the local clan were trying to kill her.

**Assessment:**

Allegations **would not constitute harm.**

**4 March 2002 – Fourth**

A Territory Housing officer contacted CPA to report that Nicholas's mother attended Territory Housing in a very paranoid state claiming people were attacking her and therefore she would not stay at her house. It was also reported that she had moved accommodation regularly with her children due to her paranoid beliefs and there were concerns about her behaviour.

**Assessment:**

Allegations would **not constitute harm.**

**Ombudsman yet to investigate:**

Were any mental health organisations contacted?

What criteria were satisfied for the allegations to be considered unlikely to cause harm to a child?

**4 May 2005 – Fifth**

There is no Intake Form available for this notification.

**Outcome:**

A Family Support Parenting case but not accepted.

**20 June 2006 and 13 March 2007 – Sixth and Seventh**

Included in notifications three and four for his brother.

**Outcome:**

No action on either notification.

**3 May 2007 – Eighth**

CPA received a completed *Child Abuse Report Form* from a Police Officer strongly suggesting that CPA follow up the matter. The officer's report stated that Nicholas's brother Jarrod was found around 10.30 pm at night in a suburb with two other children. The mother of one of the other children flagged down police and requested police take the other children home. When questioned, Jarrod told police he had been at school that day but did not say when he left school. On arrival at the family home, police spoke to Jarrod's mother who stated she was unsure of the whereabouts of her son, having seen him around 4pm after school that afternoon. The mother told police that she did not see the need to call police because Jarrod would return home whenever he wanted, having told him to return home before the sun went down. Police reported advising Jarrod and the mother of the dangers of a 7 year old child walking the streets at night and of the importance of notifying police when their children were missing.

**Assessment:**

Not Accepted. Allegations would not constitute maltreatment.

**Ombudsman comment:**

This was the third notification within 12 months about children in the same household but no investigation ensued.

**22 November 2007 – Ninth**

NTFC received a completed *Child Abuse Report Form* from a Police Officer stating Police found Nicholas walking the streets at 1.30 am in the morning and escorted him home to his mother, who said she had expected him home earlier and did not know his whereabouts. The officer reported that an Aboriginal community worker had informed him of the following:

- The mother claims the child is home even when he is not;
- Mother does not appear to care;
- Nicholas was involved in criminal activity - stole a vehicle and drove it out to Coolalinga;
- Parents put all responsibility on police to maintain children.

**Assessment:**

Accepted for a Protective Assessment - Other case.

**Outcome:**

The outcome of the Protective Assessment did not appear in CIT's records.

**26 August 2008 – Tenth**

CPA received a report from the Night Patrol Officer stating that on at least 3 occasions she had observed Nicholas, his brother Jarrod and two other boys on the streets of Darwin CBD late at night and early in the morning. The officer reported that on speaking with the boys they all said that they were hungry, their mother was on 'ganga' and they came into town seeking food. The reporter stated that the boys would beg for food at or near Uncle Sam's Takeaway. The owner would sometimes provide a meal, as would patrons. The reporter stated she had also seen the boys at Casuarina Shopping Centre begging for food. The officer took the boys to her home for a sleep and food as she was concerned for their safety.

**Assessment:**

Child Concern Report recommended.

**Outcome:**

Unsubstantiated neglect.

**21 May 2009 – Eleventh**

CPA received a completed *Child Abuse Report Form* from a Police Officer raising concerns of inappropriate sexual activity involving Nicholas, his brother Jarrod, a number of other young children - all under age, and an adult female who was named. The report recorded that the mother of Bradley (one of the boys involved in the incident) alleged that her son Bradley told her that while at the woman's house 2 weeks ago the woman '*tried to do something silly to me*'. It was alleged that the woman put her hand on Bradley's lap and rubbed his leg groin

region while at the house. Bradley also stated that the woman was in a sexual relationship with Nicholas Norton which had allegedly been going on for 2 months.

**Assessment:**

Recommended not to proceed to investigation as allegations are a police not a NTFC matter. CP Report - Allegations would not constitute harm.

**Ombudsman comment:**

There were notifications on 19 May and 21 May 2009 for Jarrod. The notifications for his brother on 21 May 2009 was a third for the same household. He was also only 13 years old.

**27 May 2009 - Twelfth**

CPA received an email notification from another Police Officer raising concerns of inappropriate sexual activity involving Nicholas, his brother Jarrod, a number of other young children - all under-age, and an adult female who was named. The summarised information reads:

- *'The subject young person is reportedly in a sexual relationship with a 27 year-old woman (and mother of 6).*
- *The sexual relationship has been occurring or at least known about by others since September 2008 when the YP supposedly told a friend of his that he had been sleeping with (i.e. having sex with) .....*
- *Police have had contact with an individual who has stated; 'I know that the lady who lives at xxx is having sex with those young boys. I heard this from some of the young boys and my son...'*
- *This individual also added, 'I have also heard from the boys that she is having sex with Norton, Nicholas. He is only 13 years old. She is always drunk or stoned. I pulled up one night and she had a bottle of rum and was having an argument with one of the young boys like a husband and wife argument.'*
- *YP is attending a household well known to Police for underage drinking, violence, drug use, hooning and other antisocial and illegal behaviours.'*

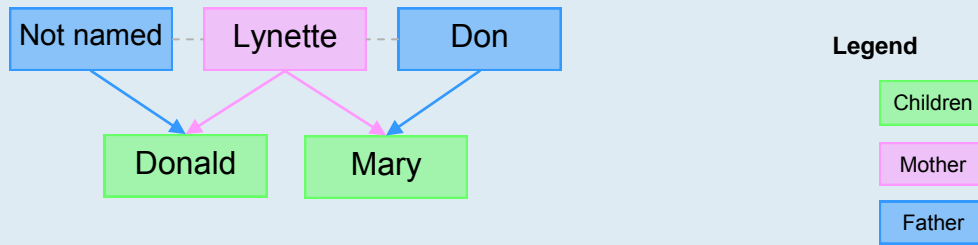
**Assessment:**

Recommended for a Child Concern investigation. (Response benchmark 5 days). Investigation not started as at 23/12/09 7 months later.

**Police History**

Records show that Nicholas had 41 involvements recorded with police when he was between the age of 6 and 11. This included being recorded as an offender, person of interest, family violence child, missing person and victim. His mother also had an extensive history of 90 involvement with police recorded about her, which included, family violence as a participant and a victim.

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**Raymond / Smith Family**

**Mary SMITH (aka Mary RAYMOND): Born July 2005**

**Family History**

The family history is detailed with the history of the next child. The mother had a serious chronic mental illness and an addiction to illicit drugs.

**Notification History****28 July 2005 – First**

A notification from a Doctor at RDH Special Care Nursery reported the following information:

- A three-week old baby was in the nursery who was born drug dependant. At the time of birth, the mother was known to be on methadone.
- Due to severe withdrawals of the baby in the first 24 hours after delivery, the Doctor suspected the mother of using IV drugs in addition to methadone. A urine analysis from the baby showed traces of morphine had transferred from the mother.
- The mother admitted to medical staff she was an IV drug user injecting 2 to 3 times a week.
- The baby had been given the name of Mary but RDH had not altered records to show this until the baby's birth was registered.
- Due to the severity of the withdrawals, the baby needed to be carefully monitored for the next two to three weeks.
- The Doctor thought that the mother's current partner was a taxi driver.
- The mother stayed in hospital for several days after the birth and was discharged.
- Over time, the mother appeared to be spending less time with the baby. The mother told staff on the ward that *'she had bitten off more than she can chew'* referring to the baby.
- The mother also found it difficult to handle the withdrawal symptoms of the baby and often left when the baby cried or was upset.
- The mother told ward staff that she worked as a receptionist for an escort agency.
- The mother had a Case Manager.
- A further complication and possible risk factor for the baby was that the mother was Hep C positive.
- The mother would need to be careful in relation to feeding the child if her nipples were cracked and sore, (as they currently were) as the potential for the Hep C virus to be passed onto the baby was high.

- The Doctor stated that if the mother took methadone the baby would be able to tolerate this but combined with IV drug usage this would pose an ongoing risk factor to the baby.
- The mother is currently 22 years old and this is her first child.

**Assessment:**

In noting the information provided, the assessment stated: *'It is recommended that this case be opened as a protective assessment to consider the impact of risk factors and lifestyle choices of the parents that may impact on the baby.'*

**Outcome:**

The outcome in the Protective Assessment Report stated *'It is recommended that the child remain in the care of the mother. There have been no protective concerns, apart from the mother's lack of confidence and parenting skills. The mother's drug addiction appears to be under control, as she is on the methadone program and she attends counselling once per week at A&OD.'* The case was closed in December 2005.

**2 December 2005 – Second**

There is no Intake Form for this notification. Referral of family to Home Strength. Centacare NT was involved over a 12 week period to assist mother in basic housekeeping chores, budgeting and child care. Observation of interaction and bonding between mother and son. Difficulties in home visits and calls due to mother not being available throughout the 12 weeks. Mother relapsed during this period and has sought assistance to get in touch with A&OD from workers and was concerned about the amount of assistance she was not getting from her partner.

**Assessment:**

There was no outcome/assessment/decision for this case.

The CCIS File Review records this as a Family Support (Intensive Family Preservation) and was accepted.

**15 May 2006 – Third**

There is no Intake Form available on file.

- There is an unsigned General Case Closure Summary form dated 25/8/06 available stating:
- Summary of Casework Intervention  
Family referred to Centacare's 12 week intensive family support program 'Home Strength'.
- Mother supported with A&OD Program.
- Provided mother with information regarding Mary's development, safety needs in the home.
- Household management information (cleaning routines, budgeting) provided.
- Mother provided with information for parenting groups and playgroups.
- Information provided for relationship counselling for mother and father. Mother willing to participate but father was not.
- Mother has proved difficult to contact. The family have recently moved residence and have not informed CPA of their full new address.

- Mother is currently attending regular appointments with A&OD. Mother has recently relapsed and there are concerns for Mary in the future if mother doesn't continue to seek counselling and support from A&OD.
- It is noted that mother appears to have a strong bond with her daughter Mary.
- Other Service Providers involved with this case.
- Centacare Home Strength 12 week intensive family support program.
- Alcohol and other drugs - Mother is on methadone program and continues to attend regular appointments with A&OD.
- Worker has attempted on numerous occasions to visit mother at home and contact her via phone without success.
- A&OD advised mother is attending scheduled appointments and has no concerns with case closure as Mary attends appointments with mother and she appears to be loved and well looked after and mother seems to be managing well. A&OD will contact CPA in the future if there any concerns about Mary's wellbeing.

***Assessment:***

There is no outcome/assessment/recorded decision for this case.

The CCIS File Review records this as a Family Support Other case and was accepted.

***Ombudsman comment:***

It was the third report within 12 months. An investigation ought to have been instigated.

***8 February 2007 – Fourth*** (Child 20 months old)

A health worker reported that:

- The child's mother was on A & OD's methadone program but discontinued since her last drug screening on 9/1/07 but was physically seen on 22/1/07.
- Mother confirmed with the notifier on 23/1/07 that she was back using Amphetamines and Benzodiazepine's.
- Last urine drug screening was conducted on 9/1/07. The results showed she had been using Amphetamines, Benzo's (unknown if Valium or Rohiptnol), Cannabis and Morphine.
- The mother confirmed she was back prostituting and leaves the baby with the father who is emotionally detached from the child. Father was not the biological father of the child and he knows this and this may be why he is also emotionally detached from the child.
- The mother leaves the child in the father's care while she is prostituting and the father is alleged to leave the child in the playpen while he is drinking and watching TV.
- The father is also known to be an 'On and Off client' of A&OD and had used the Methadone program as well.
- The mother was on 16 milligrams of methadone while she was on the program and that this is a 'high amount' and this may be due to her being a sex worker and using various drugs and quantities.

The specific concerns raised were:

- The mother's ongoing drug abuse and continued profession as a paid sex worker.
- The lifestyle decisions she continued to display could be impacting on her ability and willingness to provide care for her child and her chosen profession could be impacting upon her child's environment.
- The mother's parenting towards her child may be impacted by her continued use of Amphetamines, Cannabis, Benzodiazepine's and Morphine.
- The parents are both known to be drug substance abusers and may be having difficulty in providing support and appropriate parenting to the child and given the information about the mother leaving the child in the father's care and his reported inattention to the child, the child's emotional development may be delayed if left alone for periods of time.

**Assessment:**

The assessment recommended that the case proceed as a Protective Assessment of the child '*Care of the child; **child to remain in the family home***'.

The outcome in the Protective Assessment Report stated:

*Services required to meet child and families needs; Family to continue childcare at ABC Child Care.*

**Ombudsman comment:**

ABC Child Care does not operate on weekends or after 6pm on weekdays.

**Outcome:**

Departmental involvement/referral to other agencies- Nil. No further CPA involvement and no referral to other agencies is recommended at this stage.' The case was closed on 17/5/07.

**19 November 2007 – Fifth** (Child 2 years 4 months old)

Staff of a local hotel contacted police to report a child left unattended and crying in a room for a number of hours. The manager attended the room and found the child alone and very distressed. When the Manager contacted the father and he attended, the child did not want to go with the father. Police attended and found the room unkempt and dirty. The television was on and positioned in front of the child's bed with a portable play station on and positioned for child to view. Cannabis and equipment, syringes and needles were found in the room. Used alcohol swabs with traces of blood were found within reach of the child. Sex toys were also found within reach. Police found the father and mother and arrested and charged them with drug related offences. The family had been staying in the hotel for over a month. Following this incident the mother returned to the hotel and took the child with her to the police station. The mother later contacted a relative who accepted responsibility for the child.

**Assessment:**

The assessment recommended that this case proceed to a child in danger investigation.



**Outcome:**

The CCIS File Review of 23 December 2009 records this case as a CP Investigation with **emotional harm and neglect substantiated**.

**4 December 2007 – Sixth**

A notifier contacted CPA and provided the following information:

- On 27/12/07 (should be 27/11/07) the child's carer notified the case manager of concerns for the child's behaviour and other concerns. The carer was an experienced carer and was concerned the child was not displaying normal age-appropriate sexual behaviour.

The following specific concerns were expressed by the carer:

- The child's vagina 'looks stretched'.
- The piece of skin between the vagina and bottom (perineum) has a large lump.
- The child removes her clothes and nappy and 'plays with herself' by putting her fingers in her vagina.
- The child puts a doll between her legs and holds it between her legs.
- Concerns that the child has mood swings and is aggressive (primarily to other children).
- Referral was made to SARC on 27/12/07 (should be 27/11/07) and the child had been examined by a Doctor. Verbal feedback from the Doctor was that there was physical indication that the child's hymen had been torn and since healed. The Doctor would be providing a written report to CPA re medical examination.
- In a CPA interview with the mother on 28/11/07 the mother was asked if the child had been sexually abused at any time. The mother stated that there was an occasion she went into the hotel room and the father made 'quick movements like he was hiding something' and 'I thought maybe I saw him touching her' (the father). The mother stated she confronted the father and he did not respond like she expected, denied touching the child and began crying. The mother further stated that the child 'got funny' for a few weeks afterwards and wouldn't let the father change her.
- It was noted that a Statutory Declaration completed by the Doctor who completed a medical examination of the child on 29/11/07 reported, among other things, that these injuries indicated a previous hymeneal injury; that healing had produced scarring which accounted for the lack of movement in that part of the hymeneal edge and the penetration would have been by an object with a diameter greater than the hymeneal opening, being 1.0-1.2 cm in this child, occurring at least 6 weeks prior to the examination.

**Assessment:**

In noting the information provided, the assessment stated that the child was currently safe, however, CPA investigation was warranted to assess the likelihood of maltreatment (sexual). The **Child Concern Report box** was ticked.

The CCIS File Review showed this case as a CP Investigation with **sexual exploitation substantiated**.

## ***Police History***

Mary had a history of 3 involvements recorded with police, one as a victim, one as a family violence child and one as child welfare. Mary's mother had a history of 73 involvements recorded about her with 22 of these being as an offender. Records also indicated that Mary's father had 3 involvements recorded with police.

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### ***Donald SMITH: Born January 2009***

## ***Family History***

Donald's mother had a history of chronic mental health problems that were difficult to treat due to her on-going substance abuse and rural location. She was taken for psychiatric evaluation after displaying bizarre behaviour such as thinking her house had been bugged, receiving messages from birds and having thoughts of self harm. Donald's mother is Hep C positive and has used MS Contin IV and Ice (Speed). Following psychiatric evaluation, she was admitted, involuntarily, into the Mental Health Inpatient Unit, assessed and discharged. However, she failed to comply with her recommended mental health, drug and alcohol management program. The mother had a long history of involvements recorded with police, totalling 73, as offender, family violence participant, victim, person of interest, etc.

The CCIS File Review records for Donald show 5 approaches were made to CPA. Of these, 3 were child protections reports raising concerns of emotional harm, neglect and sexual exploitation. All were substantiated, 1 was a Family Support referral case and 1 was a Substitute Care case, which were both accepted. The first approach to CPA was in mid 2008 (before he was born) due to the family's history of involvement with CPA. The remaining notifications were made when he was between one month and two months old.

## ***Notification History***

### ***19 August 2008 – First***

Donald was not yet born at the time this notification was made raising serious concerns for the potential safety of the baby when born, due to the mother's mental illness and substance abuse. A Psychiatric Consultant and a Nurse from the Mental Health Services wrote to NTFC informing them of the potential risk to the 25 year old pregnant unemployed mother's unborn baby if it continued to full term and the mother chose to continue to abuse illicit substances in addition to not complying with care of her mental symptoms. The mother was reportedly living in a caravan and was brought into hospital on 14/7/08 for psychiatric assessment on a police warrant due to her partner's concern about bizarre behaviour, including the mother thinking her house was bugged, getting messages from birds and having thoughts of self harm, which she denied. When questioned, her partner confirmed this odd behaviour occurring over many years and thought it had become worse.

When assessed, the mother was guarded, suspicious, angry and no rapport was made. The mother reported using MS Contin IV that day and IV Speed (ice) four days prior. Following assessment the mother was briefly admitted involuntarily to the Mental Health Inpatient Unit. Apparently upon further expert assessment, she did not satisfy the criteria for a more lengthy

involuntary admission and was discharged shortly after. However, since discharge, she had not complied with her recommended mental health or drug and alcohol community management program. Given her previous presentation it was likely she would only have minimal obstetric care prior to delivery, and present to RDH for delivery.

Given this history, it was believed that the mother's baby may be at significant risk if residing with her in her current mental state. It was therefore strongly recommended that the baby be placed in the care of the Minister post delivery until the mother's mental state and social situation could be further evaluated to ascertain whether her baby may be at risk of neglect and abuse.

According to CPA there was extensive involvement with the mother and older sibling, Mary, (born drug dependant at birth due to the mother's illicit drug use) over concerns of emotional abuse, neglect and sexual maltreatment, which were substantiated and followed by CPA intervention. The mother reportedly had a history of substance abuse which included amphetamines, benzodiazepines, cannabis and morphine; had worked as a sex worker and was involved in alcohol, drugs and methadone programs.

**Assessment:**

The assessment noted the considerable risk factors and previous history, stating a directive had been made for a family support case to be opened to facilitate involvement and case planning prior to the birth of the child. A request for an alert was requested to be placed on CCIS for Central Intake to be contacted when the baby was born so that a child protection case could be considered. An outcome of Accept was required for this family support referral.

A Family Support Referral was accepted and allocated to the Casuarina Office and the case subsequently closed on 3/2/09 with the issues not having been resolved.

**5 January 2009 (1200 hours) - Second**

A social worker telephoned CPA on 5/1/09 and stated the following:

- 'There is a child protection Alert on CCIS system to notify when the subject child is born;
- There is confusion about the paternity of the subject child and the ward is uncertain who to allow contact with the subject child based on inconsistent information from the mother.
- The subject child remains an inpatient in the Special Care Nursery on withdrawal with no immediate plans for discharge.
- The subject child is doing well.
- Reporter is aware the family are well-known to NTFC with a sibling in care.
- Family have raised concerns about the subject child although reporter is not aware of what the families concerns are.
- Reporter is aware the mother has a long history of illicit drug abuse.
- Reporter is not aware of any other concerns or information in relation to the subject child.'

**Assessment:**

The assessment stated *'This notification was prompted by an unborn baby alert on CCIS. While the family are well known to CPA, the content of this notification did not outline any immediate concerns for the safety or well being of the child since the child was in a safe*

*environment at RDH at the time of the notification. It is noted that an investigation has proceeded based on another report received for the subject child - please refer to CP #15844. Based on the above, an **outcome of insufficient information** is required for this report for CCIS purposes.'*

The CCIS File Review of 23 December 2009 states the matter was not investigated due to there being insufficient information, with **no immediate concerns for the safety and well being of the child** being outlined.

***Ombudsman comment:***

I strongly suspect that this report of 5 January 2009 was written off with dummy documents. It's date coincides with the memo extending that stratagem. That explains why the information about the outcome was reported to the Ombudsman in the CCIS File Review but is not on the intake form. It is astonishing given the history of the previous child, CPA's knowledge of the mother's condition, the placing of the alert at the request of the CPA that the outcome was insufficient information.

According to the Operations Manual 'Alerts' are put in place *'as a means of notifying other NTFC work units or other Departments about significant concerns for the immediate protection and wellbeing of a client'*.

***5 January 2009 (1630hrs) - Third***

A person telephoned CPA stating:

- Concerns were raised regarding paternity of the baby of Roslyn Smith. Reporter stated that the baby's name was Donald.
- Baby was currently in the special care nursery at RDH, for 'withdrawal of methadone'
- Mother had stated XY was the father.
- Another man had presented at the hospital and also claimed to be the father.
- Reporter was aware that XY's family were willing to provide care and support for the baby if it could be proven that XY was the father.
- Reporter stated that Tom had been paying rent and other bills for the mother but would no longer do so until he knows for sure that he is the father.
- Reporter requested that XY's name not be mentioned to the mother if CPA intervened as a result of this report. Reporter alleged that mother had threatened to 'lose it' if XY involved his family.
- Reporter stated that mother's other child (3 or 4 years old) was taken into care by CPA last November because she was 'found in a hotel room on her own while the mother was out prostituting.'

***Assessment:***

The assessment, in acknowledging previous history, noted that the mother and Mary's father were currently partners and it was possible that the 'other man' mentioned by the Reporter, who is also claiming paternity of the child, is Mary's father. The assessment recommended this proceed as a child concern investigation.

***Outcome:***

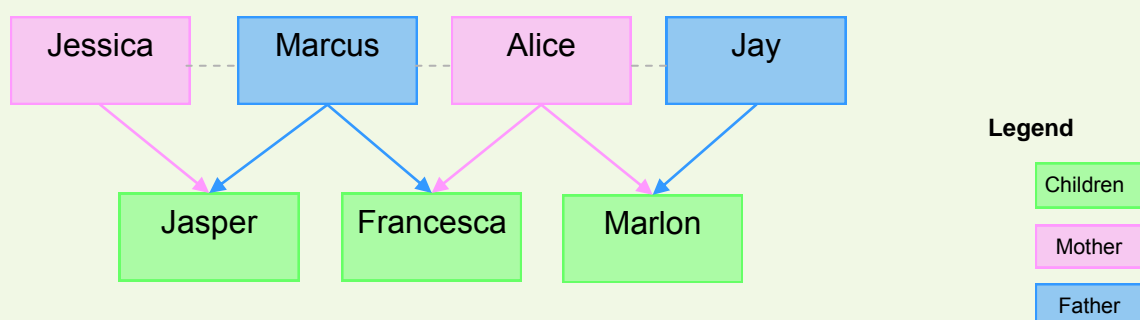
A CP Investigation Summary Report completed on 21/5/09 found **substantiated neglect** and the child was placed in the care of the CEO for 12 months.

**21 January 2009 – Fourth**

This was a duplicate report giving the same information as the notification of 5 January 2009. The date '2008' was incorrect.

**Assessment:**

The assessment noted the information provided was reiterating concerns highlighted in the previous CP report which proceeded to investigation and that as the child was in the care of the hospital for the next 2 weeks, this information would be recorded with no further action.

**Berl/Lister/Hatfeld Family**

This family is named because a public report was released by the Coroner naming the family and two of the children.

**Francesca HATFELD: Born January 2004****Family History**

Francesca was born in January 2004. By the time she was six weeks old she had been exposed to domestic violence. Francesca was in her mother's arms when her parents had a physical altercation and Francesca's mother was punched in the eye by Francesca's father. In the first seven months of Francesca's life, as a result of domestic violence incidents between her parents, police attended her home four times. Francesca was 20 months old when the CPA assessed her mother acting in a cruel manner towards Francesca.

By the age of three, Francesca was living in the long grass. At the age of five Francesca's father committed suicide. Francesca also experienced her mother being physically abused by two of her subsequent partners. One partner beat Francesca's mother with a steel bar while Francesca was watching.

Francesca's mother was recorded as a regular drinker who smoked marijuana daily. Francesca's mother was known to leave Francesca while she went to the casino to gamble. On 31 August 2009, 5 year old Francesca became a big sister to Marlon Berl. 58 days later Francesca awoke to discover that her baby brother was not breathing. Francesca attended Royal Darwin Hospital with her mother where Marlon was declared deceased. While at the

hospital Francesca was recorded as saying: *'Mummy's been drinking all day. Mummy's been drinking beer all day. Mummy's going to die; my Daddy will get out and kill her.'* A coronial inquest into the death of Francesca's brother, Marlon, was reported on by the Coroner on 13 May 2011 [2011] NTMC 009.

### ***Notification History of reports/notifications of suspected harm***

#### ***16 February 2004 – First***

Reported by NT Police as a Child Abuse matter. Francesca's mother attended at Nightcliff Police Station to report a physical altercation that had occurred between her and Francesca's father. Francesca's mother was 'bitch-slapping' her father in the head during an argument. Francesca's father retaliated by punching her mother in her left eye. The mother was holding 6 week old Francesca at the time of the physical altercation. Francesca's half brother, 4.5 years old, was present during the altercation.

#### ***Assessment:***

**It is not recommended that CPA intervene in this instance.**

#### ***21 September 2004 – Second***

Police Domestic Violence Unit (DVU) reported concerns regarding Francesca's exposure to domestic arguments between her parents and exposure to high alcohol consumption. Report outlined the following information:

- An incident had occurred on 13/09/2004 where Francesca's mother had attended at Palmerston Police Station demanding the father mind Francesca while she partake in a drinking session. The mother was conveyed to RDH for assessment of mental health and injury.
- There had been 5 Domestic Violence incidents for the year. The mother's behaviour was reported as being irresponsible and irrational during these incidents.

