Own Initiative Investigation Report
Services Provided by
Territory Families and carer FC to
C2 and C1, C3, C4 and C5

REDACTED FINAL REPORT

14 February 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.
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JURISDICTION

This investigation was conducted in accordance with section 10(1) (a) (ii) of the Children’s Commissioner’s Act 2013 (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 Department of Children and Families and Families and Children Services, noting that the department was renamed Territory Families (TF) on 12 September 2016.

PRELIMINARY ENQUIRY

In November 2017 a preliminary enquiry was conducted pursuant to section 28(3) of the Act. As a result the Commissioner determined an Own Initiative Investigation be conducted. The initial overarching aim of the preliminary inquiry was to review the standard of care provided by FC (FC) an authorised carer with TF. This required a review of case management, as well as a review of the level of monitoring of the safety and wellbeing of children placed in FC’s care. This also included an assessment of the adequacy of investigations conducted by TF in relation to formal complaints regarding the safety and wellbeing of children placed in the care of FC.

Following an assessment of all children that were in the care of the TF Chief Executive Officer (the CEO) and placed with FC, five children were subject to reports of abuse in her care that warranted investigation. This investigation also included a review of the following: child protection history for FC and her daughter MC; the carer assessment process; the carer re-authorisation process; case management; and four notifications received and ten investigations conducted by TF.

SUMMARY OF INVESTIGATION FINDINGS

It is acknowledged that placement decisions are often made in emergency situations or dictated by what placements are available at the time. However, these pressures should not impact upon carer assessments, ongoing carer management and support, and consideration of the suitability of the placement. This investigation has highlighted the need for an appropriate level of vigilance when undertaking carer assessments with a focus on the child’s needs. In particular, informed input regarding support and planning to ensure any concerns regarding the wellbeing of the child are identified and actioned promptly.
Throughout the investigation it became evident there was an abundance of information documented on the Community Care Information System (CCIS) regarding FC; the information was conflicting and should have prompted further inquiries regarding the suitability of FC as a suitable carer. It is the view of the Office of the Children’s Commissioner (OCC) that there were a number of early and ongoing indicators that should have brought into question the ability of this carer to provide a safe and stable environment for any child.

If a review of historical child protection records and information related to FC was conducted, including contradictions and concerns raised by police, health professionals, and TF staff, the decisions regarding her suitability as a carer would have been brought into question. Child protection reports and CCIS information relating to FC's biological children date from as early as 2003, and other children in the care of FC from 2012 when she was a carer for Life Without Barriers. The reports related to concerns regarding hygiene, neglect, harm and FC’s state of mind. All of these matters are recorded in CCIS, and was therefore available to TF prior to the 2014 authorisation of FC. Additionally, a review of FC’s TF Client Services file (paper file) documented thirty contacts with FC in the NT during the period 1981-1985 for financial assistance and a further one on 7 July 1982 for suspected child abuse (which was not substantiated).

TF continued to place children with this carer, while there were ongoing 'child concern in care' investigations pursuant to s84A and s83B of the Care and Protection of Children Act (CAPCA). There were also inconsistencies in the response to the ‘child concern in care’ investigations including removal of some children as a result of concerns for their welfare, whilst leaving a young and vulnerable toddler in the placement despite the fact 10 different ‘child concern in care’ investigations had occurred. Two of the investigations related to the safety and wellbeing of the toddler.

The investigation found that, in breach of TF’s own policy, it ‘rationalised’ a resolution of two investigations based on the fact that the children were no longer residing in this placement with FC. Also in breach of its own policy¹, TF failed to consider all children residing in this placement when a child protection notification was received.

It is evident that TF failed to translate its policies and procedures into appropriate actions to ensure the safety and protection of the children. There was an absence of proper case management and carer assessment, which resulted in children being put at risk.

It was also apparent during the investigation that TF failed in its basic record keeping requirements. For example, many of the records and documents viewed by the OCC had incorrect dates, incorrect names of children, incomplete reports, conflicting or incorrect information, CCIS records were not updated and there were no Placement Agreements for some periods of respite care.

During the investigation it was noted that FC

¹ Concerns About The Safety Of Children In Care
INVESTIGATION SCOPE AND METHODOLOGY

The November 2017 preliminary inquiry determined an Own Initiative Investigation would be conducted in accordance with section 28 (2) of the Act.

This investigation involved:
- A review of the TF pre-screening, assessment and re-authorisation process for carer FC
- A review of the Life Without Barriers carer screening and assessment process for FC
- A review of relevant TF legislation, policies, procedures
- A review of CCIS
- A review of FC’s paper files kept by TF
- A review of five children that resided in placement with this carer that warranted further investigation during the period 26 September 2014 to 3 April 2017
- Five other children that resided with this carer during the period 3 June 2012 to 15 December 2015
- A review of TF documentation and records relating to FC and MC (daughter) including child protection notifications and investigations

There are 10 relevant Child Protection investigations for the period 2015 to 2016, which are summarised in the following table:

<table>
<thead>
<tr>
<th>Intake</th>
<th>CP Investigation</th>
<th>Outcome</th>
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</thead>
<tbody>
<tr>
<td>5/11/2015</td>
<td>C1 CPINV #</td>
<td>Not Substantiated</td>
</tr>
<tr>
<td>Physical Abuse</td>
<td>C2 CPINV #</td>
<td></td>
</tr>
<tr>
<td>Siblings C1 (</td>
<td></td>
<td></td>
</tr>
<tr>
<td>yrs.) C2 (</td>
<td></td>
<td></td>
</tr>
<tr>
<td>yrs.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12/01/2016</td>
<td>C1 CPINV #</td>
<td>Not Substantiated</td>
</tr>
<tr>
<td>Neglect</td>
<td>C2 CPINV #</td>
<td></td>
</tr>
<tr>
<td>Siblings C1 (</td>
<td></td>
<td></td>
</tr>
<tr>
<td>yrs.) C2 (</td>
<td></td>
<td></td>
</tr>
<tr>
<td>yrs.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23/11/2016</td>
<td>C3CPINV #</td>
<td>Substantiated</td>
</tr>
<tr>
<td>Neglect</td>
<td>C4CPINV #</td>
<td></td>
</tr>
<tr>
<td>Siblings C3 (</td>
<td></td>
<td></td>
</tr>
<tr>
<td>yrs.) C4 (</td>
<td></td>
<td></td>
</tr>
<tr>
<td>yrs.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23/11/2016</td>
<td>CPINV #</td>
<td>Not Substantiated</td>
</tr>
<tr>
<td>Neglect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C5 (</td>
<td></td>
<td></td>
</tr>
<tr>
<td>yrs.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>02/12/2016</td>
<td>C3CPINV #</td>
<td>Substantiated</td>
</tr>
<tr>
<td>Neglect and</td>
<td>C4CPINV #</td>
<td></td>
</tr>
<tr>
<td>Emotional Harm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Siblings C3 (</td>
<td></td>
<td></td>
</tr>
<tr>
<td>yrs.) C4 (</td>
<td></td>
<td></td>
</tr>
<tr>
<td>yrs.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>02/12/2016</td>
<td>CPINV #</td>
<td>Substantiated</td>
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<tr>
<td>Neglect and</td>
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<td>Emotional Harm</td>
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<tr>
<td>C5 (</td>
<td></td>
<td></td>
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<tr>
<td>yrs.)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The out of home care (OOHC) placement with FC is the only placement relevant to the investigation for the period 3 June 2012 to 3 April 2017.
CARER ASSESSMENT AND RE-AUTHORISATION

FC was approved as an authorised general carer with TF on 24 July 2014, prior to this she was approved as a carer from 26 September 2011 with Life Without Barriers (LWB). She was re-authorised as a carer with TF for the period 15 July 2015 to 14 July 2017.

