CITATION: *Inquest into the deaths of Master W, Miss B and Master JK* [2020] NTLC 020

TITLE OF COURT:	Coroners Court
JURISDICTION:	Darwin
FILE NO(s):	D0082/2018, D0122/2018, D0185/2019
DELIVERED ON:	15 December 2020
DELIVERED AT:	Darwin
HEARING DATE(s):	13 October 2020 – 19 October 2020
FINDING OF:	Judge Greg Cavanagh
CATCHWORDS:	**Volatile substance abuse by children in remote Aboriginal communities, failure of government agencies to assist, unlawful practices by Top End Health Service, previous assurance of compliance not observed**

REPRESENTATION:

Counsel Assisting:	Kelvin Currie
Counsel for Education:	Helena Blundell
Counsel for Territory Families:	Tom Hutton
Counsel for Top End Health Service:	Peter Bellach
Counsel for family of Master JK:	Ian Grant
Counsel for family of Miss B:	Mark Thomas

Judgment category classification:	B
Judgement ID number:	[2020] NTLC 020
Number of paragraphs:	211
Number of pages:	59

IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

Nos. D0082/2018, D0122/2018, D0185/2019

In the matter of an Inquest into the death of

MASTER W
ON: 21 MAY 2018
AT: GAPUWIYAK

In the matter of an Inquest into the death of

MISS B
ON: 10 AUGUST 2018
AT: YIRRKALA

In the matter of an Inquest into the death of

MASTER JK
ON: 3 NOVEMBER 2019
AT: MANINGRIDA

FINDINGS

Judge Greg Cavanagh

Introduction

1. This inquest was the second of two inquests dealing with Aboriginal children known to government agencies to be at risk of severe harm, who despite knowledge of their difficult and high risk circumstances, received no genuine assistance or support.[1] Like the first inquest the lives and deaths of

[1] The first inquest conducted a month earlier was the *Inquest into the deaths of Fionica Yarranganlagi James, Keturah Cheralyn Mamarika and Layla Leering* [2020] NTLC 022

these children are confronting. Similarly confronting are the failures of the government agencies funded to assist them. I undertook an inquest in 2005 into the deaths of three young people who died from volatile substance abuse (VSA).[2] In 2018 and 2019 three children with a history of solvent abuse died in East Arnhem Land. Two died while sniffing solvents and the third child took her own life, after almost five years of sniffing.

2. Sniffing solvents is said to affect the young more often than adults and particularly the young from "socioeconomically deprived and marginalised groups, and rates are particularly high among some Aboriginal and Torres Strait Islander peoples".[3]

3. In 2006 the Northern Territory introduced the *Volatile Substance Abuse Prevention Act 2005*. One of the objects was, and remains, "the protection of persons, particularly children, from harm resulting from volatile substance abuse". [4] The framework to achieve that included a mechanism for application to be made for the assessment of a person believed to be abusing volatile substances.

4. The assessments are conducted by the volatile substance abuse (VSA) assessors. In the top end of the Northern Territory, that is a group of four clinicians employed by the Top End Health Service. Each year since 2009 the VSA assessors have dealt with at least 169 volatile substance users. In 2012 the number rose to 351. In 2015 it was 381 and for the first half of this year, 163. The figures also indicate that a large proportion of those that go to voluntary and involuntary rehabilitation do not complete their treatment.

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[2] Inquest into the deaths of Kumanjay Presley, Kunmanara Coulthard and Kunmanara Brumby [2005] NTMC 086

[3] The *Consensus Based Clinical Practice Guideline for the Management of Volatile Substance Abuse in Australia* (National Practice Guidelines) was published in 2011, page 24

[4] Section 3(1)(b)

Year	Individuals referred to TEHS	Treatment Orders made	Treatment Orders Completed	Voluntary Rehab Entry	Voluntary Rehab Completed	Cases Closed
2008	42	6	3	7	3	42
2009	199	11	7	8	3	199
2010	179	20	18	8	4	179
2011	169	14	8	20	5	169
2012	351	7	4	21	3	351
2013	271	11	4	22	3	271
2014	289	12	5	21	2	302
2015	381	10	4	38	15	397
2016	285	2	1	43	9	280
2017	283	6	1	55	9	273
2018	290	10	3	61	14	288
2019	255	4	1	51	10	248
June 2020	163	4	2	9	2	101

5. The three children the subject of this inquest were subject to assessments by the VSA assessors, notifications to the child protection agency and had disengaged from the education system.

6. Their parents asked that their identities be supressed and I made an order suppressing their identities. Accordingly, I refer to them by the pseudonyms suggested or agreed to by their parents.

Short Story

7. Master W was 12 years of age when he died. There were two applications for VSA assessment due to Master W's petrol sniffing and four notifications made to Territory Families, two of those in relation to sniffing. The last notification was received on 18 April 2018. Nothing happened between then and when he died a month later.

8. He was not a regular attender at school and there is little evidence that there were any significant or sustained efforts to engage with him and his family about his school attendance. From 2015 (9 years of age) his attendances became rare.

9. Master W was assessed to be at risk of severe harm by the VSA assessors on 3 October 2017 (4 months after the request for assessment) with a plan for him to attend rehabilitation. However, he was 11 years of age and the residential rehabilitation providers contracted to government could not take him.

10. His family became frustrated and upset with the inability of the government agencies to assist. They took him to an island to remove him from solvents. Eventually, after he turned 12 years of age he was accepted into BushMob (a residential rehabilitation facility in Alice Springs). That was 6 months after the application and Master W had continued to sniff solvents throughout that period.

11. He was expelled from BushMob on 26 February 2018 for fighting and property damage. He was returned to the community of Gapuwiyak. There was no plan to keep him engaged or safe after returning to the community.

12. His family wanted him to go back to rehabilitation. However, the VSA assessment team said there were no places. There was no aftercare plan or plan for intervention developed. The high risk he was at on his return was not elevated to the Chief Health Officer (CHO) as it had been done prior to him turning 12 years of age. Many Colours 1 Direction, a rehabilitation service that had agreed to take him previously was not considered. No options were provided to the family.

13. When the assessors were in the community on 5 April 2018 they were told he was sniffing and had forced 5 to 7 year old children to sniff as well. That only induced another notification to Territory Families from the VSA assessors. His family took him once more to an island where there were no solvents. He stayed for 17 days. The day after he returned he died while sniffing petrol.

Longer Story

14. Master W was born on 22 November 2005 at Royal Darwin Hospital. He lived at Gapuwiyak (Lake Evella) Community. His mother died on 16 April 2006, when he was just 6 months of age. He was an only child and after her death he was primarily cared for by his uncle and at different times, his grandmother. His father lived in Milingimbi.

15. He was first enrolled in preschool at Gapuwiyak in 2009. His final enrolment was in year 7 also at Gapuwiyak in 2018. However, he was also at times enrolled in Milingimbi School, Shepherdson College and Nhulunbuy Primary School. His attendance rate was generally low with an average attendance from preschool to year 7 of 33.6%. From 2015 his attendance fell. Mr Shane Dexter, General Manager, Quality School Systems and Support in the Northern Territory Department of Education, undertook a review of Master W's school experience and found no evidence of efforts to re-engage Master W in a timely, consistent, sustained or effective manner. He said:

> "Earlier intervention and/or escalation during his critical early years of schooling may have assisted in developing good attendance habits for [Master W] and his family."

16. The first time his poor attendance was escalated to the School Attendance Team was in 2016 during his eighth year of schooling. In the view of Mr Dexter that was too late given that he had long periods of low attendance from the time he commenced school.

17. He only sat for the NAPLAN assessment on one occasion. That was in year 3, in 2014. He was assessed as below the national minimum standard in all domains except spelling. He was absent for the scheduled tests in 2016 and 2018.

18. Mr Dexter found that there were multiple missed opportunities to engage with Master W and his family over his attendance, his lack of learning and achievement and after he attended funerals (12 occasions).

19. In 2012 there was a notification (**first notification**) to the Department of Children and Families (DCF) for neglect due to a boil on this leg. The notification was not substantiated. It was another 5 years before the next notification.

20. On 27 November 2014 just after Master W turned 9 years of age he was taken to the Health Clinic after having ingested petrol when attempting to syphon it from a motorcycle, for the purpose of sniffing. At 11 years of age he was sniffing AVGAS at Gapuwiyak to such an extent that in March 2017 his family sent him to his grandmother who was living at Ski Beach (near Nhulunbuy). However that did not stop his sniffing.