#### ***Assessment:***

**A child concern within the required 5 day time frame is warranted.**

#### ***Investigation outcome:***

No evidence to substantiate allegations.

#### ***Ombudsman yet to investigate:***

How extensive was the investigation?

How long did it take to do the investigation?

Why was the police report of 5 DV incidents not 'evidence'?

Were the medical records of the mother from RDH considered?

A five year old brother was mentioned in the previous notification. Was he present on any of the five DV incidents?

#### ***09 November 2005 – Third***

Reported by Aboriginal Health Worker (AHW) at remote community. Requested CPA involvement for safety of child. Reporter observed the mother hitting, pinching and threatening to further hurt her by pinching and asking her 'Does it hurt?' 'Do you want me to do it again?' Child was kept in bedroom most of the day with an expectation that she should

sleep. Child's mother allowed her out for an hour to play and had expectations, when the child made a mess, that the child would clean it up. Child one year and ten months. Mother smoked marijuana on a daily basis.

**Assessment:**

Child at risk box indicated – no comments.

**Investigation outcome:**

Unsubstantiated.

**Ombudsman yet to investigate:**

Who investigated, when, whether child spoken to?

Why AHW's observations not accepted?

How adequate was the investigation?

**05 January 2007 – Fourth**

The following details were obtained from a progress note:

*Event date 05/01/07 Entered date 09/01/07 – phone call from distraught mother saying her former partner was 'rowing' with his current woman over the care of the child and threatening to 'dump' the child with maternal aunt who lives in Darwin.*

*Issues: mother asked father to care for child approx 2 months ago when she needed a break for mental health reasons. Mother indicated she was out bush because she couldn't handle living in Darwin. Mother expressed concern father not caring for child properly. Mother ready to resume care but does not have the funds to travel to Darwin to pick child up. Ongoing disputes with father over care.*

**Assessment:**

**Recommendation that the referral not be accepted.**

**Ombudsman yet to investigate:**

Why self referral not accepted for at least an assessment?

The mother was known to have mental health issues and drug and alcohol abuse issues. The report indicated that one parent did not want to care for the child and the other asking for help to do so. What consideration was given to the wellbeing of the children?

**14 April 2007 – Fifth**

NT Police reported they attended a residence at 14.00 hours on 14/04/2007. On that day Francesca's father attended at the property where Francesca and her mother were temporarily staying. A physical altercation between the parents took place resulting in the grandmother taking the child away from the father as he had started to punch Francesca's mother. The mother and child were conveyed to Palmerston LPO for purpose of DVO. The father left prior to police attendance. The child was 3 years and 3 months old.

**Assessment:**

**Recommended not proceed with this notification as Insufficient Information.**

**Ombudsman yet to investigate:**

What further information was needed?

Were any attempts made to obtain it from police, grandmother or anyone else?

This was the fifth notification in three years, two months for this child, in addition to six notifications for a sibling between 2000 and 2002. Was that history referred to by the assessing intake worker?

NB: This notification was received the same day as the next notification but from a different source.

**14 April 2007 – Sixth**

At 1410 hours Francesca's father called with concerns about his daughter indicating the child was being raised in a neglectful environment and maltreated. His list of concerns included:

- Ex partner has custody of three year old child.
- Mother allegedly living in the long grass with no fixed address.
- Child being dragged from one address to another.
- Mother allegedly in and out of Cowdy Ward who say she does not have a mental health issue.
- There is fighting and drinking at the house where she is staying.
- The mother is allegedly an alcoholic and drinks continually.
- The mother physically hits and kicks the child. He states he has witnesses who saw this about one month ago.
- The mother refuses to seek help for her drinking problem.
- The mother and child just got off a plane an hour ago and when the father tried to see Francesca a tousele occurred between the parents. Father states that the mother is 'flinging the child around like a rag doll.' This appears to be the context of concern, that the father would try to take the child from the mother.
- The father says there is no food in the house, that there are a mob of children fighting over any food and that the family were asking him for money to get food.

**Assessment:**

*'The allegations are vague and generalised with **no specific concerns that would constitute maltreatment** able to be identified. There is limited history on CCIS with some previous CP Reports however no abuse of neglect has been substantiated. Therefore it is recommended that this matter does not proceed to investigation.'*

**Ombudsman yet to investigate:**

Three reports from police of child witnessing DV on 7 occasions before she was 3-5 years old. One report from an AHW. Six notifications about an older sibling, with physical abuse substantiated, report of physical abuse of child in front of witnesses, referral for family support in November. What more is needed before a matter such as this proceeds to investigation?

Was the record of notification about Francesca's sibling made known to the Coroner?

8 reports from police sent to CIT not entered in CCIS from 2004 – why not?



**21 May 2007 – Seventh**

Report by visiting Paediatric Registrar to Danila Dilba Health Services reporting disclosure by Francesca's mother of 3 year old Francesca having been sexually abused by her 7 year old half brother in December 2006 and January 2007 during access visits to her father.

**Assessment:**

**There is no role for CPA at this time. It is recommended to Not Accept this referral.**

**19 June 2007 – Eighth**

Police Report of domestic violence between Francesca's mother and new partner. Francesca was present at this time.

**Assessment:**

**Recommended not proceeding this notification as Insufficient Information.**

**22 May 2009 – Ninth**

Neighbour made a report about a violent assault on Francesca's mother by her new partner with a steel bar. Francesca was present at this time. Reported that for the past month Francesca's mother was constantly drinking and smoking cannabis. She was also asking 'people' for money to buy more drugs and when refused became abusive. The mother was so intoxicated recently she had soiled her underwear and remained sitting in the faeces. Residence is supposed to be alcohol free as there is a government sign stating this. Francesca's mother was 5-6 months pregnant at the time. The father of the unborn child was out of gaol and was living with Francesca's mother (breach of DV). Both the mother and the new partner have been 'standing over pensioners for money' and bugging as many 'people' as possible for money. There is also a lack of consistent school attendance of Francesca. Francesca was living with her grandmother. Report states mother got Francesca back due to her fear that parenting payments would cease. Francesca has been known to sometimes ask people for food having been sent by her mother. The mother was only buying bread, milk, tea and cigarettes, the rest being spent on drugs and alcohol. Report further detailed activities relating to an unsafe home environment for Francesca and goes on to report the mother had sex with various partners and was very noisy when doing so. Further stated the mother talked about sexual activities in front of Francesca.

**Assessment:**

Recommended matter proceed to investigation as a child of concern.

**Investigation outcome:**

No clear investigation documents were attached behind the intake form. A document on the file titled '*Information on the intervention that NTFC have undertaken with Francesca Hatfeld and her Family*' shows for this intake – **Due to the work load demands of the assessment team this case was not allocated.**

**1 September 2009 – Tenth**

A nurse from RDH reported on behalf of a paediatrician at the hospital that Francesca's mother had given birth to a baby boy, born 31/08/2009. Reporter said there was a history of domestic violence and there was a DVO against the father. Notes on intake report indicated the following: '*Intake worker looked at the former intake and it was approved as a child*

*concern but there is no case created and there is a history of mother drinking/smoking marijuana during pregnancy'.*

### **Assessment**

Recorded as an Intake Event only.

### **27 October 2009 – Eleventh**

Notification from RDH staff. Francesca accompanied her mother and brother, 8 weeks old Marlon to RDH when Marlon was brought in by ambulance. Francesca had been in bed with her mother, Marlon and her mother's boyfriend and overnight Marlon suffered a fatal injury. Francesca was heard to say at the hospital that *'Mummy's been drinking all day. Mummy's been drinking beer all day. Mummy's going to die; my Daddy will get out and kill her'*.

### **Assessment:**

Recommended proceed with child in danger response.

### **Ombudsman yet to investigate:**

Whether the investigation was done, what the outcome was?

What are Francesca's living circumstances now? According to the report of the Coroner she has been placed with a relative for 12 months from October 2009 but this is not recorded by CCIS. Reports from NT Police about Francesca being present when police attended DV incidents were sent on each of the following dates. Only one was recorded in CIT's records.

<b>DATES - BRIOS</b>
18/6/08
<b>31/5/07</b>
<b>14/4/07</b>
<b>13/2/07</b>
13/10/06
23/11/05
<b>2/10/04</b>
<b>5/9/04</b>
<b>27/3/04</b>

### **Police History**

Police records indicate there have been 87 involvements with Francesca's mother between February 2002 and July 2010. At least 25 of these involved domestic violence. Francesca's father had a history of 80 involvements with police which included 24 incidents as a family violence offender/participant.

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***Jasper KYTE-HATFELD: Born November 1999***

Jasper was seven months old when CPA were made aware of issues involving his parents.

***History of Notification to CPA***

***14 June 2000 – First***

Concerns raised by Centrelink staff who witnessed a physical altercation involving Jasper's parents with him present.

***Assessment:***

**Allegation would not constitute maltreatment.**

***23 September 2000 – Second***

Reported by Police that 10 month old Jasper's father was in rehab centre and during a visit Jasper's mother 'lost it'. She was threatening to kill herself, hurt herself and hit herself and locked herself in the bathroom. She was taken to RDH A&E. The police were hoping she would be admitted to Cowdy Ward for assessment but she was released and went to stay with her parents. It was decided to take Jasper to his maternal grandparents for care until CPA followed up on Monday. Jasper's grandmother advised that Jasper's father had recently been in the NT News having been convicted of a physical assault on a young girl.

***Assessment:***

**Not proceed to investigation.**

***1 June 2001 – Third***

Jasper's uncle reported he found 18 month old Jasper walking alone down the road approximately half a kilometre from his home. He advised that Jasper's parents were no longer together and a Family Court order had given his mother full custody. Uncle had called Jasper's grandfather. Mother and grandmother arrived. The mother was very angry and gave two contradicting stories – one that she was asleep inside and the other that she was next door. Either way, she stated that 18 month old Jasper had 'broken out'.

***Assessment:***

Proceed to investigation as child of concern.

***Investigation outcome:***

Unsubstantiated neglect maltreatment.

***07 December 2001 – Fourth***

Jasper's mother left him with a friend for an extended period and did not collect him at the arranged time.

***Assessment:***

Allegation would not constitute maltreatment.

**23 July 2002 – Fifth**

Reported by a family day care worker who had been contacted by the family's neighbour with concerns for Jasper who was at the time of this report 2 years and 8 months old. She heard the mother threatening to kill him. When CPA spoke with Jasper's mother on the phone she stated '*Jasper won't listen to me, Jasper screams up to an hour at a time, Jasper hates me, when he goes away for one night everyone says he is an angel, constantly goes to bed late and Jasper is a bit psycho*'. When asked about hitting Jasper the mother stated she '*hit the child to the point her hand hurt, could not tell how many times she hit the child, she has left bruises and advised that she broke an egg flip on child's bottom, would continue hitting the child as he does not do as she asks and that she would hit him harder in the future*'. Arrangements were made for Jasper to go to family day care for the night and for his mother to see CPA the following day to assess her ongoing needs.

**Assessment:**

Proceed child at risk.

**Investigation outcome:**

**Substantiated physical abuse.**

**Referral to Family Support Service.**

**04 November 2002 – Sixth**

Jasper's mother is requiring ongoing support to care for her child following Child Protection investigation.

**Assessment:**

**Not accepted for family support services** in assistance with parenting skills as **no resources available**.

**Ombudsman Note:**

There is no record of Jasper's circumstances after this date. His sister, Francesca was born in 2004. There were 11 notifications about her and another 8 police reports but Jasper does not get a mention. In July 2002 after finding physical abuse substantiated there was a referral to family support services. In November 2002 the mother asked for support. The outcome was there were no support services available. What happened between July and November, was any support given?

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**Marlon BERL (D'ced): Born August 2009**
**Family History**

CPA was notified the day following Marlon's birth due to the extensive history of domestic violence in the family and a Domestic Violence Order against his father. This information was attached to an existing open notification for his sister and no further action was taken at that time. Fifty six days later Marlon was admitted to RDH with serious physical injuries and passed away. Concerns included mother's abuse of alcohol and illicit drugs, namely marijuana. On the morning Marlon passed away RDH received a call approximately 5 mins prior to ambulance arrival advising '*I have a 4 week old baby, full resuscitation required, we are going*

to give it a go, ETA about 5 minutes'. After resuscitation attempts by the ambulance and the hospital staff, baby Marlon was pronounced dead.

### **Notification History**

#### **01 September 2009 – First**

This notification was made by a paediatrician from RDH on 1 September 2009, CPA received a report in relation to the birth of Marlon and concerns in relation to the mother's abuse of alcohol and illicit drugs namely marijuana. Both Marlon and Francesca were subject children. The matter was recorded as an Intake Event.

#### **01 September 2009 – Second Advice**

A nurse from RDH reported on behalf of a paediatrician at the hospital that Francesca's mother had given birth to a baby boy, born 31/08/2009. Reporter said there was a history of domestic violence and there was a DVO against the father.

Notes on intake report indicated the following:

*'Intake worker looked at the former intake and it was approved as a child concern but there is no case created and there is a history of mother drinking/smoking marijuana during pregnancy.'*

#### **Assessment:**

This information was in addition to Intake #17718 a current Child Concern Report. **The new information had been recorded as an Intake Event only** ie. no action.

#### **27 October 2009 – Second**

Reported by three RDH staff and recorded as follows:

- Reporter One at 0811 hours provided details relating to Marlon being admitted on 26 October 2009 at 1612 hours with bleeding from ears, mouth and eyes. The reporter stated that the mother reeked of alcohol and family home is full of drunks. The reporter believed the five year old sibling of Marlon may have witnessed what occurred.  
It was also stated that the grandfather had tried twice during the week to take the children into his care but had not been successful.
- Reporter Two at 1311 hours advised that Reporter One had time lined out. The second reporter advised that Marlon was admitted to RDH at 4.50am on 27 October 2009. He was not breathing on admission. Medical staff attempted resuscitation until 5.10am at which time Marlon was declared deceased.
- Reporter Three at 1726 hours provided the following observations of Marlon:  
*'Wearing a nappy, dried blood around mouth, blood coming from right ear, dried blood on the suction tubing, pupils were fixed and skin was mottled. Mother presented intoxicated and using florid language. Mother asked Marlon's five year old sibling "did you kill the baby"?' The reporter also stated that the mother was accusing boyfriend of injuring the infant and said 'I want all those c..nts out of the house I will kill them all'. Francesca was reported to have said she 'saw someone come in and bash the baby'.*

#### **Ombudsman Note:**

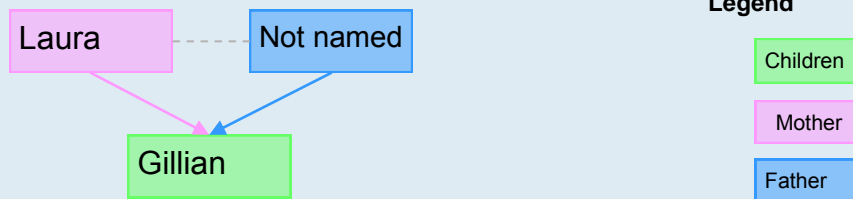
The Coroner decided Francesca's information was not established.

**Assessment:**

Recommended to proceed with child in danger response.

**Police History**

Police records indicate there had been 87 involvements with Marlon's mother between February 2002 until July 2010. This included involvements since Marlon's death. At least 25 of those involved domestic violence. Marlon's father had a history of 129 involvements with police recorded against him which included 23 as a family violence offender/participant.

**Roylston Family**

**Gillian ROYLSTON: Born May 2003**

**Family History:**

Gillian was two and a half years old when the first notification was received raising concerns that she was suffering from serious malnutrition, suspected sexual abuse, neglect and chronic failure to thrive. Gillian had a long history of suffering from a range of serious medical conditions and as a result had spent considerable periods of time in and out of hospital requiring ongoing monitoring and treatment. One doctor described her condition as *'looking like an African child, thin, and sullen looking with sunken eyes'*. Gillian's mother was 18 years old and the identity of her father had not been disclosed. The CCIS File Review records 4 approaches were made to CPA. Of these, 3 resulted in Family Support Referrals being accepted and 1 case of neglect was substantiated. My Office was only provided with two intake forms from CIT recording notification.

**Notification History****15 December 2005 - First**

CPA received a phone call from the Sexual Assault Referral Centre advising that a two and a half year old child from a remote community was coming into Darwin for examination following allegations of sexual abuse. The notifier advised that the child had come to Darwin following allegations that 2 boys from the community had interfered with her. The mother claimed that the child was asleep with her 2 Aunts on a mattress when she noticed a spot of blood on the mattress between the child's legs and thought she had been sexually assaulted. A Sexual Assault Identification Kit had been done and *'showed nothing remarkable.'* The

notifier advised CPA that the child was admitted to hospital for treatment for *'the worst case of scabies I've seen'*. The child was also suffering from malnutrition.

**Assessment:**

A Family support case was accepted.

**11 February 2009 - Second**

No Intake Form was provided for this notification.

The CCIS File Review records that a Family Support Referral (Family Preservation) was received outlining the following concerns:

- *The Remote Community Health Centre Manager and doctor expressed concern for Gillian who was admitted to RDH with difficulties with weight gain.*
- *It was noted that the child's mother may require assistance, as the house appeared as being unkempt.*

*The Family Support Referral was accepted and the matter was allocated to the CPA Remote Office. A child protection report was initiated on 12 March 2009.*

**Ombudsman questions:**

What was the outcome of the child protection report initiated on 12 March 2009?

What was the date of the report?

Was there an investigation done prior to the report?

How extensive was it and who did it?

**11 March 2009 - Third**

An allied health professional informed CIT that Gillian was admitted to RDH and was being treated for anaemia and weight loss (failure to thrive). The notifier wrote the following:

*Gillian has a long history of low weight, failure to thrive (inadequate food intake) and skin problems dating back to 2003. During the past 12 months several appointments have been scheduled for medical review and follow up in the community with paediatrician... family have been non-compliant in attending these.*

**Assessment:**

Assessed as a Child of Concern investigation. The intake worker stated:

*Gillian has suffered from ongoing medical concerns since a very young age. Laura does not appear to have the capacity to adequately care for Gillian nor does Laura appear to have an understanding of the detrimental effect long term medical concerns can have on the future health and well being of Gillian.*

**Outcome:**

The CCIS File Review indicates:

*This matter was allocated to CPA Remote and an investigation commenced on 11/03/2009.*

*On 02/04/2009, neglect was substantiated as a result of a non-organic reason for failing to thrive. The child's mother was listed as the Person Believe Responsible for the neglect. However the child remained in the family home, with the issues being listed as resolved.*

***Ombudsman comment:***

How were these issues 'resolved'?

***11 May 2009 – Fourth***

No intake form was provided for this notification.

The CCIS File Review indicated that this notification was accepted for a Family Support Referral with the issues resolved with the child remaining in the family home on 04/09/2009 and the case subsequently closed.

***Ombudsman yet to investigate:***

Who made the notification?

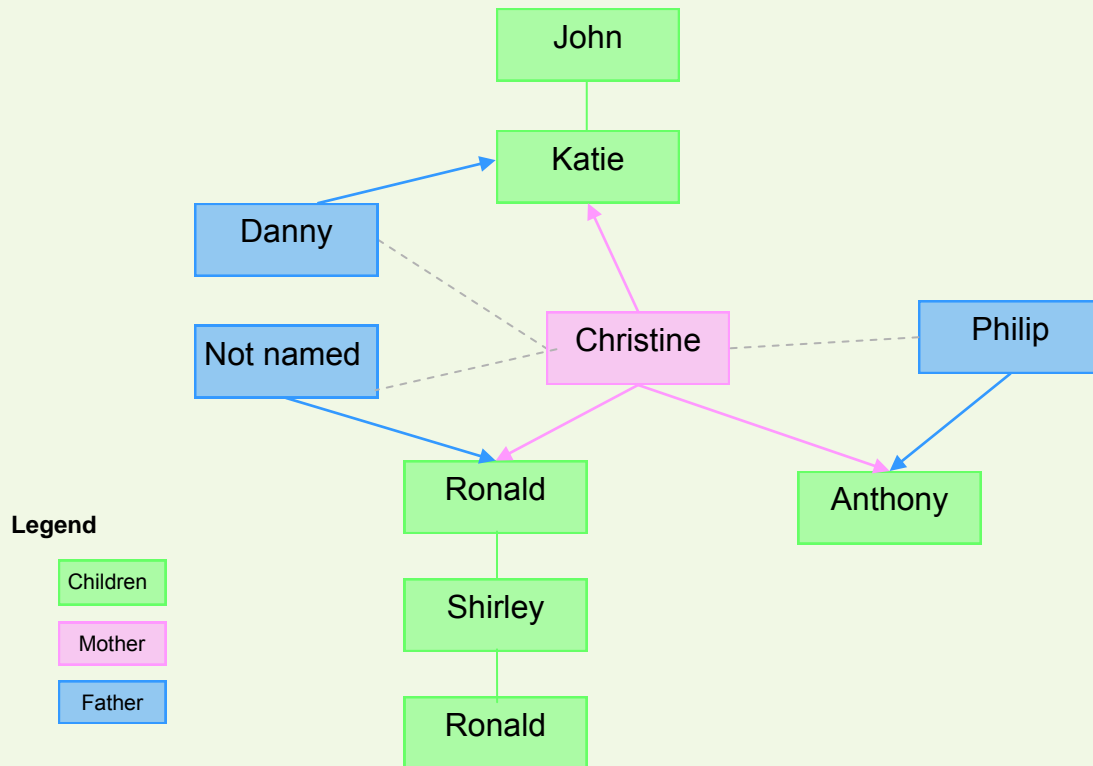
What were the concerns outlined in the notification?

What support or steps were undertaken between when the notification was made on 11 May 2009 until September 2009?

In a remote community which services provided support and what was the nature of that support?

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**Katie Winston (Reeves) Family****Katie Winston: Born August 1979**

Katie's story is included because it shows two generations of children affected by violence and abuse of alcohol. The story of Katie's children follows.

**Family History**

Katie was the fifth child born into a family who already had a substantial involvement with the Department. This involvement, which commenced in 1976, was based on the Department's concern regarding the mother's abuse of alcohol and the subsequent neglect of her children. At the time of her birth, Katie's mother and her de facto had no fixed abode and were living with extended family members. Although her parents were her main caregivers, various extended family members provided care when her parents were intoxicated and unable to care for Katie adequately. At the age of 2 years and 5 months Katie became a big sister to a little brother. She then had three step brothers, one step sister and one brother. Her baby brother John was only three months old when he was taken into care due to physical neglect.

During the years that followed Katie's parents continued to abuse alcohol and were unable to provide adequate care for their children. At age nine, Katie was interviewed by police in relation to alleged sexual abuse. She told the police that the previous Christmas she and John and her parents stayed with friends. All the adults were a little drunk. While her parents were asleep in the lounge a man came into her room picked her up and put her in his bed. She described in detail a sexual assault on her as well as other assaults on her brother and another male child. The day after the interviews Katie's aunt stated that she and her husband were prepared to care for Katie and her brother until they turned 18. So it was requested that Katie

and her brother be placed in the sole guardianship of the Minister for Health and Community Services for a period not extending beyond their 18<sup>th</sup> birthdays.

By mid February of the following year Katie's aunt had contacted the Department to advise that she didn't feel she could cope with the children's behaviour and by March there was a request for emergency accommodation. Because of the special needs of Katie and her brother it had proved impossible to place the children and a senior welfare worker agreed to care for them for three weeks while other arrangements were made. At this time Katie was 10 years of age.

The following is a chronology of CPA involvement with Katie: (some names have been changed)

On 30/1/1982 the Department received a neglect complaint in respect of the children. The reporter was concerned about the safety of the children, as there were 'frequently drunken fights' involving their parents and other adults frequenting their home. The report was substantiated. It was felt that with support from the Department the family could be assisted to provide adequate care for their children.

On 30/4/1982, CPA were contacted by the Police who notified them that Katie had been found at a Darwin Shopping Centre. A home visit was made. The only adult in the house was Katie's grandmother who was asleep on the lounge floor.

On 8/5/1982 Police advised the Department that Katie had been knocked down by a car at 7pm and had suffered superficial injuries. The child was unsupervised. Katie was taken into Custody under Section 31 of the *Child Welfare Act* and placed in a departmental Family Group Home.

In Mid May 1982 both Katie and her brother John were placed with their paternal grandparents in Perth by agreement. There was no adequate assessment of their ability to be foster carers and no financial support provided for the children's needs or their foster caring services. After one month, the grandparents felt unable to continue to care for the children. Katie's parents requested the children be returned to their care. As there was no Court Order in respect of the children, they were returned to their parent's care in June 1982.

Between February and March 1983 there was substantial involvement with Katie's parents with respect to the care they were providing for their children. Numerous support systems, such as Homemakers, organized child care, financial assistance, regular visitations by Welfare and Health, were put into place.

On 23/11/1985 the Manager of the community where the family was living contacted the Department with concerns about the safety and standard of care being provided for John and Katie. The allegations of neglect were substantiated. Some support systems were put in place to enable the parent's to continue to care for the children. The Department records referred to the support as 'appropriate'.

On 23/9/1985 a 19 year old man was arrested and charged over the alleged sexual assault of Katie then 6 years old. Both of her parents were allegedly in their demountable home with the door locked when the assault occurred.

On 3 October 1985, due to the parents being in a highly intoxicated state, Katie was cared for away from her parents for a short time.

On 9 October 1985 Katie and John were placed in a Family Group Home.

From October 1985 to December 1985 regular access visits were arranged for regular contact between Katie's parents and the children. These visits were only *'marginally successful due to the parents inability to attend because of their over indulgence in the consumption of alcohol'*.

In January 1986 a contract and roster for access visits was drawn up. Irrespective of this the parents continued to break scheduled access visits and demand access to the children outside visiting hours. Both parents continued their abuse of alcohol and did little to alter their lifestyles.

On 23 May 1986 the parents were asked to leave the community due to their drinking and generally disruptive behaviour. On 9 May 1986 John, Katie and Shirley were placed with a departmental foster parent.

On 22 July 1986, Katie's father's parents from a remote town expressed an interest in caring for John and Katie. Katie's parents moved to the remote town in an attempt to 'sort themselves out' and to work towards reunifying the family. Katie's grandparents were prepared to assist them by providing them with accommodation. On 29 September 1986 Katie's grandmother wrote to the Department advising that she did not think the parents had *'settled down enough to care for the children adequately'*.

John and Katie returned to the care of their parents for the Christmas vacation from December 1986 to January 1987. On their return from the remote town the children resumed residing with the foster parent. She was concerned by the apparent deterioration in the children's behaviour. John and Katie were displaying age inappropriate sexual behaviour at school. This behaviour had been present when the children were originally placed with her, however had subsided after counselling.