The assessment process for TF is managed by the Carer Assessment and Support Team (CAST), who conduct assessment checks in accordance with the Authorised Carer Assessment Procedure, which necessitates the following pre-assessment screening checks:

1. Australia wide Police check
2. Working With Children clearance (WWCC)
3. Child protection history check
4. Medical assessment
5. Referee Reports
6. Home Environment safety check
7. Current / prior caring experience referee report.

A review of the assessment process raised concerns for the OCC regarding the following:

- the adequacy of child protection history checks
- medical assessment versus self-reported history
- the conduct of carer assessment interviews
- declaration of Aboriginality
- inadequate assessment of information available to TF, by CAST

It appears that the child protection history recorded for FC’s biological daughter, MC, was overlooked due to pre-screening checks not being conducted in accordance with the TF Authorised Carer Assessment procedure. Discrepancies in relation to the information provided by FC in the LWB and TF carer assessment interviews, and medical checks, were also not detected.

If due diligence had been applied at the time the initial carer assessment was undertaken, patterns of behaviour in relation to the carer could have been identified, and which would likely have resulted in FC’s application being rejected. At a minimum, a higher level of case management and support should have occurred, particularly in response to the notifications regarding this carer in late 2015. Each issue viewed in isolation may not raise concerns, however consideration of all the evidence and notifications would very likely have resulted in a different outcome regarding authorisation and re-authorisation as a carer.

This is based on the following:

Medical - FC undertook three medical checks, one for Life Without Barriers on 31 August 2011 and two for TF (25 January 2011 and 29 May 2014). With the exception of a stabilised condition of hypertension and hypercholesterolemia noted on the medical dated 29 May 2014, no other physical or psychological conditions were reported. The OCC identified that FC failed to disclose several medical issues she had self-reported during her assessment interviews with Life Without Barriers and TF. The information reported by FC included:

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2 Document provided to TF on 2 November 2011 via email
3 Document provided to TF on 2 November 2011 via email
4 Dept. of Children and Families Carer Assessment Report 3/7/2014
Aboriginality - the definition of Aboriginal as prescribed in the CAPCA is:

**Aboriginal** means:

(a) a descendant of the Aboriginal people of Australia; or

(b) a descendant of the indigenous inhabitants of the Torres Strait Islands.

On three different occasions (x1 LWB and x2 TF) FC completed a carer application form, where she nominated that she was Aboriginal. Conversely, during the same process as part of the interview component she stated she was born to parents who moved from [ REDACTED ] to Australia and clearly articulated in her interviews (initial carer and re-authorisation) with TF that she was not of aboriginal descent but rather had sound knowledge of aboriginal culture. There is no evidence that these discrepancies were ever queried.

The OCC also identified recording anomalies on CCIS where FC is recorded as both a non-Aboriginal Carer and Aboriginal Carer depending on which child’s records were reviewed. A number of the care plans reviewed by the OCC rely on FC’s disclosure as being Aboriginal as meeting the children’s cultural and identity needs.

**Carer Assessment Interviews** - a comparative review was undertaken of the initial carer assessment interviews conducted by LWB and TF (noting that TF were provided with a copy of the LWB assessment on 2 November 2011). FC provided very detailed accounts of her life during these interviews including...

**Child Protection Checks** - these were conducted on three occasions by TF for FC and on one occasion for MC (daughter).

On 26 September 2011 checks were conducted in NSW, WA, NT, and QLD with the result that no child protection history had been recorded.
On 21 March 2014 checks were conducted in WA and the NT. There was no child protection history recorded in the NT, however, the WA Department of Child Protection and Family Support advised that there had been four contacts for [redacted].

The re-authorisation report dated 10 June 2015 outlined that a further CP check was required on 12 June 2016. A review of TF records found no evidence that this occurred.

On 7 April 2017 a child protection check was conducted as part of the two yearly re-authorisation process. This check detailed a recorded CP history for FC as the person responsible for harm in five child protection investigations:

- CPINV [redacted] and [redacted] for neglect
- CPINV [redacted] and [redacted] for neglect and emotional harm
- CPINV [redacted] emotional harm

Following an OCC review of FC’s historical documentation held by TF, 30 contacts with FC were recorded in the NT during the period 1981-1985 (for financial assistance) and one on 7 July 1982 for suspected child abuse (not substantiated).

Despite CP checks being undertaken on four separate occasions (x3 FC, x1 MC) it appears that records which detailed six CP reports regarding FC’s biological child were not considered by TF until 6 November 2015, during a subsequent investigation into allegations of physical abuse (CPINV [redacted], discussed later in this report). A CCIS progress note dated 6 November 2015 stated:

“... during meeting both CM’s looked at carer’s history and discovered on CCIS a history with MC, all notifications screened out. Further follow up regarding initial assessment to consider if these notifications were addressed during assessment.”

The OCC investigation found no record or evidence of any further scrutiny or discussions by TF regarding these matters.

MC (daughter) undertook a CP history check on [redacted], and TF documentation stated there was no CP history recorded as a person 'believed responsible'. A review of CCIS by the OCC ascertained there had been six CP notifications to TF in relation to MC. [redacted] A comprehensive matrix in relation to the CP history is outlined in Attachment A. [redacted]
<table>
<thead>
<tr>
<th>Student</th>
<th>Test</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>John</td>
<td>80</td>
<td>B</td>
</tr>
<tr>
<td>Sarah</td>
<td>90</td>
<td>A</td>
</tr>
<tr>
<td>Mike</td>
<td>75</td>
<td>C</td>
</tr>
<tr>
<td>Lisa</td>
<td>65</td>
<td>D</td>
</tr>
<tr>
<td>Tom</td>
<td>85</td>
<td>A-</td>
</tr>
<tr>
<td>Emma</td>
<td>70</td>
<td>C+</td>
</tr>
</tbody>
</table>

The table above shows the test scores and grades of several students. The test scores range from 60 to 90, and the grades range from A+ to D. The students included in the table are John, Sarah, Mike, Lisa, and Tom. Emma's score is 70, which is a C+.
The information outlined in the above table was available to TF at the time of the initial carer assessment.

