CITATION: *Inquest into the death of Kalib* [redacted] [2010]	NTMC 006
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Darwin
FILE NO(s):	D0132/2007
DELIVERED ON:	19 January 2010
DELIVERED AT:	Darwin
HEARING DATE(s):	11 – 22 May 2009
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	Death of baby interstate but normally resident in the Northern Territory, child in need of care, responsibilities of relevant Government agencies.

REPRESENTATION:

Counsel:

Assisting:	Chris Hoy QC
Instructing:	Dr Celia Kemp
Police:	Jack Lewis
Dept. of Health and Families:	Stephen Walsh Q.C.

Judgment category classification:	A
Judgement ID number:	[2010] NTMC 006
Number of paragraphs:	159
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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0132/2007

In the matter of an Inquest into the death of

KALIB [redacted]
ON 1 JUNE 2005
AT AN UNKNOWN LOCATION BETWEEN 22KMS SOUTH OF PORT WAKEFIELD AND PORT WAKEFIELD

FINDINGS

19 January 2010

Mr Greg Cavanagh SM:

INTRODUCTION

1. The deceased's mother pleaded guilty and was sentenced to manslaughter of baby Kalib in the Supreme Court of Australia. Extensive findings in relation to this death were made by the Criminal Court. It was submitted at the commencement of the inquest by Mr Hoy SC that it was appropriate for the findings of fact from the Criminal proceedings, and many of the statements collected in preparation for those proceedings, to be accepted without hearing further oral evidence about them. These have enabled determinations to be made as to identity, date, place and cause of death. Some additional information was secured from Dr Cala, the pathologist, in relation to time of death. The focus of the inquest was therefore on the relevant circumstances of the death, and in particular on the role of government agencies involved (FACS and police) in the lead up to this death and whether they could have prevented death by taking action earlier. I intend to refer to the Government agency responsible for child care as "FACS", this agency is part of the Department of Health and Families.

2. Pursuant to section 34 of the *Coroners Act*, I am required to make the following findings:

> "(1) A corner investigating –
>
> (a) a death shall, if possible, find –
>
> (i) the identity of the deceased person;
>
> (ii) the time and place of death;
>
> (iii) the cause of death;
>
> (iv) the particulars needed to register the death under the Births, Deaths and Marriages Registration Act; and
>
> (v) any relevant circumstances concerning the death

3. Section 34(2) of the *Act* operates to extend the function as follows:

> "A Coroner may comment on a matter, including public health or safety or the administration of justice, connected with the death or disaster being investigated."

4. Additionally, I may make recommendations pursuant to section 35(1), (2) & (3):

> "(1) A coroner may report to the Attorney-General on a death or disaster investigated by the coroner.
>
> (2) A coroner may make recommendations to the Attorney-General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the coroner.
>
> (3) A coroner shall report to the Commissioner of Police and Director of Public Prosecutions appointed under the Director of Public Prosecutions Act if the coroner believes that a crime may have been committed in connection with a death or disaster investigated by the coroner."

5. I have held this Inquest pursuant to my discretion found in section 15(2) and 15(3) of the *Coroners Act*. Despite submissions to the contrary, I am of the view that the death of Kalib is a "reportable death" pursuant to section 12 of the *Coroners Act*.

RELEVANT CIRCUMSTANCES SURROUNDING THE DEATH

6. Kalib's mother, [redacted], was born and grew up in Melbourne. She had a troubled upbringing. At 17 she commenced a relationship with the father of her eldest son, a relationship that lasted for three years. They moved to Alice Springs in 1989 and thereafter moved between Victoria and Alice Springs for some time. She had her first son when she was 20, and the relationship ended shortly thereafter. At 25 she commenced a relationship with Simon Borrett. The relationship was dysfunctional, and marked by considerable violence. Ms [redacted] has a history of using illicit drugs, including heroin and amphetamines.

7. Ms [redacted] had seven children. Their dates of birth of the first six are as follows:

   - [redacted] was born on 11 February 1992
   - [redacted] was born on 8 June 1998
   - [redacted] was born on 29 July 1999
   - [redacted] was born on 26 February 2001
   - [redacted] was born on 8 August 2002
   - [redacted] was born on 10 October 2003

8. [redacted] gave birth to Kalib [redacted], her seventh child, on 13 April 2005 at the Alice Springs Hospital. He died seven weeks later.

9. Kalib's mother and her other children were well known to FACS Alice Springs. There was an ongoing history of concerns and contact relating to the children extending back to 2000.

10. In February 2000 the eldest son, [redacted], made allegations of physical abuse and neglect to FACS workers, stating that his mother had held a knife to [redacted] throat and attempted to smother himself and [redacted], that she was a

drug user and that he was left home by himself to care for his younger siblings and was not attending school. FACS investigated the allegations. ██████ and ██ were taken into care for a short period. Police were present when ███ and ██ were removed ███ and ██ were returned soon afterwards. Ms ████ denied the allegations. She tested positive to methamphetamines. ███ retracted the allegations of physical abuse some weeks later and said he wanted to return home to his mother, and he returned home. His mother gave undertakings to FACS in relation to the care of ███. A Court Report written by FACS workers states that 'the allegations were not substantiated however FACS were concerned about the current circumstances of the children'.

11. In June 2000 a notification was received stating that Ms ████ and her children were sleeping in a car. There were no documented outcomes in relation to this notification (that is there is no record as to whether it was 'substantiated' or 'not substantiated' which is the FACS terminology used in relation to notifications). Later that month a notification was received that ███ had been thrown across a room and punched by Simon Borrett. Simon was charged and convicted in relation to this. The notification was 'substantiated' and ███ lived away from his mother for a period. In September 2000 Ms ████ rang FACS requesting respite care for ███ and said 'If you don't come and pick up ███ I will kill the cunt, I can't fuckin' handle the prick'. FACS workers observed Ms ████ grab ███, twist his arms behind his back, put him in a headlock, cup his mouth with her hand and tell him he was a dickhead and an arsehole. ███ was taken into foster care for 14 months. The care order in relation to ███ was discharged in December 2001.

12. ███ had been born on 26 February 2001. She had weight problems following her birth. She was only in hospital for a short time. Subsequent community health records reveal an unhappy trail of attendances and fluctuating weight with comments such as 'weight down – advice given on feeding' and 'not putting on weight'. FACS did not know about these issues.

13. In July 2002 FACS received a notification that Ms [redacted] and her children were living in a car. FACS records indicate that 'the investigation failed to find Ms [redacted] so the allegation was not substantiated'. On 8 August 2002 [redacted] was born. FACS found Ms [redacted] on 26 August 2002 staying at Larapinta Lodge. She was defensive and did not want to engage with FACS.

14. On 4 November 2002, when [redacted] was aged 3 months, FACS received a notification that she looked like she was dying; 'haunted and as though she was a bony skeleton'. FACS workers visited Ms [redacted] that day. She said she had a medical appointment the next day to have [redacted] checked. FACS workers noted that '[redacted] appeared like a skeleton with skin stretched across her face'. The FACS workers checked and found out that there was indeed an appointment, and so they reached an agreement with Ms [redacted] that she would contact them after the appointment. However Ms [redacted] did not attend the appointment on 5 November and later that day FACS decided to remove [redacted] to enable them to secure medical attention for her. FACS workers called police and together they attended Ms [redacted] residence and took [redacted] to hospital. She was admitted and medical records reveal that she was 'Very thin, pale emaciated minimal subcutaneous tissue loose skin folds...lusty cry good strength in limbs...' At the time she weighed approximately 500 gm less than her birth weight. Various descriptions from hospital staff, as well as photographs, indicate that she was grossly emaciated. She was diagnosed as having suffered 'severe nutritional failure to thrive'. There were grave concerns for her health. There were also grave concerns in relation to the quality of care provided by her mother who seemed unable to recognise her grossly wasted condition and who had failed to seek any medical intervention. Indeed so serious was [redacted] condition that advice was sought from another paediatrician who had specific experience in managing starvation in developing countries before medical staff embarked on a re-feeding regime.