In October 1987 a Child Protection Investigation was conducted by the Darwin Welfare Office. John and Katie were interviewed regarding suspected sexual abuse. From interviews with the children no abuse could be proved beyond reasonable doubt, however, it was felt that the children's behaviour suggested that they were 'at risk'.

John and Katie were returned to the remote town on the condition that their grandmother was to be the main caregiver of the children, with their parents providing care on the weekends. No financial or other support was given to the grandparents for their service as foster carers or for the needs of the children.

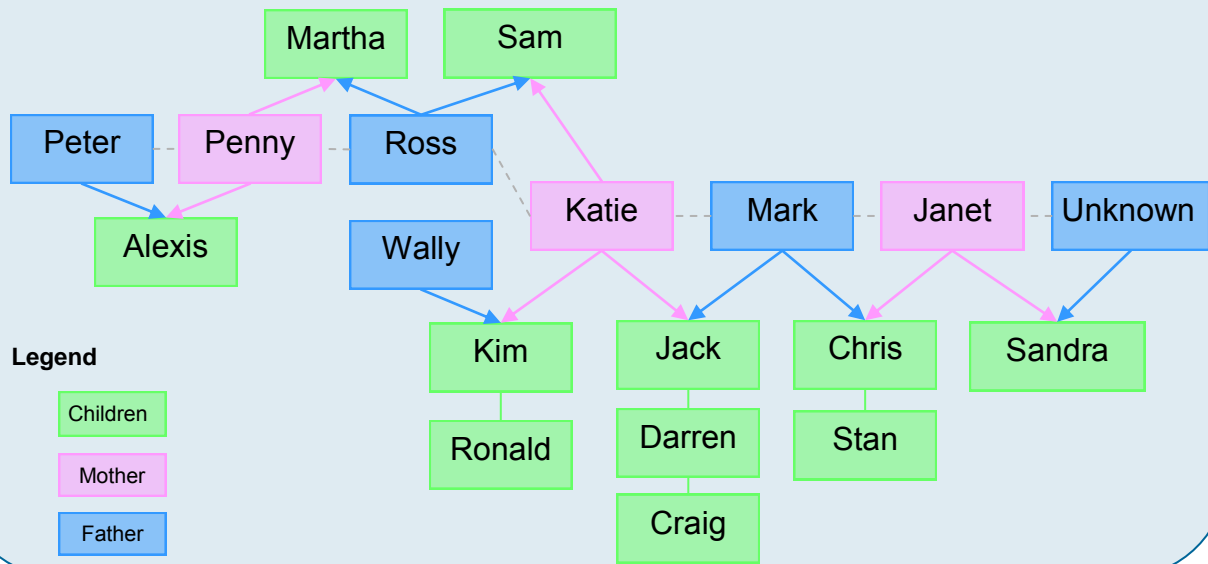
On 25 November 1988 when Katie and John were in the care of their grandmother they alleged that they had been sexually interfered with by a male friend of their parents the previous week.

Both Katie and John provided details of the alleged assault, and both stated that they had told their parents. A third child not related to them had also allegedly been assaulted. Their grandmother immediately contacted the Welfare Liaison Worker at the remote town and advised her of the children's disclosure. The worker contacted the Katherine Welfare Office and was advised that the grandmother should go to the police at the remote town and report the allegations. The welfare worker was also instructed that the police had the power to place a child in a place of safety for 48 hours, Section 11(1)(3)(a) *Community Welfare Act 1983*. She was further advised that the Katherine Welfare Office would contact the remote town police in respect of the report. John and Katie were placed in temporary foster care on the evening of 28 November.

Formal interviews were conducted with the children commencing on 29 November. On 30 November 1988, John and Katie were taken to Darwin and placed in a departmental Family Group Home. On the same day Katie and John's paternal aunt contacted the Department. She stated she had previously applied for the care of the children, however this had never eventuated. She stated that she and her husband were prepared to have the children placed in their care until the age of eighteen years.

Katie at adulthood became a parent. The next case study is about her children.

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**Smyth/Winston/Reedman/Dunfield Family**

**Kim SMYTH: Born February 2002**

**Family History**

Kim has one brother, four step brothers and two step fathers. At the age of one Kim's primary caregiver was his father. Due to a history of domestic violence involving his parents, Kim came to the notice of CPA at the age of 1 year and 10 months old. Domestic violence has been a common experience in Kim's life. On Christmas Day when Kim was two years old he spent the night at a refuge shelter. Kim more recently was involved in a criminal damage incident at a local shopping centre.

**Notification History****30 December 2003 - First**

CIT was contacted by Darwin Aboriginal and Islander Women's Shelter (DAIWS House). Kim's mother had rung stating her ex-partner was threatening to kill himself and Kim. Kim was only one year and ten months old at the time. Due to a history of domestic violence between Kim's parents this report would be treated as a Child in Danger.

**Assessment:**

Rationale of physical abuse and child in danger. Father had threatened to seriously injure/kill the child.

**Investigation outcome:**

Unsubstantiated – no evidence of maltreatment by father. Father provided explanation of incident.

**25 December 2004 – Second**

When Kim was 2 years and 10 months old he was taken to DAIWS House with his mother and two of her other children. They went there after a referral from RDH due to a domestic violence incident. Kim was unwell and was returned to RDH for an examination. A sore was found behind his ear by one of the workers. When this was commented on, one of the other boys said uncle (Kim's father) grabbed Kim's ear and twisted it when he was naughty. During the examination, when the doctor was removing the nappy, Kim said very clearly '*please don't hurt me*'. After an examination by an officer from SARC it was determined that the findings were consistent with nappy rash although it did not rule out the possibility of sexual abuse.

**Assessment:**

A child concern response is appropriate.

**Investigation outcome:**

Unsubstantiated.

Reproduced here is a copy of the Child Abuse Report Form from NT Police to CIT advising of the second notification for Kim Smyth. Note the previous incidents which under General Orders were required to be sent at the time of the incidents. Even if not sent contemporaneously with those incidents they were made known to CIT by this child abuse report form on or about 25/12/2004.

**CHILD ABUSE REPORT FORM**

PLEASE RETURN TO:

Manager, Child and Family Protective services

TO; DIRECTOR, CHILD AND FAMILY PROTECTIVE SERVICES (Darwin Region)

<u>Name of Child:</u>		<u>Kim Daniel Smyth (dob: 27/2/2002)</u>
<u>Time and Date of Incident:</u>		<u>From 25/12/2004 onwards</u>
<u>Child's present whereabouts:</u>		<u>With parents</u>
<u>Mother:</u>		<u>Katie Winston (dob: 1/8/1979)</u>
<u>Mother's Address:</u>		
<u>Father:</u>		
<u>Father's Address:</u>		
<u>Type of Abuse:</u>	<u>Delete as Applicable)</u>	<u>EMOTIONAL NEGLECT</u>
<u>Action Taken:</u>		<u>Report to FACS</u>
<u>Contract Officer:</u>		
<u>Contract Officer Phone:</u>		
<u>From:</u>		<u>NT Police DPVPU-Darwin</u>

This report is written to advise the domestic violence incidents reported to police.

The report numbers and dates are as follows:

**Promis #1250078 – 25/12/2004;** Police responded to a domestic disturbance and liaised with the father. He stated being involved in a verbal argument with his de-facto, the mother. She admitted to becoming very angry, and punched her arm through the bedroom window of the unit, causing lacerations to her arm. She was treated and conveyed to RDH. Nil concern for

welfare. Attending members explained DV legislation and options to both parties. The mother stated that she is pursuing with a restraining order.

**Promis #807558-9/01/2004:** Reported to police by FACS for concern for child welfare. She stated receiving information from 3<sup>rd</sup> hand that the father made threats to kill his 22 mths old son Kim Smyth and then kill himself. Police attended and located both the father and child Kim Smyth. Both appeared in good health and spirits. Child was clean, well fed and dressed in clean clothes. Unit was in clean and in good order. Nil concern for welfare for either person.

**Promis #1213501-19/11/2004:** Report of mother attended premises in regard to picking up their child. Both mother and father had an argument leading to physical altercation. Mother hit father and he grabbed her by the throat. Nil wished to proceed with a formal complaint and nil breach of order.

**Promis #125078-25/12/2004:** Report of domestic in progress. Police attended and the witness informed that the mother sustained several blows to the face by father's fist and then hit her with a glass bottle. Tufts of hair were ripped out of her head were she had been dragged inside by him. SJ Ambulance was called to the scene who took her to RDH for treatment. There were three children present; they were also transported to RDH. Mother made a complaint of aggravated assault and breach of dv. The matter is set for court hearing.

### ***18 September 2006 – Third***

(This Intake was not listed on the Intake Search Results Report). Report received by CPA from a police officer in relation to a domestic violence incident involving Kim's mother and her new partner. Police advised that this was the fourth incident of domestic violence in 2006 that Kim had been exposed to along with some of his step siblings, one being in January and two in August of 2006.

#### ***Assessment:***

Recommendation proceed to investigation **as a child of concern**.

#### ***Investigation outcome:***

**Substantiated.**

### ***17 July 2008 – Fourth***

A report made by an anonymous/neighbour stated that the mother was constantly swearing and yelling verbal abuse at her children. The caller thought there were three children in the home but didn't know the name of the mother or the children. There was a man who comes and goes but he doesn't yell at the children.

#### ***Assessment:***

Information provided by the notifier. Although concerning and not the most ideal parenting, did not reach the threshold for maltreatment as defined by the *Community Welfare Act*. It was therefore recommended to not proceed as there was insufficient information to warrant statutory intervention at that time.

**27 May 2010 – Fifth**

At eight years old the police located Kim with some other children at Palmerston Shopping Centre at 02.30am. They were involved in a criminal damage incident. The children had been observed throwing rocks at the shopping centre glass doors and causing extensive damage to the glass. It is alleged that they had been hanging around the shopping centre all evening until they were picked up by the police. It is stated that the parents were unaware of the children's whereabouts when the police returned them home.

**Assessment:**

Recommended to proceed to an investigation as a child of concern for Kim Smyth pursuant to section 20 (d) of the CAPCA 2007.

Status at 17 September 2010 – CP Report approved but case(s) not acted on. (4 months later)

**Police History**

Police records indicated there had been 12 involvements with Kim between July 2002 and May 2010, the most recent being as an offender. Police records further indicated his mother had 76 involvements between May 1999 and March 2010, 33 being for domestic argument and family violence. Kim's father had a history of 48 involvements with police recorded about him, which included 12 as a family violence offender/participant.

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**Ronald WINSTON-SMYTH – Born March 2004**
**Family History**

Ronald was eight months old when he needed to be placed in foster care. Domestic violence involving the adults in Ronald's life would be a repeated pattern throughout his childhood. There had been numerous occasions when his mother had been involved in either verbal or physical abuse. By the time Ronald was two years old his mother had a new partner and Ronald had a new step brother. The relationship between Ronald's mother and her new partner was also volatile with numerous domestic violence incidents occurring.

By the time Ronald was five years old he was familiar with frequent police and CPA attendances at his house. When Ronald was five years old his mother was found unconscious on the road side, intoxicated and had been bashed. She was suffering short and long term memory loss and could not care for Ronald and his step brothers. A temporary custody agreement was put in place. During the next month, Ronald's mother was arrested driving under the influence with Ronald and his 3 step brothers in the car. The children were placed in care until their father returned from work, which was out of town.

In March of 2009, when Ronald was about 5 years old, police attended his home on two occasions. After a complaint from neighbours, police attended to find his mother extremely intoxicated. There had been a loud argument with another woman who was leaving the house when police arrived. On the second visit from police, they found the children, all under the age of 5, locked out of the house. Their mother was slightly intoxicated. The children were then allowed back inside.



In September of 2009 it was established that since 2006 there had been 18 incidents of domestic violence recorded involving Ronald's mother and his step father, with 6 of these recorded in 2009. At just 5½ years old, Ronald and his younger step brothers were already acting aggressively towards each other and this was attributed to the environment in which they were living. Towards the end of November of the same year another report to the police was made about yelling, screaming and children crying. At that time Ronald was the subject of investigations as a result of three notifications.

### ***Notification History***

#### ***10 November 2004 – First***

Police picked up Ronald, his step brother and their mother from a residence where they had attended a party. Due to her level of intoxication police contacted CIT to place the children in care. Their mother was released from lock up the next day.

#### ***Assessment:***

Child in danger.

At this point given the lack of information that would identify that these children were subjected to abusive behaviour by their mother a response to address the immediate concerns and provide support for the mother was recommended.

#### ***Outcome:***

Children were safe. Children had been sighted on a number of occasions. Interaction between mother and children was positive and affectionate. However, reports from the Domestic Violence Unit indicated that the police had attended disputes between the parents on six occasions from June 2004 to the most recent incident on 12 January 2005. The number of reports and the degree of violence was of concern for the safety of the mother and her children.

#### ***Recommendation:***

Maintain family support for mother. Encourage her to report any breaches of the current DVO.

#### ***28 August 2005 – Second***

An ambulance attended the residence as someone had made a report that Ronald had stopped breathing. The ambulance found a husband and wife but no children. The mother had taken Ronald to the hospital where Ronald was examined. There was no obvious diagnosis and the mother was told to give him iceblocks to eat. The mother presented as unable to tell a coherent story and talked about Ronald having '*funny turns and fits for a month, we have to hang him upside down*'. Ronald and his mother left before a discharge discussion took place.

#### ***Assessment:***

Mother appeared to have acted protectively of Ronald by taking him to RDH.

***Ombudsman yet to investigate:***

Why was it not cause for concern that a child had been 'fitting' for a month and it was only when he 'stopped breathing' that 'protective' action was taken? The mother then left the RDH before discharge with no investigation of the cause of the fitting.

***13 November 2006 – Third***

Police reported they had been called to a domestic disturbance. Police reported that Ronald's mother had been awakened by her partner upon his return from his drinking session. He had verbally abused her and then struck her on the back of the head. There was a baby lying next to Ronald's mother on the bed and Ronald was in his own bedroom. Ronald's step father was arrested by police and taken to the watch house.

***Assessment:***

Proceed to investigation as child concern.

***Investigation outcome:***

**Emotional maltreatment substantiated** for children due to exposure to domestic violence. Safety decision – children are **conditionally safe** in parental care.

***Ombudsman yet to investigate:***

What are the 'conditions' and is there any monitoring of how or when they might change?

***21 February 2008 – Fourth***

On this afternoon Ronald's mother did not pick him up after pre-school which finished at 2pm. One of the staff from the pre-school took him home, only to find his step brother was home but locked out of the house, so Ronald and his step brother were taken to the police station. The police contacted CPA to make arrangements for the boys to be taken into temporary care for the night.

***Assessment:***

Child in Danger.

Ronald was a very young boy totally vulnerable and dependant on an adult for suitable care and support.

Ronald and his brother had been abandoned that day by their mother.

The mother had not collected the boys from school and it had been four hours since school finished.

***Investigation outcome:***

Placement in substitute care for one night. Assessment occurred the next day and it was viewed appropriate for the children to return to their mother's care.

***4 April 2008 – Fifth***

Ronald's step father contacted CIT and explained his two children and his step son had been dropped off the night before by his ex partner stating she wanted to leave them with him for a couple of hours. He told her 'no' as he needed to get some sleep to enable him to get up early for a flight to his remote workplace where he had a new job. He tried to ring her but had been unable to contact her. He had by this time missed the plane and needed to get to his workplace somehow.

**Assessment:**

The children were all very young and vulnerable.

Given that the adult appeared to be highly stressed and his history of domestic violence it was recommended to proceed as a Family Support/Parenting Support.

**Investigation outcome:**

Child was not in need of care and no further action was required by CPA.

**Ombudsman yet to investigate:**

Was the referral for Family Support accepted by a support service and by the mother?

What services were provided and for how long?

**17 July 2008 – Sixth**

The same circumstances as notification four for Kim.

**Outcome:**

Insufficient information to warrant intervention.

**21 January 2009 – Seventh**

Notification was received from a professional at RDH. The police had taken Ronald, two of his step brothers and his mother to the hospital. Ronald's mother was found unconscious on the side of the road, intoxicated and had been bashed. Ronald's mother had indicated that she was not coping with the children.

**Assessment:**

Recommended that this matter proceed as a Family Support/Parenting Support.

**Investigation outcome:**

Family support referral.

When this matter was finalised the initial case plan remained incomplete.

**Ombudsman yet to investigate:**

Was the referral for Family Services accepted by a support service?

What was put in place, when, and for how long?

Were the services any more extensive or effective than the referral on the sixth notification in April 2008?

If the matter was 'finalised' with the plan incomplete does this mean that services were not provided?

**8 February 2009 – Eighth**

At 12.00 hours Police contacted CIT to advise they had arrested Ronald's mother for driving under the influence of alcohol. At the time there were four boys in the car, being Ronald and three of his step brothers. Ronald's step father was working away and when he was contacted he provided the name of someone who could care for the children.

**Assessment:**

Recommend proceed as **a child in danger**.

***Investigation outcome:***

Substantiated neglect – other.

***Ombudsman yet to investigate:***

What was done as a result of an investigation substantiating neglect?

***1 September 2009 – Ninth***

CIT received a report from two people expressing concerns regarding the environment the children were living in. There were concerns that the mother's alcohol use could be impacting on her capacity to supervise and meet the emotional needs of the children. The mother engaged in verbal abuse of the children and it was alleged that she pushed her partner to breaking point when physical altercations occurred. Ronald's 18 month old step brother had been seen pushing the 38 week old baby in a pram on the road. It would also appear that the children were engaging in aggressive behaviour.

***Assessment:***

Recommended that the notification proceed to investigation as a **child concern**.

***Investigation outcome:***

Substantiated emotional abuse.

***Ombudsman yet to investigate:***

In the space of 7 months there were two investigations both substantiating neglect. Why was this third notification only a '*child concern*'?

When another report was received next day from NT Police why was the level of risk not escalated after the tenth notification?

***2 September 2009 – Tenth***

Police notified CPA of another domestic violence incident involving Ronald's mother and his step father. At about 1.27am the police arrived at the house and were approached by the mother who appeared extremely agitated, intoxicated and yelling '*get that black cunt out of my house, he doesn't live here, get him out of my house*'. She alleged that she had been choked and hit in the head with a lump of wood. Ronald's stepfather made counter allegations in the same vein against her. While in police presence and while holding the couple's youngest child the father started to argue and wanted to fight with another male passing in the street. He was prevented from doing this by the police and he agreed to hand over the baby to the mother. He was then taken to the city watch house. It was noted at this time there had been 18 recorded domestic violence incidents in the three years 2006 to 2009. Six of these had occurred in 2009.

***Assessment:***

Matter to proceed as a **child concern**.

***Investigation outcome:***

Substantiated neglect.

***Ombudsman yet to investigate:***

What action was taken for the wellbeing of the child after three substantiated neglect findings within 7 months?

***23 November 2009 – Eleventh***

Police made a report to CIT after being called to the house at 10.30pm due to reports of yelling and screaming and children crying. When police arrived they found the mother severely intoxicated on her bed with an infant alongside her and another child asleep at the side of the bed. All the children in the house were exposed to verbal abuse, yelling and threatening behaviour. Both parents were given new DVO's prohibiting each of them approaching each other when under the influence of alcohol or other substances.

***Assessment:***

Recommended that the report proceed as a **child concern**.

***Ombudsman yet to investigate:***

Was an investigation done?

What was the outcome?

***21 June 2010 – Twelfth***

An anonymous report was made with the following concerns outlined:

- the mother being a bad cook;
- the house stinks and smells like the boys wet the bed;
- dogs go inside the house;
- the mother drinks and smokes 'ganja' everyday;
- the mother doesn't worry about the children, only the money she gets from Centrelink;
- the mother hits the boys every time they are naughty and she can't even keep the house clean for them.

***Assessment:***

Pursuant to section 20, there is **insufficient information for the above notification to proceed to investigation**.

***Ombudsman yet to investigate:***

How this report could result in no action given the history of substantiated neglect?

What would amount to 'sufficient' information?

***Police History***

Police records indicated there had been 16 involvements with Ronald between June 2004 and November 2009 with 13 of those being for family domestic violence. Police records further indicated his mother had 76 involvements between May 1999 and March 2010, 33 being for domestic argument and family violence. Ronald's father had a history of 48 involvements with police recorded against him, which included 12 as a family violence offender/participant.

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## **Jack REEDMAN: Born February 2006**

### **Family History**

Jack was born into a family which already had extensive involvement with CIT. The notifications to CIT about his siblings are detailed in the two previous case records. At nine months old Jack was asleep in bed beside his intoxicated mother when his father returned home intoxicated. He started to yell at Jack's mother and called her a 'slut'. He then hit her on the back of the head a number of times and she ran outside with Jack, calling her neighbour. She handed Jack over the fence to the neighbour who locked Jack in her house as the father wanted to take Jack. The police attended, Jack's father was arrested and a restraining order was issued. At three years of age Jack was left without a carer when his intoxicated, unconscious mother was picked up by police and taken to RDH. A month later his mother was arrested for driving under the influence of alcohol while having four of her children in the car. In March of 2009, a three year old Jack attended day care with a black eye. He said he got the black eye from falling over. His father had explained to his mother it was from a fall off his bicycle. When CIT spoke with his father he said that Jack had run into a stroller.

By September 2009 it was noted that, over a period of three years from 2006 to 2009 there had been 18 domestic violence incidents recorded and 6 of those were in 2009.

It was also noted that Jack's mother's insight into the risk/harm her behaviour had on her children was limited. Further, it was documented that Jack's mother did not accept that her alcohol consumption impacted on her parenting ability and that she was putting her children at risk during those times.

### **Notification History**

#### **18 September 2006 – First**

Refer to Notification Three for Kim Smyth – This notification is the same incident affecting this child.

#### **Assessment:**

Recommendation: proceed to investigation as **a child of concern**.

#### **Investigation outcome:**

**Substantiated.**

#### **13 November 2006 – Second**

Notification three for Ronald Winston-Smyth – The circumstances are the same for this sibling.

#### **Assessment:**

Proceed to investigation as **child concern**.

#### **Investigation outcome:**

**Emotional maltreatment substantiated** for children due to exposure to domestic violence. Safety decision – children are conditionally safe in parental care.

**4 April 2008 – Third**

The same circumstances as notification five for Ronald Winston-Smyth. Outcome: No further action by CPA.

**17 July 2008 – Fourth**

The same circumstances as notification four for Kim Smyth. Outcome: Insufficient information to warrant intervention.

**21 January 2009 – Fifth**

The same circumstances as notification seven for Ronald Winston-Smyth. Outcome: Referred for Family Support but no plan completed.

**8 February 2009 – Sixth**

The same circumstances as notification eight for Ronald Winston-Smyth. Outcome: Child in danger – neglect substantiated.

**30 March 2009 – Seventh**

A call to CIT from a family centre worker who advised that Jack had come in that day with a 'shocking black eye'. The reporter had taken photos of the injured eye. Jack had said he got it from falling over and he had gone to the doctors. It must have occurred over the weekend as he didn't have it on Friday.

**Assessment:**

Recommended that this matter proceed as a child in danger.

**Investigation outcome:**

Unsubstantiated. Injury deemed to be accidental.

**1 September 2009 – Eighth**

The same circumstances as notification nine for Ronald Winston-Smyth. Outcome: Substantiated emotional abuse.

**2 September 2009 – Ninth**

The same circumstances as notification ten for Ronald Winston-Smyth. Outcome: Substantiated neglect.

**23 November 2009 – Tenth**

The same circumstances as notification eleven for Ronald Winston-Smyth. Outcome: Not recorded.

**21 June 2010 – Eleventh**

The same circumstances as notification twelve for Ronald Winston-Smyth. Outcome: Insufficient information to investigate.

## ***Police History***

Police records indicated there had been 24 involvements with Jack between September 2006 and December 2009 with 18 of those being for family domestic violence. Police records further indicated his mother had 76 involvements between May 1999 and March 2010, 33 being for domestic argument and family violence. Jack's father had a history of 72 involvements with police recorded about him, which included 28 as a family violence offender/participant, and 3 as a family violence victim.

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### ***Darren REEDMAN: Born December 2008***

## ***Family History***

Darren first came to the attention of the Department when he was six months old. Darren's father had contacted CIT saying that Darren's mother had left the children with him and he needed to catch a plane to his remote workplace. The mother could not be contacted. Due to the father appearing to be highly stressed it was decided that CIT would respond. Again at six months old Darren was a subject child in another report in which his mother had been heard screaming at her children and using offensive language. This information was provided anonymously and was deemed insufficient to warrant intervention. At sixteen months old Darren's mother was picked up by the police. She was unconscious, intoxicated and had been bashed. The following month she was arrested for drink driving and four of her children were in the car. Darren's father was away working and gave the name of someone the children could be left with until his return. Mid morning in March 2009 police came to the home and found the children locked out of the house. The children were all under the age of 5 years. Their mother was intoxicated and said they were locked out because they '*gave her the shits*'. At this time she let them back into the house.

For a three year period up to September 2009 there had been 18 recorded domestic violence incidents, six of which had occurred in 2009. Darren's mother did not accept that it was her alcohol and drug use that was impairing her judgement and her parenting abilities. Darren was only two years old when a neighbour found him at her front gate with no adult in sight. The police again attended at the house in November 2009. The children had been witness to yelling and screaming and appeared a little shaken. New Domestic Violence Orders were issued to both parents but no further action was taken as the mother was still breast feeding a baby and was needed at home.

There have been other CIT Intake Forms completed for Darren, however these all related to domestic violence or verbal abuse between adults and while Darren was present during those instances, it was determined that no abuse could be substantiated.

## ***Notification History***

### ***4 April 2008 – First***

The same circumstances as notification five for Ronald Winston-Smyth.  
Outcome: No further action by CPA.



**17 July 2008 – Second**

The same circumstances as notification four for Kim Smyth.  
Outcome: Insufficient information to warrant intervention.

**21 January 2009 – Third**

The same circumstances as notification seven for Ronald Winston-Smyth.  
Outcome: Referred for Family Support but no plan completed.

**8 February 2009 – Fourth**

The same circumstances as notification eight for Ronald Winston-Smyth.  
Outcome: Child in danger – **neglect substantiated**.

**1 September 2009 – Fifth**

The same circumstances as notification nine for Ronald Winston-Smyth.  
Outcome: **Substantiated emotional abuse**.

**2 September 2009 – Sixth**

The same circumstances as notification ten for Ronald Winston-Smyth.  
Outcome: **Substantiated neglect**.