11 FACS Intake Form 11/11/2004
12 FACS Intake Form 13/9/2005
NOTIFICATIONS AND INVESTIGATIONS

A major component of this investigation consisted of assessing all notifications that were made to the TF Central Intake Team from 5 November 2015. In doing so, consideration was given to what was known by TF at the time of each notification, and the subsequent decisions and actions that were taken to safeguard the children placed with FC.

A summary of the notifications (via ‘intake’) is detailed at Attachment B. There were a total of four ‘intakes’ consisting of one for physical abuse, two for neglect and one for neglect and emotional harm.

C1 AND C2

Siblings C1 and C2 came into the care of the CEO on  under a Short Term Protection Order, following seven CP notifications pertaining to neglect and emotional abuse. The siblings were placed with FC for the period 2014 to 2016.

There were two notifications in relation to C1 and C2 during their placement: one in relation to physical abuse and one for neglect. This resulted in four CP investigations, and all were unsubstantiated.

In summary, issues identified by the OCC during C1 and C2’s placement include:

- Placement Agreements were not completed
- Inadequate home visits, due to no access to the carer’s dwelling
- Delays in responding to reported CP concerns
- Lack of due diligence and decision-making during TF planning meetings
- Breaches of the Concerns about the Safety of Children in Care Policy due to not including all children in the investigation who were residing at the placement, and the affected children were not interviewed as part of the investigation.
- Poor record keeping, incomplete documentation, and a failure to complete documentation in a timely manner (in one case – a delay of nine months)
- Response standards were not met
- The placement of other children with the carer during abuse-in-care investigations
- No identifiable justification for investigation closure.

Intake # 05 November 2015 - Physical Abuse

The first notification was received on 5 November 2015 regarding siblings C1 ( yrs.) and C2 ( yrs.) and related to physical abuse by FC (who was alleged to have slapped C2 across the face) and the carer’s daughter MC (holding C1’s head under water in the pool, threatening her with a knife and hitting her with a spatula as well as further threats of harm to C2). The notifier was TF Case Manager based upon information provided to him by C1. It was recommended the matter proceed to further investigation with a response required within 3 days, and that a CP investigation commence pursuant to s 84A (CPINV C2 and C1). On 6 November 2015 the Investigation Plan was completed and a Planning Meeting was convened on 9 November 2015. The meeting minutes dated 9 November 2015 (and the Investigation Plan) stated;

"Interview carer about concerns before deciding how to proceed further". "... it is likely that the children will be interviewed...."
The minutes also stated:

"Apart from the daughter of the carer, there is a of the carer who also resides in the home, and also a child – no one present knew if this was the carer's child or where they had come from, but they are not in the care of DCF.... A third child in care has just been placed with the carer, but no one has any further information re this, or how long it may be for" (emphasis added).

The OCC could find no records to verify that C1 or C2 were interviewed. The TF "Concerns about the Safety of Children in Care" policy states:

A s 84 Abuse in Care Allegation investigation will be completed within 28 days and must involve interviewing the child, and the individual/s believed responsible. Investigations that confirm that a child in the care of the CEO has suffered, is suffering or is likely to suffer harm or exploitation will be substantiated (emphasis added).

Additionally, the policy statement articulates that the Department must respond to all concerns for the safety and wellbeing of children in care in order to ensure that the child, and all other children in care, are safe and not at risk of harm (emphasis added). OCC enquiries established one of the two children referred to in the minutes was C5 (aged yrs. months), who commenced in this placement on 2015 (the date of the notification), however in relation to the other child the OCC could not find any CCIS record of any other child placed with the carer as at 2015. In breach of TF policy13 there is no evidence that either child was included or considered as part of the investigation.

Of further concern is that the CCIS records show that C9, yrs. months) was placed with this carer for the period 2015 to 2015 during an ongoing investigation.

CCIS progress note dated 14 October 2016 stated:

"Is it possible for you to review case and for C1 and C2? These cases are old and were received in November 2015...."14

The Investigation Summary Reports and General Case Close Summaries were finalised on 20 October 2016 (9 months later). Both documents recorded the investigation outcome in terms of the children having expressed their desire to reside with their kinship carer, which had occurred in April 2016. Neither document provided any clarification as to whether the complaints were substantiated or not. Contrary to TF policy15 requirements, the other children (C5 and one other unidentified child) referred to in the Planning Meeting minutes were not included or referenced as part of the investigation.

In the CCIS system under event, "Update CP Investigation", the investigation is noted as ending on 23 December 2015 with the outcome "no abuse or neglect found". Likewise, the Planning Meeting minutes dated 14 January 2016 in relation to a second notification about C1 and C2 concerning this carer, states:

"...discussed that there is a (sic) s84A from November 2015 in which the carer allegedly hit the children and the carer’s daughter (MC) (sic) had threatened them. The case has an outcome of no abuse or neglect found."

A review of CCIS detailed numerous face-to-face contacts with both the children and the carer during their placement. However, further scrutiny of these events revealed no evidence that any

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13 Concerns About The Safety Of Children In Care
14 Concerns About The Safety Of Children In Care
15 Concerns About The Safety Of Children In Care
of the TF contacts for the period 2014 to 2015 (the date of the first complaint) actually included a home visit wherein TF workers had entered the carer’s residence. The documented face-to-face contact with the carer and children occurred during family access visits, drop off and pick-ups for the children, and at TF offices. This arrangement appears to have been conveniently instigated by FC.

**Intake # 12 January 2016 - Neglect**

C1 and C2

On 4 January 2016 C1 and C2’s grandmother, reported via email to CM, that both children were staying with her on a respite placement. reported that:

“... the children are infected with lice, C2 has sores on his head, both are low on iron and the clothes provided by carer are a “bag of rags”. The children are not showering every day and C1 is paid $1 to change another child’s nappy who is also residing in the placement”.

Further it was alleged there were repercussions for C1 from the carer (FC) regarding the 5 November 2015 complaint and that she had been punished for lying.

On 12 January 2016 (8 days later) CM forwarded the email to the Intake Team who noted the current open CP investigations (s 84A - CPINV and ) from 6 November 2015 with respect to physical abuse concerns for both C1 and C2. An intake worker determined the matter should proceed to investigation pursuant to s 83B of the CAPCA with a response required within 5 days (CPINV C1; and C2). The Planning Meeting minutes noted the date the concerns were reported to the Department as 12 January 2016, whereas it should have been 4 January 2016, when the e-mail was first received by TF.

The investigation ‘General Case Closure Summary Report’ dated 27 May 2016 stated that the carer denied all allegations at interview on 1 March 2016 (approx. 2 months after the notification). The summary also noted that the children were interviewed (no date), and that they did not raise any concerns regarding the carer, however, they did say they would like to live with their maternal grandmother. The documents indicate that the rationale for closure of the investigation was that there was no evidence to suggest that the carer had caused harm to the children, and the children were no longer residing in FC’s care. CCIS progress note dated 28 January 2016 detailed a discussion between the CM and both children, wherein they were asked about their placement and the reason for not wanting to live with FC. The children advised it was ‘boring’ and there were no fun activities. This discussion occurred when the children were being transported by the CM to an access visit with their parents (28 days after the second notification).