15. It is notable that in this case FACS responded swiftly by assessing the situation, completing an Intake Form (the required documentation for a notification), prioritising it as 'Child in Danger (Response in 24 hours which is the highest level of response) and taking ██████ into care and to hospital within that 24 hour period. FACS obtained a Care Holding Order and then a Care Order and ██████ was placed into foster care. She remained in foster care for almost 2 years. She was returned to her mother in October 2004, 6 months prior to Kalib's birth.

16. Meanwhile, in 2003 there was further information conveyed to FACS by concerned people as to the welfare of the children. There were complaints about poor attendance at school and pre-school, the unit being filthy and without power, the children being dirty and Ms ██████ using speed. There were reports that Ms ██████ hit ████ and ██ on the head with a closed fist and hit █████ with the palm of her hand and that the children were hungry and were being sworn at. In March 2003 the children were taken into care for a brief period, however they were returned shortly thereafter, the notifications being 'unsubstantiated'. In August 2003 there was a notification that some of the children were being physically abused by their father. This was also 'not substantiated' by FACS.

17. In October 2003, within a year of ██████ going into foster care, █████ was born. His birth weight was 3666 gm. Within 3 days of birth he was re-admitted to hospital. Domiciliary and FACS records reflect immediate concern as to his progress. Upon re-admission it was clear he was suffering from weight loss (he now weighed 3190 gm), dehydration and jaundice. He was later discharged with a plan for proposed regular weighing.

18. Ms ██████ failed to keep appointments for weighing. A notification was made to FACS, in addition FACS workers had concerns themselves from the information they already knew. They were closely involved with monitoring the well being of █████. On 18 November 2003 when █████ was 4 weeks old he was again admitted to hospital because of poor weight gain. He then

weighed 3820 gm and a FACS investigation found that ██████ was failing to thrive due to not being given adequate food. He put on weight in the hospital, and after being hospitalised for 9 days was discharged to the care of his mother with a weight increase to 4290 gm.

19. In 2004 FACS received information that Ms ██████ was 'shooting up' and had been evicted, that she was looking for accommodation, verbally abusing her children and her children were under-dressed for the cold, that one of the young girls was hanging out with a group of teenagers, and that Ms ██████ had beaten her oldest child against a shop window with fists and slaps until he fell to the ground. In 9 October 2004 ██████ returned to her mother's full time care although there were residual concerns about the bonding between Ms ██████ and ██████. In November 2004 FACS were told that Ms ██████ had called her son a 'fucking cunt', and 'fucking useless' and threw a spanner, and that he had 'incredibly frequent' absences from school. In January 2005 the Court Order in relation to ██████ was discharged.

20. I find that these facts demonstrate that FACS had a close ongoing role with this family since 2000. FACS had a very large volume of information in relation to the family. There were multiple notifications received in relation to the welfare of the children. FACS were also in possession of a large amount of information from their own workers' contact with Ms ██████ and the children in their attempts to support the family. It was beyond the scope of this inquest to examine in detail how the notifications were dealt with extending back to 2000, on the face of the records it seems that some were appropriately identified as notifications and investigated, and either substantiated or not substantiated, some were identified as notifications but not investigated (which they should have been) and some were not formally identified as notifications that should have been.

21. The events of 2000-4 are important in providing the context in which the events of 2005 occurred; that is on a background of a history of ongoing

concerns about the care of the children. They also indicate that Ms ██████ was not reliable in her dealings with FACS; she did not always turn up to appointments, or keep promises she made to them in relation to the care of her children. Pauline Hickey, a case worker who had dealings with Ms ██████ during this period gave evidence that she was *inconsistent*. Patricia Thomas, another case worker, describes Ms ██████ as being 'incredibly difficult' to deal with. Larissa Ellis, the intake officer, says Ms ██████ was hard to engage and reluctant to do anything suggested by FACS.

EVENTS IN 2005

22. In the first half of 2005, the Director of FACS was Jenny Scott. She was in charge of services across the Northern Territory, but for this inquest the Central Australian staffing is most relevant. David Ross reported directly to her as the Senior Manager, Central Australian Services. Jackie Walsh reported to him as the Manager of Intervention Services/Child Protection. In that position, she was the Manger of a number of Divisions, one of them was the Urban Child Protection Division. Catherina Griffin was a Team Leader in that Division, reporting to Jackie Walsh. Karyn Hodson was a senior Case Worker, and Bernadette Butler was a more junior case worker. They both reported to Catherina Griffin. There was also an intake officer position which was separate to the Urban Child Protection Division. The intake officer was responsible for taking calls in relation to concerns about children and determining the appropriate place to refer them (either within FACS or externally) or the appropriate course of action. This position was held by Larissa Ellis.

23. In 2005 there appears to have been an escalation of concerns in relation to the family, and in particular in relation to ██████. ██████ had been returned to her mother's care in October 2004 despite some concerns about her mother's bonding with her. In January 2005 FACS formed a plan to finance childcare for ██████ and ██████ for three days a week for three

months to 'monitor the health of the children'. However from February 2005 not only did the children not attend day care regularly but there was a steady stream of notifications about serious physical abuse and neglect of the children, and in particular.

24. In February 2005 Police attended a disturbance in a food court and were told by two witnesses that Ms had given her son to a friend, Larissa, who had smacked him around the head and was verbally abusive to him. Police tried and failed to locate Ms . An officer completed a child abuse form (which said 'slapping child's cheeks, verbal abuse') in order to report the matter to FACS. There are no FACS records in relation to receiving this report. FACS record-keeping was in a very poor state at the time, this is detailed further on in these findings, and the files are missing many significant documents. In addition there is considerable evidence of instances in the first half of 2005 where FACS did not respond in a timely fashion to information it was receiving in relation to this family.

25. In mid March 2005 there were three notifications from separate notifiers detailing serious concerns:

    1. On 18 March 2005 a notifier told FACS that three of the children were grotty and hungry, one child said he was 'starving' and Ms had told the notifier that there was no money for food. The notifier said that had a large black bruise on her thigh, an 'excessive' number of scratches, bruises and bite marks, and 6 weeks before the notifier had seen an L-shaped bruise on bottom. The notifier stated that Ms had been asked to leave a Shopping Centre due to 'excessive hitting' and that was withdrawn and clingy whereas in the past she had been outgoing and sociable.

    2. On 21 March 2005 a notifier told FACS they had witnessed an incident in a shopping centre 6-8 weeks ago where Ms screamed abuse at and and then began to hit

, who was sitting in a shopping trolley and couldn't get away. The notifier said Ms was screaming that she was a 'little bitch' and hitting her with both an open and a closed hand, punching and pushing her against the metal of the trolley, and the hits were 'dreadful wallops all over the body'. The notifier had also seen them since that time and said Ms was verbally and physically abusive to her children, hitting and screaming at . The children were 'scraggy and filthy'.

3. On 23 March 2005 a notifier contacted FACS to say they had observed being smacked across the head and punched in the arm, that she was often not allowed to get out of her pram and they had seen her cry herself to sleep in the pram. They said that on that day they had seen Ms buy a plate of chips for lunch, the children had about three each, Ms and her friend ate the rest. Ms was always yelling and screaming abuse at the children. The children were filthy with no shoes, matted hair and often wear the same clothes for days. The notifier had heard that Ms was using drugs and dealing drugs from her motel room.

26. These notifications were appropriately identified as notifications and a Child Protection Report was completed and an 'Initial Child Danger Assessment' form was filled in by Larissa Ellis, the intake officer at FACS. She assessed, again appropriately, that these notifications required the highest level of response; that is 'child in danger' requiring a response within 24 hours.

27. In addition to the three notifications that were formally recorded as such received in March 2005, in late March 2005 information was received that and had not been at school since 11 March. On that date Ms was spoken to about their poor attendance, arriving late and not being picked up on time and in response she swore and the children had not been to school since. This was not treated as a formal notification.

28. The three notifications detailed above proceeded to the Alice Springs Urban Protection Unit to be allocated to a case worker. On 30 March 2005 a case was opened in relation to the five children (was staying in Melbourne at this time and Kalib had not been born yet) and it was allocated to Bernadatte Butler as Case Manager.

