Own Initiative Investigation Report into The Circumstances Surrounding the Alleged Sexual Assault on C1 and Services Provided to the WF

FINAL REPORT

2 May 2018
Pursuant to section 46 of the *Children's Commissioner Act*, this investigation report and any other ancillary material provided with this report cannot be disclosed to any other party except to relevant service provider staff where the disclosure is required for case management, implementation of recommendations, review and training purposes; to a party that has been expressly approved by the Children's Commissioner; or where otherwise the disclosure is required or authorised by law.
INTRODUCTION

JURISDICTION

This investigation was conducted in accordance with section 10(1) (a) (ii) of the Children’s Commissioner’s Act 2016 (the Act), which empowers the Commissioner to conduct an Own Initiative Investigation.

The grounds for the investigation are defined under section 28(2) and (3) of the Act, which states that the Commissioner may investigate a matter on the Commissioner’s initiative only if satisfied that the matter may form a ground for making a complaint (irrespective of when the matter occurred and whether or not a complaint was made in relation to the matter).

FORMALITIES

Reference to Territory Families (the Northern Territory government agency responsible for child protection and, more recently, youth justice) in this report should be taken to include the Office of Children and Families, Department of Children and Families and Families and Children Services, noting that the department was renamed Territory Families on 12 September 2016. It is acknowledged that Territory Families are undergoing significant transformation to address long standing issues in child protection through the implementation of a substantial reform agenda. The issues identified in this investigation cover a period of 16 years and therefore has not been the sole responsibility of the current Department.

EXECUTIVE SUMMARY

On the 21 February 2018 I commenced an Own Initiative Investigation into the care and services provided to C1 and her family.

C1 is a child who was allegedly sexually assaulted in her home at the age of two years and nine months. Her injuries were significant and painful. This resulted in C1 transfer from Tennant Creek Hospital, to Alice Springs Sexual Assault Referral Centre (SARC) then onto the Adelaide Women’s and Children’s Hospital for further examination and surgery, including a blood transfusion. She tested positive for a sexually transmitted disease and was provided with post exposure Human Immunodeficiency Virus (HIV) medication. This was not the only violence that C1 had been exposed to, and experienced, in her short life.

C1’s family, including her four siblings, were well known to Territory Families (TF), NT Police, Department of Education, and the Department of Correctional Services, and other service providers in Tennant Creek. Each department and service has documented interactions with the family.

Child protection reports and Community Care Information System (CCIS) information relating to the WF children date from as early as 2002. The reports related to concerns regarding experience of, and exposure to domestic violence and parental substance
abuse, lack of education (attendance), neglect, emotional harm, physical harm and sexual abuse of the children. All possible harm types have been identified for these children. Fifty two child protection notifications were received for the children for the period 2002 to 2018. Of the fifty two notifications, twenty six were screened-in and proceeded to child protection investigations; thirteen were substantiated.

Significant contact with police had also occurred with her siblings and both parents, culminating in over one hundred and fifty recorded interactions. In addition, multiple convictions were identified in police records, including eight for aggravated assault (P2), and six for driving under the influence (P1). Prior to the most recent alleged sexual assault upon C1, police had also conducted investigations in relation to sexual and physical abuse upon her siblings, some of these investigations resulted in prosecutions, with the perpetrator incarcerated. Police records also detail thirty five domestic violence incidents recorded between P2 and P1. At the time of this investigation P2 was incarcerated in Alice Springs Correctional Facility for the aggravated assault of P1.

Prior to the birth of C1 TF had available to it, an abundance of evidence relating to the substantial neglect and numerous harms suffered by all of her older siblings. This included the fact that they themselves sought safety and regularly self-placed with different extended family to avoid returning to the care of P1 who was often intoxicated or impacted upon by the effect of family violence.

Tennant Creek is the fifth largest town in the Northern Territory with a population of just under three thousand people. Socio-economic data available on Tennant Creek paints a dire picture, with high unemployment rates, substance abuse and endemic crime.

This investigation examined the reported concerns relating to the family, child protection history, interactions and interventions by TF, police and other service providers.

A significant number of issues were identified in relation to TF’s service delivery to C1 and her siblings, with some service delivery issues attributable to the Northern Territory Police.