**20 October 2009 – Seventh**

At around 04.40pm a neighbour contacted CIT because when she had arrived home, she had found two year old Darren at her front gate. He was on his own and his house was locked up with no one home. She stated that she could not look after him for very long as she had things to attend to that afternoon. CIT told the notifier that someone would attend in the next half an hour. At 5.10pm the neighbour called again to advise that the parents had come home in a car and had taken the child from her. Darren's mother said that a neighbour had been looking after all four boys and Darren had wandered away.

**Assessment:**

Recommended that this matter proceed to investigation as **a child at risk**.

**Investigation outcome:**

The notification was investigated and **no abuse or no neglect found**.

**23 November 2009 – Eighth**

The same circumstances as notification eleven for Ronald Winston-Smyth.  
Outcome: Not recorded.

**21 June 2010 – Ninth**

The same circumstances as notification twelve for Ronald Winston-Smyth.  
Outcome: Insufficient information to investigate.

**Police History**

Police records indicated there had been six involvements with Darren between February 2009 and November 2009, four of those for family domestic violence.

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***Craig REEDMAN: Born October 2007******Family History***

Craig is the youngest member of a dysfunctional family that has had extensive involvement with CIT since the middle of 1998. By the time Craig was born his mother had been in three relationships. All of these relationships had been marred by domestic violence. Numerous domestic violence orders had been issued to and from Craig's mother in relation to not having any contact with partners when under the influence of alcohol and/or drugs.

Craig was one month old when a notification was received about him by police who had found his mother unconscious on the side of the road bashed and intoxicated. Craig's father worked at a remote location and could only care for the children on a short term basis.

When Craig was two months old his mother was arrested for driving under the influence and at the time she had four of her children in the car. Again Craig's father was away at work but gave the name of someone who would care for the children until his return to Darwin. A report to CIT stated that Craig was being pushed in a pram by his older brother on the road with no adult supervision evident.

The following day at 1.27am police were called to Craig's house where it was reported there was an argument between a male and female. Craig's mother was seen to be extremely agitated, intoxicated and yelling obscenities. The father started to argue and wanted to fight with another male passing by in the street while he had Craig in his arms. He was prevented from doing this by the police. Police issued reciprocal domestic violence orders and the father was taken to the watch house.

Two months later police were again called to his family home. The mother was extremely intoxicated and she was in bed with an infant and another child. New reciprocal DVO's were issued.

There had been 18 recorded domestic violence incidents in the three years from 2006 until 2009. Six of these incidents occurred in 2009. In mid 2010 an anonymous caller contacted CIT with concerns regarding the family and the continued violence and lack of adult supervision of all of the children. This information was passed on to the case worker for the family, however it was deemed that there was insufficient information to warrant an investigation.

***Notification History******21 January 2009 – First***

The same circumstances as notification seven for Ronald Winston-Smyth.  
Outcome: Referred for Family Support but no plan completed.

***8 February 2009 – Second***

The same circumstances as notification eight for Ronald Winston-Smyth.  
Outcome: Child in danger – **neglect substantiated**.

**1 September 2009 – Third**

The same circumstances as notification nine for Ronald Winston-Smyth.

Outcome: **Substantiated emotional abuse.**

**2 September 2009 – Fourth**

The same circumstances as notification ten for Ronald Winston-Smyth.

Outcome: **Substantiated neglect.**

**23 November 2009 – Fifth**

The same circumstances as notification eleven for Ronald Winston-Smyth.

Outcome: Not recorded.

**21 June 2010 – Sixth**

The same circumstances as notification twelve for Ronald Winston-Smyth.

Outcome: Insufficient information to investigate.

**Police History**

Police records indicated there had been 10 involvements with Craig between February 2009 and December 2009 with 8 of those being for family domestic violence.

**Sam DUNFIELD: Born August 1996****Family History**

Sam is the eldest child in a complicated family structure. Sam has five step brothers and two step sisters. He also has had a variety of adults as care givers. Sam was born with Foetal Alcohol Syndrome as a result of his mother's abuse of alcohol during his gestation.

At 2 years old Sam came to the attention of CIT. It was reported that Sam was hosed down and left outside for extended periods as a form of punishment.

At six years of age Sam was seen begging for food from people at a fast food restaurant. By seven years of age Sam's father was in gaol for a domestic violence offence. It was at this time that Sam's behaviour was observed as being disruptively unpredictable and sexually charged. Sam told a story about visiting the mangroves with three other boys. He said these boys threatened him and forced him to perform oral and anal sex. He was receiving counselling at a medical service - Emotional and Social Wellbeing Centre.

At eight years of age Sam's birth mother contacted CIT to get assistance to be able to see her son. She stated she had not seen him since he visited her five years ago when she was in a coma in hospital after a car accident. In this same year police picked up Sam, one of his step brothers and their mother. Sam's mother was detained by police due to her level of intoxication. One month later Sam's mother visited a doctor and said that she had been finding it hard to cope with Sam's behaviour. She also said she had been drinking a lot of alcohol, smoking a lot of ganja and had been taking Sam's Ritalin medication. Three days later

Sam's mother was referred to DAIWS after a domestic violence incident and Sam and one of his step brothers were placed in care for three days.

By the time Sam was eleven his behaviour at school had become so violent that the Principal suspended him. Sam associated with a gang known to police and was a person of interest in some undisclosed matters. Sam was 12 years old when he was relinquished by his mother and father into other care. At twelve years old Sam was experiencing an extended period of instability. He had multiple foster care placements, was living on the streets, breaking the law and absconding. Two days before Christmas 2008 Sam was in the Youth Justice Court and was held in custody at Don Dale Juvenile Detention Centre. This was the first opportunity for a psychological assessment because previously Sam had absconded when appointments had been scheduled. Guided by the results of the testing, CPA would make a referral to their specialist care unit.

### ***Notification History***

#### ***26 July 1998 – First***

A reporter advised the child was hosed down by a parent as punishment and left outside late at night.

#### ***Assessment:***

It proceeded to investigation. No abuse or neglect found.

#### ***Ombudsman yet to investigate:***

Was the report of hosing down disproved or was it considered not to amount to abuse?

How adequate was the investigation?

Was the reporter interviewed?

#### ***24 July 2002 – Second***

Police reported that six year old Sam may have witnessed two domestic violence incidents. The following was also noted:

- Sam's father was known by police to be violent but it was not known if this impacted on his ability to care for Sam;
- Sam's father's girlfriend alleged that Sam '*has been kicked and back-handed on occasions*' by his father.
- Police contacted the school and were informed that the school had no concerns regarding Sam's behaviour or physical presentation. Sam **had attended school 37 days out of 100** in the first semester that year. There had been no involvement with CPA for Sam since 1998.

#### ***Assessment:***

Proceed as a child concern report.

#### ***Outcome:***

Not proceeded with due to insufficient information.

**7 November 2002 – Third**

Sam's school contacted CIT concerned that he had been arriving at school on his own. He was 6 years and 3 months old. As he had to cross a busy road at peak hour, the school held concerns for his safety. Sam had also been observed at the local McDonalds, begging for food from other customers and at this time he was also on his own. Sam had also been observed at an Aboriginal community in Darwin unaccompanied. The school Aboriginal Islander Educational Worker (AIEW) contacted Sam's father to discuss concerns. Initially Sam's father was reluctant to speak with the AIEW, but attended the school two days later for further discussion. Sam's father had been allowing him to go to school on his own, but after the school voiced their concern, he again took him to school on his bike.

**Assessment:**

Proceed as a child concern report.

**Investigation outcome:**

No abuse found.

**Ombudsman yet to investigate:**

Were the facts found to be correct or not or were the facts deemed accurate but not amounting to abuse?

How rigorous was this investigation?

**6 May 2003 – Fourth**

A couple of months prior to his seventh birthday, the School Principal rang CPA with concerns regarding Sam's behaviour in the school. These behaviours included screaming, shouting and verbally abusing other children and teachers at the school. She said these behaviours had been getting worse throughout the school term and that Sam was terrorising the other children. He was also starting to exhibit some sexual behaviours such as touching girl's vaginas through their dresses. The Principal said that Sam's behavioural difficulties might need psychological assessment. A couple of days later the Principal called CIT again to advise that she had spoken to Sam's father who had expressed anger towards Sam regarding his behaviour. Sam's father said, '*wait till I get you home*'. The Principal said Sam appeared to respond with fear to this statement from his father. The next day in a chat with Sam he told the Principal his father had struck him on the thigh with an egg flip.

**Assessment:**

Proceed as a child concern report.

**Investigation outcome:**

Unsubstantiated physical and emotional abuse.

**Ombudsman yet to investigate:**

How extensive was the investigation?

Who was interviewed?

Were the facts substantiated but consider not to be the result of abuse?

Was there any referral for assessment of the child's behaviour.

**17 December 2003 – Fifth**

A doctor contacted CIT with concerns regarding Sam's sexually charged and unpredictable behaviour. Sam told the doctor of an alleged sexual assault on him by three other boys two years previously. He said the boys threatened him and forced him to perform oral and anal sex and that they would kill him if he told anyone. The following information was also reported that:

- Sam is 'touching up' girls at school
- Sam needs close supervision and responds well when limits are set by a familiar consistent authority figure.

At the time of this notification Sam's father was in prison and Sam was living with his aunt.

**Assessment:**

Given that Sam was currently safe, the context of the sexual abuse was uncertain, and his aunt and uncle were committed to his care and accessing the appropriate services to assist him with his behaviours there was **no role for CPA at this time.**

**Ombudsman yet to investigate:**

What services were being provided?

What support was being given to the aunt and uncle?

Had the aunt and uncle been assessed as foster carers?

Were they paid?

Was financial assistance provided for the child's needs?

Had CPA sanctioned or arranged the foster carers?

**26 August 2004 – Sixth**

Sam's mother said that Sam was staying with a family member, a relation of Sam's father and they refused to give her access to him. Sam's care arrangement had been agreed upon amicably following a previous child protection case. Sam's mother became upset stating she had heard that Sam was saying horrible things about her. When asked when she last saw her son, she said it was in 1999 when she was in a coma after a car accident.

**Assessment:**

It was explained that CPA could not address access/custody issues and that Sam's mother should look into mediation with the family and obtain legal advice. Since Sam was placed with extended family there had been no further reports of concern for him.

**Ombudsman yet to investigate:**

What contact with Sam did CPA have?

Did CPA make arrangements for family reunification or access when placing Sam?

Were carer's assessed?

Were they paid for the care of Sam?

Was financial support arranged for his needs?

What weight was given to the overall family history and notifications about other siblings?

Five previous notifications had either not been investigated or were unsubstantiated. How did it happen that the child was placed by the Department after a 'child protection case'?

**10 November 2004 – Seventh**

Refer to Notification One for Ronald Winston-Smyth.

**22 December 2004 – Eighth**

Sam's mother visited a doctor to advise that she was having trouble coping with his behaviour. She also advised that she required more Ritalin for Sam's ADHD because she had taken it and was also smoking a lot of ganja and drinking a lot of alcohol.

**Assessment:**

Recommended that this matter be dealt with through the current open Protective Assessment case.

**Investigation outcome:**

Children are safe.

**Ombudsman yet to investigate:**

When was Sam returned to his mother?

How did CPA know the children were safe?

There was no record in CIT of a referral for a protective assessment. When and in what circumstance did that happen?

**26 April 2005 – Ninth**

Sam's mother had a new partner, whose his ex-partner called CPA with concerns for Sam's safety. She advised she had been in a violent relationship with the mother's new partner for 10 years. Her children had returned from a visit with their father and advised her that Sam's mother had '*flogged them with a hose*'. One of the boys told her '*we got nothing compared to Sam*'. The boys told her that their father had hit Sam around the head several times and threw him against the wall and onto his bed.

**Assessment:**

Child at risk.

There was no indication that the children were distressed or that they were harmed therefore this was assessed as insufficient.

**Investigation outcome:**

Investigation outcome of unsubstantiated.

**Ombudsman yet to investigate:**

What investigation was done?

Why was lack of distress being displayed by the children assessed as '*insufficient*'?

Does '*unsubstantiated*' mean '*proves no risk of harm*'?

Was the child interviewed?

Was mother interviewed?

Were reporter's children interviewed?

Were there any notifications to CPA about the reporter's children, when their mother lived with the father, now Sam's defacto stepfather and carer?

**25 May 2007 – Tenth**

The Principal from Sam's school rang with concerns that Sam was becoming so violent in his behaviour that they would have no option other than to suspend him. Sam had already been suspended for 41 days in the first 5 months of the year. The school also had concerns that his father would not allow him to be medicated for ADHD and that when Sam was suspended he hung around the home with his father. The Principal was of the opinion that *'exposure to the dangerous environment is being manifest in his behaviours'*. There was a current active police alert with respect to the father which identified the father as being *'paranoid and threatening about domestic situation with threats to bash person who has made complaint'*. In the previous year **school attendance was noted as 19 days of school for the last 12 months**. Sam went back to live with his mother at this time and she was to work with other service providers including the Department of Education and Centrecare to ensure his long term safety and well being.

**Assessment:**

Recommendation that this proceed as a Protective Assessment.

**Assessment outcome:**

Sam to remain with his mother and she is to maintain care of Sam and work with other service providers including Department of Education and Centrecare.

**Ombudsman yet to investigate:**

Was the recommendation for a protective assessment acted on?

What did it disclose?

If there was no protective assessment why not?

What service providers was he referred to?

What services provided, for how long, and with what result?

**23 December 2008 – Eleventh**

A fax was received advising that Sam had appeared before the Youth Justice Court and was being held in custody at Don Dale Juvenile Detention Centre.

**Assessment:**

As per protocol requirements, a protective assessment case was required to progress (ie. requested by Court).

**Police History**

Police records indicated there had been 138 involvements with Sam between the age of six and ten years old.

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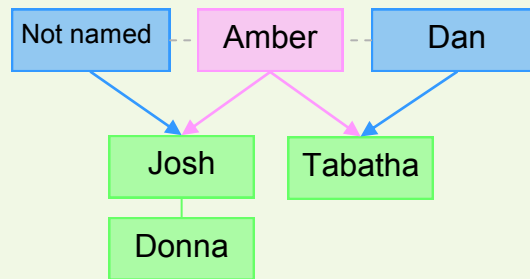


**Waller / Clifton Family****Legend**

Children

Mother

Father

**Tabatha WALLER / CLIFTON: Born October 2004****Family History – Two Generations**

Tabatha's father from age seven was known to CPA. Reports included that he and his siblings were subjected to verbal abuse by their mother. When he was eight a real estate agent found he and some other children asleep in a residence being shown to prospective tenants. The night before they had taken part in a break and enter, driven a vehicle and stolen some clothing. When the police took Tabatha's father home his older brother began assaulting him and police had to intervene. A month later it was alleged that his mother was obtaining and allowing the children to watch videos with pornography and violence in them.

Aged eleven Tabatha's father was arrested and charged over various offences including stealing, receiving stolen property and unlawful possession. The Court heard that Tabatha's father possibly had witnessed a domestic argument between his mother and her boyfriend that involved a baseball bat and an injury resulting in 19 stitches to one of the adults.

Tabatha first came to the attention of CPA as a two year old after her mother contacted police about threats made by her partner to 'knock her out'. Tabatha was taken to the community clinic when she was 3 years and 5 months old. During this visit it was also discussed that Tabatha had a rash on the genital area. Her mother asked her if anyone had touched her 'minni' (genital area) and Tabatha told her it was uncle. Tabatha spent time living with both her mother and her father. After one visit to her father she came home limping and coughing. X-rays showed a fracture and Tabatha said her cousin had jumped on her leg. A cast was applied. During this visit Tabatha had two different injuries to her head and face. Tabatha had black and bloodshot eyes and said someone had punched her. The battle between her parents continued and on the day following her fourth birthday a report was made by her father's solicitor. Her father was attempting to show harm caused by Tabatha's mother and took photos of the alleged injuries for use in court. He stated this was because Tabatha's mother had reported him to CPA previously.

In December 2008, still in her fourth year, another report was raised with CPA by her mother regarding the Family Court order giving Tabatha's father unsupervised access visits. No action was taken by CPA and the notification was written off without any initial danger assessment being completed under the authority of memos dated 24 October 2008 and 5 January 2009.

## **Notification History**

### **3 January 2007 – First**

CPA received a report from police that they were contacted by Tabatha's mother regarding threats from her partner to knock her out. Tabatha's father had previously broken her mother's nose and jaw. On arriving at the home police could not locate Tabatha or her father who were apparently travelling to Katherine.

#### **Assessment:**

Recommended that the investigation not proceed due to **insufficient pertinent information**.

### **11 April 2007 – Second** – Not entered in the CPA records.

Child Abuse Report Form from police dated 11 April 2007 stated the following information:

*It is believed that the children have witnessed their mother drink herself into an extreme level of intoxication. Whilst doing so the mother has instigated a verbal argument with her sister. During this argument has been unable /unwilling to control her behaviour and language. The mother was heavily intoxicated and it is the opinion of the reporting member, in an unfit state to provide even the most basic care for the children. This opinion was formed as a result of police locating approximately eight children ranging in age from infancy to 14 years cowering in a rear bedroom. While it could be argued this cowering behaviour was a result of police presence it should be noted that members observed the residence for at least five minutes prior to announcing their arrival. During this time no children were seen or heard moving around the residence.*

*Once the police presence was identified the mother's behaviour escalated forcing members to become physically involved. As a direct result of the above and the mother's continual interference with members and influence over the other people present, the children's details were unable to be recorded. It was only after the mother was removed to another residence members were able to record her children's details.*

*The woman referred to in this report is not Tabatha's mother and the male is not Tabatha's father. It is noted that Tabatha was listed as being present at the time but no information is on file at NTFC for Tabatha in relation to this incident.*

#### **Ombudsman Note:**

All such reports of DV where children are present are provided to CPA by NT Police.

### **26 October 2007 – Third**

CPA were contacted by a legal aid service who were representing Tabatha's mother. The following information was provided:

- Child is currently with her father in Katherine. Tabatha's father has a new partner and young baby. The father is leaving Tabatha at home with his partner and the partner is leaving Tabatha at home with her younger brother – age unknown. This is reported to occur quite regularly.
- There is a domestic violence background between mother and father and it is reported there is a lot of domestic violence between the father and the new girlfriend.

- On 17/09/2007 the child was taken to the doctor by her grandmother. Tabatha was coughing up blood. The doctor has said that the mother has concerns that the father is not caring for Tabatha appropriately.
- Other symptoms that Tabatha had was yellow mucus, vomiting and a bad odour in her mouth. Tabatha was meant to go for a review with Ear Nose and Throat specialist and did not present for appointment.

**Assessment:**

It was expected that if the doctor had significant concerns for the safety and welfare of the child, a report would have been made by the doctor. There was **no CPA history for this child**. Information was vague and in the writers opinion did not warrant seeking further information re DV history from police at that stage, however, current information may be considered in assessing future reports.

**Outcome:**

No action.

**30 November 2007 – Fourth**

Information provided by Tabatha's mother that she was concerned for Tabatha's safety. Tabatha in the care of her father and people had been telling Tabatha's mother that he was selling drugs. Tabatha's mother is concerned that *'while he is packing his bags of marijuana she's been beside him counting them'*. The father is in Alice Springs and the mother lives in Darwin. Tabatha's mother stated that Tabatha had recently been to the doctor and the doctor had written a certificate saying the father was not taking care of the child. Tabatha had sores on her top lip. The doctor's report stated that Tabatha had been *'spewing blood'*. Tabatha's mother said that Tabatha was with her grandmother in Katherine while her father was in Alice Springs looking for his girlfriend. The mother hadn't seen Tabatha for one month. Tabatha had missed an appointment with the Ear Nose and Throat Specialist.

**Assessment:**

Insufficient information for CPA action – NFA.

**19 January 2008 – Fifth**

CPA received two phone calls to advise that Tabatha was naked and wandering unsupervised around units in Katherine. CIT requested police conduct a child welfare check at the address. When the police attended they could not locate any naked child wandering unsupervised.

**Assessment:**

Mother advised that the situation had been checked by the police and CPA would not become involved.

**26 March 2008 – Sixth**

Report made by Community Registered Nurse that she had seen Tabatha who was aged 3 years and 5 months. Her mother wanted a certificate to show that Tabatha had mosquito bites and not sores, so it didn't look like she was neglecting her care. This was due to an ongoing 'nasty' custody battle with her former partner. It was also discussed that Tabatha had a rash on the genital area. Her mother asked her if anyone had touched her 'minni' (genital area) and Tabatha replied that her uncle had. Tabatha was referred to SARC for counselling.

**Assessment:**

This is subject to the third report rule therefore it is recommended to proceed to investigation. A child concern response is considered appropriate after consultation with the team leader.

**Ombudsman yet to investigate:**

Whether an investigation occurred within 5 days or at any time and with what outcome?

**8 July 2008 – Seventh**

Nearly 4 years old Tabatha was again brought to the attention of CPA by three reporters, her mother, a RDH Social Worker and a RDH Doctor. Tabatha was returned to her mother's care after a period with her father. Tabatha had a cough and was limping. The father told the mother he had taken Tabatha to a clinic because of a leg injury. It was suggested that a cast be put on to aid healing of the leg but this was declined. Tabatha's mother took her to the RDH where she had an x-ray taken of her right leg and her chest and was prescribed antibiotics. A cast was applied to her leg. Tabatha said that her cousin had jumped on her leg off a fence. Later the same day the social worker called CPA again to advise that Tabatha also had two head and face injuries. One injury looked to be 7-10 days old and the other 3-4 days old. Tabatha told the doctor that someone punched her. The doctor considered the head injuries to be non-accidental.

**Assessment:**

Recommended to proceed to investigation as **child at risk**.

**Investigation outcome**

**Neglect substantiated** with the father identified as the person responsible. Matter proceeding through the family courts.

**28 October 2008 – Eighth**

Father's solicitor contacted CPA to advise that she had seen photos of a large welt behind Tabatha's knee and a mark on her neck. The father said he had taken the photo so that he could 'show the court' this. These injuries had not been reported to the staff at Centrecare. As the reporter had only seen photograph of the alleged injury no investigation would proceed.

**Assessment:**

Recommended that the report not proceed to investigation on the basis of insufficient information.

**Ombudsman yet to investigate:**

Why was a photograph of injuries not accepted as cause for follow up?

Was it believed the photo was faked?

How were Centrecare involved?

What was the relevance of 'no complaint to Centrecare'?

**12 December 2008 - Ninth WRITE OFF**

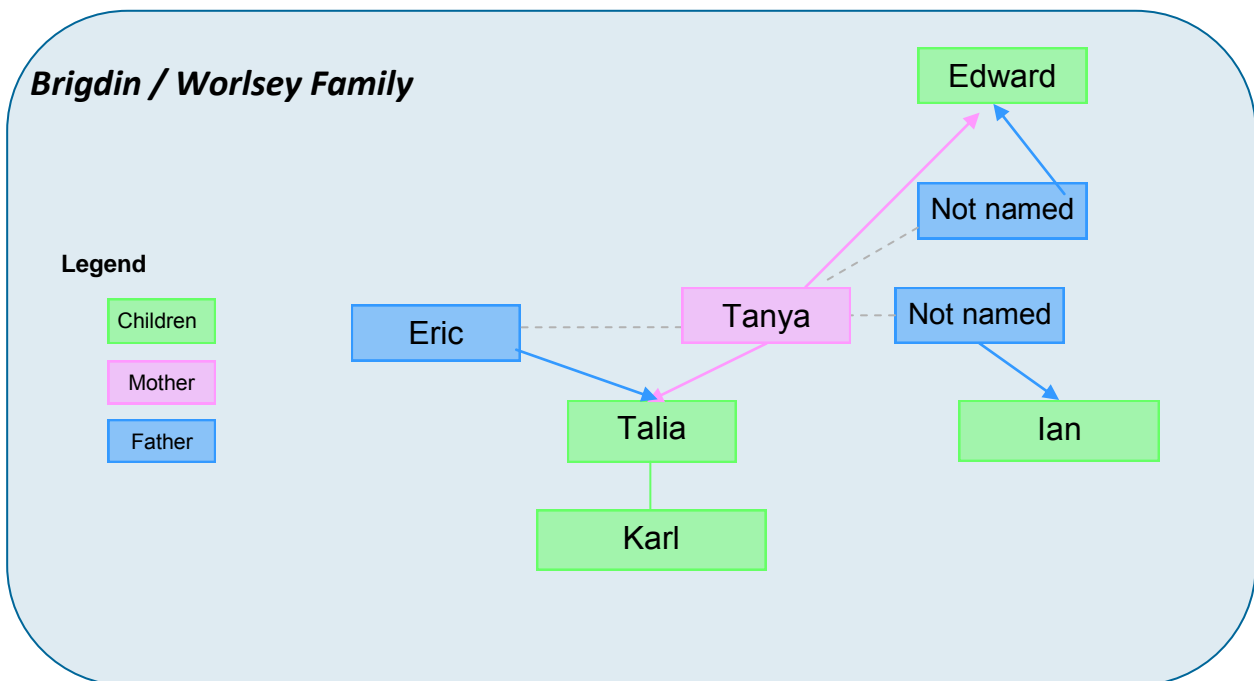
Report raised with CPA by Tabatha's mother regarding the family court order giving Tabatha's father unsupervised access visits. This was written off under a memorandum dated 5 January 2009. No action taken.

**Assessment:**

Written off under a memorandum dated 5 January 2009, no action taken.

**Police History**

Police records indicated there had been 262 involvements with Tabatha's father from May 1999 to May 2010. These included 56 incidents as an offender, 59 as a person of interest, 8 for breach of bail and some in the nature of domestic violence. Tabatha's mother had a history of 7 involvements with police recorded about her. Records also indicated that Tabatha was listed as having four involvements with police three of those as a family violence child and one for child welfare.



**Talia BRIGDIN: Born November 1996**

**Family History:**

Talia's mother had a history of approximately 100 involvements with police, which included 37 incidents of domestic violence. Talia was only four years old when she was taken to a shelter with her mother by the police. By the time she had turned five, Talia had become a big sister to a little brother. Two more brothers followed when she was aged ten and twelve. Talia lived in a community outside of a regional town with her mother and brothers. Her father did not live with the family.

**Notification History****30 November 2000 – First**

Police contacted CPA to advise that four year old Talia had been found with her mother. Her mother was unconscious following a drinking session. Talia and her mother were taken to a sobering up shelter. Talia's mother was unconscious and unable to be awakened.

**Assessment:**

Child in danger.

**Outcome:**

A 'child protection investigation' determined '**substantiated neglect**'.

**1 October 2005 – Second**

There was no information provided to the Ombudsman about this notification..

**Outcome:**

A 'child protection investigation' determined the report was a 'false allegation'.