A review of the Placement Agreements for both children while they were in the care of FC did not show any agreements in place with their grandmother (kinship carer located in ), for respite care for the period 2015 to 2016. It was noted there was an agreement in place commencing 2015 until 2016 with a carer (a non-government organisation), who contacted TF on 28 December 2015 querying why the children had not arrived for their placement. It appears there was some confusion within TF about where the children should be, however, following a discussion with FC it was established that on the children had gone into respite care with .
At this time C5 (  yrs.  months) was residing in the placement, and in breach of TF policy\textsuperscript{16} he was not included in this investigation, nor considered as being a part of the investigation.

\textbf{C3, C4, AND C5}

Siblings C3 (  yrs.) and C4 (  yrs.) came into the care of the CEO on \textbullet\textbullet\textbullet\textbullet\textbullet\textbullet\textbullet 2016 following significant concerns of cumulative harm across three states, dating back to 2008. There were extensive CP reports relating to neglect, and included lack of supervision, poor health and nutrition, sexual abuse, physical harm, emotional abuse and school absenteeism. The history also included concerns regarding parental substance use, domestic violence, parents’ mental health issues including suicidal ideation, self-harming and mother's diagnosis of \textbullet\textbullet\textbullet. In addition, C3 failure to thrive as a baby, and failure to attend medical appointments and treatment were also concerns. C3 has \textbullet\textbullet\textbullet and C4 was diagnosed with \textbullet\textbullet\textbullet\textbullet. The siblings were placed with FC from \textbullet\textbullet\textbullet\textbullet\textbullet\textbullet 2016 to \textbullet\textbullet\textbullet\textbullet\textbullet\textbullet 2016. There were three notifications regarding C3 and C4 during their placement for neglect and emotional harm, resulting in four child protection investigations. All were substantiated.

C5 (  yrs.  months) came into the care of the CEO on \textbullet\textbullet\textbullet\textbullet\textbullet\textbullet 2014 following evidence of family violence in the home, the use of inappropriate physical discipline by C5 mother and \textbullet\textbullet\textbullet\textbullet\textbullet\textbullet\textbullet\textbullet cumulative harm, neglect, and alcohol and substance abuse by his mother. C5 is subject to a long term parental responsibility order until \textbullet\textbullet\textbullet 2031 and as at the time of writing this report has been in six different placements since coming into the care of the CEO.

C5 was in a placement with FC for the period \textbullet\textbullet\textbullet\textbullet\textbullet\textbullet 2015 until \textbullet\textbullet\textbullet\textbullet\textbullet\textbullet 2017. There were five notifications to TF about FC during C5’s placement, which resulted in ten CP investigations. Two of these were in relation to child safety concerns regarding C5; one was not substantiated, and the other was substantiated.

Issues identified by the OCC during C3, C4 and C5’s placement include:

- Inconsistent decision making by case managers during CP investigations, particularly regarding health and safety concerns at the carer's residence, and decisions to remove children
- Breach of the Concerns about the Safety of Children in Care Policy, by not including C5 in investigations following notifications reported on 5 November 2015 and 12 January 2016
- Delays in responding to reported CP concerns
- Poor governance and decision making during the planning meetings. In particular, delayed meetings and incomplete information being presented (and relied upon) regarding subsequent notifications and previous investigations
- Breach of the Concerns about the Safety of Children in Care Policy, as an investigation planning meeting was not held relation to Intake #\textbullet\textbullet\textbullet\textbullet\textbullet\textbullet on 2 December 2016.
- Response standards were not met, and
- Deficient record keeping, incomplete documentation, and failure to complete documentation in accordance with the timeframes specified in the Concerns about the Safety of Children in Care Policy.

\textsuperscript{16} Concerns about the Safety of Children in Care
Intake # 23 November 2016 - Neglect

On 16 November 2016, [redacted] made a notification to CM [redacted]. There was a second notification from [redacted] (C3 and C4's mother) on 22 November 2016. CM [redacted] advised the intake worker that the Case Support Worker had told her the "carer's home is not tidy or hygienic with a very hazardous (sic) yard". The CM informed the intake worker that she was yet to visit the house but had been recommended to do so as there were protective concerns for the children in the home.

[redacted] advised the CM that the children were bringing mouldy and dehydrated food to [redacted] and had told her they only had an orange for breakfast and after questioning the children about what they eat at home she determined it was not nutritious.

[redacted] advised that C4 had told her they were kept outside for long periods of time, they were always hungry and that he had been stealing food. The carer had found out and told him people used to get their hands cut off for that (stealing food), and the carer was showing the children pictures of evil clowns and told them clowns will come to get them if they do anything wrong. It was further alleged the carer was failing to provide adequate nutrition.

In accordance with TF policy C5 was included in the notification by the intake team as he was residing in the placement. The intake assessment determined the notification would progress under s 83B of the CAPCA with a 'Priority 3' designation, requiring a response within 5 days (CPINV C4, C3 and C5).

A Planning Meeting was convened on 7 December 2016 (15 days later). The OCC notes that at this time a second notification in relation to these three children had been received by TF on 2 December 2016 (intake # [redacted]), and this notification was not discussed or considered during the meeting. The minutes reflect the following discussion;

A/Team Leader [redacted] and CM [redacted] for C5 advise

"the report is not in relation to C5, there are no issues for him and they had discussions with the Central Intake Team and he should not have been included in the intake notification. Also the [redacted] have not observed rotten food for C5".

The decision was made to close the investigation (CPINV [redacted]) in relation to C5. The CCIS progress notes dated 29 November 2016 detailed the Case Worker's visit to [redacted] Childcare Centre, which documented that they provided morning tea, lunch and afternoon tea to C5.

The CAST advised the meeting attendees that

"there were no previous concerns about neglect, however there was a previous s 83b (sic) report that the carer slapped a child's face and a report of a [redacted] using a spatula to hit a child when behaviors had escalated around a pool".

There does not appear to be any reason why CAST were unaware that the matter they were referring to was investigated pursuant to s 84A (intake# [redacted]), and:

- why they appeared to have failed to consider the previous s 83B investigation (intake #[redacted] - neglect), and
- why they also appeared to have failed to consider the new notification received 2 December 2016 (also for neglect - see intake #[redacted])

The Casuarina SC (case management) determined that the children were to be interviewed that day (7 December 2016) and the carer at a later time, in separate interviews. They also raised concerns...

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about the reports from last year, and stated that “this new intake raised new harm”. It was reported that the placement team was aware of the previous reports but unsure of the outcome.

On 28 November 2016 Case Worker [redacted] conducted a home visit for face-to-face contact with C5 and the carer. CCIS progress notes for this event detailed “the house was cleaned, lawn not level and C5 was happy”.