29. On 5 April 2005 two further notifications were received. The first notifier, a long term acquaintance of Ms , told FACS that had bite marks so hard that there was bruising around them. She said Ms pulled by the arm and slapped her over the head. The children were filthy and hungry, the acquaintance had fed them, and the family was about to be kicked out of the Gap View motel. The second notifiers (there were two) came into the FACS office to say they had seen Ms 'beating' with an open hand. One had observed Ms standing over , who was lying on a bed, and hitting her across the head with some force. Ms was using and dealing drug with the children present.

30. Ms Ellis assessed these two notifications as indicating 'child in danger' and requiring a response within 24 hours. They were opened as a case and also allocated to Bernadette Butler as Case Manager.

31. Bernadette Butler was a locum worker who was new to FACS. Consequently Karyn Hodson, a more experienced practitioner, was allocated to the cases as well to assist Ms Butler.

32. On 6 April 2005 two further 'notifications' were received although they were not formally treated as such. A notifier rang FACS on 6 April 2005 to report concerns about ; she was not with the other children when Ms was out, and she had heard she had been bitten by her mother and had a fever, the caller was worried about her safety. This was received after hours and an 'after hours contact sheet' was filled in and placed on the hard-cover file but no further paperwork was completed in relation to it. The evidence for the second notification comes from an e-mail sent by Pauline

Hickey, a FACS officer who as at that time in the 'Regional Placement Team' and was in contact with the previous carer of [redacted]. Ms Hickey sent an e-mail at 9:10 am on 7 April 2005 to Ms Walsh, Ms Griffin, Ms Butler and Ms Ellis. It read as follows:

> "I am aware that there have been a number of C.P notifications made in relation to [redacted] from a number of individuals. I am aware that the case has been allocated, but an investigation is still to be commenced.
>
> Yesterday I received a phone call from [redacted] who advised that a woman rang her and requested an appropriate person to contact at FACS in relation to serious concerns about [redacted]. [redacted] advised this person to ring Larissa and gave her the phone number for FACS.
>
> This woman...informed [redacted] that [redacted] has bruises on her legs, arms and back. Also she advised...that [redacted] has bite marks on her body which it is alleged were inflicted by the mother.
>
> In addition to this the woman also informed [redacted] that [redacted] mother will ask [redacted] if she loves [previous foster carer] and if [redacted] answers yes, she is hit.
>
> I spoke to Catherina and Bernadette in relation to these concerns yesterday.
>
> Can you please provide me with feedback in relation to these concerns."

33. Ms Hickey gave evidence that she was 'very concerned' that an investigation had not yet commenced, that she wanted a response, that she had deliberately included the manager, Ms Walsh, because she 'wanted her to be aware' and that she was asking for help for [redacted].

34. Up to this point the evidence is that nothing at all had been done in relation to investigating or taking action in relation to the notifications. I find that this is concerning as (a) weeks had passed since the first notification, (b) the content of the notifications was serious enough that most, if not all, warranted action within 24 hours, (c) they detailed serious maltreatment of a child who had been removed because of serious life-threatening neglect and

only recently returned, and (d) the repeated receipt of such serious notifications from different concerned people increased the likelihood that they were true.

35. It appears that the e-mail sent on 7 April 2005 prompted a response because later that day Ms Butler and Ms Hodson commenced their investigation into the notifications by conducting a 'home visit' to the Gap View motel. Ms Butler's file note (which was entered in June 2005, that is many weeks after the event occurred) records that Ms stood in the doorway with the door closed and was defensive and hostile, she said she would arrange a suitable appointment time to talk to them, but she didn't.

36. The next day, 8 April 2005, Ms Butler and Hodson went back to the motel. Ms Butler's file note (again entered in June 2005) records that the children were naked and the room was dirty and smelt like faeces. Larissa Connix, a friend of Ms s, took away and dressed her, and when she returned gave the children noodles to eat. The workers saw a bite mark on arm. said that 'mum' did it. Ms said that another child at child care did it. Ms said she was in a hurry to get to child care, the FACS workers left after informing Ms n that they needed to speak to the children and would return as soon as possible to do so.

37. That same day Ms Butler called the child care centre who said there was no record of such an incident, that had not been there the day Ms said it occurred and in fact the two children were only attending one out of three days, they arrived late and were picked up late.

38. Ms Griffin's statement says that she debriefed with the workers after both of these visits. Although the visits made an urgent situation even more urgent by providing further evidence to back up the notifications, it appears nothing further was done by FACS to progress the investigation until 22 April 2005 when there was another 'home visit'.

39. On 13 April 2005 Kalib [redacted] was born at the Alice Springs Hospital. He weighed 3400 grams at birth.

40. On 14 April 2005 FACS were notified in relation to the birth by the Hospital. The only record of this is an e-mail sent by Ms Ellis to Ms Butler, Ms Griffin and Ms Walsh on 15 April 2005 which reads as follows:

> "Hospital yesterday informed me that [redacted] gave birth to a baby boy on 13/04/2005. She discharged herself 2 hours later, baby left without having had neonatal screening. Hospital didn't know why, but the Police came onto the ward today looking for [redacted]. DOM care [domicillary care] went out to see [redacted] at the Gapview on 14/04 but she was not there."

41. Ms Ellis also added the new baby, at that stage unnamed, to the previous notifications on CCIS, the computer system. However this matter was not entered as a new notification.

42. It is apparent from the domicillary records that Kalib was visited by the domicillary service, and weighed, on 15, 17 and 21 April 2005. An attempt was made on 19 April but Ms [redacted] was not present. Kalib was not weighed after 21 April 2005. There is no evidence that FACS were aware of this.

43. On 22 April 2005 Catherina Griffin took charge of the investigation. She gave evidence that she did this:

> "because nothing was happening and we needed to get on with it and so I think Karyn [Hodson] was leaving at that stage and it was evident that Bernadette wasn't going to be able to do what she needed to do and so I stepped in."

44. On that day Ms Griffin and Ms Butler did a home visit to the Gap View Motel. Ms [redacted] refused to let them speak to her children without a lawyer present. The children were not spoken to at this time. The workers saw another bite mark on [redacted] cheek, Ms [redacted] said she had fallen from her pram. She said that Kalib had been weighed the day before, and his weight was normal. She said she would enrol the children in school when

she knew where they would be living, and that she hadn't been taking the girls to childcare because of transport difficulties.

45. I note that FACS workers are not required to delay speaking to children, or taking them to medical care, in order to wait for the presence of a lawyer.

46. On 26 April 2005 FACS staff returned to the Motel but Ms had left. Staff told the workers that they were concerned about the impact of her lifestyle, and in particular her drug use, on the children. had run to the office saying 'they [Larissa and his mother] were sticking needles into their arms'.

47. FACS were unable to locate the family for a period of time from this point. Ms Butler's (very retrospective) progress notes indicate that she contacted the Alice Springs Hospital and Congress and was told that Kalib hadn't been weighed. This was not in fact the case, Kalib had been weighed on three occasions but by the Domicillary Midwife service and there is no record to suggest Ms Butler contacted that service. The clearest evidence as to the knowledge of FACS workers at the time comes from a facsimile sent by Ms Griffin to Centrelink on the morning of 18 May 2005 in which she says that there is a new born baby who 'has not been weighed to FACS knowledge.' Given the history of failure to thrive of two other children this should have been of particular concern.

48. It is now known that in late April/early May 2005 Ms flew with Kalib, and a friend to Adelaide, to buy a vehicle and drive it back to Alice Springs. The friend has given a statement which says that Ms would not feed Kalib on the plane trip, instead giving him a dummy and sometimes a finger. She said he had a 2 minute breast feed once. He was very thin and his eyes were bulging in his sockets. She said on the way back on the train she was left with both children for the whole night, and she fed Kalib with milk bottle. This was not information in the possession of FACS at the time.

49. It seems likely that there was an additional notification received by FACS in May 2005, although there is no record of it on the CCIS progress notes (the FACS computer records) or the FACS hard copy files. Anita Thamm (Anita Weibusch at that time) states that she was given information by a daughter of a client that there were bite marks on █████ and that Ms █████ had said that she had bitten █████. She says she put this into an e-mail, stating that the notifier was happy to be contacted, and sent it to Ms Griffin and Ms Butler. She said her understanding of the procedure at the time was that if you get information that is already in a notification that has been activated that it doesn't get put through as a new notification. However she said that possibly this should have gone as a progress note on the case. She said that now, because this came from a new notifier, the process would go through as a new notification.