21. On 31 May 2017 his grandmother made an application for assessment (**first application for assessment**). It was received by the assessment team on 7 June 2017. His grandmother said in the application he had continued to sniff at Ski Beach, he hadn't attended school and was sleeping all day and going out late at night. She said he was difficult to manage or motivate and

requested that he be referred for rehabilitation. A comment in the notes of 7 June 2017 says, “There are no rehab centres available in the NT to take someone this age”.

22. On 7 June 2017 Territory Families (formerly DCF) received a notification from the VSA assessment team (**second notification**). The notification repeated the information in the application for assessment. The notification was screened in (accepted).

23. A VSA assessor attended Ski Beach on 29 June 2017 and spoke to the grandmother, however was unable to speak with Master W because he was in Galiwinku. It was determined that a referral would be sent to CAAPS rehabilitation service for participation in the Healthy Families Program. The referral was sent on 14 July 2017. However he was rejected on 18 July 2017 due to being under the age of 12 years. The response indicated that once he was closer to 12 years of age they would reconsider.

24. On that day (18 July 2017) contact was made with his grandmother. She said she had just returned to Gapuwiyak with Master W and wasn’t aware of any recent solvent use but continued to be concerned because he was still losing weight. The plan was to follow up with Master W and his grandmother on the next trip by the Darwin based team.

25. On 21 July 2017 he was taken to the Health Clinic to get his blood lead levels taken. He slept through the entire procedure. The VSA assessment team sent a *VSA Notification of Escalation of Risk* memo to the CHO. It stated Master W had been inhaling aviation fuel for the last three months, that he had been healthy and chubby but was now “small and skinny”, it indicated that he was not eligible for any residential facility due to his age and asked the CHO to “consider what other facilities or services might be

available". That was signed by the CHO on 9 August 2017, although it went no further. In the Laurie inquest[5] in relation to a similar issue, I said:

> "In effect, the lack of available options was not elevated high enough within the Top End Health Service (TEHS) and Department of Health that an appropriate treatment or intervention was identified and resourced. That seems to have been the case despite the Chief Health Officer seeing the memoranda sent to him stating that there were no facilities available."

26. The assessors travelled to Gapuwiyak on 10 August 2017. However they could not locate Master W or his family.[6] The results of the blood testing were provided to the assessors on 28 August 2017. They were 24.7ug/dl, about 5 times the average level. That was believed to be an indication that he continued to sniff AVGAS. A referral was sent once more to CAAPS in the hope that the intervening 6 weeks would be sufficient to convince them to accept him.

27. On 30 August 2017 an application for assessment (**second application for assessment**) was received from the Gapuwiyak Health Clinic. The application stated:

> "… Serious concerns from Grandmother regarding [Master W] and sniffing behaviours.
>
> [Master W] engaging in sniffing each night at the Gapuwiyak Lake with friends.
>
> [Master W] admitting to sniffing last night.
>
> States he sniffed petrol with x2 friends."

28. On 31 August 2017 the clinical manager at CAAPS advised that Master W could not be accepted because of organisational policy and their contract with the Department of Health requiring that their clients be a minimum of

[5] Inquest into the death of Edward James Laurie [2017] NTLC 015
[6] It was agreed that it was a theme that the services went to the communities without first checking whether the persons they wished to see were there. I was told that has since been corrected.

12 years of age. A referral was sent to BushMob (an entity subject to a similar contract).

29. On 1 September 2017 the assessor saw Master W. He was staying with an uncle and sneaking out at night. Over the weekend Master W got into a lot of trouble when he and some of his cousins broke into the council building and caused $20,000 damage. The school said, “there seems to be a little gang that hang out together at nights and possibly engage in sniffing”.

30. On 5 September 2017 BushMob said they couldn’t offer him a placement because he was too young. On 12 September 2017 the assessors noted that an initial assessment had been completed and determined that if there was further evidence of sniffing there was to be a recommendation that he be referred to Brahminy, “to enable/push them to pay for this program”. Five days later, on 17 September 2017, he was found sniffing petrol.

31. The next day the volatile substance abuse (VSA) assessors went to Gapuwiyak. They found the family very concerned about his sniffing, he had been sniffing the previous night. One of his uncles was said to go out at nights looking for him. One community member said there were kids sniffing every night near the lake, contractors said they were broken into almost every day, the nurse said that there had been reports about Master W sleeping by day, not attending school and being violent at times.

32. Master W wasn’t at home at that time, but he was found at a neighbouring property by his uncle. Master W said he had been sniffing petrol stolen from contractors, with 3 friends. He said he smoked ganja and cigarettes when he could get them and had smoked a bucket bong just before the assessors arrived.

33. His family wanted him to attend rehabilitation and were happy to assist with transporting him to Darwin. The plan was to submit another Escalation of Risk memo to the CHO recommending the Brahminy Foundation (Many Colours 1 Direction).

34. The *VSA Assessors Initial Assessment Report* and a *VSA Notification of Escalation of Risk* memo was sent to the CHO the next day (21 September 2017). The Assessment Report indicated that he was at risk of severe harm and recommended the Many Colours 1 Direction residential rehabilitation program. The Escalation of Risk memo indicated that he remained at risk of harm and had been denied entry to both CAAPS and BushMob. It set out the cost of the Many Colours 1 Direction option seeking a minimum 3 month placement. The CHO approved the placement. On 28 September 2017 a referral was made to Many Colours 1 Direction. It was accepted the following day. However the funding was never approved for him to go and he was not sent.

35. Although the CHO sits in the Department of Health, the VSA assessment team is part of the Top End Health Service. That appears to have meant that although the CHO could approve the placement it required the Chief Operating Officer (COO) of the Top End Health Service to approve the funding of the placement. The process to obtain that approval was commenced on 2 October 2017 when it was sent from the VSA assessors. It had to be signed off by the Operations Manager, the General Manager and then finally, the COO. Twenty three days later it had still not passed the General Manager.

36. On 6 October 2017 Territory Families closed the protective assessment case, opened in relation to the second notification on 7 June 2017, essentially because the family were actively involved in attempting to protect and rehabilitate him.

37. The Top End Health Service say that information was received prior to 17 October 2017 that the family had moved Master W to another community and that he was no longer sniffing. That appears to have been a mistaken interpretation of the information. Nevertheless, the application for funding for him to go to Many Colours 1 Direction was stopped on 25 October 2017.

38. The Community Care Information System (CCIS) indicates that on 9 October 2017 the family indicated that Master W was at Ski Beach with his grandmother. That information was confirmed on 12 October 2017 in a call to his uncle. It is likely that he was moved back to Ski Beach with his grandmother in an attempt to stop him sniffing. However it was known that he had a history of sniffing at Ski Beach. Indeed, the first application for assessment was from his grandmother about him sniffing at Ski Beach. There was therefore significant information that should have raised some doubt about the likely success of that option. It certainly should not have led to cancelling the plan to send him to rehabilitation.

39. The next relevant entries in the CCIS notes are on 25 and 26 October 2017 when the assessor attempted to call family and left messages to call back. Family called back on 31 October 2017 but the call was missed. The assessor rang back on 1 November 2017. In that call it was said that Master W was still at Ski Beach and his grandmother was very worried about him. He was not attending school and was going out at night. She said she wanted him to go to rehabilitation as soon as possible. She asked that they try BushMob again. She was told that an assessor would be at Ski Beach and would contact her. A referral was made to Anglicare Reconnect. However there was no attempt to reactivate the application for funding so as to send him to Many Colours 1 Direction.

40. The next day the assessors met the grandmother. She said she wanted him to go to CAAPS where he could also go to school. The assessors told her there were no places available at CAAPS. His grandmother became frustrated and accused the assessors of not wanting to help and not being caring. They said they would reassess if there were further reports of sniffing.

41. On 3 November 2017 the assessors made another referral to BushMob. On 8 November 2017 BushMob responded that they were unable to take him due to “current dynamics”. On 9 November 2017 the assessors spoke to the grandmother again. She said she was sick but he was being looked after by

an uncle in Nhulunbuy. She had been told that he goes out at night to sniff petrol with other youth. The plan was to follow up the Anglicare Referral and refer also to Raypirri Rom, a program run by the Miwatj Health Aboriginal Corporation.

42. On 22 November 2017 Master W turned 12 years of age and on 27 November 2017 he was accepted to go to BushMob. He travelled to Alice Springs and commenced the rehabilitation program at BushMob on 6 December 2017. He was the youngest child at BushMob. He did not attend school, he said because he had been teased at school in the past. Otherwise, it was said, he was doing well. He was due to complete his rehabilitation on 28 March 2018.

43. On 13 December 2017 Territory Families received a notification (**third notification**). It related to disclosures about fighting and violence back in the community. However there were no names and there was said to be a language barrier. The notification was screened out (not accepted).