The examination of this particular child’s life highlights critical intervention points where the system has failed her and her siblings. This appears to be a result of inadequate and ad-hoc provision of services and support, the failure to appropriately assess cumulative harm, a culture of reporting and referrals with no or limited evidence of meaningful actions or outcomes. Other key issues include non-compliance with TF child protection policy and procedures, a lack of comprehensive risk and safety assessments and interventions were not commensurate to the significant needs of the children based on the level of trauma experienced. At the time of finalising this investigation report the OCC was advised on 5 April 2018 by the Child Protection, Medical Unit Head, Adelaide Women and Children’s Hospital, that C1 and her brother C5 have been removed from their mother’s care by the Department of Child Protection South Australia.

The system failures highlighted throughout this investigation report occurred over a significant period of time, and are not new issues. The Northern Territory child protection system has been over-reviewed, however the failures remain. The failures have been repeatedly identified in previous reviews and inquiries specific to the

These failures have been well documented and recommendations made for system reform to achieve collaboration and coordination across agencies and service providers. However, despite this becoming a common mantra this investigation has identified that agencies and service providers continue to work in silos to the detriment of the safety and wellbeing of children.

Sharing of confidential information regarding vulnerable children still represents a barrier to a holistic response to vulnerable children regardless of previous amendments to the Care and Protection of Children Act (CAPCA) to allow for this in certain circumstances. The balance between the privacy rights of children and their families versus the need for service providers to access information to protect children is always considered. The current legislation under the Information Act and the CAPCA creates confusion and a reluctance by individuals acting on behalf of government or government funded services to share information which often prevents timely interventions.

The concept for a better information sharing framework has been mooted for many years and recently emerged in the Royal Commission into Institutional Responses to Child Sexual Abuse as an area for immediate reform. While the Northern Territory Government has argued that the need to protect children and keep them safe supersedes their right to privacy, there is still no real change in this area despite the rhetoric.

If the system failures that led to the tragic and inevitable trauma that C1 experienced are not addressed urgently, it is likely that other children will be subjected to, and suffer from, similar traumatic experiences which will continue to affect them throughout their lives.

The way forward to resolve these issues is not limited by capacity and resourcing. It is essential that a new way of thinking and understanding of harm and abuse (including domestic violence) and the cumulative impacts it has on children. Timely, responsive and meaningful intervention must be provided to vulnerable children and their families if outcomes are to be improved. Or alternatively, where there has been no improvement in a family's circumstances, relevant action is required to safeguard children, including the application for protection orders and formalisation of kinship care arrangements when required.

This investigation demonstrates the need for increased governance and monitoring of child protection service delivery. A commitment and focus on a quality assurance and continuous improvement which acts on the known and frequently identified service system gaps and inconsistencies is imperative.

The immediate focus should not be about operational practice reforms which seek to adopt a new approach, new models, new tools and different frameworks. Rather, it is
about a sustained focus on existing structure and service delivery models and ongoing professional development and monitoring mechanisms that support the workforce to effectively implement and provide the required service. This ought to include continual improvement measures to consistently promote the intent of current policy and procedure as it relates to legislation and child rights obligations and responsibilities.

In accordance with the Northern Territory *Education Act* all parents must ensure their child is attending school or participating in an eligible option, unless the child is exempt or sanctioned from attendance under the *Education Act*.

At the age of six years a child is of compulsory school age. This compulsory requirement extends until a child has completed Year 10, or turned seventeen years of age, whichever comes first.

Department policy outlines that parents must be notified where a child is absent from school for a period exceeding three days, and a medical certificate must be provided.

Where a child demonstrates ongoing non-attendance, the parent may be subject to enforcement measures and may face legal consequences.

It was apparent during this investigation that these legislative requirements were not applied to the three eldest children. It was not evident what action the Department of Education took to address non-attendance and re-engage the children that had disengaged.

**CONDUCT OF INQUIRY**

The aim of this investigation was to determine if it was foreseeable that C1 was at risk of sexual assault and whether that risk could have been managed or mitigated.

In view of the limited timeframe involved (one month), the investigation primarily concentrated on the roles and actions of TF and the NT Police who have powers under the *Care and Protection of Children Act 2016*.