**17 June 2006 – Third**

No details provided to Ombudsman.

**Outcome:**

'Family Support – not accepted.

**4 November 2008 – Fourth**

There was no information available for this notification.

**Outcome:**

A 'child protection report' recorded as 'insufficient information'.

**Ombudsman comment:**

Why were the records of three reports not available?

When considering later notifications was there any information available to the intake worker about previous history?

Did the CIT worker know what protective action was taken when neglect was substantiated when the child was 4 years old?

The 4<sup>th</sup> notification was at the time notifications were written off with blank assessments, was this notification treated as one of those?

**Police History**

Talia had a history of four involvements recorded with police three of these were as a family violence child. Talia's mother had 98 involvements with police recorded which included 38 for family and domestic violence.

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**Karl BRIGDIN: Born December 2001**

**Notification History**

**10 January 2006 – First** (Child 5 years old.)

A doctor from the Alice Springs Emergency Department contacted CPA to advise that Karl's mother had been assaulted by his father and she had soft tissue damage. While examining her it was observed that Karl had blood around his nose and that it was slightly swollen. There was a superficial laceration to the left of the nose. Karl spoke little English. Mum asked if dad had hit him, Karl replied 'no'. Karl's mother did not recall Karl being hit by his dad. The reporter was arranging accommodation at a women's shelter.

A Child Abuse Report Form was sent by the Police Domestic Violence Unit and explained the following:

It was alleged that the perpetrator assaulted his wife while she was holding Karl in her arms. It should also be noted that there was a domestic violence order stating that the perpetrator should not be near Karl. This order was taken out at xxx Community on the grounds that there had been a history of violence towards this child.

**Assessment:**

Not accepted - insufficient information, no one saw alleged assault on child by father. Child himself said that dad did not hit him.

**Outcome:**

False allegation.

**Ombudsman comment:**

Was the DVO current? Even if not current the fact it showed a history of violence toward the child why categorise two notifications as 'false allegations' as a result of response from a 5 year old without further investigation given the contents of the police report. The grounds on which the DVO was made would have been readily accessible from NT Police.

**12 April 2007 – Second** (Child 6 years old.)

The reporter was a relative.

The following is detailed:

*Darwin FACS after hours contacted Alice Springs After hours and reported they had been contacted by the police in relation to two children being left with three children, the mother had gone drinking. Children's name unknown at this time. Requested FACS attendance to assess the situation re removal.*

This intake relates directly to **Notification Three**.

**Outcome:**

A 'child protection investigation' outcome recorded as '**substantiated neglect**'.

**12 April 2007 – Third**

Police Communications contacted CPA Darwin after hours at approximately 5.25pm and advised the following:

- *Police received a phone call advising that a 5-6 month old baby had been left with three approximately 12 year old girls [in a regional city].*
- *Police had attended and were at the address at the time of the call from Police Communications requesting FACS attend to deal with the matter.*
- *Limited information was available from police.*
- *Three girls approximately 12 years old were at the address. The names given by police were ..., ... and ...*
- *There was an infant whose age was estimated to be 4 - 6 months of age that the girls were looking after.*
- *The mother of the baby is unknown and the girls believe she has gone off drinking, they do not know when she may return.*
- *Police advised that the baby had scabies on its foot.*

*1735hrs PCT ... [City] Frontline worker advising of the situation and requesting that she attend in person to assess the situation.*

*2000hrs call from Frontline worker to advise the following:*

- *Frontline and backline workers attended the address. Workers identified two young siblings: a male aged approx 4 years of age known as **Karl** and a male infant known as **Ian** approx 4 - 5 months of age. It was the three 12 year old girls who contacted police for assistance. Workers could not identify any suitable adult supervising the children. Workers assessed that the children were in need of care and removed the children to a safe placement for the night. Mother's name and whereabouts are still unknown, exact names and DOB of the children unknown, children unable to be located on CCIS so added as new clients to CCIS with the names as known today.*

**Assessment:**

Recommended this matter proceed to investigation as child in danger.

**Outcome:**

'Child protection investigation' and the outcome '**unsubstantiated neglect**'.

**Ombudsman comment:**

These two reports were about the same incident but reported by two different people. One event resulted in two different outcomes one 'unsubstantiated neglect' and the other 'substantiated neglect'. How did that happen?

**17 June 2008 – Fourth**

No record of information reported.

**Outcome:**

Family support - not accepted.



**4 November 2008 – Fifth**

No information about facts reported.

**Outcome:**

Child Protection Report – ‘Insufficient information’.

**Ombudsman Comment:**

The date of this report coincides with the ‘dummy’ documents. Even the dummy intake record was supposed to include the name of the notifier and a brief summary of the facts. That is what the Minister was told.

**19 May 2009 - Sixth**

A notification was received that Karl and his cousin were still at the school, no one had come to pick them up and school had finished an hour earlier. Karl had walked home while his cousin waited for some one to pick her up. However, when no one showed up, Karl’s cousin was driven home. Karl was found sitting on the fence with no adult supervision at the house. Karl and his cousin were then taken back to the school. The school had tried a number of times to phone the mother with no response. A CPA worker drove to the school and found a neighbour with the children. The neighbour explained that the mother and the family had gone shopping and had arranged for her to collect the children but unfortunately the neighbour was delayed.

**Assessment:**

The allegations did not constitute significant harm.

**13 July 2009 – Seventh**

A report was received from a social worker at RDH that an ambulance had just brought in a 7 year old boy who was not accompanied by an adult. The child had been at Casuarina Shopping Centre with his mother and had become very sick (vomiting). His mother had left him unsupervised and when police and ambulance workers arrived the mother told them she wanted nothing more to do with the child. Ambulance workers took the child to Accident & Emergency. The mother turned up later. The ambulance workers stopped her when she tried to run away. It was reported that the mother and child were not engaging with each other and she was sitting a fair distance from him. The mother had 2 other children with her, one a baby. Karl was fairly quiet and was not only ill (with nausea), but had a very swollen left knee, causing him to walk with a limp. Being dark skinned, the notifier was unable to tell whether there was bruising of the knee and was also unsure if the injury was suspicious in any way. The Intake Worker asked the reporter to contact Intake again if they believed there was anything suspicious about the injury or if the mother disappeared.

**Assessment:**

A Child in Danger.

**Outcome:**

*'Child protection investigation' - 'unsubstantiated neglect'.*

A progress note dated 14 July 2009 refers to a hospital visit by the CPA workers between 4pm and 5pm on 13 July 2009. It is recorded that during that visit the mother informed the workers of the following:

- Karl had not been vomiting and whoever said that was just *'guessing that he had been vomiting'*.
- Karl had a sore right knee for the last 2 weeks and she was unsure of the reason.
- She had swiped Karl on the front of his face at Casuarina Shopping Centre when he did not share a soft drink with his brother. During this time Karl sat on the floor sulking and would not get up off the floor.
- The police got the ambulance from outside near the taxi rank. She, Karl and her two younger children got in the ambulance and went to the hospital.
- The police had commented to her that Karl had not had a shower that day. Karl's mother said that was incorrect, that Karl did have a shower and that he was a clean boy. The police got the ambulance for no reason.

A progress note dated 15 July 2009 recorded that on that day a home visit occurred and the worker advised:

*Karl's mother said that she needs to be mindful in the future when out in public that people will report to the authorities if she again says things like she did about Karl that she did not want him and if they see her hit him again in public.*

**Police History**

Karl had a history of five involvements with police as a family violence child. Karl's mother had 98 involvements with police recorded which included 38 for family and domestic violence.

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***Ian WORLSEY: Born January 2007***

**Family History**

When Ian was born he became baby brother to an older half brother and sister. His father was known to be a married man and his wife did not know about the child. At three months old his mother had left him along with his older brother in the care of three children so she could go drinking.

**Notification History**

There were four notifications about this child – 12 April 2007 x 2, 17 June 2008, 4 November 2008. The first two were the occasions when two reports about the same incident had different outcomes. The other two the CPA had no information about; only the date of the notifications and the outcomes which were no action taken. The November 2008 notification was most likely written off with dummy documents.

## ***Police History***

Ian had a history of 6 involvements recorded with police as a family violence child.

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### ***Edward WORLSEY: Born February 2009***

## ***Family History***

Edward was born at RDH and spent some time in the Special Day Care Nursery. His mother made it clear that she did not want anything to do with him, refusing to participate in the baby's daily care and needs. His mother was reported to be ashamed of the baby who was a suspected 'rape child'. The identity of Edward's father was unknown. Edward was one day old when an email was sent from an RDH social worker to express concerns about his mother's lack of engagement with her new born. Edward mother had difficulties coping with her other three children, who were sometimes being cared for by extended family members. The mother had also reportedly been in a violent relationship, drank alcohol during the time she was pregnant with Edward and had attempted to unsuccessfully terminate the pregnancy. The mother had a history of approximately 100 involvements recorded with police, which included 37 incidents of domestic violence.

## ***Notification History***

### ***20 February 2009 – First***

Email report from a social worker raising concerns that the baby was a patient of RDH Special Care Nursery (SCN) and may be considered to be a child 'at risk'. The mother had indicated to RDH staff she did not wish to keep this child and refused all offers of being involved in his daily care needs. Attempts were made to engage the mother in discussions around her decision and what options may be available to her, however, she was reluctant to discuss the matter and refused to acknowledge her newborn son. A family support worker had visited the mother and reported having previous involvement with this family and awareness of their history. In a follow up phone call from the reporter on 24 February 2009 it was also stated that the mother drank throughout her pregnancy. Adoptions were contacted however nothing more occurred with them. A worker from a Family Centre said that the baby was a rape baby and the mother never wanted to go through with having the baby.

### ***Assessment:***

Recommended that this matter not proceed to investigation due to **insufficient information**.

### ***Ombudsman comment:***

In early 2009 CIT was writing off a number of notifications marked as insufficient information. Was this one such write off due to workload pressure? Given the history of the mother known from reports about three other children, in my opinion there was ample information to carry out further investigation. It was also a third report within 12 months for the children in the same household and should have been investigated.

### **25 February 2009 – Second**

A worker from xxx Family Centre called advising Edward's mother had been discharged from hospital after the birth of her 4th child. She was a single mother and had tried to terminate the pregnancy but was 4 days too late to do this. She had fallen pregnant under 'abnormal circumstances'. When the child was born she did not want to see it, and had told the hospital staff she didn't want it. When the reporter went to visit at the home, the baby was seen lying on the floor and was still in the same nappy it had been in when discharged from the hospital the previous day. The reporter had grave concerns for the baby that the mother had not engaged with it at all. The mother told the reporter that she struggled with 3 children and could not cope with 4 children. When asked about the name of the child, the mother was not sure and said it was written on a piece of paper. The reporter was concerned that the child would die, as he had been chubby when born and believed he had already lost weight. She did not think the mother was feeding it. A phone call from the same reporter later in the day stated she had just seen the mother at the bus stop with 2 or 3 of her older children. She asked the mother where the baby was. She said it was at home and would not be long. When asked if it was by itself, she did not respond. The baby was just 6 days old. The reporter stated that the child was home alone.

### **Assessment:**

This must proceed as a **child in danger**. The other concerns about the mother not engaging with the child or meeting his needs must also be investigated.

### **Outcome :**

*Neglect was unsubstantiated with the child being considered as safe remaining in the family home.*

The Child Protection Investigation Summary Report, undated, recorded under the heading 'outcome of investigation' the following:

*Edward was not left alone in the house as reported by the notifier, as he was left in the company of his (sic) sister Talia who is twelve years old. He was clean and healthy and sleeping on a bed in a ventilated room.*

### **Ombudsman yet to investigate:**

Why was it considered 'safe' to leave a 6 day old child in the care of a twelve year old?

Did the investigator arrange to weigh the child?

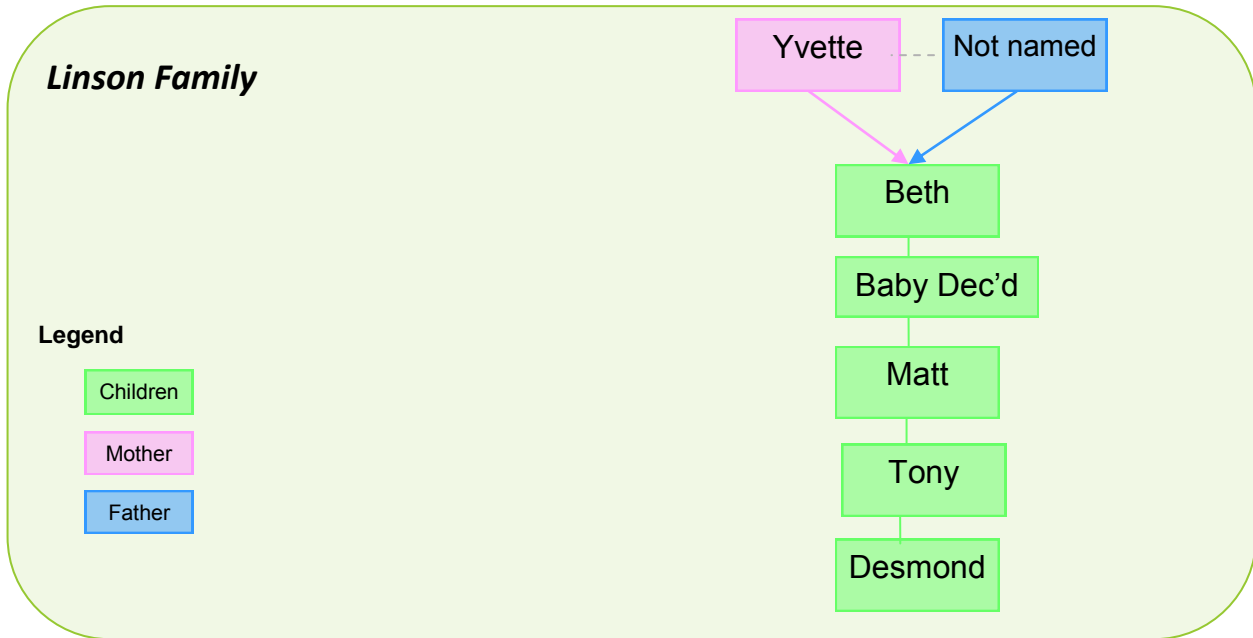
What importance was placed on the child's nappy not having been changed for over 24 hours?

What reliance was placed on the information in the previous notification 5 days earlier?

Were the details of the report 5 days earlier in CCIS at all given the backlog in February 2009?

What are the child's circumstances now at age 2?

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### ***Desmond LINSON: Born March 2009***

#### ***Family History***

Desmond was born prematurely and underweight at a remote community health clinic. He had major medical issues, so he and his mother were evacuated to RDH and Desmond was placed in the special care nursery. The mother soon returned to her community. Desmond was only a few weeks old when concerns were raised for his welfare and safety. Authorities made numerous attempts to have the mother visit her baby, all of which failed. The mother had not seen her baby for more than 2 months and authorities were concerned that the mother was not interested in seeing or caring for her baby.

The mother's police record reported that she had a history of drug abuse, of abandoning her child and of neglecting her other children. The father's identify was unknown. Desmond had an 8 year old sister, and 2 brothers aged 3 and 5, who were themselves the subject of child concern notifications. As the mother or extended family members could not be contacted, the baby continued to remain at RDH. He was then placed in temporary care.

#### ***Notification History***

##### ***19 March 2009 - First***

Notifier 1 was a social worker from who RDH contacted CPA to advise that Desmond's mother had been discharged from RDH on 10 March 2009. Desmond remained in the Special Care Nursery due to premature birth and low birth weight. Additional complications had warranted further medical investigation, however, there had been limited contact by Desmond's mother since her discharge from RDH and staff had not been able to contact her. Attempts had also been made to contact the mother and her family via the Community Clinic regarding this child, without success. Clinic staff had indicated that the mother had returned to the community.

A report the next day from a nurse at the community clinic provided the following information:

- *The child was born at 25 weeks (prematurely) at the health clinic in the community. Due to the medical needs of the baby the mother and child were evacuated by air to Royal Darwin Hospital.*
- *The health workers basically had to push the child's mother on to the plane.*
- *The child is in the Special Care Nursery at RDH.*
- *The mother has abandoned the child at RDH and is now back in the community.*
- *The mother has three other children who remained in the community with their father. Other family cares for 1 of the children as the mother apparently believes that the child, 'looks a bit funny.'*
- *The mother does not look after herself.*
- *The baby is neither a rape baby nor an unwanted baby.*
- *Mother does smoke marijuana and is known as a gambler.*
- *The child has some major medical issues, but it looks as if the baby will survive.*
- *The mother has apparently said she might go back to the hospital, but that she is not 100% sure about this.*

This was not treated as a separate notification but included as a consecutive report.

The following actions were taken by the intake worker:

23/03/2009 at 10:11hrs — Telephone call to Notifier 2 who provided the following information:

- The hospital had not been trying to contact the clinic and had definitely not made contact with them over the weekend. In fact, Notifier 2 contacted the hospital on Friday to let them know that the mother was back in the community and that she was not expressing milk. According to the Notifier, the staff at the hospital 'didn't seem to care about this information — weren't concerned' and were 'blasé'. The staff also knew that the mother was back in the community.
- When Notifier 2 had spoken to the child's mother, she had said that she may be returning to the hospital on Friday 27th March 2009. However, the Notifier said that due to the fact that she 'just took off' patient travel would probably not pay for her return to Darwin, so she will need to finance this travel herself.
- Notifier 2 and Intake worker discussed that the mother had been discharged from the hospital as a patient and that it was not surprising that she had returned to the community as she was aware that the child was being cared for in the hospital and she had other children at home.
- Notifier 2 was going to locate the child's mother and see whether she could definitely verify whether she would be returning for the child.
- Notifier 2 would also get the child's mother to contact the hospital.

31/03/2009 at 09:58hrs — Intake worker telephoned Notifier 2.

- Notifier 2 was not available, so Intake worker spoke with the Manager of the Community Clinic.

- Manager let Intake Worker know that the child's mother was still in the community. No one had been able to determine whether she planned on returning for the child.
- Manager said that the child's mother had done this before and someone else was caring for one of her children.
- Mother often gives birth prematurely as she is a 'heavy smoker'.
- According to manager, it is the traditional way to leave any babies that are born prematurely or are twins.
- According to manager, the community considers this mother to be strange.
- Intake worker informed the manager that this matter would proceed.
- Manager said that he would contact Intake if he found out any further information.

**Assessment:**

Recommended that this matter proceed as a child concern.

**Outcome:**

The CCIS File Review indicates that *'this matter was allocated to the NTFC Casuarina office and a case is yet to be created.'* (ie. No action taken.)

**Ombudsman comment:**

A child concern report investigation should be commenced within 5 days. This investigation had yet to be created 1 year and 9 months later.

**29 April 2009 - Second**

A RDH social worker reported concerns regarding the lack of contact the mother had had with Desmond since he had been in hospital. The social worker provided the following information:

- The mother was weaning another child and would be returning to Darwin to be with Desmond at RDH on 28 March 2009. However she never arrived.
- On 3 April 2009 a community midwife visited Desmond in hospital and informed staff that the mother had planned to visit that day with the father. No contact was made.
- On 23 April 2009 a social worker contacted the community clinic and a nurse at the clinic told the social worker that the mother remained ambiguous about caring for the baby. The nurse expressed significant concern for the baby and the other children as she considered them at high risk due to continued neglect.
- Desmond had recently been moved from the Special Care Nursery to the Paediatric Ward.
- Desmond remained an inpatient in order to put on weight.
- On 27 April the nurse at the clinic had managed to get the mother to come to the clinic so she could meet with them to discuss her plan in regards to the child. The mother advised that she planned to go to Darwin that weekend.
- Desmond was close to discharge.

**Assessment:**

Recommended that this CP Report proceed to investigation as child concern.

**Outcome:**

*This matter was allocated to the NTFC [Regional] office and an investigation commenced on 6 May 2009. On 7 July 2009 neglect was substantiated for failing to provide the child with food, clothing or shelter.*

**4 June 2009 – Third** (No Intake Form provided).

The information contained in the CCIS File Review stated that a Family Support Referral was received outlining concerns that the mother was not willing/able to care for the child and this resulted in a family placement with the grandmother.

**Outcome:**

The Family support referral was accepted and remains as an open case with an NTFC regional office as at 23 December 2009.

**23 October 2009 – Fourth** (No Intake Form provided)

The CCIS File Review records that:

*A temporary Placement agreement was drawn up on 23 October. This agreement recently expired on 22 December 2009. The child was placed in the care of a Departmental Foster Carer who was not indigenous for the duration of the agreement. Please note that the child was placed with a non-indigenous carer as there were no indigenous carers available at the time.*

*This case remains open with a NTFC regional office.*

**Police History**

Police records indicated there had been three involvements with Desmond's mother between November 2008 and March 2010.

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**Tony LINSON: Born March 2006**
**Family History**

Tony was 16 months old when he was brought into a remote clinic by his grandmother, suffering from an infected excoriated skin/leg wound. It was also suspected that Tony had recently suffered a right rib injury consistent with trauma raising further concerns that he may have suffered physical abuse. Tony's grandmother stated that the mother was always drinking, gambling and neglected Tony. A child at risk investigation found a case of physical abuse and neglect was unsubstantiated since Tony was back in the care of the mother who had the support of other family members and, since X-rays of the baby's injury did not indicate physical abuse, this case was subsequently closed.



## **Notification History**

### **11 July 2007 – First**

A Registered Nurse from the community clinic informed CIT 16 month old Tony had been brought in by his grandmother. Tony had an excoriated (torn) skin/wound on his leg and it was very infected. The Registered Nurse advised that the grandmother told her that the mother was always off gambling and drinking kava, didn't look after the baby and hadn't bonded with the baby. The grandmother told the nurse that the baby was being neglected. The nurse was also concerned about the discharge slip from a recent hospital visit admission notes 'right rib injury consistent with trauma'. The nurse was concerned about how this baby may have sustained the rib trauma as there was no record of him being presented to the health clinic for any injury.

### **Assessment:**

Determined that a Child at risk investigation should occur. A child at risk investigation should commence within 3 days.

### **Outcome:**

A full danger assessment (FDA) is a tool utilised to reassess the initial danger factors identified. The FDA recorded that the initial home visit or investigative interview occurred nearly a month after the notification on 15 August 2007. The FDA recorded that:

- A skeletal x-ray had been done and had come back clear.
- Aboriginal health worker said that she played cards with the mother and she thinks the mother is doing a good job.
- Mother said she still plays cards but leaves Tony with her sister when she does.
- The clinic confirmed that the mother was doing a good job.
- Mother had been bringing the child into the clinic for regular check ups.
- The grandmother was returning shortly and provided a lot of support for the mother.
- Once the grandmother returns home CPA recommended '*unsubstantiating and closing case.*' This was based on the skeletal x-ray being all clear, indicating no trauma and assessment of mother's parenting skills was good.

The CCIS report showed a notification for another sibling named Beth on 6 May 2007 for a Family Support-Family Preservation case. However, no Intake Form was provided for this notification and no other notification.

### **Ombudsman comment:**

This case is very puzzling. The report was made by an RN at the clinic. She saw a discharge slip from a '*recent hospital admission*' showing a right rib injury. The CP investigation must have arranged another x-ray. If that was 6 weeks later the original injury could have healed. If the mother had been bringing the child to the clinic for regular check-ups why did the RN observe a torn wound which was '*very infected*'. Why had the child had a recent admission to hospital? Neither notification for this, Desmond or Tony, records the existence of a sister, Beth. A report about Desmond said that the mother could not return to collect him from Darwin because she was '*weaning*' another child. Was this Beth?

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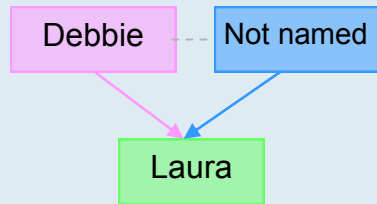
### **Watson Family**

#### **Legend**

Children

Mother

Father



### **Laura WATSON: Born September 2009**

#### **Family History**

Laura was born to a 19 year old mother who had no fixed address. Laura's mother was a 'long grasser'. The identity of her father was unknown. Concerns were raised with DCF about the vulnerability of this new born infant's exposure to harm, such as domestic violence, the mother's homelessness and the mother's inability to care for her.

#### **Notification History**

##### **15 September 2009 - First**

Report made by a social worker from RDH that a woman was admitted to RDH on 12 September 2009 and gave birth the next day. Nursing and medical staff advised that she was living in the long grass and the victim of ongoing violence. Alcohol may also be implicated. The patient was ready for discharge and both mother and child had been medically cleared. Laura's mother had indicated that in the immediate next few days she would stay at a residence. The newborn was considered to be in a high risk situation which may have needed further assessment and intervention.

On the same day the notification was received the intake worker sent a follow up email to clarify alleged harm to child and indicators of possible risk. The email stated:

*I have tried to call you a couple of times this afternoon but haven't been able to get through. To assess this bub's situation we need some more information about the presenting risk factors for the child and the mother's ability to be protective and maintain the child. It would appear that she is from [a regional district] and I was curious to know how long she has actually been in the Darwin area.*

The notifier responded the following day and advised:

*In relation to your queries regarding the risk factors and this mother's ability to act protectively, hospital staff are not in a position to undertake further assessment as this patient was discharged at 20:06 last night. In addition, assessment of the environmental risks for this three day old baby cannot be undertaken by RDH staff.*

*Given the information provided by the staff of the Maternity Ward and included in yesterday's notification at 13:50, the concerns include some demonstrated incapacity to care for such a young and vulnerable baby. These concerns are directly related to the mother's lifestyle as a long grasser in the Darwin area. The information which was provided to you yesterday was all the information required for identification that this newborn is in a high risk situation.*

*Investigation and intervention by FACS is imperative in this instance.*

On 17 September 2009 (2 days after the notification had been received) another intake worker contacted the hospital but was told that, 'the person who was dealing with this matter is actually off sick and no-one else is in a position to comment on this matter.' It is then recorded that the notifier provided the following information:

- *Notifier was unable to comment on how long the mother had been living in the long grass.*
- *Notifier was able to confirm that the mother is indeed a drinker herself.*
- *Notifier also said that the mother is 'definitely in a violent relationship'. However when asked how they were definite about this, the notifier said that they knew is because the mother was very hesitant to discuss whom the father of the baby was.*
- *Notifier has noticed that since the new DV laws commenced, less and less women talk about their partners when there is DV.*
- *Notifier was unable to comment on the mother's capacity to parent the child.*
- *The notifier said that hospital staff were confident that the mother would be going to stay at the house mentioned in the notification.*
- *Notifier said that Intake worker was best to talk with the community care nurses if requiring further information.*
- *Notifier added that they are of the opinion that the house the mother is in is full of transient people and they are all probably drinkers.*
- *Notifier added that the child's mother is 20yo, living without accommodation, is a drinker and in a violent relationship — it's not good.*

The intake worker also contacted the Casuarina Community Care Centre and was informed that:

*The centre had not yet opened a file for the child or mother yet and may not have received the referral from the hospital yet. The domiciliary nurses at the hospital see babies for 10 days after birth and then they are referred to this service.*

The intake worker rang the Domiciliary Department at the hospital and left a message as no-one was available.