50. On Monday 16 May 2005 FACS received what, for this inquest, was an extremely significant notification. It was from the same notifier who had reported concerns about █████ before she was taken into hospital. The notifier said they had concerns that Kalib was 'not looking like he's being fed' and looked similar to how █████ had previously looked. There was no contemporaneous record made of this notification by anyone at FACS, and it was not treated as a notification and should have been, that is by filling out a Child Protection Report and an 'Initial Child Danger Assessment' form and allocating it for action to a case worker. The only evidence about it is a retrospective note Ms Butler made about it in June 2005, after Kalib's death.

51. FACS continued to try to find the family. In the course of their efforts they spoke to a friend of Ms █████ on Wednesday 18 May 2005 who told them she had concerns for █████ and said that Ms █████ had bitten her as a punishment.

52. On Wednesday 18 May 2005 the notifier from 16 May 2005 came into the FACS office to say that the family was at Coles, and she was concerned as

the baby was 'very skinny' and [redacted] was sick but medical help hadn't been sought.

53. Ms Butler and Ms Griffin attended at Coles. They found Ms [redacted] there with Larissa and her children, including Kalib. Ms [redacted] refused to take the baby for medical review, and Larissa and Ms [redacted] became verbally abusive. The FACS officers contacted Police for assistance.

54. At some stage Ms Walsh telephoned those at the scene, and then spoke to Ms [redacted] on the phone. Ms Walsh explained to her that there were concerns about Kalib's welfare and that he needed to be checked at hospital that day. She reminded Ms [redacted] of a past intervention by FACS in circumstances where her daughter [redacted] had nearly died of malnutrition In conclusion Ms [redacted] agreed to bring Kalib into the FACS office within 20 minutes. Ms Walsh then told Ms Griffin that this was the agreed outcome and so the FACS workers left the scene.

55. It seems clear that Ms Walsh was not aware that police were present and her advice was based on her assessment of the risk to the FACS workers in removing children without police assistance. However the police were in fact present, at least by the time Ms Walsh finished the conversation with Ms [redacted]. Ms Griffin gave evidence that she doesn't think she told Ms Walsh that police were present. Ms Walsh said that had she known police were present, she would have said that the children should have been taken with the assistance of police. I have no doubt that if this opportunity had been taken to remove baby Kalib from his mother this death may not have occurred.

56. Ms [redacted] did not subsequently attend either at the FACS officers or at the hospital. The encounter at the shopping complex was the last time Kalib was seen alive by either FACS officers or Police.

57. Ms Walsh rang police at 6:24 pm on 18 May 2005. The PROMIS (that is the police computer system) record of this call states that:

> "Jacki Walsh from FACS called to request that police be on the look out for a Caucasian family which they have a concern for welfare for there [sic] kids. She stated that she had a holding order for the kids but has not been able to find them...There is a serious concern for welfare as one of the children has previously been in danger of starving. She would like police to be aware of the situation and to contact FACS if they come into contact with this family."

58. The names and dates of birth of the parents and children are then listed.

59. However the names of Ms ████ and her children were not linked by police to the job on the PROMIS system. This meant that should an officer have had dealings with the family at a later time, and looked up the name, say, of ████ on the PROMIS system then the information that FACS wanted police to be on the look-out would not have appeared.

60. Later during the evening of 18 May 2005 FACS officers were informed that Larissa Connix and some of the children were in a room at Elkie's Backpackers. Ms Walsh and David Ross, and Police, attended and they found the friend and 2 of the children, ████ (then 6 years) and ████ (then 5 years). FACS officers took ████ and ████ into care and later obtained 'In Need of Care Orders' for both. At this time Ms Walsh spoke with Ms ████ on the telephone a number of times, again explained the concerns for Kalib and asked her to come to Elkie's Backpackers so that he could be taken in for a medical check. Ms ████ kept agreeing to do so but did not. Ms Walsh offered Ms ████ transport but Ms ████ wouldn't disclose her whereabouts. This was the last time there was any contact by FACS or Police with Ms ████ prior to Kalib's death.

61. After FACS left with the 2 children Ms ████ returned to the backpacker's room with a friend and trashed it; smashing windows, urinating on the beds and breaking kitchen goods.

62. Constable James was one of the officers who attended the job at Elkie's. On his return he opened the earlier job recording Ms Walsh's request for a look-out and he said 'Children taken into care by FACS and taken to Police

station interview room. N.F.P.A.R'. He gave evidence to the inquest that this meant 'No Further Police Action Required'. He closed the job. Assistant Commissioner McAdie gave evidence that the job should not have been closed, rather it should have remained in place until the other five children were found and taken into care. He said had the job stayed open, if the other five children had remained outstanding for any significant period of time then a decision should have been made to 'ramp up the inquiries we were making' in order to locate them and bring them into care.

63. Shortly after this series of events it is apparent Ms ██████ left Alice Springs to drive to Melbourne. She took █████ (aged 4), ██████ (aged 2 years 10 months), █████ (aged 18 months) and Kalib (just over 6 weeks). Her eldest son, █████ (aged 13 years), was in Melbourne living with his father. The purpose of the trip was to pick him up and return to Alice Springs. The evidence reveals that the family arrived in Melbourne on the morning of Thursday 26 May 2005. They stayed with Ms ███████ sister and brother in law.

64. Meanwhile FACS interviewed █████ and ███ on 20 May 2005. They both disclosed physical abuse of all the children by both parents, which was particularly bad in relation to ██████.

65. Overall between 18 May and 24 May FACS do not seem to have considered that the family may have left the state. The information that was provided to Ms Butler by the notifier on 16 May 2005 that the family was planning to leave was not recorded and does not seem to have made its way into the FACS considerations in relation to the family and so no effort was made to contact ██████ father, for instance, at this stage. FACS received some information about Ms ███████ possible whereabouts in Alice Springs on 21 May 2005, called police and went to the location but she was not there.

66. On 24 May 2005 FACS were told that ████ and ███ had spoken about their mother picking up █████ from Melbourne once she had her car. There is an

e-mail from Jackie Walsh to Ms Ellis, Ms Butler and Ms Griffin asking if anyone has spoken to [redacted] dad in Melbourne yet.

67. On 26 May 2005 Ms Butler sent an e-mail to Ms Walsh asking for an Australia wide police alert to be put out for the [redacted] family. Ms Walsh forwarded it to her superior, David Ross (the Senior Manager, Central Australian Services, the most senior position in Central Australia) writing, 'can you let interstate liaison have this, thanks.' Mr Ross forwarded it to Di Eades writing, 'Not sure of the exact protocol for this – do you to be the one requesting it in your senior role.' Di Eades held the equivalent position to Mr Ross in the North of the Territory, titled 'the Senior Manager, Urban Services'. Both Mr Ross and Ms Eades held jobs that reported directly to the Director, Ms Jenny Scott. Ms Eades opened the e-mail on 27 May 2005. She skimmed it and assumed the alert had been done and that Mr Ross had contacted interstate counterparts and the e-mail was informing her so she could alert her staff and forwarded it to relevant staff. Unfortunately there was no further activity on this front, interstate counterparts were not contacted and an interstate alert was not put in place.

68. On Friday 27 May 2005 FACS talked to [redacted] father and found out that Ms [redacted] and her children were staying at an address in Melbourne. FACS Alice Springs commenced efforts to secure action by their Victorian Counterparts. It was after hours in Victoria. The after hours number that FACS Alice Spring had was a number that only worked from inside Victoria. Ms Walsh ended up ringing the Victorian Police and was put through to the Glen Waverly police. There were two Child protection workers at the police station, police asked the workers to talk to FACS staff but the workers said they were too busy. Ms Walsh gave information about the concerns to the Glen Waverly police who said they would contact the family.

69. Ms Walsh went home and that evening Amanda Gorry, the after hours FACS worker, was rung by the Department of Human Services (DHS) in Victoria

who said that they had sketchy information about the family, but no names or dates of birth, and needed more information. Ms Gorry took down some information from CCIS (the FACS computer records) and faxed it to DHS. The DHS called back and wanted more information. Ms Gorry said that she would need to get the manager, Ms Walsh, to call with further information. She then called Ms Walsh's mobile and left a message on it. Ms Walsh did not get this message until the morning of Monday 30 May 2005 when she turned her phone on. She provided further background information on that day, however it was found that the family had left for Alice Springs the previous night.