44. On 26 February 2018 he was expelled from BushMob for fighting and property damage and on 1 March 2017 he was returned to Gapuwiyak. Two weeks later both the school principal and the Health Clinic nurse indicated that there were bottles of petrol and reports of sniffing in the community. The assessors checked with his uncle who said he was doing well, had not been sniffing and was at school.

45. On 5 April 2018 the assessors travelled to Gapuwiyak. The Health Clinic staff advised that Master W was sniffing over the Easter weekend and he had been forcing children as young as 5 years to sniff. The assessors said there were no positions available at rehabilitation. The plan was to make a notification to Territory Families.

46. On 17 April 2018 an assessor spoke to his grandmother. She said he was sniffing and she was fed up. The assessor reiterated that there were no rehabilitation positions available. The plan was, again, to notify Territory

Families. They made the notification on 18 April 2018 (**fourth notification**). The information provided was that Master W had forced two younger children to sniff petrol and that he had been sniffing regularly since his return to Gapuwiyak. The notification was screened in with a five day response time.

47. However, nothing happened prior to his death, over a month later. In her review, Ms Broadfoot saw that as "a missed opportunity to make meaningful enquiries about [Master W] which may have led to useful information being shared with the VSA Team in the period leading up to his death".

48. On 30 April 2018 the assessors attended Gapuwiyak. They were told that his father had taken Master W to an island to remove him from petrol. On 19 May 2018 Master W was driven back from the island. The following night he went out with his friends. It appears that at some time during the night he got into the back of a four wheel drive that had just come back from Darwin. He found a jerrycan in the back with unleaded petrol. He was found the next morning, deceased, still in the back of the vehicle. He was 12 years and 5 months of age.

Issues

49. Following the death of Master W, the Top End Health Service undertook a Clinical Incident Review and there followed a Root Cause Analysis. The Root Cause Analysis noted seven system issues:

- VSA team focussed on rehabilitation services and none for under 12 years children. It was said that had been overcome by allowing younger children to be accompanied to rehabilitation facilities;
- No child focused VSA assessment tool. It was recommended that one be developed;

- Inadequate and delayed communication, assessment and intervention with client, family and other service providers. It was noted he was left vulnerable and at high risk. It was indicated that a project officer was to commence in late January 2020 for a period of 6 months to develop a model of care and operational procedures to address the issue;

- Need to collaborate with other agencies. The communication was found to be adhoc and informal. It was said the 6 months project officer would remedy that issue;

- The limitation of the Community Management Plans to restrict solvents in communities. It was said the project officer would remedy by implementing MOUs;

- VSA team has no formalised model of care (defined processes/policy documents). Gaps were found in the depth of the risk assessments, escalation and mitigation of risk, process transfer between agencies and rehabilitation facilities, referral and follow up. The recommendation was to develop a model of care;

- Assessments and Interventions not documented appropriately. It was said there had been further education on documentation by time of analysis.

50. Those issues and recommendations were supported and signed by Michelle McKay, the Chief Operating Officer of the Top End Health Service on 11 May 2020. To date there is no information as to whether a project officer was employed, if any changes have been made or whether there is a formalised model of care.

51. The other recommendation, for a Child Focused VSA Assessment Tool, may overlap with a review undertaken in 2017 that recommended “an appropriate

VSA risk assessment tool". The progress of that is recorded as at 1 October 2020 as "being finalised".

52. However what was not recognised during the Root Cause Analysis was the failure to follow the framework required by the Act and guidelines. Specifically the need for the assessment to be undertaken within a short timeframe (2 weeks 'if practicable') and that if the child was at risk of severe harm, a report be provided to the CHO with recommendations for appropriate treatment programs. Had the procedures outlined in the Act and guidelines been followed it may not have been considered that the model of care was lacking.

53. The first application for assessment was received by the VSA assessment team two weeks after the findings into the death of Mr Laurie.[7] The time from receipt of the first application for assessment until his death was just under one year: 7 June 2017 to 20 May 2018. The Laurie findings in paraphrasing the Act stated at paragraphs 79 and 80:

> 79 The amended section 34 states that if the Assessor was satisfied on the information provided that the person was at risk of severe harm the Assessor **must** make an assessment of the person, **must** prepare a report and **must** give it to the Chief Health Officer (my emphasis).[8]
>
> 80 If the assessment found the person to be at risk of severe harm the assessment report **must** recommend an appropriate treatment program (my emphasis).[9]

54. Despite, what one might have thought would be a heightened awareness of the law following those findings, it took four months before the CHO was

[7] Inquest into the death of Edward James Laurie [2017] NTLC 015 findings delivered on 15 June 2017
[8] Section 34(1)(b) & (c)
[9] Section 34(3)

appraised of this case and only then because the assessors could not find a rehabilitation facility that would take Master W. It took another two months (21 July 2017 to 21 September 2017) before a plan was formulated to put him into rehabilitation with Many Colours 1 Direction. It was another two months (21 September 2017 to 27 November 2017) before he was admitted to BushMob for rehabilitation.

55. After Master W was expelled from BushMob there was no aftercare plan. From 26 February 2018 to 19 May 2018 the VSA assessment team provided no further options for treatment or intervention and had no further meaningful input. Their only plan was to notify Territory Families and as easy as it might be to criticise Territory Families for not doing anything in the month that followed, the notification was about sniffing, the core work of the VSA assessment team.

56. I find that Master W died on 21 May 2018 in Gapuwiyak community in the Northern Territory. The cause of death was due to inhalation of petroleum vapour. The cause of death was confirmed by forensic pathologist, Dr John Rutherford. The details required by the Registry of Births Deaths and Marriages will be provided separately.

In the matter of an Inquest into the death of

MISS B
ON: 10 AUGUST 2018
AT: YIRRKALA

Short Story

57. Miss B was raped by a family member in late 2013 when she was 12 years of age. Solvent abuse followed. The period of time from when she was raped until her death was 4 years and 8 months. During that period she was likely raped on another two occasions, saw her friend suicide and was beaten up by her boyfriend on at least two occasions. In that same period there were 9

applications to the VSA team for assessment and 13 notifications to DCF/Territory Families.

58. She went to a rehabilitation facility on three occasions:

- BushMob from 4 March 2016 until 31 March 2016;
- CAAPS from 23 June 2016 – 24 August 2016 and again from 23 September 2016 to 14 November 2016,
- BushMob again from 16 February 2018 to 12 April 2018.

59. The last time she was admitted to BushMob she was known to have been sniffing, fighting, sexually assaulted and had tried to kill herself. She had been admitted to the Mental Health Unit and said she would rather die than return to community. She was discharged from BushMob after she threatened to self-harm. The psychiatrist said she was at high risk and that a return to Yirrkala would not be helpful. The VSA assessment team facilitated her return. There was no aftercare plan.

60. On her return she 'wiped herself out' on cannabis, then in July 2018 threatened to kill herself and was admitted involuntarily to hospital. In August 2018 she killed herself.

Longer Story

61. Miss B was born on 17 April 2001 in Darwin. She lived in Yirrkala, an Aboriginal community 18 kilometres from Nhulunbuy on the Gove Peninsula. She had two younger brothers and a sister. Her father died when she was 7 years of age. She was at variously cared for by her mother, grandmother and two aunts.

62. Her school attendance average from transition through to year 12 was 41.4%. It fluctuated, in year 2 (2008) she attended for 95 days, down from 144 days the previous year. In 2012 she attended for 139 days but in 2013 only 48 days. From 2008 her student progress reports began to indicate that her low attendance made it difficult to assess her. From 2011 the school

started making home visits, engaging with her carers and searching for her in the community. That didn't improve her attendance and in 2015 she was referred to the school attendance team. Again there was no sustained improvement and in December 2016 she fell out of scope for the School Enrolment and Attendance Measures (SEAM) program. [10]

63. For the purposes of the inquest, Mr Shane Dexter, General Manager, Quality School Systems and Support in the Northern Territory Department of Education undertook a review of Miss B's school experience. He found that attempted interventions were too late in her schooling (first in 2011 when she was in year 5), were not consistent, sustained or effective and when her carers exited the scope of the SEAM program the school stopped its attempts to engage.

64. Miss B undertook NAPLAN testing in years 3, 5, 6 and 7. She was always assessed as being below the minimum standard in every domain. Mr Dexter found that there were many missed opportunities to engage with her and her family over her attendance, lack of achievement, the many funerals to which she was exposed (28), her substance abuse and her self-harming.

65. It was during the Christmas school holidays in 2013, when she was just 12 years of age that she was raped by an older nephew who lived in the same house. On 30 December 2013 her Grandmother took her to the Gove District Hospital. It was late in the evening and there were no interpreters or Aboriginal liaison officers available. Communication was said to be difficult and Miss B was said to be shy. The medical notes record: "headache, runny nose,?fevers for two days", "large blood and moderate leukocytes in urine. Patient denies menstruation".