### **Assessment:**

*There is insufficient information in the notification to suggest that the mother's social circumstances are going to impact on her ability to provide for and care for the child. No further information was provided to NTFC in relation to the mother's attachment to the child or any issues in relation to feeding the child. The nurses at the hospital are meant to follow up with the mother at home and are able to notify if there are concerns for the child. All of the concerns raised in relation to the mother's circumstances appear to be generalisations and assumptions due to lack of information.*

**Other Information:**

The notifier in this notification was not satisfied with the response received so approached the Manager of Social Work at RDH. The manager subsequently sent the following email to the Executive Director of CPA on 16 September 2009:

*This notification was sent yesterday as a matter of some urgency. The mother and new born baby were discharged last night without FACS intervention. The Social Worker concerned was emailed at 1445 15/9/09 requesting further information. My understanding is that all relevant information was included in the initial notification.*

*Given the nature of this case, that of a new born baby discharged into the care of a homeless woman aged 20 living in an environment where ongoing domestic violence and alcohol abuse are major factors, I would request an immediate response to this as both myself and the social worker concerned consider **this child at imminent risk of serious harm.***

*The response expected yesterday by myself and the social worker concerned was a immediate intervention and investigation on behalf of FACS given the age of the child. Instead of this the only response was an emailed request for further information that due to time constraints was not opened until 0830 today.*

A response was provided by the Chief Executive's Assistant on 16 September 2009:

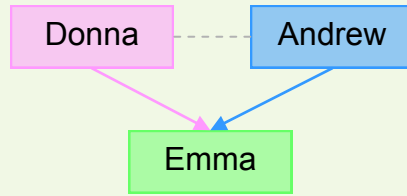
*I have spoken to Jenny on the phone today and due to ...the Executive Director being in Alice Springs, she has requested that I reply back to you and cc ..., Director Child Protection Services to follow up this matter.*

*The Director Child Protection Services overlooks the operational side of Child Protection Intake team and will be able to provide you with some information on this problem.*

**Police History**

Police records indicated there had been five involvements with Laura's mother between August 2008 and May 2010 with two of those noted as family violence incidents. The mother was between 18 and 20 during that period.

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**Portman Family****Legend**

Children

Mother

Father

**Emma PORTMAN: Born Jan 2009****Family History**

The first two months of Emma's life were spent in the RDH special care nursery due to her premature birth. Emma suffered from congenital abnormalities and a heart defect and these complications were consistent with exposure to alcohol in utero. Emma's mother had a history of heavy alcohol abuse and liver failure. She was found heavily intoxicated on several occasions bringing concealed alcohol into the ward, while visiting Emma and while as a 'rooming in patient' to enable her to care for Emma and was escorted off the premises by police. The mother's alcohol abuse issues continued despite reportedly receiving treatment for her addiction and abuse. Although she was known to visit and be supportive of Emma, there was concern over the mother's addiction.

Three notifications were received from health workers and medical specialists in Emma's first year. Concerns raised included serious health problems such as failing to thrive and the mother's abuse of alcohol.

**Notification History****27 March 2009 – First**

Concerns were raised by a social worker from RDH regarding two month old Emma. She was in the Special Care Nursery (SCN) due to her premature birth. Her mother was recently re-admitted to RDH as a rooming-in patient to enable her to establish demand breast feeding and carry out the baby's daily care needs. During Emma's admission to SCN her mother and maternal grandmother had generally visited on a daily basis. The social worker informed CIT that:

- The family usually reside at a place 180 km from Darwin, but had been staying with a friend in Darwin in order to be close to the hospital.
- Emma's father had only visited sporadically, due to distance and work commitments.
- Staff on SCN had, at times, noticed the mother smelling of alcohol and additional concerns about her capacity to safely care for the baby had been raised by nursing staff when observing her attending to Emma's needs.
- Emma had indicators that are consistent with Foetal Alcohol Syndrome (FAS) as diagnosed by a paediatrician.

- Discussions with Emma's mother about her alcohol use had caused her to become very upset and she denied having any problems.
- The doctor has informed the mother of the implications of FAS and how they may impact on the child and family, specifically given their isolated living conditions. He had provided the mother with a referral to another doctor and the Alcohol and Other Drugs Clinic.

On 15 April 2009 some 18 days later the intake worker contacted the Paediatrician treating Emma who provided the following information:

- *Subject child has been discharged from RDH special care nursery and was considered safe to be discharged to mum's care;*
- *Dr ... aware of the notification to NTFC and stated the main purpose of the notification was to mobilise support for the family if required;*
- *Subject child was a patient of Specialist Care for premature birth and congenital abnormalities, including a heart defect, consistent with exposure to alcohol in utero. Foetal Alcohol Syndrome (FAS) has not been diagnosed yet however the congenital abnormalities are consistent with FAS;*
- *Dr ... identified no specific child safety concerns or support needs apart from mother's history of heavy alcohol consumption;*
- *Mother has a known history of heavy alcohol consumption with liver failure. There was some suspicion that heavy alcohol consumption may still be current as mother was observed smelling of alcohol on occasions;*
- *The mother accepted a referral to Dr ... from Alcohol and Other Drugs (AOD) service and understood to be engaging in the service;*
- *Dr ... not aware of any actual harm to the subject child by the parent or guardian;*
- *Palmerston community care centre are providing outreach support and understood to have visited the family last week;*
- *The maternal grandparents are providing support to the mother and residing in the same home for the short-term following baby's birth and discharge;*
- *2 Police checks undertaken of the mother - NIL criminal history or police involvement relevant to any CP concerns.*

### **Assessment:**

The intake worker recorded the following assessment:

*This report is in relation to a newborn baby who has features consistent with exposure to alcohol in utero, and the mother has an alleged history of heavy alcohol consumption which is suspected to still be current. These are clearly risk factors, however they are significantly negated by the strong protective factors in place including the presence and support of extended family and the father, involvement of health care services including AOD and community care centre and the family's engagement with these services. Additionally, while the mother is known to have a history of high alcohol consumption, it is unknown if this is a current and significant issue that would significantly impact on the subject child. There are no specific concerns reported for the mother's care skills towards the subject child, and the child was considered safe to be discharged to the care of the mother. Due to these factors, the level of risk to the subject child of harm is not significant to warrant statutory involvement. Police checks reveal no additional risk factors. There is insufficient information to indicate current and future risk of harm.*

### **22 November 2009 - Second**

A health care nurse called CPA to advise them that Emma and her mother were admitted to hospital on 17 November 2009 due to baby's failure to thrive. The concerns were recorded as:

- Mother bringing alcohol onto ward and staff observed that the mother was not adequately caring for the child.
- Emma's failure to thrive was as a result of her mother's sub-standard parenting style.
- Concerns the child may also be suffering from alcohol foetal syndrome.

### **Assessment:**

This child protection report was proceed to investigation as a child concern report for the following reasons - neglect, child failing to thrive and the mother was failing to provide adequate care.

This matter was allocated to CPA After Hours. As at 23 December 2009 the investigation had not begun.

### **14 December 2009 - Third**

A paediatric registrar reported that Emma suffered from FAS and had a congenital heart disease. At eleven months old she had been in RDH for a month. She was admitted for poor growth however this is likely to be from medical issues rather than neglect. Her mother had been escorted off the premises by the police at least twice in the previous week for bringing alcohol into the hospital and because she was too drunk to be on the ward. The mother had been getting so drunk that she hadn't even been able to hold her baby properly. On one occasion she was so drunk she could not even see her child lying in the cot in front of her and the nurses had to point out where the child was.

The father was also around the hospital often. The father was concerned about the mother's drinking. The father stated that the mother was depressed and was self medicating. Social workers at the hospital were involved with this family and were working on getting services involved. The parents had had a lot of contact with the hospital since the child's birth and were very aware of the child's medical needs. Someone from Alcohol & Other Drugs had spoken to the mother about her drinking, but she continued to show no insight into the effects of her drinking on her child. It was unlikely the child would be discharged before Christmas. The reporter was seeking the involvement of CPA for when the child was discharged.

### **ACTIONS TAKEN BY INTAKE WORKER**

*Police History Check reveals no history (See CCIS Documents).*

*Phone call made to Social Worker of Ward 5b at Royal Darwin Hospital...,at 9.30hrs on 16.12.09. She advised the following:*

- *Jo sat in on a meeting with the mother, the father, and an indigenous liaison officer at the hospital where they discussed the mother's drinking. The mother was made aware again that it was not acceptable, and that the hospital security have advised they cannot allow her to enter the grounds anymore when drunk or with alcohol.*

- *The mother was quite upset at this meeting, and is aware that she has 'mucked up'. Jo believed the mother is aware she has a problem.*
- *The mother has sought counselling support through (a drug and alcohol rehabilitation service) and has her first appointment booked for today, indicating she is trying to address her problems and is genuinely concerned about her actions.*
- *The mother's partner and child's father, Andrew, is very supportive and appears to be fit, able and willing to care for the child. He has also committed to making an effort towards making sure the mother attends her counselling session and continues to seek support.*

**Assessment:**

The intake worker assessed that:

*The current notification contains concerns regarding the mother's ability to provide care and protection for her child given that she has a significant problem with misusing alcohol. The reporter expressed concerns that the mother sometimes gets so drunk she also may pose a threat of physical harm to the child, less through direct intention to harm, but more through her inability to care for the child when intoxicated. However, it would appear that there are sufficient protective factors in place to ensure the child's wellbeing is maintained, including a supportive father and partner who is reportedly capable and willing to care for the child. In addition, the mother has now sought counselling support services in order to deal with her alcohol dependency and mental health concerns.*

*As such, it is recommended this matter does not proceed to investigations - there is **insufficient information to suggest the child has been harmed or is at risk of harm.***

**Ombudsman comment:**

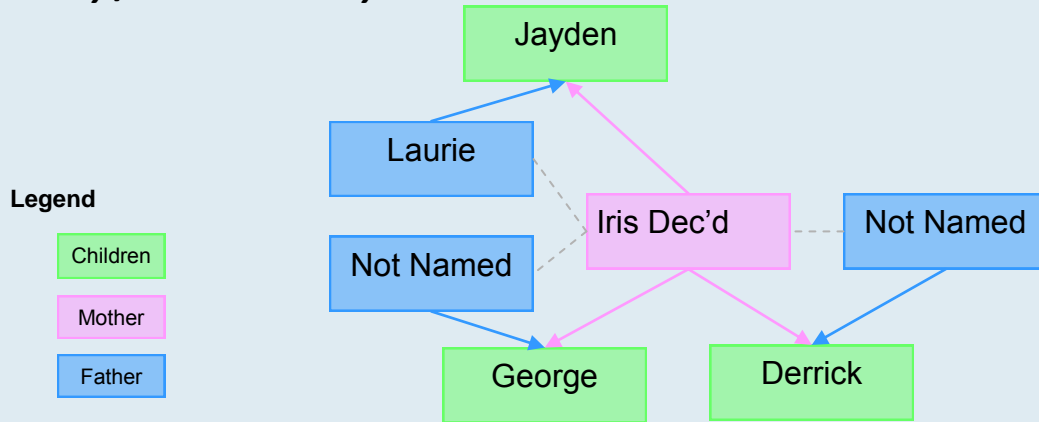
In March 2009 and April 2009 the mother was referred to Alcohol and Drug Services. Despite repeated warnings she abused alcohol during pregnancy. Her partner frequently urged her to curtail her drinking. In December 2009 she was bringing alcohol on to the Ward despite being escorted off on two occasions.

Why would an intake worker at CIT place any reliance on the mother's statement that she was seeking counselling without checking whether she kept the appointment at the Drug and Alcohol Rehabilitation Service?

The child was in the RDH for a month for a heart condition and failing to thrive. She had already been harmed. The only indication that anything might be different in the future was the mother's statement that on 16/12/09 she had an appointment at a drug and alcohol rehabilitation service. There was another report on 14/12/09 that '*she had no insight into the effects of drinking on her child*'. I would have thought that before deciding the child was not at risk of harm that CIT would have found out whether or not the mother kept her appointment.

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**Mawley / Fenwick Family****George MAWLEY: Born June 1992****Family History**

George was born in June 1992 and suffered from autism. His mother died in hospital a few days after giving birth to his brother in 2009. It is not known who George's father was although he had two brothers, one born in May 2001 with special needs and the other born July 2009. He also had an uncle, and a Grandmother. The family experienced significant stress following the death of the mother. All three children were being cared for by a relative, who alleged that the Grandmother was aggressive and had smacked the other two children while in her care. There were several reports of neglect, abuse and emotional harm received from 1999 due to concerns regarding the mother's and her partner's abuse of alcohol, drugs and gambling.

In 2005 George's parents separated. In 2006 a report of the mother gambling and misusing money to the neglect of the children was received with the children reportedly in the care of a relative. Police records showed the mother and her partner had a history of involvement with police in domestic violence related issues over a long period of time.

Eleven approaches were made to CPA. Of these, 1 case was accepted, 1 case was not accepted, 2 cases were deemed insufficient information, 4 cases were deemed allegations would not constitute harm, 1 case was deemed no action possible, 1 case had no outcome recorded and 1 case had issues resolved.

**Notification History****16 November 1999 – First**

A school teacher contacted CPA and raised the following concerns:

- 6 months ago the Mother had commenced a relationship with an Aboriginal man.
- Since his presence in the family, problems had occurred.
- George's relative told the school that there was constant drinking, smoking marijuana (bongs and buckets left lying around the house), and that the mother's new partner's relatives visited the family and partied all day and night. Consequently George was

always hungry and tired, his personal hygiene had deteriorated and he had started to use poor language, ie swearing, 'fuckin bastard'.

- George was autistic and had poor communication. He repeated things he heard, making the school and family believe this was the kind of language being used at home.
- George had recently started to spit and hit others.
- The school and the relative had tried to talk to the mother but she was generally unresponsive. The relative suggested to the mother that he care for the child but she became upset and defensive.

### **Assessment:**

There was no assessment/outcome/decision recorded on this incomplete Intake Form. However, the CCIS File Review of 23 December 2009 recorded this notification as a CP Investigation with an outcome of '*Insufficient Information*' indicating it was not actioned.

### **6 June 2000 - Second**

A teacher reported the following concerns to CPA regarding George:

- The notifier had made a previous notification on this child for similar concerns.
- The child attended a special school for children with disabilities. George had Autism and had been attending the school for five years. He had only developed speech within the last two years.
- The mother's current partner is an Aboriginal person and the school had concerns about the environment that the child was living in.
- The school had recently received a letter from the child's relative which stated the following; the child had been sick often and the mother had no money to buy him medication or food.
- The family believed that the child was very thin and when he had been in their care in the past he had put on weight. The family believe that the child became sad and angry when he had to go back home after being at their house. The relative would like custody of the child so that he may grow up in a secure and loving environment. The relative approached the school for some help with the situation as they believed that the child was being neglected.
- The school shared some of these concerns. The teacher advised that the mother may have a mild intellectual disability and therefore did not fully comprehend the special needs of her child. The school had worked closely with the mother in the past to help her with the child's behavioural problems due to his autism. They had linked the mother into Somerville Community Services for counselling to help with George's behavioural problems.
- The school had a concern that since the mother had been living with her partner (18 months) she had put her own needs first and neglected those of the child. The mother had disengaged from support services and had had little to do with the school since the partner had been on the scene. The school had approached the mother on various occasions at her home and she had not invited them inside. They found that when they called her on the phone she had been 'cagey' about things.
- The mother had previously received support from her own family. The family told the school that they now did not see her very much. The mother apparently had not taken George to her mother's house since the school made the first notification to CPA.
- The school had information from the relative to suggest that the mother and her partner drank alcohol and abused drugs. They often had parties at their house and they had

friends over who were conducive to this lifestyle. George had been attending school very tired and this may have been due to the adults who had been coming over at night and having parties.

- The school had had concerns about George's swearing at school. He had been calling people inappropriate names such as '*You fucking cunt*'. George also repeated a lot of what he heard and had been continuously saying '*Go and get the ganja now*'. The school believed that the language he was repeating was from his home environment.
- The school also shared the same concerns as the mother's family that George appeared very thin. The notifier advised that children with Autism often had an eating disorder, however George tended to be very hungry at school and his relative had advised that he ate a lot when he was at his house.
- The notifier advised that she would attempt to get the mother to attend the school and speak with her to discuss their concerns.
- The school were concerned that George was not receiving the stimulation that he required and was not progressing as well as he should.
- The notifier explained that George needed stimulation at home.
- The school believed that George was not happy at home as he appeared to be very happy to come to school and often did not want to go home at the end of the day.

### **Assessment:**

George may be placed at risk and the mother may not have much insight into this. The issues may be able to be addressed by the school initially by meeting with the mother to discuss their concerns.

### **Ombudsman yet to investigate:**

What decision was made about the course of action recommended?

My office was informed that the outcome for this notification was '*allegations would not constitute harm*'. Records show the child was reported by the school as being hungry, swearing, tired and a report of medical neglect. What criteria led to the conclusion '*allegations would not constitute harm*'?

### **Ombudsman comment:**

The report was the second by the school. In essence it said '*we have tried*'. *The mother has stopped going to Somerville. Our relationship has broken down because the mother was angry at the school notifying CIT earlier. We are out of our depth.*' The response of CIT was in my view obtuse.

### **19 October 2000 - Third**

The child's carer contacted CPA to raise concerns about George. The carer advised that George had Autism and attended a local school. He raised the following concerns:

- The mother and her partner were not attending to George's special needs. On the weekends he spent time with George reading to him and took him out.
- When George was at home he was not given any attention. He came home from school, had dinner and went to bed.
- George spent every weekend with him and the maternal grandmother and did not want to return home to his mother at the weekend. He stresses out, cries and complains about going home.

- The mother's partner drinks alcohol and yells at George, he had seen the mother's partner yelling at the school bus driver for being late and also at George's doctor.
- These concerns were raised with his sister. However she says she cannot do anything about it, she knows that George is not happy at home and acknowledged her partner had created some problems but did not feel she could tell him to leave. She told the relative that she didn't care if he called the police or CPA because this would give her an excuse to make her partner leave.
- In the last five weeks George's behaviour had been difficult. He apparently hit a teacher for the first time at school.
- The teachers had apparently raised similar concerns about the child's behavioural issues and were concerned that the child refused to go home at the end of the day.
- The relative was willing to have the child reside with him and gain custody of him.

### **Assessment:**

The assessment, in acknowledging the information provided by the notifier, stated that *'whilst the school have had concerns about the child, the worker believes that they are taking appropriate action in terms of referring the family to a family therapist and a paediatrician for review'*.

### **13 May 2004 - Fourth**

A caller contacted CPA with the following information:

- The caller resided near the subject family but did not have an address or names.
- The caller and other neighbours heard screaming at all hours of the night.
- A child was screaming 'hysterically' and was estimated to be around 18 months to 2 years old.
- The child had been seen running to and from the front fence during the day appearing normal.
- An older boy possibly 8 years old may be disabled.
- The father was heard saying *'stop that fucking noise'* and was heard banging or thumping around the house.
- No female voice was heard.
- Screaming was on and off throughout the late hours of the night into the early hours of the morning.
- During the day everything was 'fine'. The mother was seen with a stroller.
- The family appeared to be indigenous, however, it is not the 'normal indigenous lifestyle with families coming and going'.
- The caller was not sure if the child was 'at risk' but believed the family may be under stress and did not know how to deal with it.
- The caller stated that if she knew the family she would offer to help them.
- The child sounded as though he was 'choking with hysteria'.

It was recorded that the intake worker spoke to the caller and clarified whether police had been called. The intake worker suggested that if the crying/screaming was occurring in the early hours of the morning and the caller was very worried, the police should be called. The intake worker explained the process and the limitations with CPA attendance in these instances and asked the caller if she could find out the address of the house to enable further inquiries to be made. The caller was cooperative and willing to assist.

The caller contacted the intake worker again and provided the family's address, adding that at 0230 hours that day, she and neighbours had again heard the child screaming and called Police. The caller reinforced that she believed the family needed help, stating the neighbours all agreed that the child had a disability. The intake worker acknowledged the caller's community mindedness.

The intake worker sent an email to Territory Housing to determine who the occupants of the house were and to the DVU Unit to determine police involvements for the residence.

The DVU provided the following information:

20/04/2002 – Report of father intoxicated and aggressive towards Jayden's mother and other family members after losing his bets at the races. Jayden's father had threatened Jayden's mother and other family members with a machete. The adults left the house while Jayden remained with his father in the house. Police attended and arrested Jayden's father and domestic violence orders were explained to Jayden's parents.

18/05/2003 – Report of domestic in progress. Police attended. Children were present.

16/03/2004 – Report of verbal argument. Police attended and spoke to both parties. Jayden's mother was recorded as saying that she got sick of Jayden's father drinking and called the police. Nil signs of violence.

**Assessment:**

Appropriate referral for case manager/s to assess what supports are needed for this family to manage children with disabilities. The CCIS File Review records this notification as a Family Support-Parenting Support with an outcome of 'accepted'.

**13 March 2006 - Fifth**

The Principal of Jayden's school forwarded CPA an email he had received from a teacher raising concerns about George. The email recorded that George's relative had informed the Principal and a teacher that George's mother had left one evening to go to the Casino with her mother, leaving the boys alone in the house until the relative got home. He told the teachers that this was not the first time she had left the boys alone in the house and asked them to make a report to CPA about this as he was too close and did not want it coming from him. One of the teachers said she was pretty sure that the relative would not leave the boys alone over the weekend. In addition to this George was on very complex medication and the timing of the dose had changed since the previous Monday when one of the teachers, the Mother and George went to Tamarind Centre together. Both teachers observed noticeable behaviour changes during the week. The relative was not informed about the medication change and said he did not trust the mother to give George the correct amount. Also it is very hard for her to administer the medication if she is not around to do so. The relative also wanted CPA to know that unless he was there George did not get fed properly.

The teacher felt very concerned for George's welfare. There were also concerns that George's attempts to physically assault staff had escalated the previous week. George was raising his hand to hit people. George had a relief teacher all week who would need lots of support and back up. There was also a concern raised regarding George's brother, Jayden, as he was likely

to be affected and the Principal thought that CPA should contact the school Jayden attends to provide this information to them.

**Assessment:**

The school had agreed to discuss issues with the mother and at the current time it is recommended that this case **not proceed to investigation on the basis of insufficient information.**

The notes in the intake form recorded the following:

- CPA would note the issues as child protection concerns but was unlikely to act upon the reported information;
- The intake worker also discussed that the report makes it difficult to assess the current situation from CPA perspective.
- Principal happy to discuss issues further with the mother in an attempt to resolve issues.

**Ombudsman yet to investigate:**

What additional information was required to proceed to an investigation?

Why would CPA note the issues as child protection concerns but are unlikely to act upon the information?

On the Intake Form under the heading 'Intake Workers Assessment' it is recorded that, '*it is possible that medication change in relation to George could produce a change in the child's behaviour.*' Was the Tamarind Centre or any expert contacted to determine the potential affect of the medication and the consequences of not taking it?

Was the Principal contacted at a later stage to determine whether the discussion with the mother had resolved the issues?

Why weren't family support services offered?

**28 March 2006 – Sixth** (There was no intake form produced to the Ombudsman giving details of this notification).

A family support service for parenting support was recommended but the outcome of that was that it was not accepted. (It is not stated whether it was not accepted by the mother or by a service provider.)

A progress note on the file dated 28/03/2006 recorded the following information:

Email from School Assistant Principal is as follows;

.....

*This second report is in regards to two concerns we have about George.*

1. *Increase in school absences.*
2. *George has a younger brother who attends xxx Special School. This school called us on Friday to report that Jayden/ George's mother Iris had stated that George was hurting family members and that she believed this to be a result of an increase in medication. George's teacher, ..., attended the most recent psychiatric appointment with ...George's mother and there has not been an increase in medication but a change in time when it is taken. We are concerned that George is not being given the correct medication. ...the mother is also*

*reported that she keeps George at home when there has been an assault on the family the previous night or afternoon. Please see email below and please confirm receipt and status of both these reports.*

...

*Assistant Principal*

*xxx School*

...

1415 Hours

Phone call from ... xxx School.

...

... provided the following information;

The school was planning a meeting with the family in the next week. The child Jayden Mawley attended the School. His brother attended xxx School. Both children had disabilities and were on medication. ... believed that George could be very violent at times. It is alleged that George sometimes picks Jayden up and throws him on the floor. Considerable supports were in place within the family to support the children and mother. Regular respite care was arranged every second weekend. Disability Services were involved Tamarind were involved The-Early-intervention –Team was involved. xxx and xxx Schools were also involved Jayden was on the wait list with Disability Services for extra support. ... was concerned that the child Jayden was also attacking his mother and leaving bruises on her. The mother's brother assisted the family and stayed at the house at times.

#### INTAKE WORKER'S COMMENTS / ASSESSMENT

A CP Report ... already exists in relation to information the Assistant Principal attached with this email which is not included here.

Feedback was provided to Principal ... in relation to this email on 13.03.2006 School absences were a school related matter rather than a CPA issue. It was not inconceivable that the mother may have wanted to keep the older boy home from school after an incident where his behaviour had been extremely challenging. The issues of medication and medication balance for the child was a medical issue and/or one the school could take up directly with the mother. Feedback was provided to the Acting Principal via email on the 31.03.2006

#### ***Ombudsman yet to investigate:***

Why was it that school absences were not considered an indicator of cumulative harm? This question was discussed further under the heading Non Attendance at School.

Why was failure of the mother to administer medication as prescribed not an indicator of neglect?

Why was it assumed that the violent attacks were done by the child not the mother's partner as it is common for victims to be kept away from school until bruises or cuts heal?

The CCIS File review notes that the service provided as Family Support – parenting support but the outcome was not accepted. Does this mean not accepted by the mother/family or the referral was not accepted by Family Support Services?