At the same time, the respective requirements of the *Care and Protection of Children Act 2016* was considered to determine if they were met. The investigation also sought information pursuant to section 35 of the *Children’s Commissioner Act 2016* from other agencies involved with the family to build an overall picture of the family’s history.

The Office of the Children’s Commissioner (OCC) analysed TF and NT Police client files and records in the context of relevant legislation, policy, and program and practice standards to gain an understanding of their involvement with the WF.
Education History
FINDING

It was foreseeable that C1 was at risk of harm and that risk could have been managed or mitigated.

This finding is reflective of the legislative definition of harm encompassing all of the harm types experienced by C1 and her siblings, culminating in the alleged sexual assault of C1 on the 15 February 2018.

The Care and Protection of Children Act 2016 defines harm to a child as;

(3) Harm to a child is any significant detrimental effect caused by any act, omission or circumstance on:
   (c) The physical, psychological or emotional wellbeing of the child; or
   (d) The physical, physiological or emotional development of the child.

(4) Without limiting subsection (1), harm can be caused by the following:
   (d) Physical, physiological or emotional abuse or neglect of the child;
   (e) Sexual abuse or other exploitation of the child;
   (f) Exposure of the child to physical violence.

The legal definition of foreseeability is where the consequences of an action can be predicted or anticipated. The foreseeability of the risk of harm is clearly identifiable throughout this report.

RECOMMENDATIONS

A number of the following recommendations were identified as a result of the Royal Commission into the Protection and Detention of Children in the Northern Territory. I fully support the implementation of these recommendations by Territory Families, with additional actions and timeframes in order to ensure timeliness of implementation to achieve required outcomes.

1. By 30 November 2018 Territory Families undertake an audit of the outcomes of notifications reported to the Central Intake Team\textsuperscript{14}. The audit will include an examination of the impact of the Central Intake reforms to be implemented from 1 July 2018. Additionally the audit will comprise;
   - a minimum sample of 200 notifications;
   - an analysis of the assessment process;
   - the application of the structured decision-making tools\textsuperscript{15},

\textsuperscript{14} Royal Commission and Board of Inquiry into the Protection and Detention of Children in the Northern Territory recommendation 32.2
• recording practices;
• call wait times; and
• the impact of the reform agenda subsequent audits completed for successive notifications in 6 monthly time frames.

2. Territory Families ensure that Central Intake is adequately resourced to accommodate peak periods including the provision of standby practitioners.16

3. Territory Families immediately develop a strategy to address the current backlog of overdue investigations,17 including a plan to manage investigations on an ongoing basis.

4. Territory Families immediately rectify data-recording processes so that any subsequent notifications in relation to a particular child are separately recorded notifications, so there is a clear recording of the total number of notifications and substantiations pertaining to that particular child.18

5. Territory Families immediately:
• adopt a consistent definition of cumulative harm
• develop internal guidance for practitioners regarding the assessment of cumulative harm,19 and
• implement consistent practice direction to incorporate a consideration of child protection history.

6. Territory Families develop a quality assurance framework to establish an ongoing review of child protection policy and practice, identify and address service gaps and inconsistencies, enhance critical decision making, and foster a culture of continuous improvement led by skilled staff with proven knowledge and experience.

7. The Territory Families child protection practice framework be finalised and implemented as a priority, supported by an internal oversight mechanism to ensure comprehensive and high quality practice that considers:
• a child-focussed, safety and best interest outcomes
• holistic risk analysis and safety planning
• parenting capacity, service engagement history and cumulative harm

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16 Royal Commission Board of Inquiry into the Protection and Detention of Children in the Northern Territory recommendation 32.7
17 Royal Commission and Board of Inquiry into the Protection and Detention of Children in the Northern Territory recommendation 32.9
18 Royal Commission and Board of Inquiry into the Protection and Detention of Children in the Northern Territory recommendation 32.5
19 Royal Commission and Board of Inquiry into the Protection and Detention of Children in the Northern Territory recommendation 32.6
• the effects of coexisting harm types, particularly neglect and/or substance abuse
• trauma-informed intervention with children and responses that address associated impacts, particularly children continually exposed to family violence

8. As a priority Territory Families provide the Children’s Commissioner with an implementation plan identifying timeframes for the nineteen recommendations detailed in the Internal Investigation Report: Territory Families Services Provided to C1 and her Family.