[10] Improving School Enrolment and Attendance Through Welfare Reform Measure

66. The CARPA (Central Australian Rural Practitioners Association) standard treatment manual is used by health practitioners in the Northern Territory to assist with remote practice. The nurse wrote:

> "CARPA states if no frequency or dysuria, do not treat however collect urine for gonorrhoea + chlamydia + treat for STI stat. I am not prepared at this time to do the above as nil interpreter/nil health worker and inappropriate time of day when also patient came in for headache. Will link to clinic with above re: follow up."

67. Miss B was treated for urinary tract infection and referred to the primary health care provider for counselling around sex and STI testing. Three weeks later on 23 January 2014 she attended at the Yirrkala Health Clinic. She said she was not sexually active however received an Implanon contraceptive implant because her grandmother was worried that she was. She was tested for sexually transmitted infections and the results returned on 30 January 2014 were positive for trichomonas infection. The Department of Communities and Families (DCF) was notified. It was the **third notification** received in relation to Miss B and the first in 10 years. They referred the notification to the Child Abuse Taskforce (CAT) and screened the notification out (did not accept it).

68. The CAT referred the case to Nhulunbuy general duties police. They spoke to Miss B in the presence of her grandmother and recorded, that "both immediately denied everything and were reluctant to speak to police".

69. On 1 April 2014 Miss B disclosed to a community health nurse that she had been raped in the 2013 Christmas school holidays. DCF was notified (**fourth notification**) and referred it to the CAT, but again it was screened out.

70. A review conducted by Territory Families Executive Director, Ms Karen Broadfoot, in preparation for the inquest found that to be inappropriate. She said:

> "I consider this to be a significant failure …It was unacceptable for Miss B to remain at her grandmother's house … without an investigation being completed and steps taken to ensure [her]

> ongoing safety within the home … A critical opportunity to provide [her] support was missed … Screening the notification in could have changed [the agency's] entire engagement with Miss B"

71. Ten days later on 10 April 2014 it was reported that Miss B had been raped while sniffing on the Yirrkala oval. It was said that she had been screaming. When asked about what had happened she said a male pulled her hair and hit her in the back of the neck. The 'older ladies in the community' said she was raped. When she returned home at 6.00am her grandparents called police and they took her to the hospital for review due to her sniffing. She said it was the first time she had sniffed petrol.

72. Applications were made by the hospital and police for Miss B to be assessed to determine whether she was at risk of severe harm, pursuant to the *Volatile Substance Abuse Prevention Act* (**first and second applications for assessment**). The Top End Health Service, VSA assessment team made two attempts to locate Miss B and rang other agencies. There were no reports of sniffing and on 30 June it was determined to close the file finding her not to be at risk. The CHO formally signed off on the closure on 14 July 2014.

73. There were also two notifications made to DCF on 14 April 2014 in relation to the sniffing and sexual assault. The notifications were combined by DCF and screened in (**fifth and sixth notifications**). Amongst other concerns, it was noted that she had been sexually assaulted twice that year and tested positive to a sexually transmitted infection.

74. On 15 April 2014 the CAT was in Yirrkala (in relation to the sexual assault reported on 1 April 2014) and a multi-disciplinary meeting was held between Health, Education, the CAT, and DCF. Her family were said to be concerned about her speaking to police about the rape and had removed her from school. Police went looking for her. They found her with family. A safety plan was made for her to stay with different family members where she felt safer.

75. There was a Remote Aboriginal Family Care Worker (employed by DCF) working in Yirrkala who assisted with organising interventions and monitoring Miss B. By 28 May 2014 it was reported that Miss B was participating in the Girls Group, playing footy with the girls and regularly attending school.

76. On 3 June 2014 there was a meeting held with her family. It was considered that Miss B had not been sniffing but her aunt worried that she continued to go out at night. There was also unease that the VSA assessment team had not, to that point, been involved. It was determined that she would have more STI screening and the prospect of going to boarding school would be raised with her. On 22 July 2014 the child protection investigation report was finalised, neglect was found to be substantiated, however the child protection case was closed with no further action.

77. On 21 November 2014 when Miss B was 13 years of age she went to the disco with her 15 year old cousin-sister (who was also known to sniff solvents). When they got home her cousin-sister asked her to go inside and make a cup of tea. When she returned she found her cousin-sister hanging from a rope tied to a branch of a nearby tree. The community blamed Miss B for her death and there was talk of payback.

78. The Yirrkala School undertook a critical incident response over the next week along with a Suicide Bereavement Workshop. The child protection agency indicated that as they didn't have an open case for the cousin-sister there was no need for their involvement.[11] There is no evidence of any supports specifically provided to Miss B. It was noted that her sniffing of petrol increased following the suicide.

79. Miss B was next reported to be sniffing petrol on the weekend from 7 – 9 February 2015. On 13 February 2015 a notification was received by DCF

[11] Email from Quinlan dated 24 November 2014

(**seventh notification**). Miss B and 20 other children between 8 and 16 years of age were said to have been involved in breaking into premises to obtain solvents and sniffing them. The notifier said that a community meeting would be held on 19 February 2015 that would be attended by all relevant government agencies and non-government organisations. The notification was screened out. Ms Broadfoot was of the opinion that in isolation that was appropriate given that it was being dealt with as a whole of community issue. However she went on to say:

> "Had DCF substantiated the sexual abuse notification received … in April 2014, Miss B's VSA may appropriately have been understood as a response to trauma that Miss B had suffered …"

80. On 24 February 2015 an application for assessment (**third application for assessment**) was received from a staff member of DCF in relation to Miss B and 11 other children. On 26 February 2015 a multi-agency meeting was held in Yirrkala. The following day Miss B and three others were found by police sniffing petrol at the pump house at the lake. There was further information that she was sniffing on 17 March 2015. However there were no further reports from then until 26 June 2015 and the file was closed with a finding that she was not at risk of severe harm.

81. On 2 March 2015 a notification was received by DCF relating to Miss B sniffing petrol with three others at the pump house (**eighth notification**). It appears to have been the intention to recommend that the notification be screened in and proceed to investigation because of a recognition of cumulative harm. However, for reasons that are not clear it was screened out on the basis that the "allegations do not meet the threshold to investigate".

82. On 2 October 2015 there was a notification (**ninth notification**) to DCF stating that Miss B was not attending school because she was sniffing petrol. It was mentioned that she was living in a house where another person had suicided. The notification was screened in with a response priority of 10 days.

83. It was three weeks later, 23 October 2015, before anything happened. The information gathered was that she was spending time with a group of girls involved in anti-social behaviour and sniffing. Nothing of note appears to have happened thereafter. The notification remained unallocated at least until December of that year. The final outcome was that neglect was substantiated and the file closed on 26 April 2016. Ms Broadfoot commented that DCF actions "did not include additional support, targeted towards the [suicide]".

84. In the meantime, on 29 December 2015 an application for assessment (**fourth application for assessment**) was made by police. They had found Miss B sniffing with 5 others. They took her back to her family. The VSA assessment team did not seek to meet with Miss B or her family until 22 February 2016. They did not seek to notify anyone ahead of their visit on that date and they couldn't find her when they visited.

85. However, prior to the VSA assessment team visiting Yirrkala and seemingly without their knowledge, the Reconnect Worker at Anglicare made an application on 28 January 2016 for Miss B to attend BushMob rehabilitation centre in Central Australia. Miss B was 14 years of age at the time. The application recounted that she had been sniffing for "14 – 18 months minimum".

86. Miss B was seen sniffing petrol over the weekend of 7 – 9 February 2016 and again on 21 February 2016. On 24 February 2016 an application for assessment (**fifth application for assessment**) was made by the Community Child Safety and Wellbeing practitioner (an employee of DCF).

87. She went to BushMob voluntarily on 4 March 2016. She was expelled on 31 March 2016 due to ongoing disruptive behaviour. It was thought that a male also at BushMob was culturally her intended partner. He became upset when she paid attention to other males. A note stated:

> "[Miss B] is exiting today – phone check-ups required as she displayed anxious behaviour due to returning home."

88. The discharge report in part stated:

> "…been engaged in VSA from age of 14 on a regular basis, heavy user and no period of reduction prior to attending BushMob and sometimes smokes cannabis".
>
> "She needs to be involved in something engaging back in the community and not make wrong choices."

There was however, no aftercare plan.