### **8 December 2006 - Seventh**

The children's relative contacted CPA and raised the following concerns:

- The mother spent child payments at the Casino every Thursday.
- The mother did not have money to pay for school fees.
- Both George and Jayden have special needs.
- George is Autistic. His brother Jayden has mild Autism.
- The mother can't be bothered getting up in the morning to get the children ready for school if she has just returned from the Casino.
- He lived with the children and attended to their needs.
- He was worried that when he returned to work in a week's time the children would not have any supervision and their care needs would be secondary to the mother's gambling and frequenting the Casino.
- The children's maternal grandmother also attends the Casino with the mother (her daughter) and they only care about the Casino.
- The relative said 'I want her to wake up to herself they are her kids and she has got to look after them.'
- The mother calls the children 'spastic'.

### **Assessment:**

Following recorded:

*Worker advised relative that there were no child concerns, as is inadequate parenting by the mother, but no child maltreatment concerns, but would make a notification for our records, but that the report would be recommended to not proceed. Worker further advised that although the mother was displaying questionable parenting, that they were having their care needs met by him and as such there were no concerns about the child's care and well being. Worker further advised the relative that if these circumstances changed to contact FACS and make a notification. Worker discussed this matter with a supervisor who advised that she was in agreement with assessment. No concerns as the children are having the needs met and that there are no concerns to the children's safety.*

### **Ombudsman yet to investigate:**

Inconsistent information is contained in the intake form. The intake form records that the matters not proceed to investigation however under the heading, 'Recommended Response Classification' the box for child concern report is ticked. What was the actual outcome for this notification?

What is the criteria for deciding when 'poor parenting' becomes 'neglect'?

What reliance was placed on previous notifications?

### **16 February 2007 - Eighth**

The children's Godmother contacted CPA and raised the following concerns:

- The mother frequently leaves the children home.
- Both boys have disabilities and have not developed mentally for their age.
- Both boys attend special schools.
- Her main concern was that the mother leaves the boys, gambles, does not have enough money for the children's food and spends a lot of time chasing men around.
- Notifier was genuinely concerned for the wellbeing of the children.



- The children were often sent to respite which was positive but worried that the mother still abused the time that she did have with the children.
- She was concerned that in the past, the youngest child had had bruising on his bottom. She was unsure of the frequency and was told this by one of the respite carers.

**Assessment:**

There is no clear decision/recommendation recorded in the Intake Form although a Child Concern Report box was ticked, which required a response within 5 days. Note that a 1 page Initial Child Protection Team Report dated 12 July 2007 (some 5 months later) is attached containing limited information, stating the following:

- A strategy meeting was not held.
- An investigation did not take place in relation to this report.
- It was recommended by the Acting Manager that this case now be closed without investigation.
- Rational: The rational for this was that the report was proceeded as a result of the third report rule and the information contained in this report was quite vague, and alone, would not warrant CPA investigation. There had been no new notifications since this one received in February 2007.

**Outcome:**

In the outcome it is recommended this case be closed without investigation as outlined in the above rationale.

The CCIS File Review of 23 December 2009 shows this notification as a CP investigation with an outcome of 'no action possible'.

**Ombudsman yet to investigate:**

What was the actual assessment for this notification?

Does the Child Protection Team Report (CPTTR) dated 12 July 2007 refer to this notification?

If the CPTTR does refer to this notification why was the response 5 months later?

If the CPTTR does not refer to this notification which notification does it refer to as there was no record of a July notification?

**7 August 2009, 30 September 2009 – Ninth and Tenth**

This child was included in the second and tenth notifications for his brother.

**Police History**

George had a history of 4 police involvements as a family violence child. His mother had 22 recorded involvements with police, which included 13 incidents of domestic argument and family violence. George's relative who cared for him on weekends and who lived with him from July 2009 also had a history of involvements with police recorded about him including a Domestic Violence Order taken out against him. He had been convicted of an assault occasioning bodily harm and of breach of a restraining order.

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## **Jayden MAWLEY: Born May 2001**

### **Family History**

Jayden was born with special needs and suspected mild autism. Jayden had two brothers. His mother died in hospital a few days after giving birth to his brother in July 2009. One of Jayden's brothers had autism while the other was severely handicapped. The family experienced significant stress following the death of the mother. All three children were being cared for by their relative, who alleged that the Grandmother was aggressive and had smacked the other two children while in her care. There were several reports of neglect, abuse and emotional harm received from 1999 due to concerns of the mother's and her partner's abuse of alcohol, drugs and gambling. In 2005 Jayden's parents separated and his father wanted to put the child in foster care due to the mother's neglect and gambling. Police records show the mother and her partner having a history of involvement with police in domestic violence related issues over a long period of time. According to CCIS File Review records, 13 approaches were made for Jayden. Of these, 1 was accepted, 3 were not accepted, 3 were considered insufficient information, 2 were classified as '*the allegations would not constitute harm*', 1 was proceeded but no action possible, 1 with no outcome recorded, 1 case with issues resolved and 1 case with no further action.

### **Notification History:**

There were six notifications on:

13 May 2004

11 January 2005

31 January 2005

13 March 2006

28 March 2006

8 December 2006

The circumstances were the same as reported for his brother

### **12 May 2006 – Seventh**

The Principal of the school Jayden attended contacted CPA advising that the mother had telephoned to say that Jayden would not be coming to school during the week. The notifier stated that Jayden had attended school the previous day with a black eye, believed to have been caused by his brother George, who has autism. The notifier stated she was more concerned that the mother may be neglecting Jayden and leaving him at home unsupervised.

The notifier told of an instance where a taxi driver went to pick up Jayden to take him to school one morning. However, when no one came out, the taxi driver phoned the mother who said she was at the Casino and had forgotten the child had to go to preschool. It appeared the 2 boys were at home on their own.

The notifier advised of another incident where the taxi driver took Jayden home after school one day but no one was home.

The school phoned the mother who said she was at the Casuarina Club and had forgotten about Jayden. The notifier stated that if the boys' relative was not home then there was no one to look after them and George the older boy was incapable of looking after Jayden due to

his own high level needs. The notifier stated that the mother was very slow to process information, did not understand everything said to her and had to be given very specific instructions regarding the care of the children.

**Assessment:**

The following comments were recorded in the intake worker's assessment:

Given the above, the assessment recommended not to proceed due to insufficient information and that if another report was received it would be subject to the third report rule.

**Ombudsman comment:**

There were notifications on 13 March, 28 March and this one in May 2006 was the third report, so the reference to the next report being the third is an error. When the next report was made, being the fourth within 12 months, it too did not trigger an investigation.

**16 February 2007 – Eighth**

The children's Godmother contacted CPA to advise the following:

- The mother frequently left the children at home.
- Both boys had disabilities and had not developed mentally for their age.
- Both boys attended special schools.
- Her main concern was that the mother left the boys, gambled, did not have enough money for the children's food and spent a lot of time chasing men around.
- She was genuinely concerned for the wellbeing of the children.
- The children were often sent to respite which was positive but she worried that the mother still abused the time she did have with the children.
- She was concerned that in the past, the youngest child had bruising on his bottom. She was unsure of the frequency and was told this by one of the respite carers.

**Assessment:**

The Child Concern Report box was ticked, which required a response within 5 days. However, a 1 page document, titled 'Initial Child Protection Team Report' dated 12 July 2007 (some 5 months later) recorded the following:

*'a strategy meeting was not held. An investigation did not take place in relation to this report. It was recommended by acting Manager that this case now be closed without investigation.*

*Rational: The rationale for this is that the report was proceeded as a result of the third report rule and the information contained in this report was quite vague, and alone, would not warrant FACS investigation. There have been no new notifications since this one received in February 2007.*

*Outcome: In the outcome it is recommended this case be closed without investigation as outlined in the above rationale'.*

***Ombudsman comment:***

There must have been a notification in July 2007 which was not entered as a report. It appears that the Third Report Rule was not complied with on three occasions. There had been seven previous notifications for this family. The purpose of the third report rule was to identify cumulative harm.

***7 August 2009 – Ninth***

Refer to notification one for Derrick Mawley.

***30 September 2009 – Tenth***

A relative of George contacted CPA and provided the following information about events regarding the children that occurred between 4 August 2009 and 31 August 2009:

- A man accidentally left his razor on the basin after shaving.
- Later that day, Jayden was seen in the bathroom trying to shave his eyebrows with that razor, claiming he wanted to be like everyone else.
- The relative reprimanded Jayden for his actions and the person who left the razor lying around.
- The children's carer returned from work sometime in the evening and was informed of what happened. It is alleged the relative walked towards Jayden, slapped him, pulled him up by his hair to a standing position and scolded him.
- The notifier and the other person were alarmed at the relative's reaction because he had already been told that Jayden had been reprimanded. The carer's excuse for his behaviour was that he needed to make the children tough.
- The carer subjected Jayden to daily emotional abuse and that Jayden was called a girl whenever he cried.
- The notifier said that Jayden was an autistic child.
- The notifier advised that the relative was reluctant to accept family support.
- That the Grandmother's numerous offers of assistance to the relative were turned down and her efforts to visit her grandchildren had been futile.

**Actions Taken By Intake Worker**

Intake worker requested police involvement for William Mawley. Results revealed: the relative had 3 convictions in 2000, one for assaulting a person who suffered bodily harm. In 2005, the relative was also convicted for failing to comply with a restraining order.

***Ombudsman Note:***

The relative used an alias and his involvement with police was much more extensive than recorded above. Between 1999 and 2007 he was recorded as a family violence offender on seven occasions and eight warrants had been issued for him.

***Assessment:*****Jayden**

Information presented raised concerns of emotional and physical harm to the subject child. William's reported behaviour and rationale for his actions was concerning particularly given that Jayden was reported to be autistic. It was noted that there was an open investigation around Derrick's (sibling) well-being and William was a suspect. In consideration of CPA current Involvement with Derrick, coupled with Jayden's vulnerability it was recommended to proceed investigation as a child concern.

**George**

Whilst acknowledging that George resided in the same house as the subject child and Derrick, there was no information to suggest that child had been harmed or was at risk of harm. He was also of an age where he can be largely responsible for his own care and protection. Information provided had made no reference to George. It was recommended not to proceed with the investigation on the basis of insufficient information.

***30 October 2009 – Eleventh***

No intake form with any details was provided for this notification. The CCIS File Review indicated that the notification was recorded as an intake event with no further action as the outcome.

***11 November 2009 – Twelfth***

No intake form or details was provided for this notification. The CCIS File Review indicated it was a child protection report and that the outcome was insufficient information.

***8 February 2010 – Thirteenth (Child aged 8 years 9 months)***

A School teacher contacted CPA three days earlier and made the following notification concerning Jayden displaying sexual behaviour:

- Subject child was sitting together with about ten other children on bench at a bus stop after returning from a swimming trip.
- Subject child was sitting forward while the boy next to him had his back to him, facing away.
- Subject child moved into a 'spooning' position. Put one leg over back of bench, positioned himself behind the boy and put his arms around the boy next to him.
- Subject child had his eyes closed, mouth open, as if to kiss the boy. From his facial expression subject child looked like '*he was trying to make out*'.
- Notifier mentioned an informant spoke of another incident involving the subject child. While playing, the subject child had tried to '*hump*' another child.
- Notifier stated behaviour of concern was '*sexual*', especially given age of subject child and, belief of notifier, had nothing to do with intellectual disability of subject child.
- Notifier stated the mother of the subject child passed away the previous year and subject child is cared for by the relative. According to the notifier, the subject child had no contact with the father.

***Assessment:*****Protective factors/family strengths**

- Current CPA involvement
- CPA contract made with extended family members to support caregiver in caring for subject child.
- School involved: positive behaviour plan in place.

**Rationale of CIT for assessment/outcome**

This notification concerned a report of the subject child exhibiting sexualised behaviour in front of other children. While there was significant child protection history recorded for the subject child, there was currently insufficient evidence to suggest the child had suffered any sexual harm pursuant to Section 16 of the *Care and Protection of Children Act*.

- It was therefore recommended that this notification not proceed as the child was not in need of protection.

A/CAT Manager's comments:

Discussion between A/CAT manager and A/OIC 22/2/2010.

CPA-CP Report is not proceeding to investigation as the child was not in need of protection, pursuant to *S20 Care and Protection of Children Act 2007*.

Police- Nil further action.

CP Report emailed to CAT North Police and Darwin SARC on 22/02/2010.

***Ombudsman comment:***

There were notifications on 23/10/09, 30/10/09, 11/11/09 and 8/2/09. The Third Report Rule mandated an investigation. None occurred.

***Police History***

Jayden had a history of 4 involvements recorded with police, all as a family violence child. The carer with whom the child resided was a family violence offender on seven occasions and on eight occasions had been the subject of a warrant or Court order. He had been convicted of breaching a restraining order and of assault occasioning bodily harm.

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***Derrick MAWLEY: Born July 2009***

***Family History***

Derrick was born prematurely at RDH. His mother died in hospital a few days later. Nothing is known of his father. He has a brother aged 17 and an 8 year old half brother. Both had special needs. The family experienced significant stress following the death of the mother. All three children were cared for by a relative, who alleged that the Grandmother was aggressive and had smacked the other two children, while in her care. Derrick's two brothers were already the subject of eighteen notifications of suspected neglect and emotional abuse over a number of years. At 2 months of age Derrick returned to hospital.

Medical examinations showed that Derrick had an inflicted head injury with raised intracranial pressure, multiple fractures to his limbs and other serious medical conditions that required further medical treatment, monitoring, rehabilitation and follow up. These injuries were considered to be non-accidental.

Derrick remained in the care of RDH. An investigation began and police were notified. A joint investigation was undertaken by police and NTFC. Derrick was taken in to the protective care of the CEO of the Department and subsequently placed in Foster Care.

## **Notification History**

### **5 August 2009 – First** (No intake form completed for this notification by CIT)

An allied health professional at RDH made an email notification about Derrick. The following information was provided:

- Derrick was a premature baby, an inpatient at RDH since birth and was a 'child at risk'.
- Derrick's mother became gravely ill after giving birth to him and was in Intensive Care Unit at RDH, in a coma and on life support.
- The relative was presently caring for Derrick's two other siblings aged 17 and 8 who both had disabilities and the relative also had his own medical problems.
- The Grandmother also offered to care for the children but due to her age and language concerns, required support.
- The notifier advised that although they were working with the family to find support services for the family they requested CPA involvement to assess the family's situation and provide additional family support.

### **Assessment:**

The assessment decision/outcome for this notification is unknown because no record of it was disclosed by the Department in response to a summons requiring production of all of the Child Protection Authority's records for this child.

### **Ombudsman yet to investigate:**

Why was this email notification not entered into CCIS?

### **7 August 2009 - Second**

An email was sent by an allied health professional stating that a family meeting had been held to discuss who would be able to take care of the children. The Allied Health Professional stated: *'I would appreciate your urgent response to this matter, with the view to your **assessment of the family** situation, and alternative care options available to the family, should the relative decide that he can no longer care for the children'*.

### **Assessment:**

There was an extended family willing to care for the boys and the family had been linked/referred to other service providers for ongoing assistance. At that point in time there was no role for CPA. In consideration of the risk and protective factors for these children, it was recommended that the CP report not proceed to investigation.

### **Ombudsman yet to investigate:**

Why was it recorded in the intake form under the heading 'Background' that *'there have been 4 previous notifications for this family but that the allegations have been vague and not sufficient to warrant investigation'* when in fact there had been 12 previous notifications about both **George** and **Jayden** and the family situation. It was recorded that the older brother liked to pick the other one up and throw him to the ground. Why was this information not taken into account by CIT when assessing the notification.

### **17 August 2009 - Third**

An Intake form was created on 20/8/09 by the intake worker following receipt of an email from the social worker dated 17/8/09, querying why she had not received any further contact

from CPA following a previous notification requesting CPA assistance, intervention and family support for the family.

**Assessment:**

The A/Child Abuse Taskforce and Central Intake Manager made the following assessment in an email to the notifier:

*'as discussed the information provided to date in relation to this family is not sufficient to proceed to investigation.'* Assessment states *'There were nil child protection or child well-being concerns raised by the notifier in regards to the subject child. Therefore it is recommended that this matter be recorded only as an Intake Event'*.

**Outcome:**

No action. (ie, no action and not even recorded as a child protection notification.)

**27 September 2009 – Fourth**

A doctor provided the following information:

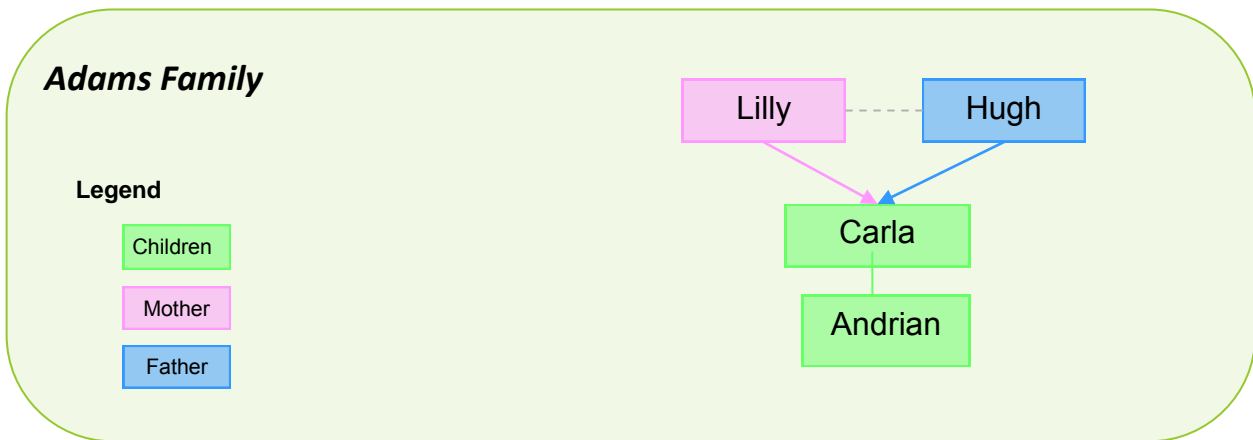
- Derrick was brought to RDH by his primary carer on 25 September 2009. He was generally unwell and his symptoms first suggested meningitis;
- He tested negatively for meningitis but his condition deteriorated;
- He had a CT scan which determined that the child had an inter-cranial haemorrhage;
- This haemorrhage being described as a 'significant bleed' with doctors uncertain of the cause;
- The presentation of the bleed was indicative of a non accidental injury;
- His carer could offer no explanation for the bleed;
- He remained in hospital and had a full examination for non accidental injury;
- The child's medical condition was described as 'very unwell';
- He had been cared for by his carer since his mother passed away shortly after his birth;
- He was born pre-maturely at 34 weeks;
- His carer also cares for his two siblings. The notes indicated that both these siblings had special needs.

**Assessment:**

The assessment stated that this notification warranted a child in danger response level. A CP Report was allocated to Casuarina CPA to investigate and to CAT North police. Neglect was substantiated.

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**Carla Adams: Born July 1998**

### **Family History**

Carla was eleven years old when she was brought into a remote health centre by her mother and father with third degree burns five days after falling into a fire. Carla had reportedly received no pain relief following the incident and the wound had turned septic and was infected with maggots. Following treatment, arrangements were made for her to be hospitalised given previous and current concerns about the family's unreliability to look after her. Reportedly, there was a history of previous neglect by the child's father, who would take his family members to hospital and then go drinking. Carla also had a 6 year old brother. An investigation commenced and the parents were believed responsible for neglect, with the case remaining open.

### **Notification History**

#### **18 June 2009 - First**

The remote community clinic nurse contacted CPA with concerns in relation to the time taken to bring Carla to the clinic. She had been burnt when she fell asleep next to a camp fire and fell forward into the fire. This was five days prior to being seen at the clinic. Her wounds were infected, with maggots present. The father said the family were unable to get from the outstation to the clinic as he did not have any petrol. The notifier stated that they believed there was a lack of effort to bring the child to the health centre earlier. The notifier said that Carla would require intense medical treatment and would need to have a consistent and reliable escort. There were also concerns with regard to her father acting as an escort as in the past when he had taken other family members to the hospital he had gone off drinking. The notifier said that Carla was *'currently withdrawn and not coping well.'*

#### **Assessment:**

Proceeded as a child concern report. An investigation would need to include an assessment of the parent's capacity and willingness to ensure the child received the ongoing medical treatment she would require.

The CCIS File Review records indicated that **neglect was substantiated** as a result of the child's parents failing to provide medical aid. The parents were listed as the people responsible. The review records that this case remained open in an CPA regional office.

***Other Information:***

The Full Danger Assessment<sup>40</sup> indicated that Carla's father did not take her to the clinic due to '*ongoing history*' between him and the clinic manager at the health centre.

An email was sent by a RDH social worker to the Manager of NTFC regional office on 24 June 2009 following a discussion the social worker had with the community clinic. The social worker advised the manager at NTFC of the additional information she had received from the clinic. The information included:

- Clinic personnel had known the family for some time and had had ongoing concerns regarding Carla's and her elder sister Tammy's well being.
- The clinic had attempted to work tirelessly with the family in order to encourage School attendance. The father had refused assistance in this regard. The clinic had tried to provide learning activities for the girls to complete however there had been no co-operation from the father with this. The father told clinic staff that he would not send the girls to school as they had previously been bullied at another school.
- The children are often not brought in for follow up appointments with the clinic, including dental care.
- The children are '*scared of their father*'.
- The children are '*never playing with other community children and are always just with the parents*'.
- The family live in an out-station with no house. She said that the '*family camp in the bush*' and have no running water.
- The father had a number of medical conditions. He was prescribed some pain medication however presented to the clinic continuously for more. The father would often present daily (even up to 6 times a day) for more pain medication. The clinic described a history of the father being given 50-panadeine forte tablets on a particular day and then attending the clinic to request a further 50 panadiene forte tablets six days later.
- The father could become quite volatile when his demands were not met and had a history of threatening staff and self harm.
- The Clinic reported that the father had been assessed by a visiting psychiatrist.

The social worker also indicated in the email that a referral to Alcohol and other Drugs had been discussed with the father however he had refused this referral.

***Ombudsman yet to investigate:***

What steps were put in place to ensure that Carla received the medical treatment required upon her return to the community?

Once neglect was substantiated what steps were undertaken to ensure that Carla did not suffer similar treatment in the future?

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<sup>40</sup> Refer to acronym table at page???

The records provided by the Department show that an email notification was also made on 22 June 2006 by a social worker at RDH. The information contained in the email was the same as the information provided in the first notification. How was this notification recorded?

What steps were taken in response to the information provided by the social worker in the email dated 24 June 2009?

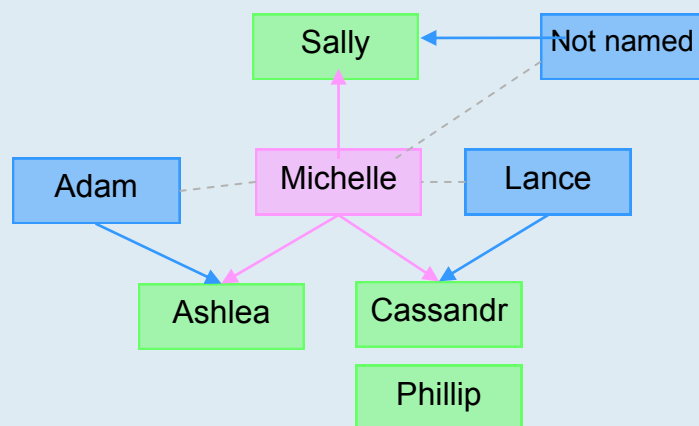
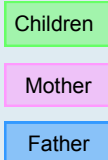
The CCIS File Review indicated that a family support service was accepted for Carla's sibling, Andrian on 3 July 2000. No notification documentation was provided in relation to this referral. What information was received by the Department that resulted in a family support case being opened?

### ***Police History***

Police records indicated there had been two involvements with Carla between June 2009 and October 2010. Carla's mother had one involvement recorded for domestic violence

### ***Brinkle/ Sampson Family***

#### **Legend**



### ***Cassandra BRINKLE: Born July 2002***

### ***Family History***

Cassandra is the oldest child in her family. She has one brother and one step brother. Cassandra was seven years old when she first came to the attention of CIT. While there had been no previous connection with CIT, Cassandra's family was involved with the Family Court. Her father had recently been released from prison for bashing her mother. Cassandra's parents were no longer together and her mother had a new partner. In August 2009 CIT were contacted by Cassandra's school with concerns regarding bruising and scratching on her face and a cut on her arm. Cassandra stated these injuries were caused by her mother.

## ***Notification History***

### ***11 November 2008 – First***

Information taken from Intake Search Results Report and Event History Search Results shows a referral for FS/FSPS (Family Support). The request was from the mother and was for respite as she reported difficulty in coping. Siblings Phillip and Ashlea are also included in this report.

#### ***Referral Outcome:***

**Not Accepted.**

### ***10 August 2009 – Second***

CPA received a report from Cassandra's school advising that Cassandra had come to school with facial bruises and Cassandra said her mum did this with her hands. There was also a cut on her arm and this was also caused by her mother using an egg flip.

#### ***Assessment:***

Recommended that this proceed to investigation as a child in danger to ensure the safety of the child.

#### ***Investigation outcome:***

Substantiated. Mother accepted responsibility for causing physical injury.

#### ***Ombudsman yet to investigate:***

What was done to ensure the child's safety?

Did the investigation reveal other instances of abuse?

### ***19 August 2009 – Third: Siblings Phillip and Ashlea are also included in this notification***

A RDH social worker made a report about the number of times Cassandra and her siblings had presented at the hospital. The social worker reported 14 presentations in a three year period at the Emergency Department for various injuries. The social worker explained that the presentations suggested the possibility of poor supervision by Cassandra's mother. At this time Cassandra's mother appeared stressed due to the recent release of her ex-partner from prison.

#### ***Assessment:***

Recommended that this **proceed to investigation as a Child Concern report.**

#### ***Investigation outcome:***

The family is receiving support from Centacare, Strengthen Families Program and continues to be monitored by the Strengthen Families Team, Casuarina.

***Ombudsman yet to investigate:***

What was the nature of these services?

When did they start?

There was another notification 3 months later, was the support in place then?

***02 November 2009 – Fourth: Blank Document – Write Off***

No information is provided on this intake form due to this being a 'write off'<sup>41</sup>

***Ombudsman comment:***

This memo was a direction to intake workers to 'write off' intakes received up to the end of January 2009. This notification was received after this period. A sibling, Phillip, was included in this notification.