70. On Sunday 29 May 2005 the family, now including [redacted], left Melbourne to drive back to Alice Springs. Thereafter the family's movements are not entirely clear, but there is evidence that Ms [redacted] made a wrong turn and travelled through Shepparton before returning to the Great Western Highway travelling on the Dukes Highway, through Adelaide and then onto the Port Wakefield Road (National Highway One). It is also apparent that on the nights of 29, 30 and 31 May the family slept in the vehicle at roadside stops or parking bays.

71. They arrived in Port Wakefield on the morning of 1 June 2005. Ms [redacted] stopped at an Express Service Station on Snowtown Rd Port Wakefield at approximately 8.40 am. She had no money. Her initial purpose in stopping was to seek directions to the nearest community welfare office and the nearest pawn shop. Kalib was in a baby capsule in the rear seat of the car, between two of the other children. Neither were wearing seatbelts. She went to the main counter, asked where the Centrelink was, saying she had lost her wallet and needed money for fuel and food.

72. [redacted] was then with her mum. Staff at the Service Station noticed she really wanted one of the sandwiches on display. They talked about whether they could help the family.

73. Ms went back to the car. Upon returning to the vehicle she reached in and removed Kalib from the car seat. She says at that point she noticed that Kalib was not breathing. A staff member had followed her to the car, intending to give her money to buy food. The staff member took Kalib inside the Service Station as one of the staff was also a volunteer St John's Ambulance Officer. The Ambulance Service was called. The St John's Ambulance Officer examined Kalib and observed he was cold, his eyes were open, his pupils fixed and dilated and his face pale. She says he was starting to stiffen and had a purple blue tinge. She thought he was dead and that nothing could be done for him. She spoke to the Ambulance Service and relayed what she'd found.

74. Ambulance officers arrived at 8:55 am. They confirmed Kalib was dead. He was taken to Balaklava Hospital and at 10.00 am formally pronounced dead by a medical practitioner. Police also arrived and the criminal investigation commenced. Ms told witnesses that Kalib had been crying when they pulled into the Service Station, she was out of the car for 5-10 minutes, and Kalib wasn't breathing when she returned. She said that she had last fed him at about 5.00 am. She said that he had last made a noise about 10 minutes before she pulled into the Service Station.

75. A SA Transport Officer indicated that he had seen the family's vehicle parked on the side of the road a little earlier, at about 7.50 am. This was on the side of National Highway One, Wild Horse Plains SA, approximately 22 kilometres south of Port Wakefield.

76. An autopsy was performed by SA Forensic pathologist Dr Alan Cala. He has provided two signed reports the first dated 29 September 2005 and an Addendum dated 27 January 2006. He concludes the cause of Kalib's death was 'Failure to thrive due to insufficient caloric intake'. He also raises the possibility that hypothermia may have contributed to the death due to light clothing, sleeping overnight in the car, low night temperatures and minimal fatty tissue and general emaciation.

77. Dr Cala also advises that Kalib was extremely small for his age and extremely undernourished. Dr Cala states:

> "this child did not receive sufficient calories to allow him to grow and develop normally, and ultimately, this grave situation led to his death."

78. He concludes that the virtual absence of food substances throughout the upper or lower gastrointestinal tract lends support to his view that insufficient calories were offered to Kalib for the duration of his short life. He also says that he would not expect to find the stomach empty, as it was, if the child had been recently fed prior to death.

79. Dr Cala provided an opinion in relation to the time of death. He says that he considers that Kalib had been dead for possibly up to several hours (2-3) prior to being examined and he bases this on the objective observations of a trained ambulance officer and a doctor. I do not accept the evidence of Ms ██████ that Kalib was crying as they pulled in to the Service Station, rather I prefer the objective evidence that he had started to stiffen and had a purple-blue tinge when examined. I find that Kalib died between 5 am and 8 am.

80. Kalib was in a shocking physical condition at the time of his death; he was extremely thin, his skin was wrinkled on his limbs and there was obvious muscle wastage. He was emaciated. He weighed only 2390 gm. At birth 7 weeks earlier, he had weighed 3400 gm.

81. Growth Charts are a critical tool for assessing the development of infants and young children. Sequential measurements of weight, length and head circumference are plotted on a graph to show how a child compares to other children his age. At Kalib's birth he was on the 75th percentile that is 75% of babies weigh less than Kalib did. Dr Cala says that if Kalib's growth and development had been normal, he would have been expected to weigh 5400 gms at 7 weeks. His actual weight, at death, of 2390 gms represents a stark

and dramatic decline from his birth weight to a position well below the 3rd percentile (the lowest percentile marked), 7 weeks later at his death.

82. On 1 June 2005 FACS made 'in need of care' applications (section 44 *Community Welfare Act)* in respect of the five children remaining in Ms ██████ care, that is an order was taken out in respect of Kalib. We now know that sadly Kalib had already died, however FACS were not aware of this at that point.

83. FACS took the other children into care and commenced an investigation of their care. They subsequently involved police. Evidence of serious neglect in relation to all the children over some years and evidence of some instances of physical abuse was gathered from a number of witnesses who knew the family.

84. Ms ██████ actions in relation to Kalib's death were investigated by the South Australian police, and she pleaded guilty to manslaughter before the Supreme Court of South Australia and was given a term of imprisonment.

POLICE/FACS LIAISON IN RELATION TO THE ██████ CHILDREN

85. In 2002 the CEO of FACS and the Commissioner of Police signed a Protocol entitled 'Guidelines and Procedures for a Co-ordinated Response to Child Maltreatment in the Northern Territory'. It defines 'maltreatment' in the same way that the *Community Welfare Act* did. Biting a child and leaving bite marks, serious physical impairment caused by nutritional or other deprivation, and being in an environment where there is a substantial risk such deprivation will cause impairment, all constitute 'maltreatment'. I find that the detail of the March- April 2005 notifications in relation to ██████, and the April-May notifications in relation to Kalib clearly constituted 'maltreatment'.

86. FACS are required to notify the Officer in Charge of the Police Station of all matters where a criminal offence may have been committed, including all cases of 'alleged serious physical maltreatment'. The Protocol states:

> "in all instances where a child under the age of five years is the subject of alleged physical maltreatment FACS staff will notify Police as specified above to exchange information and determine whether a joint investigation is required."

87. Both Kalib and ██████ were under five and FACS should have reported the notifications in relation to both children to Police. There is no evidence they did so and it seems likely that in fact they did not do so. This meant there was a missed opportunity to exchange information and to determine whether a joint investigation was required. A joint investigation in March or early April is likely to have revealed the serious abuse and may well have prevented Kalib's death.

88. In addition the Protocol states:

> "If, during the course of an investigation, FACS workers come to believe on reasonable grounds that a criminal offence has occurred they will cease the investigation until Police have been notified."

89. There is no evidence that FACS ever reported ██████ failure to thrive as a baby to police, although I note that police were present when she was taken into care as a baby. It is arguable that the March/April notifications in relation to ██████, in combination with the eyewitness evidence of FACS workers that she had bite marks, should have warranted referral to police under this provision also. The 16 May 2005 notification in relation to Kalib similarly may have warranted referral to police under this provision.

90. The Protocol clearly envisions a multi-disciplinary approach to serious maltreatment, I find that the situation of the ██████ children from March to May 2005 warranted such a multi-disciplinary approach but this did not occur.

EVALUATION OF THE ACTIONS OF FACS IN THE LEAD UP TO KALIB'S DEATH

91. FACS has no record at all of receiving the February 2005 notification from police and it seems likely that it was lost or mislaid and nothing was done in

relation to it, and I so find. The joint FACS/Police review said that this notification should have been subject to further discussion to determine an appropriate level of joint investigative response.

92. It was conceded by FACS that FACS did not respond to the notifications received in March and early April in relation to the children generally, but [redacted] in particular, appropriately. I find that the investigation in response to the notifications was extremely delayed in starting and extremely slow to proceed. It is concerning that two months after the first notification, and notwithstanding the string of notifications with serious content matter, and the FACS' workers own concerning observations, the children had not been interviewed, nor medically examined.