89. On 10 May 2016 she was reported to be sniffing at the beach area with others. On 30 May 2016 she was reported to be sniffing on the oval and on 31 May 2016 it was reported that she was self-harming by cutting her arms and legs. The Anglicare worker was trying to get her to boarding school but Miss B did not meet the 35% cut off attendance rate.

90. On 2 June 2016 a notification was made to DCF (**tenth notification**). It was said that Miss B was sniffing petrol again and her family had taken her to the health clinic. It was considered that the VSA assessment team was the best service to respond and the notification was screened out.

91. On 8 June 2016 it was recorded that she wanted to go to CAAPS Aboriginal Corporation rehabilitation program as soon as possible. She said she would rather go than wait for planned funerals. She was referred by the VSA assessment team on 15 June 2016. After the referral she was seen sniffing on 16 and 17 June 2016.

92. She commenced the CAAPS program on 23 June 2016. She attended for 16 weeks and 3 days in total (9 weeks from 23 June 2016 – 24 August 2016 returned to community for sorry business and then 7 weeks from 23 September 2016 to 14 November 2016). While in rehabilitation there was a concern about her attempted "ongoing self-asphyxiation".

93. When she returned to the community between 24 August 2016 and 23 September 2016 she was known to have sniffed regularly. On 23 September 2016 Territory Families (formerly DCF) received a notification about Miss B being assaulted by her boyfriend (**eleventh notification**). The notification was screened out because the information did not disclose neglect on the part of her carers.

94. There were no reports of her sniffing after completing the CAAPS program on 14 November 2016 and on 17 January 2017 the assessment team found her not to be at risk of severe harm and the signature of the CHO was obtained on 19 January 2017. The file for the fifth application was closed.

95. On 23 April 2017 Miss B was taken to the emergency department of Gove Hospital at 8.31pm. She had been assaulted with an axe or hammer to the head, left forearm, right shoulder and lower back. She appeared intoxicated. Her boyfriend (the one that had previously been thought to be her intended partner) had attacked her after sniffing with her all day. She escaped and ran to her family.

96. On 24 April 2017, Territory Families received a notification from police in relation to the assault (**twelfth notification**). It was screened out for the same reasons as the previous assault. Of that, Ms Broadbent stated:

> "However, given that this was the second assault by the same individual and with [Miss B's] history of trauma allegedly perpetrated by men, concerns regarding [Miss B's] ability to identify risky situations and keep herself safe warranted further consideration.
>
> At the time this notification was received, [Miss B] had allegedly been sexually assaulted, physically assaulted, engaged in VSA on a number of occasions, and lived in a household with a young person who had committed suicide – all of which had occurred while [Miss B] was at a very young age …
>
> A proper assessment of the cumulative harm experienced by [Miss B] in April 2017 should have resulted in the notification being screened in and an investigation commenced. This was a missed opportunity

> for Territory Families to engage [Miss B] and those around her, to verify her safety and wellbeing, and to intervene if necessary."

97. On 25 April 2017 police made application for a VSA assessment (**sixth application for assessment**) relating to the same sniffing and the assault. Throughout May 2017, Miss B wanted to go to BushMob. On 3 May 2017 she called BushMob herself. She said she was sniffing every day. On 9 May 2017 she spoke to a VSA assessor. She said she was sniffing on a regular basis and wanted to go to BushMob. On 25 May 2017 there were reports that she was sniffing a lot and wanted to go to BushMob.

98. The VSA assessor said local clinic staff had mentioned girls in the community were sniffing petrol so they could go to BushMob. There was no indication as to why that was thought to be the case. Nor, was that information reported to Territory Families. The General Manager of Alcohol and Other Drugs, Mr Campion conceded that sniffing by girls so as to be removed from the community was a "huge red flag".

99. There were no more reports of her sniffing after 25 May 2017. On 5 June 2017 her grandmother said she wanted Miss B to stay (rather than her going to BushMob) so Miss B could look after her. The assessment was completed on 24 August 2017. She was assessed as not being at risk of severe harm and the file was closed on 25 September 2017.

100. On 7 February 2018 an application for assessment was made by a family member saying that she was sniffing with friends after school (**seventh application for assessment**). The following day she attempted to kill herself. She was found by family lying on the bed with the cord of a hair straightener around her neck. On arrival the paramedics found visible ligature marks around her neck. She was taken to the Gove District Hospital and then evacuated to Royal Darwin Hospital due to mental health and safety concerns. She was admitted to the Youth Inpatient Unit of the Top End Mental Health Service. She said she would rather die than return to the community.

101. On 9 February 2018 another application for assessment (**eighth application for assessment**) was made by the school. It alleged that on 4 February 2018 while at Shady Beach, Miss B and others had videoed themselves sniffing and fighting.

102. That same day Territory Families received two notifications relating to the attempted suicide (**thirteenth and fourteenth notifications**). The first notifier said that Miss B was frightened because 'something had happened' and she had been stalked by a man who threatened her and her family with a knife. The other notifier said that she had been dragged by the hair and hit to the back of the neck. The doctors thought she had been sexually assaulted.

103. Both notifications were screened out by Territory Families because at the time she was in the mental health unit and arrangements were being made for her to go to BushMob. In the opinion of Ms Broadfoot, they should have been screened in because there was no resolution as to her safety when she returned to community and the cumulative harm was continuing to accumulate for Miss B.

104. She remained in the mental health facility until 15 February 2018. She was then discharged to BushMob. On arrival she was rated as a "serious imminent risk". On 5 April 2018, while still at BushMob, she threatened self-harm. The psychiatrist wrote:

> "anxious and a little avoidant, at high risk due to peer group petrol sniffing and self-harm habits.
>
> Engaging in a psychotherapy process will be helpful. Unfortunately it seems her support system in Yirrkala is for VSA and self-harm, so return to this will not be helpful. Any connection to healthy programmes up there will be vital. When she gets very anxious here she may voice self-harm as an escape, calming, soothing, orienting, supportive responses are recommended."

105. The following day a decision was made by BushMob to expel her for "non-compliance, behaviour issues and wanting to return home". She was returned to Yirrkala on 12 April 2018. Despite the opinions of the psychiatrist there was no plan or engagement to assist and support her on return to the community.

106. A final notification was received by Territory Families on 1 May 2018 (**fifteenth notification**). The notifier stated that on her return to the community she was acting 'crazy' and a family member had provided to her a 'bag of weed' to calm her down. She had been smoking it all week. She said she was trying to 'wipe herself out'. The notification was screened in for investigation. The investigation obtained her health records that indicated she was a medium to high risk for depression, suicide and alcohol and other drug use. Territory Families attempted to visit her on 4 occasions between 17 May 2018 and 6 July 2018 without success.

107. On 12 July 2018 family called Police to say that Miss B was saying she was going to hang herself. She had been drinking rum and sniffing petrol and started arguing with her poison-uncle about her sniffing. She became angry and threatened to kill herself. She was sedated and taken to Gove District Hospital where she was involuntarily admitted. She was said to have implied that she had been given the alcohol by males.

108. She was not thought disordered and said she was not suicidal, just angry. She wanted to go home. She was assessed as highly vulnerable to alcohol, sniffing and sexual exploitation but the risk of self-harm was thought to be low. The hospital contacted Territory Families who said they would follow up with her in "the next day or two". She was discharged and taken home by family.

109. Inquiries of family indicated that they were supportive of Miss B and the child protection case was "outcomed" (finalised) that same day (12 July 2018). No abuse or neglect was found.

110. An application for assessment was made by police due to her sniffing and the other events of 12 July 2018 (**ninth application for assessment**). There was no action in relation to that application. However on 24 July 2018, just 12 days later, in relation to the earlier application received since 9 February 2018, the assessment team found that she was not at risk of severe harm and the CHO endorsed the recommendation that the file be closed. There was no recognition of the application on 12 July 2018 or the events described in that application. The CHO wrote a letter to the notifier stating:

- Miss B had been assessed and monitored by a Specialist Assessor;
- She was not currently using volatile substances;
- There had been no reports of her using solvents since 9 February 2018; and
- No treatment order would be sought.

At least two of those assertions were clearly false

111. Just over two weeks later, on 9 August 2018, Miss B went into Nhulunbuy and at 7.00pm met up with friends at the beach where she drank rum and coke. At about 10.00pm she walked into town with the group of friends. She met her brother who was unhappy with her state of intoxication. Their disagreement turned into a fight and she stabbed him to the back and stomach (not fatally).

112. She found her mother who waved down police and they in turn waved down a Night Patrol vehicle. Night Patrol took her the 18 kilometres back to Yirrkala. She went into the house got an extension cord and hung herself from a tree. It was the same property at which her cousin-sister had hung herself almost 4 years earlier.