Recommendations specific to Northern Territory Police:

9. Northern Territory Police in consultation with Territory Families establish robust policies and procedures to ensure police comply with the requirements of the Care and Protection of Children Act as it relates to inquiries, investigations and reports, including a review of SupportLink and its effectiveness in compliance with section 26 of the Care and Protection of Children Act.

10. Northern Territory Police in consultation with Territory Families review the Child Abuse Taskforce (CAT) mandate to ensure current practice aligns with the operational objectives to deliver coordinated, holistic and integrated responses, including a focus on strategies that reduce the underlying causal factors of child abuse and neglect.

Recommendations for the Northern Territory Government:

11. The Northern Territory Government review the achievements of the Children and Families Standing Committee, and make relevant amendments to position the Committee to effect leadership and drive inter-departmental cooperation and communication to improve outcomes for children and families in the Northern Territory.

12. The Northern Territory Government ensure that recommendations of the pending productivity study of Northern Territory child services expenditure are implemented as a priority, and a robust funding framework implemented to deliver evidence based prevention and early intervention services which incorporate key performance indicators and monitor service outputs.

13. The Northern Territory Government review the objectives of the Family Safety Framework and its operations across the Northern Territory to achieve effective identification and coordination of services to high-risk families to address family violence.

14. The Northern Territory Government establishes a framework for professionals across a range of agencies, including child protection workers, police, teachers and health professionals, to share information about children in order to promote their safety. This will require legislation and the tools for professionals to use including the capacity to link data. The legislation should aim to improve early risk identification and intervention, to change a risk-averse culture in
relation to information sharing and to increase collaboration and sharing between child and services.

DEPARTMENT OF TERRITORY FAMILIES AND NORTHERN TERRITORY POLICE RESPONSE

On 12 April 2018 Territory Families and the Northern Territory Police were provided a copy of the draft investigation report for comment, their response was due 26 April 2018.

A meeting occurred on 20 April 2018, between my Office and senior representatives from Territory Families and the Northern Territory Police to discuss the draft report. Further discussions occurred on 23 April and 24 April 2018 between the Office of the Children's Commissioner and Territory Families.

Territory Families response dated 30 April 2018 accepted the recommendations and proposed that the finding be amended.

Territory Families response in part states:

‘Many of the recommendations for Territory Families are well aligned to current work in progress within Territory Families, including the introduction of a robust Practice Framework and a project to ensure enhancement of the Central Intake Team.

Territory Families commits to continue to brief you about progress in achieving these recommendations through quarterly reports and the Territory Families and Office of the Children's Commissioner fortnightly meetings.

Territory Families does not support this finding and submit that there was not sufficient evidence before the Commissioner to draw this finding, see Annexure A for the reasoning.’

The OCC response to the TF submission is at Attachment D with OCC responses in italics.
The NT Police response in part states:

‘...NTPF commenced reviewing the SupportLink arrangements related to
child abuse notifications....With your finalised report now imminent, NTPF
will meet with Territory Families to ensure that clarity exists for all
notifications made under section 26 of the Care and protection of Children
Act and that the policy, procedure and tools used related to notifications
and investigations are appropriate and rigorous.
The NTPF commenced reviewing the NTPF / Territory Families /
Australian Federal Police Child Abuse Taskforce in March 2018. This
review is still underway and will incorporate the direction set from
recommendation 12 in your draft report....the NTPF will consider the
recent Family Safety Framework Review together with your report findings
and consider and implement any changes that may be required to
strengthen arrangements under that framework.’

Ms Colleen Gwynne
Children's Commissioner
2 May 2018
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ATTACHMENT D

Territory Families Response to the Finding of Children’s Commissioner’s Own Initiative Investigation into the services delivered to C1 and her family

Territory Families refutes the finding that “it was foreseeable that C1 was at risk of sexual assault and that risk could have been managed or mitigated”.

AIM OF THE INVESTIGATION

Territory Families notes that the aim of the investigation cited on page 8 of the Children’s Commissioner’s report varies to the aim of the investigation notified to Territory Families in writing on 21 February 2018. The letter advised Territory Families that the intention was to conduct an “Own Initiative Investigation in relation to the care and services provided to C1”. The report states “The aim of this investigation was to determine if it was foreseeable that C1 was at risk of sexual assault and whether that risk could have been managed or mitigated”. Territory Families request that this be amended in the final report.