93. In addition FACS conceded that:

> "some notifications received in relation to the [redacted] children, an in particular in the critical months of March, April and May were not recorded as separate notifications and this impacted on the ability of investigating officers and their managers to see the escalating risks for the children and there was a lack of investigating planning during the investigation in April, and this contributed to miscommunication between staff about what course of action could and would be taken as events unfolded."

94. I find that had FACS responded in accordance with their own policies and procedures, as they should have, and responded to the information they were receiving in a timely and professional manner, then the children would have been interviewed and [redacted] taken for medical examination. This should have occurred in March 2005. The interviews would likely have revealed the serious abuse that was revealed when the children finally were interviewed. Medical examination of [redacted] is likely to have confirmed that she was suffering from human bite marks. FACS would then have had grounds for orders in relation to at least [redacted], and probably all the children, and would have had the power either to remove the children or to strictly monitor Ms [redacted] parenting to ensure the welfare of the children.

95. ██████ was born in the midst of a period of intense FACS involvement with Ms ██████, as attempts were being made to reunify ██████ with her mother, and although he failed to thrive, this was picked up on quickly and he was hospitalised and given the care he needed. If FACS has been monitoring Ms ██████ as closely as they should have been in March, April and May 2005, then Kalib is much less likely to have "slipped through the cracks."

96. In addition, I find FACS did not appropriately respond to the notification received at Kalib's birth, nor to the notification received on 16 May 2005 that he looked as though he was not being fed (and similar to how ██████ had appeared). The birth of a baby, when the two previous children had to be hospitalized because of failure to thrive, and in the context of significant and escalating concerns about the parenting of other children, was of serious concern. The 16 May 2005 notification, which was received from the same notifier who had informed FACS that ██████ was starving, and had sadly been proved to be correct, was alarming. However it was not passed on to the intake worker, it was not treated as a formal notification and so the appropriate paperwork including a risk assessment was not filled out. Had this occurred, it would have been clear that Kalib was at very high risk and it would have helped guide decision making on 18 May 2005 when the family were found at Coles.

97. FACS conceded that:

> "the unintended miscommunication between staff during the 'Coles incident' meant that there was a missed opportunity for the Police to assist FACS in the removal of any of the ██████ children on 18 May."

98. I find in addition that had the information notifiers provided to FACS been correctly recorded, and had the investigation been conducted in a timely and efficient manner, it would have been abundantly clear that at least Kalib and ██████ should have been taken for a medical examination and the decision

would not have been made to let Ms [redacted] go on the promise of a future appointment.

99. FACS had some difficulty in locating the family at the end of April and start of May 2005. It was clearly a difficult task. Firstly, this was only a problem because FACS had failed to act in a timely fashion in relation to the serious notifications. Secondly, this highlights the importance of involving police, an organisation with significantly greater power to locate people. There is a retrospective file note from Ms Butler stating that she rang the police on 8 May 2005 and asked them for a police alert. However she made no contemporaneous records and a search of all the police records that day reveals other calls from FACS but not that one. I find that, on the balance of probabilities, this call did not occur. I note that police should have already been involved in accordance with the Protocol in place at the time, as discussed above. I find that FACS should have contacted police soon after they were unable to find Ms [redacted] to ask for their assistance.

100. I find that FACS efforts to find the family after May 18 2005 were similarly ineffective. No one at FACS appeared to realise the family may have been interstate until 24 May 2005 even though information that the family was going interstate was contained in the notification on 16 May 2005. Although it is abundantly clear that as of 19 May 2005 there was ample information to justify removing the children, there were no attempts to get Court orders made. This must have made the task of attempting to convince interstate counterparts that the matter was urgent more difficult.

101. There was no interstate police alert put out due to a communication breakdown between two senior staff and a lack of procedures and protocols. When interstate contact was finally made on 27 May 2005, there was a difficulty in providing the information required to convince an interstate counterpart that the matter was urgent, this information was not readily available to the after hours worker (and this is not surprising as the evidence is that there were few contemporaneous notes in CCIS about what was

happening with the children) and contact was not able to be made with a more senior worker who knew the information. FACS stated in their submission to the Victorian DHS inquiry that they considered 'that the death may have been preventable if the processes for communication between states about child protection concerns were clearer,' and I agree.

EVALUATION OF THE ACTIONS OF POLICE IN THE LEAD UP TO KALIB'S DEATH

102. Police received two notifications in February 2005 and April 2005. They referred both to FACS. Assistant Commissioner McAdie states that on the first occasion police would have had a reasonable expectation that the matter would be followed up and any evidence to support a prosecution provided by FACS to police. On the second occasion he says that because FACS said they would deal with it, it was not surprising police took no further action. He states that:

> "with hindsight, of course it would have been desirable for Alice Springs Police to have left the PROMIS case open and followed up with FACS whether assistance was needed or whether a prosecution was merited."

103. He also said that it would have been better to make a formal documented report to FACS, rather than just the phone call.

104. One of the officers who attended at Coles gave a statement saying that he was of the view that unless an order was in place, he would not have been empowered on that occasion to take a child from their parents. He gave evidence at the inquest indicating he was now aware that he could remove a child in circumstances where he believes that there is a risk to the child, without an order.

105. Assistant Commissioner McAdie said that the job was considered to be of the type 'assist other organisation' and that:

> "the usual expectation in these circumstances is that we are present for the purpose of allowing staff of another organization to exercise

> statutory powers with the protections of police being present. It would be usual for police officers in this context to expect the other organization to exercise its statutory function according to its own discretion. It is frequently the case that police may have a matching power or function, but unless there are good reasons for doing so, where the function being exercised does not fall within the core functions of policing; we would be led by the agency for which the statutory function is a core function. He says that in this case there would have been an expectation on behalf of attending police that the decisions as to the disposition of children would be made by FACS...and it seems reasonable to support their decisions at the scene."

106. I find that this was indeed the expectation given what police knew and I do not criticise them for not seizing Kalib on the day. However this expectation also demonstrates how far the situation was from the one envisaged in the Protocol between FACS and Police. If the protocol had been followed, and police were fully seized of the information in relation to the suspected maltreatment of ██████ and Kalib, then police would have been able to take a much more active role and may well have formed the view on this day that Kalib needed to be removed.

107. Assistant Commissioner McAdie conceded, that writing off the PROMIS job requesting police look out for the ██████ children after two had been taken into custody was wrong and that the job should have remained in place until the other five children were found and taken into care. It does not seem likely that this would have made a difference, but it is possible that it would have done so.

CONTRIBUTING FACTORS TO THE POOR FACS RESPONSE

Poor record keeping

108. There are hard copy records and computer records kept at FACS. The hard copy client files are kept for each client, so there is a separate file for each ██████ child. Similarly the computer files are kept for each client, again there is a separate file for each child. I have before me the hard copy files and the CCIS (computer) records for each child, they are seriously deficient.

For instance, on the hard copy file for ████ the first entry is in May 2005. There is no information whatsoever about the substantiated notification in relation to his weight that resulted in the hospital admission. A worker who read the file would have no way of knowing that there had been any failure to thrive issues in his infancy at all.

109. As well as lacking much relevant material, the hard copy files are in no particular order, and do not contain summaries or overviews so it is not possible, for instance, to look at ████ file and gain an overview of her history.

110. The evidence is that Ms Butler made no contemporaneous notes on CCIS at all in relation to Kalib, all her entries about her actions in April onwards were entered into CCIS after Kalib died, in June 2005. I heard evidence that it was not uncommon practice to keep a record of action in a notebook, or in a word document on a computer, and then when time permitted to cut and past them into the files.

111. FACS conceded:

> "record keeping in the hard copy and CCIS files for all of the ████ children was not in accordance with departmental requirements and was unacceptable. This appears to have contributed to the difficulty investigating officers and managers had in making timely decision about the appropriate intervention strategies to protect the children."