Issues

113. For Miss B, 2013 was a difficult year. She was 12 years of age and attended school on only 48 occasions. The year ended with her being raped. However the years that followed were no better and there were many indicators that she was vulnerable and at high risk. Most of the indicators were recognised from time to time.

Top End Health Service

114. Following the death of Miss B, the Top End Health Service undertook a Clinical Incident Review and there followed a Root Cause Analysis (RCA). The RCA was completed on 18 November 2019. The team stated:

> "In the course of this investigation, the case review teams were unable to identify a root cause or contributory factor that resulted in this incident. The case review teams did identify a range of systems issues that could increase the likelihood of adverse events." [12]

115. The system issues mentioned were:

- Lack of a child focussed VSA assessment tool. A recommendation was made that one be developed, inclusive of 'trauma informed care' and added to the Guidelines;
- Assessments and interventions were not documented appropriately. That was said to have since been remedied;
- No formalised model of care. Gaps were found in the depth of the risk assessments, escalation and mitigation of risk, process transfer between agencies and rehabilitation facilities, referral and follow up. There was a recommendation to develop a model of care;

[12] Page 21

- Limited integration between the VSA team and the rest of Alcohol and Other Drugs. It was said strategies had already been implemented to remedy;

- Lack of adherence to documentation standards policies. It was said a new electronic medical record system was being developed.

116. However, again the reviewers did not identify that there had been a lack of compliance with the procedures set out in the Act and guidelines and if there had been there is unlikely to have been the requirement for a model of care.

117. There were nine applications for assessment:

1) 10 April 2014 – 2 applications - after sniffing on oval all night and being raped. Two unsuccessful attempts to visit. Closed on 14 July 2014 after no reports received about sniffing for 2 months;

2) 24 February 2015 – after sniffing with 11 other children. The next day sniffing with 3 others at pump house. Sniffing on 17 March 2015. No further reports in the 2 months after that. Found not at risk and file closed 26 June 2015.

3) 29 December 2015 – sniffing with 5 others. VSA team attempted to see her on 22 February 2016. Nothing of note happened apart from 'monitoring'.

4) 24 February 2016 – appears to have been joined to previous application – sniffing 7 – 9 and 21 February 2016. Went to BushMob on 4 March 2016 – discharged on 29 March 2016. On 10 May 2016 openly sniffing on the beach with others. On 30 May 2016 sniffing on oval. On 31 May 2016 cutting arms and legs. Sniffing on 2, 16 and 17 June 2016. Went to CAAPS 23 June 2016 – 24 August 2016. Seen sniffing 24 August 2016, 6 September 2016, 7 September 2016 and 15 September 2016. On 21 September 2016 hostility and violence in

community between sniffers and non-sniffers. Returned to CAAPS 23 September 2016 and remained until 14 November 2016. On 17 January 2017 assessment completed. Found not at risk and no recommendations.

5) 25 April 2017 – sniffing and assaulted by boyfriend. Wanting to go to BushMob. Saying sniffing every day. No reports of her sniffing after 25 May 2017. Assessment completed 24 August 2017. Found not at risk.

6) 9 February 2018 – Two applications received and merged. Sniffing with friends after school and videoing themselves sniffing and fighting on 4 February 2018. On 8 February 2018 she tried to kill herself. Taken to hospital, evacuated to Darwin and admitted to Mental Health Ward. Discharged to BushMob on 15 February 2018. On 5 April 2018 threatened self-harm. On 6 April 2018 expelled from BushMob. Assessment completed 21 June 2018. No further reports of sniffing. Found not at risk. Signed off by CHO on 24 July 2018

7) 12 July 2018 – sniffing, drinking rum and threatening to kill herself. Taken to Hospital. No action by VSA assessors. Died 9 August 2018.

118. If the Act and Guidelines had been followed the assessments would have found that Miss B was at risk of severe harm on at least 4 occasions: numbers 2, 4, 5 and 6 above. That is, if the assessment had been conducted with some urgency (within 2 weeks, if practicable), it would have been found that during the period of assessment Miss B was either sniffing petrol on a regular basis prior to the application or continuing to sniff petrol after the application. In 4 and 6 above she was obviously thought to be at high risk because she went into rehabilitation and yet the assessment when it was eventually completed found her not to be at risk.

119. If she was found to be at risk of severe harm the assessor would have been required to prepare an assessment report recommending an appropriate

treatment program and include each treatment or intervention to be provided by the program. That was never done. Instead, rehabilitation was arranged without an assessment and without a treatment program. There was never a plan for Miss B as to how she would be supported in the community, particularly after completing rehabilitation (or after being expelled). Clearly there was a lack of appropriate assessment and care planning. That was probably less to do with their being no child focussed VSA assessment tool or a formalised model of care, and more to do with a failure to follow the Act and guidelines.

120. There was no change to the procedures of the VSA assessment team after the Laurie inquest and findings. If there had been, it would be expected that there would have been a change in the procedures responding to the last three, or possibly four, applications for assessment.

121. The applications numbered 6 above were closed on 24 July 2018 by the CHO stating there had been no use of volatile substances since 9 February 2018. That was clearly incorrect. Twelve days previous to that date the VSA assessors had received an application for assessment detailing sniffing and her threatening to take her own life.

Territory Families

122. From the age of 12 there were 13 notifications to DCF/Territory Families:

1) 30 January 2014 – tested positive to STI at age 12. Referred to CAT and screened out;

2) 1 April 2014 – disclosed rape in December 2013. Referred to CAT and screened out;

3) 14 April 2014 – 2 notifications - sniffing and rape on the oval. Screened in, neglect substantiated. Interventions included joining

Girls Group, playing footy and assistance in attending school. Case closed on 22 July 2014;

4) 13 February 2015 – with group of 20 children sniffing and breaking into premises to obtain solvents. Screened out.

5) 2 March 2015 – sniffing petrol at pump house on 25 February 2015. Screened out.

6) 2 October 2015 – not attending school, sniffing petrol and living in house where another had suicided. Screened in. Remained unallocated for a number of months. Neglect was substantiated and file closed on 26 April 2016.

7) 2 June 2016 – sniffing. Screened out.

8) 23 September 2016 – assaulted by boyfriend. Screened out.

9) 24 April 2017 – assaulted by boyfriend while sniffing. Screened out.

10) 9 February 2018 – 2 notifications – Thought to have been sexually assaulted and attempted suicide. Both notifications screened out.

11) 1 May 2018 - had returned to community from BushMob acting "crazy" and had been given a bag of "weed" to calm her. Tried to "wipe herself out". Screened in. Attempts to visit but not seen. She died 9 August 2018.

123. Part of the problem with the intake procedures of DCF/Territory Families was the use of the *Structured Decision Making Policy and Procedures Intake Manual* (SDM Intake Manual). 'Sexual abuse' was defined as that 'imposed on a child by his/her parent/caregiver'. 'Neglect – Failure to protect from others' would be screened in where 'there is insufficient information to determine that the child's parent/caregiver is/will be

protective AND the circumstances of the alleged harm suggest the child will require protection'.

124. It seems that superimposed on those definitions was a reversal of the onus such that where there was insufficient information on the notification to determine that the parent or caregiver was neglectful that the case was screened out rather than in.[13]

125. The resulting screening out of 9 out of 13 notifications are of significant concern. Those notifications screened out included STI's found in a 12 year old refusing to acknowledge having sex, two alleging rape, two alleging assaults in a domestic context and an allegation of attempted suicide after being sexually assaulted.

126. Perhaps the definitions were not well suited to the life as experienced by children like Miss B in Aboriginal communities where there were multiple carers, frequent changes in care arrangements and an inability of willing and protective carers to protect children. I was told that the SDM Intake Manual is being phased out and being replaced by the Signs of Safety Practice Framework (Signs of Safety) and that the Signs of Safety necessarily requires a more holistic assessment of the risks and safety of a child.

127. I was told that if the Signs of Safety had been in place, there would have been significantly more occasions that Territory Families engaged with Miss B and her family. More importantly, if the second of the above notifications had been screened in, it would likely to have led to an appreciation of the trauma that was driving the sniffing and if that happened many more of the notifications would have been given appropriate attention.

[13] Statement of Karen Broadfoot paragraph 76.

128. I was told that in the case of Miss B there was a failure to appreciate the role of cumulative harm, but that since 2017 Territory Families have taken steps to train staff to recognise the accumulation of harm.

Education

129. The Department of Education was aware of Miss B's disengagement from school, her attendance at 28 funerals over the course of her schooling and her petrol sniffing. They made an application for her to be assessed by the VSA team on 9 February 2018. It was conceded that there were multiple opportunities for the department to engage that may have mitigated Miss B's vulnerability and reduced the risks to which she was exposed.