On 7 December 2016 CM [redacted] collected C3 and C4 from school and they attended the Casuarina Office where the children were asked to complete the “3 houses exercise”\(^1\), in which C4 refused to participate. C3 explained that the ‘house of worries’ (which reflects the placement) had a ghost in the room, and she said that when C4 runs away from the placement the carer does not look for him and won’t try and get him back.

At 4pm on [redacted] 2016 Team Leader [redacted] and CM [redacted] conducted a home visit to meet with the carer and determined that the condition of the premises posed a health and safety risk to the children due to the standard of hygiene and level of clutter in the house. The lounge room was grotty and unhygienic, there was cobwebs on walls, and dust and dirt on the floor and furniture. The children slept in sectioned-off areas in the lounge room separated by curtains. The beds did not appear to be normal sized single beds, and both rooms smelt strongly of urine. The carer’s daughter, MC, was very aggressive towards TF staff and got so angry she left the room and went outside.

Following this visit, and C4’s disclosure that he had been physically disciplined in the placement, the Team Leader was so concerned she directed a Placement Respite Form (PRF) be actioned, to identify another placement for C4 and C3. The Team Leader also referred to the previous disclosures from other children who had been placed with this carer\(^1\).\(^2\)

There was no reference to C5 being sighted during this visit, and nor does the documentation reveal that he was considered at risk and should also be removed from this placement. Noting that C5’s investigation was closed at the Planning Meeting the morning of the home visit, the OCC considers this to be a significant oversight as C5 was [redacted] years old, which obviously makes him highly vulnerable and at substantial risk of further harm.

The Investigation Summary for C3 and C4 created on CCIS on 9 December 2016 and approved on 17 January 2017 stated that neglect against C3 and C4 was substantiated. The investigation reports detail that following an inspection of the house by the Team Leader and the CM it was determined the premises posed a health and safety risk to the children, and that the carer had failed to provide the children with adequate food and clothing and had not provided a safe, appropriate clean home for the children.

The General Case Closure for C3 and C4 was created on CCIS on 20 January 2017 and finalised for C3 on 30 May 2017 and C4 on 17 July 2017 – both documents are incomplete. The documents do not record a case-start or end-date, and there is no outcome recorded i.e. substantiated or not. The rationale for closure states:

\(^1\)The ‘3 houses exercise’ enables social workers to discuss a child’s likes/hobbies/strengths/protective factors, dislikes/worries and risks related to the child and dreams/hopes/wishes.
“Investigations are complete, the children have been moved from the placement, the case has now been opened as an 84A and the children are subject to case management through current open sub care case”.

C3 and C4 were placed in respite care with a different carer on [redacted] 2016.

There is no investigation summary for C5, however there is a General Case Closure summary dated [redacted] 2016 (the same day it was decided to remove C3 and C4 from the placement), which states:

“Through my interview and investigation, there was no information to suggest that C5 has suffered neglect or likely to as a result of the acts or omissions of FC”.

Details of a home visit conducted on 28 November 2016 were also included in the summary.

It is of significant concern to the OCC that in the view of one CM there were no issues identified during the home visit on 28 November 2016 and yet nine days later on 7 December 2016 another CM and her Team Leader were so concerned following their home visit that they immediately sought an alternative placement for C4 and C3.

C5 remained in the placement.

CCIS records state the response standard was met for C5, which is clearly incorrect. Also, the response standard for C3 and C4 was not met.

**Intake # [redacted] 02 December 2016 Neglect**

The notification was made by [redacted], Mother of C3 and C4, in relation to both children. In accordance with TF policy C5 was included in the intake as he was also residing in the placement. The notification raised concerns regarding the “…children’s personal hygiene, they were not being fed, they were begging their carer for food, wearing ripped and dirty clothes, [redacted] the children presented with urine soaked clothes, the carer turns the power off…” The children had told their mother they did not want to return to the carer. [redacted] also advised that the problems emerged one week after placement with FC.

The intake worker spoke to Case Support Worker [redacted] who confirmed that she had concerns regarding the children’s presentation as their clothing was stained, had holes and did not fit, and their hair was oily, and that when she had picked them up on 1 December 2016 they both smelled strongly of urine.

The intake worker met face-to-face with the Palmerston Long Term Care Team Leader [redacted] who reviewed notes with the CM about the placement and advised that nil concerns were recorded. This is despite the previous notifications made on 12 January 2016 and 5 November 2015. The intake assessment determined the notification would proceed to investigation (CPINV [redacted] C4, [redacted] C3 and [redacted] C5) pursuant to s 84A as a ‘Priority 2’ matter with a response required within three days.

Contrary to TF procedure no Planning Meeting occurred, and the CCIS progress note dated 9 February 2017 stated:

“There was no email notification from CIT to advise Practice Integrity of the 84A intake, therefore a case planning meeting was not held. Please refer to 83B cases # [redacted] and [redacted] for the meeting minutes”.

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As set out earlier in this report, this matter was not considered or discussed at the Planning Meeting held on 7 December 2016, 5 days after this complaint was received.

The children were interviewed on 14 December 2016 (12 days after the second notification). TF workers observed the children to be of poor hygiene and they smelt strongly of urine. C3 had reported that she had not showered for three days due to having a cast on her leg: "[ ] does not help her when she wets herself, she can’t shower because of the cast on her leg and she has to clean herself with baby wipes, [ ] does not help her." The children were extremely frightened of the carer when disclosing their concerns and begged the TF workers not to tell the carer. They described the carer as cruel and that they were taken out of their beds at night and told the demons will come and get them. They said that she takes the kids “far out bush” and C4 was made to stand alone in front of the car headlights to wait for the demons (both children drew pictures of this experience). "[ ] puts hot sauce on the food, I don’t know which food has the hot sauce so I don’t eat it and [ ] says that clowns eat naughty people”. The carer also made C4 drink milk that had gone ‘off’, as a form of punishment for eating and drinking without her permission.

FC was interviewed on 14 December 2016 and said the following:

- the children’s shirts were stained but not dirty
- that when C3 came to the carer she was wearing nappies, however she is not incontinent.
- when C3 wet herself she did not change her “as I am not playing that game” (C3 is eight years old, has cerebral palsy and a cast on her leg)
- (regarding C3’s blisters) she did not notice it as C3 takes care of her own hygiene, and it is chaffing as C3 is a big girl and her legs rub together
- that she did not say the clown would get them, and that the children had seen clowns at a school assembly
- described the children as ‘her project’ and that she had goals to fix them

Throughout the interview the carer became visibly upset, raising the fact that she had been a foster child in care herself. The daughter (MC), who was also present during the interview, was unable to control her temper and told the TF workers they had no right coming into the home and telling them what to do, as they were looking after the children. The carer did not respond to the daughter’s behaviour.

On [ ] 2016 the CM and Investigation Officer visited the carer’s home. It was noted that the shower was a safety hazard, and the ceiling was reported to be close to collapsing due to water damage. The carer stated she would be contacting Territory Housing to request emergency housing due to the safety concerns. C5 was sighted during this visit, asleep in his room, which did not have a flyscreen on the window. The carer was distressed regarding the other children being removed (C4 and C3) and reported that the children had told her "they only made the allegations so they could return to their mother and they would do everything to come back to her".