As per section 31 of the Children’s Commissioner Act the Commissioner is required to provide the Chief Executive of the responsible agency with notification of an inquiry. This notice was provided to the Chief Executive Officer of Territory Families on the 21 February 2018. The aim of the investigation was determined following the development of the investigation plan, separate to the notification of the inquiry itself.

INVESTIGATION & ASSESSMENT

When assessing risk a complex array of factors are considered. Factors such as type, frequency, duration and pattern of harm are assessed in conjunction with any family history of care and protection concerns. However, these factors cannot be considered in isolation of protective, support and environmental factors, which also determine the probability of future risk of harm.

Any assessment of the risk to children must be made objectively and without emotion, the evidence and factors considered must be credible and not based on comments from professionals who have very limited contact and do not have sufficient understanding of the history, context and background of the family. Some of the quotes in the report that are apparently relied on are from staff at the South Australian hospital after a very short time spent with the family in an environment when the family would understandably be traumatised or under stress.
In addition it is apparent that conclusions have been drawn in regard to the family situation and the adequacy of the child protection and other services response from people spoken to by staff of the Office of the Children’s Commissioner. The content of these conversations have not been made available to Territory Families and it is noted that no evidence of these concerns have been reported by these interviewees to Territory Families, despite mandatory reporting requirements. As such, it would not have been possible for this agency to determine the foreseeability of future events without this information.

The OCC agree that a risk assessment must incorporate a consideration of the named factors, including an assessment of the historical and ongoing nature of these factors to determine cumulative harm and foreseeability of future harm.

The examination of the risk to the child/ren undertaken by the OCC investigators was based on the documented evidence held by Territory Families, Northern Territory Police, Department of Education and health organisations. The OCC maintains that the approach to child protection practice must be objective, however a level of subjectivity is required in order to accurately assess the potential risk and harm to a child.

Evidenced conclusions were reached following the examination of information including expert opinion from those suitably qualified. Refer page 8 of the report which outlines the conduct of the inquiry.

DOMESTIC INCIDENTS

The information available to Territory Families demonstrated that the pattern of harm established in this family are predominantly in relation to ‘domestic violence incidents’. It must be noted that when domestic incidents are reported to NT Police, they are either categorised as a criminal incident involving actual or threatened violence, that is, there is an offender and a victim or they are domestic disturbances involving participants (neither of which is determined to be a victim or offender). These incidents do not involve weapons, injuries or evidence of an assault, threats or physical altercation. These incidents in this case were largely verbal disputes.

The OCC refuses to minimise the impact of family violence, whether verbal or physical.

This report clearly identifies the presence and impact of domestic violence upon the children, and a simple review of evidence demonstrates that violence was not limited to verbal disputes.

The impact of domestic violence upon children is now well established in research, including the long term effects on the emotional and physical wellbeing of children, particularly relevant is the risk for infants living with domestic violence noting that fear and trauma directly affect the infant’s brain development.20

SEXUAL EXPLOITATION

The history of sexual exploitation in the family does not form a sufficient pattern either by location, child, care arrangement, perpetrator or frequency, to foresee the likelihood of future sexual harm in relation to C1. There were no allegations of sexual exploitation for a child under the age of ten years to indicate that the two year old was at increased risk. It must be noted that except in relation to the older sibling C3, no other incidents of sexual exploitation were substantiated or investigated by police.

The physical location (house, urban or community) where the children were living when the alleged sexual harm occurred varied. The persons with the day to day care of the children varied. Although the mother retained legal responsibility for the children the older sisters were often in the day to day care of extended family members, at other addresses or communities, when the allegations of sexual harm were notified. The alleged offenders varied. The circumstances of the exploitation varied eg a sibling sexually active with a boyfriend or a non-resident male presenting at the home.

Unsubstantiated matters:

- 13/11/2010 – A male removed a sibling from the home. She had been left in the care of a 15 year old cousin. Child medically examined. No specific findings although the assessing Dr noted that the absence of injury does not of itself preclude the possibility of sexual abuse / assault.