130. I find that Miss B died on 10 August 2018 at Yirrkala. The cause of death was self-inflicted hanging. The cause of death was confirmed by forensic pathologist, Dr John Rutherford. The details required by the Registry of Births Deaths and Marriages will be provided separately.

In the matter of an Inquest into the death of

MASTER JK
ON: 3 NOVEMBER 2019
AT: MANINGRIDA

Short Story

131. Master JK was 13 years of age when he died. He was known to sleep by day and wander the community with his friends at night. He rarely attended school. There were four applications for him to be assessed and seven notifications to Territory Families, all but one relating to sniffing. The first application, on 17 October 2017 for him to be assessed, followed his grandparents finding him passed out. Further applications on 20 February 2018, 1 April 2019 and 9 April 2019 were made after him being captured on CCTV at the petrol bowsers in the early hours of the morning.

132. Despite significant evidence that he was at risk of severe harm, the assessors case managed and monitored him on each occasion until there was a two month period during which no reports were received that he was sniffing, after which an assessment was completed, finding that he was not at risk. That was sent to the CHO who signed it and the file was closed.

133. In the period from 17 October 2017 until his death on 3 November 2019 from sniffing solvents, it was clear and conceded that even on the information available to the assessors he was known to be at risk of severe harm. Yet he was never assessed to be at risk. When he and his family refused rehabilitation, a treatment order available under the Act, was not sought.

Longer Story

134. Master JK was born on 19 November 2005 in Darwin. He was raised in Maningrida. He spent most of his time there but also lived from time to time in Palmerston and at Borlkjam outstation.

135. He undertook the vast majority of his schooling in Maningrida where he attended from preschool in 2009 through to year 8 in 2019. He never sustained high attendance. In his two years at pre-school he attended for 32% of the time. That rose in year 2 (2013) to 65.8%. In 2015 he was referred to the Senior Attendance and Truancy Officer. On 23 September 2015 the Australian Government advised that he had fallen out of scope for the SEAM program. His attendance rate was 13.2% in year 7 (2018) and 10.5% in year 8 (2019).

136. In his review of Master JK's school experience, Mr Shane Dexter found that there should have been earlier intervention and engagement to assist him and his family in developing good attendance habits. It was not until his seventh year that action was taken. His low attendance was reflected in consistently low academic achievement. He was absent for NAPLAN testing in years 3 and 7 but was tested in year 5 (2016). He was assessed as being below the

minimum standard for each domain. Mr Dexter found that there were successive opportunities, particularly in his early years for interventions, for Student Support Plans or Individual Learning Plans that may have assisted to keep him engaged in his education. Those opportunities were not taken.

137. Mr Dexter also found multiple opportunities that could have been taken to support Master JK, including four occasions when he received treatment for his hearing, after attending funerals (on three occasions), on three occasions he was found smoking, when he was involved in criminal activity and the two times an assessment application was made by the school in relation to him sniffing petrol. On those occasions the school received a response that "a treatment order will not be applied for at this stage".

138. At the age of 8 years Master JK was found sniffing bug spray with friends and was known to smoke cigarettes at school from the age of 9 years. On 24 June 2016 when 10 years of age a notification (**first notification**) was made to DCF. It was said that he had been located with other children sniffing opal fuel mixed with orange juice. It was said he was "known in the community for poor school attendance and supervision". DCF referred him to the Community Child Safety and Wellbeing Team and screened out the notification.

139. On 24 November 2016 a notification was made to Territory Families (**second notification**) from the school. Master JK and two other children were found sniffing petrol from coke bottles on Sunday at about 4.00pm. That was added to the previous notification as a 'duplicate report'.

140. On 17 October 2017 the **first application for assessment** was made. He was 11 years of age. His grandparents found him 'passed out' after sniffing petrol for an hour. They took him to the Health Clinic. On 18 October 2017 the VSA assessment team notified Territory Families (**third notification**). The notification was screened in for neglect and proceeded to investigation.

141. The VSA assessment team attended his home in Maningrida 10 days later on 27 October 2017. However he was with his mother in Palmerston at that time. They went to Maningrida again on 9 November 2017 with a plan to locate and review him. However he and his mother were still in Palmerston. An appointment was made with his mother to visit them in Palmerston at 11.00am on 13 November 2017. When they met, his mother said she had taken him away from Maningrida to get him away from the sniffing influences. Master JK said he wouldn't sniff anymore. He was shown a video on sniffing and provided 'education'.

142. The Territory Families investigation was 'outcomed' on 22 November 2017. No abuse or neglect was found. During the investigation, staff had been unable to meet or talk to Master JK but spoke to the VSA assessors after they met with him on 13 November 2017. It was reported that the assessors had no child protection concerns for Master JK. In reviewing that process Ms Karen Broadfoot on behalf of Territory Families had concerns that the investigation was slow to start and that Master JK was not seen and assessed by staff and as a consequence there was no information about nutrition, parenting practices and supervision. She was also critical that having been 'outcomed' the file was not closed.

143. The VSA assessors spoke to his mother again on 4 December 2017. She said he wasn't sniffing and the plan by staff was to close the file on 17 December 2017 as that would be two months after the application with no further reports of sniffing. The VSA assessors spoke to his mother again on 7 December 2017. She said Master JK had gone back to Maningrida for Christmas. The assessor noted some concern that he was back in Maningrida without his mother, at the same place he had the sniffing problem. Nevertheless, the assessment was completed on 18 December 2017. He was found not to be at risk of harm and the file was closed on 21 December 2017.

144. On 16 February 2018 Master JK was seen getting petrol from the bowsers at 1.00am. An application for assessment was made on 20 February 2018 (**second application for assessment**). The assessors travelled to Maningrida on 4 April 2018. They couldn't find Master JK or his family. The assessors phoned his mother the next day. She said there had been a big community meeting recently, regarding troubled youth sniffing, breaking and entering and having low school attendance. The issues had been causing much tension in the community. She said if Master JK continued to sniff she wanted him to go to CAAPS.

145. On 10 April 2018 another notification was received by Territory Families from the school. He had heavily infected scabies of the right hand (**fourth notification**). It was screened in and merged with the notification made on 18 October 2017 that had remained open despite the investigation being "outcomed".

146. There were no further reports of sniffing after that date and on 14 June 2018 the assessment by the VSA Team was completed. Master JK was found not to be at risk of severe harm and the file was closed.

147. Territory Families visited Maningrida in an attempt to see Master JK on 12 May 2018 (but he and his mother were on sorry business in another community). The first case about sniffing was closed on 16 May 2018.

148. On 5 July 2018 when the VSA assessors visited, Master JK and his mother were in Katherine, but on 15 August 2018 the VSA assessors found him at home. The assessors were told by his mother and grandmother that he was regularly attending the Health Clinic for his skin and was no longer sniffing. He was at that time suspended from school because he had broken into the school on 5 August 2018, destroyed property, graffitied the school bus and buildings and stolen $10,000 worth of school property.

149. In relation to the Territory Families notification, no abuse or neglect was found and the case was closed on 30 August 2018. In relation to that

investigation, Ms Broadfoot was critical that his sniffing was not adequately explored or investigated. In her opinion the "response provided to [Master JK] was not holistic". There were however no more reports of sniffing that year.

150. It is likely that there was a period from at least December 2018 to March 2019 when Master JK was in Darwin. However he returned to Maningrida on 25 March 2019. On 27 March 2019 he went back to school but left after the first few hours.

151. On 1 April 2019 an application for assessment was made by the police (**third application for assessment**). Master JK had been seen on CCTV at the petrol bowsers at 4.00am and several nights earlier was involved in an unlawful entry. His carers were doing their best to keep him from leaving the house at night but had been unsuccessful. The application stated:

> "Known issue ongoing. Youth unwilling to remain at home at night and regularly sniffing fuel. He is clearly at significant risk if he continues to reside in Maningrida".

152. The Maningrida Progress Association wrote to the assessors in the following terms:

> "Good morning we have had another wave of sniffers hanging around MPA fuel bowsers causing serious issues … wall of Alod Hasty building had fuel poured on it and set alight … they lit up the whole road from Batchelor College yard through the intersection to the Centrelink building and towards the servo they apparently had a plastic jerrycan with the latter dumped on the intersection of hostel and police house … the servo has just cost MPA another small fortune to replace cut hoses, broken nozzles and other fittings. Any ideas on what approach should be taken as it is only a matter of time before someone gets seriously hurt."

153. On 1 April 2019 Territory Families received a notification from the VSA assessors (**fifth notification**). Master JK was said to have been seen with five other youth sniffing fuel at the bowsers. The school said that prior to Master JK returning to the community there was virtually no sniffing. He

was seen sniffing on the CCTV five times in twenty hours: 4.57am, 6.41am, 11.03pm on 30 March 2019 and 12.08am and 1.00am on 31 March 2019. Territory Families screened it in with a view to proceeding to investigation.