It was reported by TF staff that the daughter became angry and started screaming and crying and was abusive to the TF staff, and then she abruptly left the residence. TF staff determined the current state of the house was physically unsafe for C5, and that the carer and her daughter were emotionally unstable such that there was a risk that C5 could be potentially harmed by this behaviour.

The investigation summaries for C4 and C3 created on CCIS on 28 January 2017, and approved on 9 March 2017, stated that neglect and emotional harm against C3 and C4 was substantiated. The report detailed that the carer had failed to provide the children with basic mandatory care.

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22 CCIS progress note 14/12/2016
personal hygiene, adequate nutrition and clothing, and had instilled fear in the children due to threats of harm. Further potential safety concerns were identified in house. It was noted that following an analysis of the carer’s responses to the investigation and the gathered information, it was evident that the carer lacked the education, empathy and insight to provide appropriate care and protection. The carer had not demonstrated a capacity to comprehend the effects of trauma, and did not have the ability to provide a safe, positive and nurturing environment. The carer demonstrated an inability to provide an appropriate emotional response to the children and appropriate behaviour management strategies for the children and her daughter (MC). Significantly, it was recorded that the carer’s behaviour has resulted in the children displaying emotional indicators of abuse.

It was also documented that previous investigations pertaining to other children in FC’s care indicate that the complaints were inadequately investigated by TF. This was due to the children being interviewed in the presence of the carer, or not being interviewed at all.

The investigation summary for C5 was created on 28 January 2017 and was approved on 9 March 2017. It stated that C5 was at risk of emotional harm and neglect if he remained in the placement with FC. Primarily, this was due to other children in the household reporting concerns of neglect and emotional harm, and potentially C5 had been subjected to the same environment. C5 was of an age where he was unable to articulate and communicate events in the environment, and due to his past trauma and abuse, he may not have understood that the behaviour displayed by the carer and her daughter was not acceptable. The potential safety concerns and hygiene conditions of the residence were also noted. The report recommended that the carer be provided with transparent feedback and education regarding her inability to provide the children with a safe, loving and nurturing environment. The report stated that FC’s ‘caregiver’ status be reviewed by CAST, and while that process was underway her registration as a carer was suspended and no further children were to be placed with her. A placement was to be found for C5 with carers who had experience in nurturing children who had experienced trauma. Finally, it was recommended that TF conduct regular unannounced OH&S checks on carer households to ensure the appropriate standard of care is provided to children in care. The investigation outcome was substantiated against FC for the child/ren being ‘at risk of emotional harm’.

General Case Closure summaries for all three children were created on 28 January 2017 and were approved on 31 January 2017 (prior to the Investigation summary reports being approved, which occurred in March 2017)

On 2016, C3 and C4 were removed from this placement and placed into respite care with another carer. C5 remained in the placement until 2016 (8 days later) when he was also placed with a respite carer.

The response standards were not met for this notification.

A request was made to TF requesting all documents relating to the recommendations contained in the Child Protection Investigation Summary report dated 9 March 2017. The recommendations and associated documents / findings in relation to the outcomes were as follows;

1. **The carer to be provided with transparent feedback and education pertaining to her ability to provide the children with safe, loving and nurturing environment.**

The carer was provided correspondence in relation to the substantiated s 84A investigation for C5, C3 and C4 on 16 March 2017, which summarised the concerns and advised that recommendations were provided to the OOHC, CM and the OOCH Division for consideration and
review. The OCC could not identify whether transparent feedback or education was provided to FC.

It is acknowledged that the substantiated investigations were discussed with FC during the re-authorisation process, which occurred in April 2017, however, this process was discontinued following FC’s withdrawal from the process.

2. FC’s caregiver status to be reviewed by the Carer Assessment and Support Team.

This review appears to have occurred as part of the carer re-assessment process in 2017, which, was discontinued following FC’s withdrawal.

3. Territory Families to resource a placement where the carers are appropriately educated in caring for children with disabilities and educated in nurturing children who have experienced trauma.

C5 was placed in respite care on 2016 until 2017, and he was then placed with a long-term carer, where he currently remains. C3 and C4 were placed together in respite care on 2016 and remain in this placement. The OCC could not identify any records or information showing that TF considered whether the carers were appropriately educated in caring for children with disabilities or children who have experienced trauma.

4. The children (C3 and C4) are placed together in placement as they are reliant on one another for emotional support.

C3 and C4 were placed together in respite care on 2016 and remain in this placement.

5. The children to be referred to ‘in care’ support services to assist with the management of trauma and psychological harm.

The children were referred to in-care support, however, it appears that they did not have the capacity to accept the referral at the time. TF records state:

"...therefore other options for therapy are being explored and both children will be referred for play therapy. C3 receives ongoing support from the Children’s development Team and all children receive ongoing support from case management"

C3 and C4 commenced play therapy on 2017 (6 months later) and attended sessions, which ceased on 2017.

ISSUES ARISING FROM COMPLAINT
The OCC identified five other children who were placed with this carer in the period 3 June 2012 to 15 December 2015. A review of CCIS records revealed that staff had concerns regarding hygiene and neglect for two of the children who were recognised as ‘high needs’ children. The first related to dental hygiene, where it was evident the child’s teeth had not been cleaned over an extended period, and the second was a failure to seek medical assistance when another child’s wounds were infected and hygiene standards in the carer’s home were deemed a risk for increased infection of another child’s wounds.

Another child, C9 (12 yrs.) was placed in respite care with FC following a physical assault upon her, at the time FC was being investigated by TF for a child protection notification regarding physical abuse.

A summary of the five children is detailed below.

**C6 (born 2003)**

C6 came into the care of the CEO on 2011, as a child with high support needs exhibiting highly challenging behaviours, including emotional highs and lows, and aggressive and sexualised behaviours. C6’s health issues included communicating by sign, and she was in a placement with FC for the period 2012 to 2015. For the majority of this time FC was a registered carer with Life Without Barriers. FC was unable to continue to care for C6 due to the child’s escalating behaviours, and she was placed in a residential care facility following an incident when C6 was removed from FC’s residence by police and ambulance officers on 2015. On 2015 C6 attended a dentist appointment where it was determined that she had heavy plaque on her teeth indicating that she has not had her teeth adequately cleaned in an extended period, nor had recent dental treatment. She was suffering from a tooth ache and required a filling.

**C7 (born 1994)**

C7 came into the care of the CEO on 2011 following reported concerns by RDH on C7’s admission to hospital for medical treatment for her pre-existing condition of Systemic Lupus Erythematosus. At that time she was significantly underweight and had untreated skin sores. The report stated that C7 was an inpatient at Royal Darwin Hospital and had lost
11kg in weight (during 2009 to 2010) and was not receiving her medication or getting assistance from family with basic hygiene. C7 uses a wheelchair to mobilize.