Territory Families submits that this notification cannot be relied upon as a premise toward the finding of foreseeability of a sexual assault to C1, for the following reasons:

1. The male who removed the child was a relative
2. A child being cared for by a 15 year old relative is not unusual or in itself cause for concern
3. There was no evidence of a sexual exploitation
4. Absence of evidence of a sexual offence should not be taken as a preclusion for an offence

- 02/05/2013 – notification referred to strange men living at the house.

Territory Families submits that this notification cannot be relied upon as a premise toward the finding of foreseeability of a sexual assault to C1, for the following reasons:

1. Mother had left the home 4 – 5 weeks prior
2. The children were living with an Aunt

- 25/02/16 and 18/05/16 – notification that a sibling is culturally married and living in REMOTE COMMUNITY B.
Territory Families submits that this notification cannot be relied upon as a premise toward the finding of foreseeability of a sexual assault to C1, for the following reasons:

1. The nature of this matter bears no similarity to the alleged crime committed upon C1
2. The child living with extended family at the time and not with this male person

- 18/10/17 – notification that a male aged 40 – 50 years of age is buying young girls clothes and taking them to hotel room.

Territory Families submits that this notification cannot be relied upon as a premise toward the finding of foreseeability of a sexual assault to C1, for the following reasons:

1. The nature of this matter bears no similarity to the alleged crime committed upon C1
2. The sibling named in the referral not living at home at the time
3. The matter was not substantiated.

One of the siblings (C3) where there were concerns for sexual harm was a teenager and had commenced a sexual relationship with an older boy. This relationship resulted in the following notifications to Territory Families on 18/08/2016, 16/09/2016, 06/07/2017 and 12/07/17. The offender was subsequently convicted of a number of matters.

C1 testing positive for gonorrhoea could not have been utilised as an indicator to predict risk of this assault as the results of this test were not known until 2 March 2018 and recorded on the Notifiable Diseases System on 23 February 2018.

The OCC maintains that the likelihood of future sexual harm is also reliant upon the ability of the parent or person exercising parental responsibility to protect the child from harm and exploitation. Refer section 10 of the Care and Protection of Children Act. As stated at page 9 of the report at different periods of time, various carer’s (including extended family) adopted responsibility for the WF children, a number of which were unable to be clearly identified from the information recorded in CCIS. On occasion C1’s siblings also appeared to be homeless as they were choosing not to return to their mothers care.

The OCC refers to section 22 of the Care and Protection of Children Act which defines:

‘A person has parental responsibility for a child if the person is entitled to exercise all the powers and rights and has all the responsibilities for the child that would ordinarily be vested in the parent of the child.’

Territory Families inference that informal family placements and self-placing of children themselves with family members is an acceptable and viable safeguard mechanism is refuted.

The evidence outlines that a number of individuals adopted responsibility for the WF children at various points in time. Territory Families displayed passive acceptance that this sufficiently resolved child protection notifications and investigations.

The need for formalised and supported care arrangements for vulnerable children was a key
recommendation of the 2010 Board of Inquiry into the Child Protection System in the Northern Territory, Growing Them Strong Together. This recommendation was made as a result of significant criticism of the then practice known as ‘family way placements’, which saw vulnerable children informally placed with family members with limited support and monitoring and led to the children being placed at further risk. The recommendation was subsequently implemented by the department at the time.

CCIS contains contemporaneous records of the above detailed incidents and the transcription of these records in Territory Families response contain various inconsistencies, an example of this is the assertion that the male who removed the child was a relative when CCIS progress note dated 16 November 2010 states ‘the male involved is not related to the child, and did not have permission to take the child’

CONTEXT

This is a tragic and unforeseeable incident. This case is not dissimilar from many of the open CP Investigations across the Northern Territory from a risk perspective or when considering the proxy indicators of child protection, coupled with the entrenched poverty, homelessness, alcohol use and domestic violence. This demographic makes up almost all of Territory Families client base in the care and protection and youth justice areas.

The Aboriginal and Torres Strait Islander Women’s Task Force on Violence (2000) states, that ‘the high incidence of violent crime in some Indigenous communities, particularly in remote and rural regions, is exacerbated by factors not present in the broader Australian community…dispossession, cultural fragmentation and marginalisation have contributed to the current crisis in which many Indigenous persons find themselves; high unemployment, poor health, low educational attainment and poverty have become endemic elements in Indigenous lives’ (p.9).