112. There are particular difficulties with record keeping when there is more than one child in a family involved with FACS. FACS Policy dictates that entries are placed on each child's hard copy file, or each child's CCIS record. This is very time consuming. The computer system does not do this automatically, rather it requires the individual FACS worker to cut and paste the entry onto each file, which is five or six times in the case of the ████ family. I find that, by and large, this did not occur, rather all the information would be kept, if it were kept at all, on the record of one of the children. Thus if a caseworker were to pick up the hard copy file for

another child whose file wasn't being used as the main reference, they would have no way of knowing that there were multiple notifications in relation to the parent of that child because of their treatment of other children. FACS conceded that:

> "there was difficulty in cross referencing information in the case notes to other members of the family."

113. It is also not clear how a new caseworker would be able to pick up important facts such as the main events that had occurred for a child or the reliability or otherwise of a particular parent in dealing with FACS without spending many hours reading poorly organised and deficient progress notes. There does not appear to be any sort of summary system to flag important information and enable a new case worker to gain the knowledge required to effectively deal with problems as they arose.

114. The events of March – May 2005 exemplify the problems with record keeping. Ms Butler kept no contemporaneous records on the CCIS or the hard copy files. She kept some hard copy notes and after Kalib's death was allocated time to put all the notes into the appropriate systems. The serious ramifications of this sort of record keeping are exemplified by (a) the 16 May 2005 'notification' in relation to Kalib not being communicated to anyone else and thus not guiding decision making when FACS and Police were with him at the shopping centre, (b) the information that the family may be going interstate not being communicated to anyone else and thus preventing them being located earlier and action being taken earlier to ensure the safety of the children and (c) the difficulties the after hours worker in Alice Springs had in providing information interstate when urgently requested because it was not on the records to be provided.

115. Ms Butler's handover in relation to the ███████ family consisted of being given a large volume of hard copy files. She says she was told to take them home and read them and she did that over the next few nights. I find that this is another instance where the poor record keeping is very significant.

The hard copy files are very deficient. Ms Butler would not have been able to discover, for instance, that there had been issues with [redacted] at all from the files. They are also voluminous and poorly organised, and would have taken a very long time to read, and an even longer time to pull out some sort of sensible summary of what had occurred.

116. I note that Mr David Ross, the Senior Manager, wrote a statement to assist with a Victorian Review of what had happened with the attempt at interstate liaison, and his statement is riddled with errors about what occurred. This is not surprising, the record keeping is so poor that it is very difficult to figure out what had happened. This must make it very difficult to make reasonable decisions based on all the information, and to gather evidence to support court orders when required. It also meant it was impossible for Ms Butler to gain the necessary background information on the family.

117. It is evident from the poor quality of record keeping over a long period of time by many different FACS workers and across multiple clients that this is not an unfortunate one-off deviation from the norm, but rather is an ongoing, serious and widespread problem. The problem was not an absence of policies and procedures in relation to record keeping, there were policies and procedures in place detailing what was required but FACS workers were not complying with them. In addition there was evidence that the computer system was particularly poor for cases that involved more than one child from a family, and it was cumbersome and, on occasion, very slow to use.

Staff experience and training

118. Ms Butler was a locum case worker. She started with FACS in March 2005. She had never worked in Child Protection. She had difficulty using CCIS, giving evidence that it was 'never something she was au fait with'. She said she did some training in CCIS sometime after she started and that it wasn't part of her orientation but occurred later. She thinks it was a few hours or half a day and in early April 2005. She doesn't remember looking at CCIS notes at all in relation to the [redacted] children. Her handover, as described

above, was being given voluminous hard copy files and being told to take them home and read them.

119. Ms Butler was very slow to act on the March and April notifications and did not take the steps required to progress them such as interviewing the children and securing a medical examination for [redacted]. She took none of the required steps to action the seriously concerning May notification in relation to Kalib.

120. I find that, as a new worker with minimal training, Ms Butler was not experienced enough to be dealing with such a resistant mother and such a complex and risky family situation. I find in addition that, because of the poor handover, that Ms Butler was not provided with the information she required to make proper decisions.

121. FACS concedes that:

> "the orientation and training of new staff commencing in the Alice Springs FACS office in 2005 was limited and consequently some staff involved with the [redacted] family were not fully aware of their responsibilities or what was expected of them."

Lack of protocols/procedures for interstate alerts

122. FACS concedes that:

> "miscommunications and the lack of a clear and complete understanding of the processes for Interstate alerts by the relevant Interstate Liaison Officers resulted in the lack of timely alerts being placed with interstate Child Protection Authorities."

123. Mr Ross, the interstate liaison officer for Central Australia at the time, gave evidence that this was the first interstate alert he had ever dealt with, and he was unsure as to how to implement the interstate liaison notification. He had not received training in it, and at the time there was no policy or procedure that spelt out what was supposed to happen in relation to interstate alerts.

124. If interstate alerts had been secured in a timely fashion this may have resulted in intervention by Victorian Child Protection Authorities which may have prevented the death.

Failure to follow the protocol between NT Police and FACS and poor liaison between the two organisations

125. FACS concedes that:

> "the protocol between NT Police and FACS in the case of [redacted] was not followed which resulted in a missed opportunity for co-ordinated intervention."

126. The joint FACS/Police review found that:

> "there is a clear absence of communication and planning between FACS and police to establish clear goals and roles in providing a joint response to child protection concerns."

127. The review found that:

> "there is insufficient clarity around the police/FACS protocols and procedures in relation to reporting and investigating maltreatment.

128. There should have been, at some point in time, a determination made between Police and FACS to pursue a joint investigation into the allegations of child abuse. There clearly was no such determination with the Police mainly taking the role of responding to requests from FACS.

Difficulties inherent in the jurisdiction

129. Ms Jenny Scott, the Executive Director of NT Families and Children provided me with a statement which included some of the challenges for the NT; difficulty in recruiting and retaining child protection workers, difficulty in maintaining a large and diverse enough pool of foster carers and the limited number of non government organisations capable of and willing to work with high risk families.

130. One of the reasons that new and inexperienced staff members were being given work that was beyond their ability was staff shortages. The

FACS/Police review shows that at the time 25% of staff positions in FACS Alice Springs were vacant. There was only one FACS staff member to perform the role of manager for all the sections, which was too high a workload. There was a lack of FACS staff experienced in child protection issues and a high workload of child protection matters.

131. Ms Walsh also described the difficulty of working in child protections in Alice Springs. She described the pressures created by the sheer number of notifications, difficult relationships with other organisations, difficulty proving matters in court, and difficulty gathering information. Ms Hickey told me that Alice Springs lacks the assistance of some of the non-government organisations that are present in larger cities and that work in partnership with FACS in those cities.

132. I find that external factors present many serious and difficult challenges to those working in child protection in Alice Springs.

Problems within the Alice Springs Office

133. As well as a difficult external environment, the evidence before me reveals considerable problems within the office at the time. The evidence of Ms Walsh in this regard was extremely candid and thoughtful and considerably assisted me. Ms Walsh said that:

> "the whole system was creaking under the pressure of what was happening."

134. She said that the levels of notifications, the number of staff there to respond and the data system that they were working with made things very difficult at the time, and at the time a range of issues were resulting in *time lines not being met.* She discussed the problems with the computer systems and with multiple siblings set out above. She said that there was:

> "quite a bit of conflict going on between the workers and the team manager.

135. She confirmed the evidence of Ms Scott that there was a huge turnover both of managers and of staff on the ground and that there was a problem getting staff who were experience and who would stay for longer periods, and that:

> "I think we could have done something about it, but we didn't because none of us had the time to address it."

136. She described how the office regularly had staff coming in and being 'totally shocked at what was going on' and leaving very quickly, saying they fell into two categories; those who just felt that it was all professionally unacceptable and left and those who couldn't cope with it emotionally. She said that she, personally, had:

> "never worked anywhere where my child protection practice has been so hugely challenged."

137. She said morale was *pretty poor* as it was soul destroying having high standards of good practice personally but not being able to achieve the standard. She said the office went from one crisis to another.

138. Ms Thomas said that the very high turnover of staff impacted on the timely response to notifications. Ms Hodson said that there were delays, a lot of cases, and a staff that was limited and untrained in child protection. She said she found it difficult to work under those circumstances and that she didn't have faith in the decision making processes. She said that she considered the delays in this matter concerning but 'not untypical' and said that in her opinion they were because of limited staffing. Ms Griffin said that people were overworked, and that the workplace was 'quite hostile'.