C7 was in a placement with FC for the period 2012 to 2012, who was a carer for Life Without Barriers at this time. A review of CCIS progress notes revealed the following:

- On 2012, Community Welfare Worker (CWW) recorded that she spoke to the school who advised ‘….while C7 was in respite care she was a lot cleaner ……that on some occasions C7 has been very smelly (stale urine and faeces) and that when the teacher cleaned C7 last week she commented that it felt so much better. It was highlighted that one day C7 came to school without any pads and she was menstruating at the time.’

- On 2012, TF raised the personal hygiene and lack of menstrual pads with FC who advised “C7 washes her front and she does her back, but she will give C7 a soapy facecloth and give her more private time in the shower and she doesn’t know what happened about the pads as she checks the bags.”

- On 2012, TF supervisor rang FC confirming plans for C7’s return to the next day. The CCIS progress notes state “FC confirmed that she had taken C7 to Medical Clinic……following writers observations and concerns for visible swelling to C7’s right foot…. “The writer has concerns regarding TCF following through having C7 available for appointment with the Clinic Nurse today despite C7’s foot being swollen and in need of medical attention. The writer’s concern is that FC would not have sought medical assistance for C7’s swollen foot without direction from the writer, despite plans for C7 to travel to community tomorrow.”

- On 2012, Aboriginal Community Worker (ACW) recorded the following: “……Writer received a phone call from FC….FC said that C7 said to her that her sore on her right ankle was hurting and it was very itchy. C7 told FC it felt like there were worms on her sore. ……..writer could hear C7 screaming in the background.”

Two hours later the ACW picked C7 up to take her to the clinic and reports that C7 looked distressed. “There was still an odour coming from her sore. FC said she could smell it as well…. The nurses put saline solution on her bandage to soften it ………and soaked C7’s foot to soften the bandages. When they got the bandages off her ankle a few maggots fell on the floor. When the nurse took all of the bandage of some more maggots were in the bandage. The sores on C7 ankle looked red and weepy although the swelling in her foot had gone down. It was reported that C7 had returned to on 2012 and had attended the clinic the same day to have her dressings changed, she returned to on 2012.

C7 turned 18 and as there was no adult guardianship order granted she returned to on 2012. On 22 January 2013 quotes were sought for respite care in Darwin for C7. Emails between OCF NRO Manager and discussed that this placement could occur with FC. Advised that he had discussions with the CWW who had voiced her concerns in relation to the condition.
of “FC’s place” regarding cleanliness and the possible risk to C7 regarding the infection of her sores\textsuperscript{29}. C7 passed away on 22 February 2015. Nothing in the CCIS notes indicate the cause of death.

C8 (born 2003)
C8 came into the care of the CEO on 2014 following involvement with TF over a number of years for issues of neglect, failure to thrive, unhygienic environment, medical neglect, homelessness (due to eviction) overcrowding, and inadequate adult supervision. C8 was in short-term placement with FC for the period 2014 to 2014. No issues were identified during this placement.

C9 DOB: 2012
C9 came into the care of the CEO on 2015 following escalating domestic violence in the home, issues relating to her mother’s alcohol use, and ultimately an assault on C9 by her mother’s partner, for which she was hospitalised. C9 was in a placement with FC for the period 2015 to 2015. As raised earlier in this report it is of significant concern that C9 was placed with FC while the carer was subject to an ongoing s 84A investigation.

C10 (DOB 2003)
C10 came into the care of the CEO on 2012 as he was considered to be at significant risk of harm, due to ongoing inadequate supervision whereby he had been left unsupervised for long periods of time. There were also behavioural concerns at school, and health concerns due to a lack of medical attention. His physical home environment was deemed unsafe as the house was often occupied with large numbers of intoxicated adults. The house was unhygienic, with dog faeces inside, and inadequate sleeping arrangements.
C10 was in a placement with FC for the period 2014 to 2014. He absconded from the placement on 2014 and did not return.

CONCLUSION

TF failed in their duty of care to provide C1, C2, C3, C4 and C5 the required care and protection to safeguard them from harm. This was primarily due to being placed with a carer who had not been subject to a proper assessment process.

In addition, CP investigations were not conducted in accordance with policy and procedure, and were sometimes incomplete\textsuperscript{30}. Subsequently, the risks regarding this carer were not accurately captured. This, combined with the lack of proper case management, left the children extremely vulnerable and resulted in further neglect and harm. The information within CCIS, despite its limitations, is overwhelming with respect to early and ongoing indicators regarding FC.

\textsuperscript{30} Concerns about the Safety of Children in Care and Authorised Carer Assessment Procedure
The OCC notes TF did not revoke FC’s authorisation, but rather, her authorisation was cancelled following her decision to cancel her registration as a carer while she was attempting to gain re-authorisation.

The OCC has concluded that:

1. TF’s decision to authorise FC as a carer was not verifiably sound.

2. TF’s decision to re-authorise FC as a carer was not verifiably sound.

3. TF failed in its basic record keeping requirements as many of the documents reviewed for this report showed:
   - incorrect dates
   - incorrect names of children
   - incomplete reports
   - conflicting information
   - incomplete records on CCIS
   - absence of Placement Agreements, and
   - documentation taking months to complete.

4. TF has not complied with policy and procedure when conducting investigations pursuant to s 83A and s 84B, especially relating to the care provided by FC.

5. TF did not adequately case manage C1 and C2 whilst in the care of FC.

6. TF did not protect C1 and C2’s best interests, and contrary to the principles of the CAPCA allegations against FC were not investigated adequately, as the children were not interviewed in one investigation, while being inappropriately questioned in the presence of the carer in the second matter.

7. TF did not adequately case manage C3 and C4 whilst in the care of FC.

8. TF did not protect C3 and C4’s best interests, contrary to the principles of the CAPCA.

9. TF did not adequately case manage C5, whilst in the care of FC, as he was not included in four investigations in breach of TF policy, and the standard of care applied to other children who were removed from the placement, was not extended to C5.

10. TF has not ensured C5’s best interests, contrary to the principles of the CAPCA.

11. TF failed to investigate the actions of the carer after the removal of children from her care, which resulted in the continued placement of other children into her care.

12. TF breached policy and procedures by not including C5 in the first two complaints (intake numbers and ).

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32 Concerns about the Safety of Children in Care
33 Concerns about the Safety of Children in Care
13. TF’s decision to leave C5 (4 yrs.) in the care of FC following substantiated investigations, was unsound and careless.

14. TF home visits and face-to-face contacts were deficient as they rarely involved entering the residence of FC, particularly as previous concerns complaints were raised about the condition of the home.

15. There was inadequate follow-up or education and training for staff when shortfalls were identified in case management or investigations.

16. There do not appear to be any protocols between TF, Safe NT (including the screening authority) regarding the sharing of information to ensure appropriate screening for the issuing or revocation of Working With Children cards (also known as the Ochre Card).

17. There was inadequate and inconsistent case management by TF in relation to the response to concerns about the safety of children in care.