A progress note refers to a phone call providing the following information:

On 02 November 2009 it was reported that mother was pregnant with baby number four and she was a single parent. When her three year old was born at home she had no one to care for her other two children. Cassandra's mother was admitted to hospital on Saturday for pre term labour and was worried who would care for the other three children if the baby did come. Intake worker stated CPA should be '***Last port of call***' but they would make inquiries into who else in the community could provide respite care. Over the weekend the father of the unborn cared for the other children. After discussion with Team Leader the following email was sent to the reporter:

***'Further to our conversation regarding Michelle and her children. Before NTFC would become involved in respite care for this family every effort needs to be made to find respite care for the children in the community. Some suggestions for respite are, NT Carers, Darwin Family Day care, or Kentish Care. It could be really helpful to link mother to a social worker at Centrelink for information regarding costs etc. Please contact NTFC if all avenues have been exhausted.'***

***Ombudsman comment:***

This call was on a Saturday. The mother was a single parent. She was already in hospital. None of the services referred to operate on a weekend. Who was expected by CIT to make these enquiries and why was it simply presumed that the other three children were safe being with the estranged father with a history of violence? This was also **the third report in 4 months**. Why did the Third Report Rule not result in an investigation?

***Police History***

Police records indicated there had been 6 involvements with Cassandra's mother since May 1999. Cassandra's father had a history of 78 involvements with police recorded against him, which included 8 as a family violence offender/participant.

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<sup>41</sup> With blank documents.

**Phillip BRINKLE: Born February 2004****Family History**

Phillip is a seven year old boy with an older sister and a younger step sister. CPA were contacted in 2009 when Phillip was 5½ years old in relation to his younger sister's attendance at RDH A&E. There had been a previous report to CPA in relation to the family that resulted in substantiated physical abuse. He was included in three notifications for his siblings.

**Ashlea SAMPSON: Born August 2006****Family History**

In August of 2009 Ashlea, a 2 year and 11 months old girl was in the Emergency Department for burns reportedly caused by a sibling's hot milo. During this visit it was noted that between the three siblings there had been 14 visits to the Emergency Department with a range of injuries in the past 3 years. There had been some head and arm injuries from falls, burns and a needle stick injury. However, it was Ashlea's injuries that were cause for concern and suggestive of poor supervision of such a young child. Nine of the 14 incidents involved Ashlea. There did not appear to be a physical or medical reason for her to have had the falls or injuries. It was noted that Ashlea had speech development difficulties and was unable to communicate easily. On returning from a visit with her father it was noticed that she was putting her fingers into her vagina and urinating in her pants. Her mother noticed that she was reddish and sore on the outside of her labia. Her mother had some concerns regarding the people living in the same house as her former partner. While this was recorded by CIT no further action was taken.

**Notification History****06 March 2008 – First**

CIT was contacted by Ashlea's father who stated that he had tried to address the issue of his wife not getting treatment for the chronic nature of Ashlea's school sores by phoning Centre Care and getting them to relay a message to her. The outcome of this was that his wife had cut off all access visits and he had not seen his daughter for two weeks. Ashlea's father said he was concerned because his son had caught the sores from Ashlea and when taken to the doctor he was advised that if they were not treated a blood disease could occur. Ashlea's father had gone back to his lawyer and had a pending Family Court hearing on 15/07/2008. The CIT worker encouraged him to try to address his concerns through this process. Another call was received on 11/03/2008 from Ashlea's father to advise they were in family conferencing rather than Family Court. Ashlea's father said he believed his ex-partner was messing with Ashlea's head getting her to call the mother's current boyfriend 'Dad'. He stated he didn't want anything bad to happen to Ashlea's mother, he just wanted her to take Ashlea to the doctor. CIT contacted Centrecare who advised the mother had informed them she had taken Ashlea to the doctor and the sores looked like bites.

**Assessment:**

Not accepted. Notification made in context of custody issues. The Centrecare workers did not have any concerns for the child.

**Ombudsman yet to investigate:**

How extensive were the enquiries of Centrecare?

If Centacare thought the sores were 'bites' on what basis did CPA record that Centrecare had no concerns?

Ashlea was included in the three reports about her two siblings:

**11 November 2008 – Second****19 August 2009 – Third****02 November 2009 – Fourth - Blank Document – Write Off****29 January 2010 – Fifth**

A doctor rang CIT while Ashlea and her mother were in the room and provided the following information:

- Ashlea's mother alleged the child had been returned to her four days ago after a visit with her father, with a split lip, missing hair on the top of her head and bruising on her rib cage.
- Since Ashlea's return the mother alleged that Ashlea had relapsed to bed wetting.
- Ashlea had developmental delay and could not articulate,.

The doctor rang later that same day and provided the following information:

- Ashlea's mother scored high on the depression and anxiety screening tool and it would appear that she had unresolved issues with Ashlea's father. The doctor could not see the alleged injuries.
- Ashlea's mother attends antenatal sessions.
- Ashlea does receive medical support.

**Assessment:**

Recommended not to proceed to investigation on the basis of insufficient information.

**29 March 2010 – Sixth**

Report made by a Doctor during an appointment with Ashlea and her mother. It was advised that after Ashlea had been returned from a visit with her father she was presenting with '*odd behaviour*' which included urinating in her pants and putting her fingers into her vagina. The mother did not believe the father would harm the child but was concerned that there were other male adults who lived in the same household. Further reading of the CCIS Service Event Summary states the mother was unable to be contacted. The medical coordinator advised that, based on the information, she was happy to wait for further information to be provided by police. Continued follow up in May of 2010 stated: '*investigation finalised and no suspicious circumstances found with the child injury*'.

**Assessment:**

Proceed to investigation as a child concern report.

Information presented did not provide any evidence that the subject child had been harmed or likely to be harmed in accordance with section 20(a) of the *Care and Protection of Children Act 2007*. **The fact that the subject child was allegedly presenting odd behaviour such as urinating in her pants, putting fingers into her vagina and redness on the subject child's labia did not suggest that harm may have occurred.** However, this matter would proceed to investigation as a child concern in accordance with the third rule requirements of the 7.7.3 CPA policy and practice manual.

**Managers Comments**

- Discussion between CAT Manager and Sergeant 06/04112010
- CPA - Child not in need of protection. The third report rule does not apply, as there has been only one child protection report and one intake event since the last child protection investigation, and the third report rule applies to child protection reports only.
- Police - Insufficient information.
- CP report to be emailed to CAT North Police

**Ombudsman yet to investigate:**

Why the third report rule did not apply?

There were notifications in August and November 2009, January and March 2009.

**Police History**

Police records indicated there had been 6 involvements with Ashlea's mother since May 1999. Ashlea's father had a history of 27 involvements with police recorded about him, which included 4 as a family violence offender/participant.

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## RECOMMENDATIONS

I made 28 recommendations. The responses to them by the CPA are set out under each recommendation. Not all recommendations relate to the CPA.

1. That Section 34 of the *Care and Protection of Children Act* (CPC Act) be amended to extend the authority of the CPA to request information:  
*'that may be relevant in connection with or incidental to a child's wellbeing', or 'relevant to information received about a child'.*

AGREED by the Child Protection Authority.

2. That a provision is inserted into Section 34 of the CPC Act to allow the CEO:  
*'to make those inquiries of any other persons who may reasonably be expected to have information about a child'.*

AGREED by the Child Protection Authority.

3. That the *Education Act* be amended and that a child or person who is the subject of any notice or action under the Education Act Amendment Bill 2011 be prescribed under Section 258(2)(f) of the *Care and Protection of Children Act* so that the Children's Commissioner can consider whether or not to investigate the matter.

AGREED – will be carefully considered by the CPA.

4. Further that Section 15(2) of the CPC Act define harm to include:  
*'A child or young person of school going age frequently does not attend school without a reasonable excuse'.*

AGREED – will be considered by the CPA.

5. That Section 26 of the *Care and Protection of Children Act* be amended to extend the mandatory reporting requirement to frequent non-attendance at school without a reasonable excuse.

AGREED – will be considered by the CPA.

6. That another phone be established seven days per week 24 hours a day that is dedicated to, and only given to professional notifiers and which receives priority in being answered. That phone number should also be available to NT Police and the Principal and Deputy Principal of schools.

NOT AGREED – will be considered.

7. That the facility for professional notifiers to email or facsimile notifications be restored to the NT public hospitals.

OPPOSED – not considered necessary.

8. That if the practice of intake workers going off line from the telephone to complete entry of a notification into CCIS is to continue that the number of intake workers answering the phones be increased.

NOT AGREED

*[OMBUDSMAN NOTE] The recommendation was made on information that the CPA says is outdated. The CPA agrees there ought to be 5 workers to answer the two phones and there are 5 since April 2011. I have left the recommendation in because I have not verified that there are always 5.*

9. That the CPA only records an outcome as “*harm/abuse/neglect/ unsubstantiated*” if the CPA has carried out sufficient investigation to be positively satisfied that the child, the subject of the report, is not at risk of harm or neglect or abuse.

AGREED -

10. (a) That the CPA reinstates the Third Report Rule to mandate that if there are three notifications within 12 months for a child or children in the same household an investigation must occur.

NOT AGREED

- (b) That the CPA amends its policy to prescribe that for the operation of the Third Report Rule 3 intake events within 12 months for a child or a member of the same household triggers an investigation.

NOT AGREED

11. That in calculating whether three intake events have occurred within 12 months any report by one or more persons notifying the same or similar information about the same child or household be treated as a single report not a duplicate report.

NOT AGREED

12. I recommend that RDH and other hospitals keep a register of notifications made to CIT. I recommend that the Quality Assurance Unit do a three monthly comparison of the hospitals’ register and CCIS to assess outcomes and convergence or differences between reports made and CIT’s assessments.

13. That a review of the adequacy of orientation training is pursued by the CPA to identify training needs for intake workers so that they have the capability to use CCIS effectively.

NOT AGREED – Training is considered adequate.

14. (1) RDH social work records be kept as separate section in the patients’ medical records for ease of reference, not interspersed within the medical and nursing notes and be more extensive than in the past **or** ;  
(2) The records of social workers be kept separately if considered that access to the social history of a family should be inaccessible to some category of hospital staff.

15. That the position of an intake worker stationed at RDH become a permanent arrangement even if only half time at RDH with that worker being able to accept notifications directly from RDH personnel.

AGREED to **continue** to provide a child protection worker.

**Ombudsman comment** – *the position has been vacant since November 2010.*

16. That the CPA examine the files of the children identified in this report whose circumstance should have been investigated under the third report rule but weren't to determine how best to configure the case management system CCIS to automatically highlight that a notification is a third one within 12 months for children in the same household.

NOT AGREED – the structured decision making tool is adequate to assess multiple notifications.

17. That administrative staff do not perform the function of reviewing previous history from CCIS. When an administrative officer performs a task, that should be recorded on the intake form.

NOT AGREED – deny that administrative officers perform this function.

18. That the Quality Assurance Unit review the logs of calls to the CIT and compare them to the rosters of staff and the leave records of CIT to determine how often an administrative officer has received/recorded notifications as opposed to mere entry into CCIS information created by a professional intake worker.

19. That the CIT Operations Manual be amended from:

*'the work unit **may** need to plan Child Protection action in advance of the birth and liaise with maternity services '*

to

*'the work unit **must** plan a child protection action in advance and **must** liaise with maternity services when there is a foreseeable risk to the wellbeing of an unborn child or if any child of the parents or either of them has previously been the subject of a report when harm was substantiated'.*

NOT AGREED – will wait until a review of the legislation has been done.

20. That all information given to the CPA about children believed to be at risk of harm be retained for future automatic retrieval and crossmatching with the child the subject of the intake event and any other child in the same household if there is a later notification.

RESPONSE – this is already the existing practice.

21. That a repeat evaluation of the 15 families who were involved in the first evaluation of Targeted Family Services by CDU be carried out. I recommend that the External Monitoring Committee guide the terms of reference for the evaluation and review the results of the evaluation.

AGREED that an evaluation be done and is being discussed as part of another CDU report.

22. Quarterly audits of a sample of notifications that have been assessed as *no further action* as a result of *insufficient information* to determine the quality of those decisions.

SORT OF AGREED – a new unit – The Complaints and Review Unit will be set up to do this.

23. The Operations Manual be amended so that it mandates enquiries be undertaken to clarify initial information where those enquiries can be made by the intake worker of the notifier or NT Police.

NOT AGREED.

24. That the CPA disclose in its annual report the number of notifications received, the number allocated to a work unit, the cases which are open and closed, at the beginning and end of each reporting period, the time from receipt until closure and break this down into regional areas.

AGREED.

25. That the CPA reviews and monitors what are classified as 'enquiries' to determine whether keeping a brief record of matters enquired about will enhance the quality assurance of decision making and identify areas that might need more education for the public, professionals and any service provider who are likely to notify children at risk of harm.

NOT AGREED- because all contacts are already being recorded.

26. That the recommendation of the Board of Inquiry that there be a staff survey of the Dept of Children and Families within 18 months of the Board's Report be expedited and a survey completed no later than 1<sup>st</sup> December 2011.

TIME FRAMES NOT AGREED – an external consultant will be engaged to do strategic plan and surveys included.

27. That the Practice Direction of 30 November 2010 and any similar direction in the CPA Operations Manual that a notifier must believe, and can be asked that harm to a child is caused by a parent or caregiver be revoked.

NOT AGREED.

**Ombudsman comment** – The response repeats the same misinterpretation of Sections 20 and 26 of the CPC Act that I pointed out.

28. I recommend that the guidelines for eligibility for PATS be altered so that where it is necessary for a mother from a community to travel twice to RDH in connection with the birth of a child then two return airfares be provided. As I pointed out to the Minister the cost of a return airfare within the Northern Territory cannot possibly exceed the cost of keeping a child in hospital for even one day.

### ***RESPONSE BY THE DEPARTMENT TO THIS REPORT***

The information in this report was provided to the CPA and to the Department to give them an opportunity to make a submission to me about any adverse comment I made. That is a requirement of Section 61 of the *Ombudsman Act*.

Separate submissions were made by the Department and by the Child Protection Authority.

The Department did not agree any of the six recommendations that were relevant to that agency. They were recommendations numbered 6, 7, 8, 13, 15, 16.

The Department asked that I remove from the report any mention of workers at RDH reporting to me that they had been bullied or suffered reprisals. I have not done so because that is what was reported to me. The Department raised a number of other factual matters for which I assume there were records. As I only received the submission a few hours before this report had to go to print to meet the deadline of 30 June, being the last day on which I would have the jurisdiction I could not re-open the investigation to consider any new documents. The submission also did not address any adverse comment made by me but statements of witnesses that the Department wanted to challenge.

## ***ATTACHMENT A - Methodology***

My investigation methodology:

- Review of Child Protection Authority client files for 61 children.
- Review of medical files for the subject children and the parents of some of them; apparently it is 4 pages.
- Review of police records for the subject children and their parents.
- Comparison and analysis of all records for accuracy and consistency.
- Review of previous reports and enquiries into the Child Protection Authority in the Northern Territory. Interviews with a number of team leaders, managers, head office staff, intake workers and health professionals from the Department including RDH.
- Interviews with the After Hours Crisis Team Personnel.
- Interviews with social workers from Royal Darwin Hospital including current and former Social Workers.
- Attendance at briefings provided by the Department.
- Analysis of information provided by the Department in response to enquiries.
- Enquiries with the Children's Commissioner.
- Interviews with a number of Central Intake Staff.
- Attendances at Central Intake Team briefings and to observe operations.
- Review of a submission provided by the Community and Public Sector Union (CPSU).
- Review of previous complaints to the Ombudsman's Office.
- Review of the CPA's Policy and Procedure Manuals from 1999 to 2010.
- A survey was conducted with past and present intake workers at Central Intake Team.

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Northern Territory Department of Health and Community Services - Northern Territory Community Services High Risk Audit - Audit Report - November 2007.

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Inquest into the Death of Marlon Clancy 13 May 2011.

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Northern Territory Government – Safe Children, Bright Futures Strategic Framework – 2011-2015.

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The Structured Decision Making System Policy and Procedures Intake Manual June 2010.

**ATTACHMENT B - Information Gathering Guide for Intake****Information Gathering Guide**

<p><b>Identifying information</b></p> <p><b>Child and family</b></p> <ul style="list-style-type: none"> <li>• Details of subject child: names, DOB / age, aliases gender, cultural identity</li> <li>• Details of household members, family surname, language spoken</li> <li>• Address and contact details</li> <li>• School or child care details</li> </ul> <p><b>Person making report</b></p> <ul style="list-style-type: none"> <li>• Name and contact details - are they willing to be recontacted?</li> <li>• Relationship to family</li> <li>• Are the family aware of the report being made?</li> <li>• Likely response of family including threats to worker or family safety</li> </ul> <p><b>Circumstances of harm</b></p> <p><b>Source of harm</b></p> <ul style="list-style-type: none"> <li>• What happened? Who was involved? When did it happen?</li> <li>• How long has abuse been going on? Has it increased/decreased?</li> <li>• How do you know what happened? (witness, disclosure, indicators)</li> <li>• Why refer at this time?</li> <li>• Are there any physical indicators of harm apparent?</li> </ul> <p><b>Opportunity for harm</b></p> <ul style="list-style-type: none"> <li>• Person responsible for harm</li> <li>• Current whereabouts/condition of child</li> <li>• Concerns for immediate safety</li> <li>• Access of this person to child or imminent exposure to harm</li> <li>• Expectations of reporter</li> <li>• Is there a protective person within the home environment?</li> </ul>	<p><b>Context of harm</b></p> <p><b>Child or young person</b></p> <ul style="list-style-type: none"> <li>• Current functioning ( mood, thoughts, activities, behaviour, anxiety, fear level)</li> <li>• Physical Developmental</li> <li>• Psychological development</li> <li>• School attendance</li> <li>• Self harm, drug use or other risky behaviour</li> <li>• Child's wishes</li> <li>• Are any of the child's siblings at risk?</li> <li>• Does the child have any previous experience of being in care or placed with other family members?</li> </ul> <p><b>Parents or primary caregiver/s)</b></p> <ul style="list-style-type: none"> <li>• Relationships/marital status</li> <li>• Current functioning (mood, thoughts, activities, behaviour)</li> <li>• Physical / mental health, disability, substance use</li> <li>• Domestic violence (perpetrator / victim)</li> <li>• Parent/caregiver - child interaction/parenting capacity</li> <li>• Caregiver attitude to child</li> <li>• Caregiver attitude to abuse</li> <li>• Efforts to resolve situation? Result of these efforts?</li> <li>• Has there been any previous involvement of Department with family either here or interstate?</li> </ul> <p><b>Networks</b></p> <ul style="list-style-type: none"> <li>• Social contacts/isolation of family</li> <li>• Community strengths/ risks</li> <li>• Other agencies/professionals involved with child or family</li> </ul>
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- 8. Other (specify):
- 9. Have the caregiver voluntarily place the child outside the home.
- 10 Child placed in protective custody because interventions 1-9 do not adequately ensure the child's safety.

**SECTION 3: SAFETY DECISION**

Identify the safety decision by marking the appropriate line below. Check one response only.

- 1. No safety factors were identified at this time. Based on currently available information, there are no children likely to be in immediate danger of serious harm.
- 2. One or more safety factors are present. Safety interventions have been initiated and the child will remain in the home as long as the safety interventions mitigate the danger.
- 3. **One or more safety factors are present, and placement is the only protecting intervention possible for one or more children. Without placement, one or more children will likely be in danger of immediate or serious harm.**

**FIGURE 5**

**CALIFORNIA FAMILY RISK ASSESSMENT**

Referral Name: \_\_\_\_\_ Referral #: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

County Name: \_\_\_\_\_ Worker Name: \_\_\_\_\_ Worker ID#: \_\_\_\_\_

<b>NEGLECT</b>	<b>Score</b>	<b>ABUSE</b>	<b>Score</b>
N1. Current complaint is for neglect		A1. Current physical abuse complaint is substantiated	
a. No.....0		a. No .....0	
b. Yes..... 2 _____		b. Yes .....1_____	
N2. Prior investigations ( <i>assign highest score that applies</i> )		A2. Number of prior abuse investigations ( <i>number: _____</i> )	
a. None..... 1		a. None.....0	
b. One or more, <u>abuse</u> only.....1		b. One ..... 1	
c. One or two for <u>neglect</u> ..... 2		c. Two or more ..... 2_____	
d. Three or more for <u>neglect</u> ..... 3 _____		A3. Household has previously received CPS ( <i>voluntary/court-ordered</i> )	
N3. Household has previously received CPS ( <i>voluntary/ court-ordered</i> )		a. No .....0	
a. No..... 0		b. Yes .....2_____	
b. Yes .....3_____		A4. Prior injury to a child resulting from CAN	
N4. Number of children involved in the CAN incident		a. No .....0	
a. One, two, or three .....0		b. Yes .....2_____	
b. Four or more .....2_____		A5. Primary caregiver's assessment of incident ( <i>score 1 if any present</i> )	
N5. Age of youngest child in the home (Age = _____)		a. Not applicable ..... .0_____	
a. Two or older .....0		b. One or more present ( <i>check all applicable</i> )..... 1_____	
b. Under two ..... 1_____		___ Blames child, and/or	
N6. Primary caregiver provides physical care inconsistent with child needs		___ Justifies maltreatment of a child	
a. No .....0		A6. Two or more incidents of domestic violence in the household in the past year	
b. Yes..... 1_____		a. No .....0	
N7. Primary caregiver has a history of abuse or neglect as a child		b. Yes..... 1_____	
a. No .....0		A7. Primary caregiver characteristics ( <i>score 1 if any present</i> )	
b. Yes..... 2_____		a. Not applicable .....0	
N8. Primary caregiver has/had a mental health problem		b. One or more present ( <i>check all applicable</i> ) .....1_____	
a. None/Not applicable ..... 0		___ Provides insufficient emotional/psychological support	
b. One or more apply .....1_____		___ Employs excessive/inappropriate discipline	
___ During the last 12 months AND/OR		___ Domineering caregiver	
___ Prior to the last 12 months		A8. Primary caregiver has a history of abuse or neglect as a child	
N9. Primary caregiver has/had a drug or alcohol problem		a. No .....0	
a. None/Not applicable .....0		b. Yes..... .1_____	
b. One or more apply .....2_____			
___ During the last 12 months AND/OR			
___ Prior to the last 12 months			

<p>N10. Primary caregiver has criminal arrest history                  a. No .....0                  b. Yes .....1 _____</p> <p>N11. Characteristics of children in household (<i>score 1 if any present</i>)                  a. Not applicable..... 0 _____                  b. One or more present                  (<i>check all applicable</i>)..... 1 _____                  ___ Developmental or physical disability                  ___ Medically fragile/failure to thrive                  ___ Positive toxicology screen at birth</p> <p>N12 Current housing                  a. Not applicable .....0                  b. One or more apply..... 1 _____                  ___ Physically unsafe, AND/OR                  ___ Family homeless</p> <p><b>TOTAL NEGLECT RISK SCORE ABUSE</b> _____</p>	<p>A9. One or more caregiver(s) has/had an alcohol and/or drug problem                  a. No .....0                  b. Yes (<i>check all applicable</i>)..... .1 _____                  During the last 12 months:                      [ ] Primary caregiver [ ] Secondary caregiver                  Prior to the last 12 months:                      [ ] Primary caregiver [ ] Secondary caregiver</p> <p>A10 Primary caregiver has a criminal arrest history                  a. No..... 0                  b. Yes..... 1 _____</p> <p>A11 Characteristics of children in household (<i>score 1 if any present</i>)                  a. Not applicable .....0                  b. One or more present (<i>check all applicable</i>)..... 1 _____                  ___ Delinquency history                  ___ Developmental disability                  ___ Mental health/behavioural problem</p> <p><b>TOTAL ABUSE RISK SCORE TOTAL</b> _____</p>
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**SCORED RISK LEVEL.** Assign the family's scored risk level based on the highest score on either the neglect or abuse indices, using the following chart:

Neglect Score	Abuse Score	Scored Risk Level
_____ -1 – 0	_____ 0 – 1	_____ Low
_____ 1-3	_____ 2 – 4	_____ Moderate
_____ 4 – 8	_____ 5 - 8	_____ High
_____ 9 +	_____ 9 +	_____ Very High

**POLICY OVERRIDES.** Circle yes if a condition shown below is applicable in this case. If any condition is applicable, override final risk level to very high.

Yes No 1. Sexual abuse case AND the perpetrator is likely to have access to the child victim.

Yes No 2. Non-accidental injury to a child under age two years.

Yes No 3. Severe non-accidental injury.

Yes No 4. Parent/caregiver action or inaction resulted in death of a child due to abuse or neglect (previous or current).

**DISCRETIONARY OVERRIDE.** If a discretionary override is made, circle yes, increase risk by one level, and indicate reason.

Yes No 5. If yes, override risk level (circle one): Moderate High Very High

Discretionary override reason: \_\_\_\_\_

Supervisor's Review/Approval of Discretionary Override: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**FINAL RISK LEVEL** (mark final level assigned):                      Low      Moderate      High      Very High

These tools were developed for use in California. They were modified to meet Northern Territory social and demographic conditions. The cost for this service was approximately \$400,000.

## **ATTACHMENT D - Response of CPA on Family Support Services 24<sup>th</sup> June 2011**

### **Response**

*At the current time the Department does not have an evidence based framework to guide future investment in the non-government sector, particularly in relation to the provision of early intervention and prevention programs. In response to Recommendations 8 – 12 and 114 from the Board of Inquiry report a Strategic Investment Framework is being developed. This framework outlines a structured evidence based approach to review current and future investment by all levels of government in child, youth and family services.*

*The Framework will:*

- 1. establish the Department's service footprint;*
- 2. help identify critical service groups;*
- 3. facilitate development of, and investment in, end-to-end services that meet client needs across the life cycle; and*
- 4. build capacity across the sector to partner in delivering an expanded range of prevention and early intervention services.*

*The Framework will be implemented in collaboration with the non-government sector and Australian Government over the coming 18 months. The Framework has three key elements that will underpin its development.*

*These elements are:*

- 1. Strategic reform – establishing investment principles and priorities, a desktop review of the current Australian and Northern Territory government services in child, youth and family services and a unit cost analysis of current and future service models.*
- 2. Sector capacity building – identifying and implementing measures to build capacity of the sector in terms of governance, workforce capacity including cultural capacity and measure to ensure services are supported to deliver an expanded range of culturally secure services; and*
- 3. Grants and reporting – developing consistent performance measures for each service model and type of investment, a best practice approach to grants administration, the introduction of a new online grants management system, and implementation of a change management strategy for the sector and DCF to embed these changes.*

*Development of the Strategic Investment Framework is a longer term initiative and will be completed in 2012. Until such time as funding rolls out under the Framework, the Department is developing an interim funding framework that will see prioritisation of new funding to:*

- Improve coordination of services in urban areas, with a particular focus on developing integrated referral networks to support targeted family support services; and*
- remote communities, to support the operation of the Community Child Safety and Wellbeing Teams.*