Aboriginal women are the most victimised from intimate partner violence in the world (Kerr, Whyte & Strang, 2017). In the NT Aboriginal women are 40 times more likely to be hospitalised as a result of violent assaults, most of which are committed by heavily intoxicated intimate partners (Ramamoorthi, et al, 2014).

It is widely reported that alcohol is a prevalent factor in family violence incidents in the NT (NTG, 2015), with Anderson and Wild (2007) describing ‘rivers of grog’ in Aboriginal communities. Alcohol involvement is recorded in about 85% of domestic violence incidents reported to police, almost 20,000 alcohol related incidents each year (Kerr, 2016).

The above introductory comment contradicts the acceptance by Territory Families that harm to C1 was foreseeable.

Territory Families assertion that this case is not dissimilar to many child protection open investigations across the Northern Territory is of concern given the gravity and serious nature of the incident of 15 February 2018. The OCC believes it necessary that the
recommendations of this report be implemented to ensure that the circumstances surrounding the WF family are not repeated in the future.

IMPACT OF FINDING

If this finding is released it is likely to have an unreasonably adverse impact on Territory Families, including employees, the Government and the children and their families of the Territory. Without the benefit of all available information in the report, the finding is likely to be interpreted as a specific finding of failure by Territory Families, rather than of a decades old systems and resourcing issue.

Child Protection alone, cannot address the issues of poverty and disadvantage that exists in this jurisdiction, Territory Families is primarily responsible for a tertiary service in the service system and there are other secondary and universal services that have a large role to play in ensuring the safety and wellbeing of children. Significantly the child protection system exists to respond to safety concerns for children, equally other agencies within the law and order system exist to respond to people acting with criminal intent. As your report does not explore the history or circumstances of the perpetrator in this case it does not have a context or evidence that would lead to a finding that sexual abuse was foreseeable. Consequently the proposed finding could be read as suggesting that Aboriginal disadvantage is an indicator of child sexual abuse.

If staff were to apply the approach suggested/recommended in both the report then many children with open CP Investigations will enter the care of the Chief Executive Officer. This approach will set a precedent and is in direct conflict with the Care and Protection legislation, our reform agenda, Royal Commission recommendations and government policy. Further the suggestion Territory Families had enough evidence to enact statutory action to prevent the sexual assault from taking place, is not dissimilar to suggesting police should have the ability to stop domestic violence homicides.

Enacting statutory action is and must be a last resort; not just when Territory Families have the evidence to meet the criteria, it has to be the best option for safeguarding the children with a focus on supporting families to keep children safe and address protective concerns.

It is apparent that a consideration of the investigators of the OCC was ‘a history of a lack of adequate parental supervision’. The older children did not grow up in a stable home environment (they moved from family member to family member) without a consistent, protective adult to monitor their safety and wellbeing. On the basis of the history, there was a stronger likelihood of the children being at risk of emotional harm and/or neglect. Territory Families accepts this view and therefore requests an alternative finding of:

*It was foreseeable that C1 was at risk of harm and that risk could have been managed or mitigated.*
The OCC accepts the proposed amendment on the basis that the term harm gives a clear legislative definition (contained in the CAPCA), which details the varied harm types and broad detrimental effect of the circumstances experienced by C1 and her siblings.

The OCC disputes that the report alludes to Aboriginal disadvantage being an indicator for child sexual abuse. For this particular family an inadequate assessment of cumulative harm, including the multiple risk factors that were present, comprising domestic violence, significant alcohol abuse, sexual exploitation and inadequate parenting in conjunction with a lack of formalised care arrangements led to this finding.

The OCC acknowledges that an interagency response is required in ensuring the protection of vulnerable children and families, which is stated in the report and reflected in the relevant recommendations.

The remainder of the concerns highlighted above have been alleviated by the amendment to the finding of the report.

REFERENCES

Aboriginal and Torres Strait Islander Women’s Task Force on Violence (2000) The Aboriginal and Torres Strait Islander Women’s Task Force on Violence Report, (Rev. Ed.), Brisbane: Department of Aboriginal and Torres Strait Islander Policy and Development.