**RECOMMENDATIONS**

1. Establish a holistic *Child Concern in Care* response\(^1\) to:
   a. coordinate effective investigations following the identification of concerns about the safety of children in care;
   b. ensure consideration of previous notifications and investigations, irrespective of the outcomes;
   c. ensure all children residing in the placement are included in the investigation, regardless of whether the child is in the care of the CEO or not.
   d. review continued placements (respite, short term and long term) of additional children in care where a carer is subject to a current investigation; and
   e. coordinate casework including intensive actions to monitor placements.

2. Territory Families ensure that as part of the reviews of authorised carers the process includes:
   a. interviews with all children in the placement with the carer, not in the presence of the carer\(^2\).
   b. a comprehensive assessment and records on the quality of the care provided by the carer or care service.
   c. documented risk management plans to address any risks identified.
   d. at least annual review of risk management plans as part of carer reviews and more frequently as required\(^3\)

3. Territory Families implement a Quality Assurance framework as the first step in working towards mandatory accreditation to:
   a. incorporate compliance with the Child Safety Standards identified by the Royal Commission into Institutional Responses to Child Sex Abuse

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\(^1\) Child Protection Systems Royal Commission Report (South Australia)
\(^2\) Royal Commission into institutional Responses to Child Sex Abuse recommendation 12.7
\(^3\) Royal Commission into institutional Responses to Child Sex Abuse recommendation 12.6
b. extend accreditation requirements to both government and non-government out-of-home-care service providers\(^4\)

4. Territory Families and out-of-home-care service providers ensure that training for foster and kinship carers, residential care staff and child protection workers includes an understanding of trauma and abuse, the impact on children and the principles of trauma informed care to assist them to meet the needs of children in out-of-home-care, including children with harmful sexual behaviours\(^5\)

5. In addition to a National Police Check, Working With Children, and referee checks, authorisation of all foster and kinship carers and all residential care staff, Territory Families develop an action plan, including timeframes to examine and commence:
   a. community services checks\(^6\) of the prospective carer and any other adult household members of home based carers

6. Territory Families, in collaboration with out-of-home-care service providers and peak bodies, should develop resources to assist service providers to:
   a. provide appropriate support and mechanisms for children in out-of-home-care to communicate, either verbally or through behaviour, their views, concerns and complaints
   b. provide appropriate training and support to carers and caseworkers to ensure they hear and respond to children in out-of-home-care, including ensuring children are involved in decisions about their lives
   c. regularly consult with children in their care as part of continuous improvement processes\(^7\)

7. Conduct regular Quality Assurance checks of children in place of care, which takes a holistic approach, aiming for system improvement and quality assurance extending beyond individuals at the operational level. This should include a review of the adequacy and reliability of the tools used for assessing risk.

8. Review the Concerns about the Safety of Children in Care policy and provide further training and education to staff to ensure:
   a. co-ordination (Planning) meeting participants have clearly defined roles, accountabilities and responsibilities including the chair (decision maker) to ensure informed and consistent decision-making.

9. The Carer and Assessment Support Team processes be revised to ensure carer assessment checks and re-authorisation processes are conducted in accordance with Territory Families policy and procedure to ensure:
   a. child protection history checks include a full assessment of all people residing in the potential carer’s residence and are not limited to a ‘person responsible’ check
   b. the processes are regularly audited to ensure consistency and currency

\(^4\) Royal Commission into institutional Responses to Child Sex Abuse recommendation 12.4
\(^5\) Royal Commission into institutional Responses to Child Sex Abuse recommendation 12.11
\(^6\) Community Services Checks are an interrogation of information held by government agencies in relation to, for example, allegations or reports of child abuse and neglect, or domestic violence, M Benton, R Pigott, M Price, P Shepherdson & G Winkworth, *A national comparison of carer screening, assessment, selection and training support in foster care, kinship and residential care*, report prepared for the Royal Commission into institutional Responses to Child Sex Abuse 2017, p67
\(^7\) Royal Commission into institutional Responses to Child Sex Abuse recommendation 12.10
c. the interview process applied for prospective carers includes exploration of their own experiences as a parent; knowledge and use of appropriate child rearing practices and an understanding of how to keep children in out of home care safe (including demonstrated empathy for past life experiences, the stigma of being in out of home care, and frequently poor health and education outcomes).

10. Information sharing protocols or procedures between non-government organisations providers and Territory Families be established, especially in relation to assessment checks, and in all cases where a carer has been de-authorised by Territory Families.

11. As a priority, develop and implement information sharing protocols and procedures between Safe NT (including the screening authority) and Territory Families when a carer has had substantiated investigations or their carer authorisation has been revoked.

12. Facilitate regular, unannounced Quality Assurance inspections of a carer’s residence, supported by effective policy and procedure.

13. Refer matters that could constitute crimes such as assault, negligently endangering life (failing to provide the necessaries for life) to NT Police for criminal investigation.

14. Refer substantiated matters (of sufficient seriousness) to the appropriate legal provider for advice in relation to legal consequences for children in care.

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8 Royal Commission into institutional Responses to Child Sex Abuse Vol. 12 contemporary out of home care chapter 5
DEPARTMENT OF TERRITORY FAMILIES RESPONSE

On 14 February 2018 Territory Families was provided a copy of the draft investigation report for comment, the response was due 28 March 2018.

On 9 March and 26 March 2018 delegates from the Office of the Children’s Commissioner met with Territory Families to discuss the draft report recommendations. As a result of these discussions minor amendments were made to the recommendations and incorporated into the final draft.

On 12 April 2018 the Chief Executive Officer Territory Families, Ken Davies provided a response to the Draft Investigation Report. The response in part states:

‘...Many of the recommendations are well aligned to current work in progress within Territory Families, including the introduction of the Quality Assurance Framework which you were briefed on 22 March 2018, and revision of the Concerns for the Safety of the Children in Care Policy.

Territory Families will continue to brief you about enhancements to the out-of-home care system through briefings, the Territory Families and Office of the Children Commissioner fortnightly meetings and progress reports in response to the final version of this Own Initiative Report which I look forward to receiving from you...’

‘...I will attend the meeting and commit to the actions required...’

Ms Colleen Gwynne
Children’s Commissioner

13 April 2018
<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibility</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>Overall project management, coordination, and decision-making</td>
<td>1 month</td>
</tr>
<tr>
<td>Team A</td>
<td>Conduct research, data analysis, and report preparation</td>
<td>2 months</td>
</tr>
<tr>
<td>Team B</td>
<td>Implement solutions, ensure compliance with regulations, and training</td>
<td>3 months</td>
</tr>
<tr>
<td>Team C</td>
<td>Provide financial oversight, budgeting, and risk management</td>
<td>4 months</td>
</tr>
<tr>
<td>Team D</td>
<td>Monitor project progress, manage stakeholder relationships, and feedback</td>
<td>Continuous</td>
</tr>
</tbody>
</table>

Additional tasks and resources are available upon request.
Legend:
SDM – The Structured Decision Making System for Child Protective Services
CPINV – Child Protection Investigation
CM – Case Manager