139. I find that the many errors made in the handling of this case reflect systemic problems within the Alice Springs FACS office at the time.

Difficulty with neglect

140. The FACS/Police review referred to DOCS (the NSW equivalent of FACS) review of the literature on neglect and said that many of the risk factors in this family were 'key components' of neglect. The review said that the

issue of neglect is more likely to be overlooked by workers than other forms of child maltreatment. The review said:

> "each incident in isolation is often seen to be insignificant however, as this review clearly demonstrates, the historical context and pattern of harm needs to be closely considered, and any decision making should be done with this in mind."

141. This is well demonstrated by this case. It is clearly particularly difficult for FACS to pick up patterns, such as those demonstrated by the history of this family, that indicate that serious neglect may be occurring.

Focus on engaging the mother rather than ensuring the safety of the children

142. The evidence revealed a very high priority placed on engagement with mother, at the expense of her children, way beyond the point where such engagement was feasible. It appears the FACS workers let their focus on developing a good relationship with mother and support her override their duty to the children. This is seen throughout FACS' dealings with Ms ██████ but is most starkly seen (a) on 22 April where the mother stating that she wanted a lawyer resulted in FACS workers leaving without having spoken to the children, or ensuring a medical examination of ██████ and (b) on 17 May where FACS and police let the mother go with an agreement to come to an appointment rather than take the children at that time over her heated vocal objections.

143. I find that Ms ██████ was particularly difficult to deal with. She was extremely experienced with dealing with, and avoiding the scrutiny of, child protection authorities. She presented a significant challenge to any FACS worker assigned to her children. However the fact remains that the primary duty of the FACS worker is to the child, not to the mother, and there was ample evidence to justify removing the children for medical examination and interview in both April and May.

Insufficient Review Mechanisms

144. There was a Child Protection Review Team which would meet to review substantiated cases. However it did not review cases which were unsubstantiated. This meant there was no formal process to review these. A number of the case workers gave evidence that the lack of a process to review unsubstantiated cases was concerning.

WHAT HAS BEEN DONE TO FIX THINGS UP IN RESPONSE TO THE DEATH?

Police/FACS co-operation

145. After Kalib's death FACS and NT Police conducted a joint critical incident review into the circumstances surrounding his death. A team consisting of a senior officer from each agency conducted the review, they interviewed various workers and reviewed files and notes, and made 8 recommendations. I commend both FACS and NT Police for undertaking this review.

146. This review is in evidence before me, as well as detailed information about what has been done in response to it, and so I will not reproduce the bulk of this information.

147. The Child Abuse Task Force, a joint initiative between Police and FACS, commenced operation in November 2006. Its' purpose is to provide an effective, responsive joint NT Police/FACS response to serious reports of child sexual abuse, physical and emotional abuse and/or chronic and constant neglect of children throughout the Northern Territory. FACS now has a centralised intake service and all intake matters are reviewed by the Child Abuse Task Force to determine if any further action is necessary. Each case is assigned to Police, FACS or a joint Police/FACS investigation team. The preliminary task in each case is to conduct a safety assessment of every affected child to ensure that, whilst an investigation proceeds, the child is, in fact, safe. The intake team is supported by a single 1800 number and provides a 24 hour a day, 7 day a week service. The centralised intake

service is co-located with the Task Force, which is located at the Peter McAulay Centre. The intake team are tasked with doing comprehensive checks across CCIS, consulting with police and looking at the history of contacts with siblings.

148. When a joint Police/FACS investigation is required the Senior Sergeant, Child Abuse Task Force and the FACS Manager of the Child Abuse Task Force are responsible for managing it, and it is assigned to an investigation team with staff from both agencies. Because the agencies are co-located, and work closely together, this has meant there is more co-operation between them.

149. Assistant Commissioner McAdie said that there are well-established protocols about how joint investigations are to be conducted. However I heard evidence that although a new Memorandum of Understanding between FACS and Police has been drafted, it has not reached formal sign-off by the agencies. In addition there are some guidelines and protocols for conducting investigations but these are not completed. Assistant Commissioner McAdie gave evidence that nonetheless they are the standard for conducting such investigations.

150. I find the fact that the MOU has still not been completely implemented is disappointing. Nonetheless it is clear that there have been widespread and significant changes designed to improve FACS/Police relationships and I heard evidence from Assistant Commissioner McAdie who stated that:

> "these practices have now been established for some time and I am able to confidently state that the issues that arose from a lack of coordination between Police and FACS...would not occur under the current arrangements."

151. A Strategic Management Group (SMG) has been formed, this is the governance body for all responses to child maltreatment and aims to promote close cooperation between Police officers and FACS workers

engaged in complex child abuse investigations. It formulates policies and procedures for the Task Force.

152. Assistant Commissioner McAdie says a joint Child Forensic Interviewing Course has been developed, each course consists of both police and FACS personnel and the aim is that all staff working within the Child Abuse Task Force will receive the training and that, eventually, no victim of child abuse will be interviewed by someone who was not done the training.

153. A new *Act* has been introduced, providing an entirely different legislative structure for FACS, and the Policy Manual has also been changed. A Quality and Performance Unit were formed in 2008 and have commenced a monthly quality audit. The results of an audit for March 2009 revealed there were still difficulties with responding to notifications in a timely fashion in the Alice Springs Office. The evidence of Ms Scott was that many changes had been made and that the process was continuing.

154. The changes described above have apparently significantly changed the way FACS and police work.

155. I heard evidence that significant steps have been taken to resolve the deficiencies in interstate communications revealed by this case. In 2005 a position was created purely to deal with interstate matters. One of the first tasks of the person in that position was to create operational guidelines which were circulated in 2006 and are updated annually. Each interstate office now has a generic e-mail account which is accessed by more than one person. I am satisfied that no recommendations are required in this area.

CONCLUSIONS

156. I find that the primary cause of this death was failure to thrive because of insufficient caloric intake caused by the neglect of Ms [redacted].

157. In my view this death was preventable, that is had FACS acted as they should have, Kalib probably wouldn't have died. I am not criticizing any

individual FACS officer, rather I find that there were serious systemic problems that made it extremely difficult to work effectively in the FACS office in Alice Springs at the time.

RECOMMENDATIONS

158. Generally the evidence in this inquest reveals that there are ongoing concerns in relation to the FACS operations in Alice Springs and I recommend, in relation to systems (including computer and hard copy files systems), staff recruitment, training and support that adequate resources be given to fix these concerns. I also recommend that the MOU between FACS and Police be formally signed off.

159. I note that many of my comments and recommendations contained in the Melville findings (handed down today) are relevant to these findings in relation to Kalib.

FORMAL FINDINGS

(i) The identity of the deceased person was Kalib ███████-███ (usually known as Kalib ███████) born on 13 April 2005 at the Alice Springs Hospital. At the time of his death he had no fixed place of residence.

(ii) The time and place of death was between 5 am and 8 am on 1 June 2005 in a motorcar along the Port Wakefield Road at an unknown location between a point 22 kilometres south of Port Wakefield and Port Wakefield.

(iii) The cause of death was failure to thrive due to insufficient caloric intake.

(iv) Particulars required to register the death:

1. The deceased was Kalib ████████.

2. The deceased was of Caucasian decent.

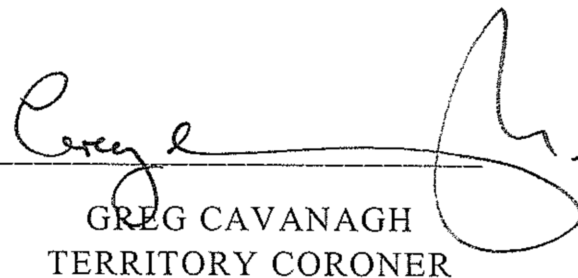
3. The death was reported to the Coroner.

4. The cause of death was confirmed by post mortem examination carried out by Dr Allan Cala, and then reviewed by Dr L Moore and A/Prof Hilton.

5. The deceased's mother was [redacted] and his father was Simon Francis Borrett.

6. The deceased had no fixed residence at the time of his death. He was an infant.

Dated this 19th day of January 2010.



GREG CAVANAGH
TERRITORY CORONER