154. On 9 April 2019 Territory Families received another notification, from the school (**sixth notification**). Master JK had been seen sniffing on CCTV at the bowsers with six other youths at 12.20am and 4.57am on 5 April 2019. It was said that he was wandering at night and not attending school. It was screened out because an investigation was currently open for the same concerns.

155. On 9 April 2019 an application for assessment was made by the school (**fourth application for assessment**). The following day the VSA assessors, accompanied by Territory Families staff, visited the residence in which Master JK was residing at Maningrida. His mother was working in Darwin at that time. They met with Master JK at 9.30am. He was said to have poor eye contact and said he was "too tired". He said he started sniffing after returning from Darwin but had quit. He was shown the 'sniffing video' and provided 'education' in relation to volatile substance abuse. The assessors told his grandfather that they would need to consider rehabilitation. His grandfather said the family would prefer closer supervision. The VSA assessors said they would return the following week to talk about rehabilitation.

156. On 12 April 2019 Territory Families staff visited Maningrida. His carers said he wouldn't listen to them and wandered at night. His family said they needed support, like after school programs and night patrol. Master JK didn't engage much but he watched an educational video. On 16 April 2019 the VSA assessors returned to Maningrida. They didn't see Master JK, but his grandfather said he was not aware of any sniffing.

157. On 3 May 2019 the school wrote to Territory Families. The school said that since his return in March 2019 he had barely attended school, that his family

had no control over him and that he was out nearly every night with other students. It was said he was very much at risk due to his sniffing.

158. On 20 May 2019 the VSA assessors were once more in Maningrida. The grandfather said that he was not aware of any sniffing and if they wanted to talk about rehabilitation they would need to talk to his mother. They did not see Master JK. Many of their other clients named Master JK as a frequent sniffer. The following day they went back to his residence where they met with him. They asked him whether he would go to rehabilitation. He said he would not.

159. Territory Families visited again on 27 May 2019. Master JK would not engage but his grandmother said she was worried because she understands how harmful the effects of sniffing can be. She said it was not just Master JK, a lot of kids were getting into trouble. His grandparents said they would take him to Darwin so his mother could keep him safe. A family plan was put in place reflecting his grandparents removing him from the community.

160. On 5 June 2019 the VSA assessors visited Maningrida but Master JK was not at home. They went back on 12 June 2019 and although they didn't see Master JK on that visit they spoke to another client who said that he had been sniffing with Master JK recently. Also on 12 June 2019 Territory Families finalised their child protection investigation. Neglect was substantiated and the report recommended the file be closed with no further action given the family plan was in place.

161. On 2 July 2019 the assessors spoke to his mother on the phone. She said she was happy for him to go to rehabilitation and was happy for the matter to be taken to court. However, the next day she said she a local elder was trying to run a program for troubled youth and she wanted her son to participate in it. The VSA assessors said they would try that program first.

162. On 9 July 2019 the VSA assessors notified Territory Families that Master JK along with another youth had been encouraging a younger child to sniff

petrol (**seventh notification**). VSA assessors said that they had tried to get him to rehabilitation but the family pulled out at the last minute. The notification was screened in. On 22 July 2019 Territory Families staff spoke to the school who said his poor attendance was linked to volatile substance abuse.

163. However, from that point there were no more reports of Master JK sniffing, and whenever either Territory Families or the VSA assessors spoke to family, they said he was doing well. Master JK underwent ceremony away from the community and returned to Maningrida on 19 August 2019. When Territory Families spoke to his mother and grandparents on 21 and 22 August 2019 they were told that he had been involved in counselling and cultural healing. He had been taken out bush for ceremony and had settled down a lot. He was said to be attending school and not sniffing.

164. When enquiries were made of the school on 3 September 2019, they were told that Master JK had only attended school on 21 and 22 August 2019 and for a half day on 26 August 2019. The VSA assessors completed their assessment of the applications on 9 September 2019. He was found not to be at severe risk of harm. That was signed off by the CHO on 18 September 2019 and the file was closed. Territory Families completed their report on 19 September 2019. No abuse or neglect was found and it was recommended the case be closed. It was closed on 23 September 2019.

165. Ms Broadfoot was of the opinion that the closure was appropriate although believed that contingency plans should first have been put in place should issues arise once more.

166. On 3 November 2019 Master JK was playing with friends outside his house in Maningrida. Later that afternoon he was in one of the bedrooms sniffing deodorant from an aerosol can. The other boys noticed him to be unresponsive with his eyes closed. He was carried outside for air. However he remained unresponsive. CPR was commenced and he was loaded into a

vehicle and taken to the Maningrida Clinic about 200 metres away. It was noted that he smelt of deodorant. He arrived at the Clinic at 8.36pm. Resuscitation attempts continued until 9.25pm however he was unable to be revived.

167. I find that Master JK died on 3 November 2019 in Maningrida. The cause of death was solvent inhalation (butane, propane). The cause of death was confirmed by forensic pathologist Dr Marianne Tiemensma. The details required by the Registry of Births Deaths and Marriages will be provided separately.

Issues

168. The first application for assessment on 17 October 2017 was 4 months after the findings in relation to the death of Mr Laurie. Again the processes set out in the Act and guidelines were not followed on that occasion or the applications for assessment that followed, the last of those being in April 2019.

169. Not once, in the two years that the assessors 'monitored' and 'case managed' Master JK was there compliance with the Act and guidelines. He was deprived of everything the Act sought to provide so as to mitigate the risks of the severe harm from the activity in which he was engaged and from which he died.

170. It became clear in April 2019 that he needed to be in rehabilitation but rather than seeking a treatment order the assessors spent the next 6 months trying to obtain agreement to a voluntary admission.

General Comments

Trauma

171. In the case of Miss B it is not necessary to have an understanding of intergenerational trauma or cumulative trauma to understand her plight. She

generally attended school less than half the time and most of the time a lot less. She never reached the minimum educational standard. She was notified to the child protection agency on 15 occasions and the agency knew that she had STI's at the age of 12 years, had likely been raped twice before she was 13 years of age and on at least one other occasion, was with an older friend when she suicided, was seriously assaulted by her boyfriend on two occasions, attempted to kill herself, tried to wipe herself out with cannabis and sniffed petrol on a regular basis. The Top End Health Service was involved in detecting her STI's and dealing with her after she was assaulted in the hospitals and the Mental Health Unit in Darwin. They also received nine applications that she be assessed for volatile substance abuse.

172. The issue is not that her trauma was not recognised. It was, to suggest otherwise would be to deny the obvious. It was even explicitly noted by DCF in relation to the eighth notification (in terms of the cumulative harm). 'Trauma' is not mentioned in the *Care and Protection of Children Act 2007*. But the definition of 'harm' at section 15 well and truly covers the details of the notifications received by DCF and later Territory Families.

173. In relation to these children the issue seems to be that an assumption was made by the child protection agency that willing family members could control and protect the children. However the notifications and facts in all three cases provide plentiful evidence that family members could not control and protect the children.

174. On 10 October 2005 I delivered findings in relation to petrol sniffing in Central Australia. One of the comments made there is pertinent to that point:

> When indigenous disadvantage and cultural confusion are added together with, (a) the lack of physical and human resources as described, (b) the complete breakdown of community governance and discipline, (c) decades of community petrol sniffing abuse which is (now) cross generational, in my view, it is simplistic in the extreme to suggest that the answer to the problems of petrol sniffing is for the addicts and their communities to help themselves. That is to say, the

> horrors of present day Mutitjulu (and other remote communities) are not sensibly addressed by peddling the myth that such disadvantaged citizens might simply help themselves and solve the problem. They and their families are not able to do so by themselves. [14]

Mitigating risk

175. All were known to have poor attendance at school, to regularly abuse volatile substances, and to wander the communities at night. Those factors alone indicated that the children were at significant risk. However there was no attempt to address those factors together. There was no real attempt to engage the children in school as part of a mitigation strategy (or at all). Two of the children were assisted into rehabilitation facilities but there was no plan to mitigate the risk when returning. The only mitigation strategy for the wandering was encouragement of family members. One family said they needed after school activities and assistance from night patrol but there was no attempt to explore those options.

176. The failure to mitigate the risks by after care plans is particularly concerning. It is an obvious point that when returning a child from rehabilitation to the same circumstances they were in when sniffing, there would be a heightened risk. But nothing was done to mitigate that heightened risk.

177. The National Practice Guidelines have a chapter devoted to aftercare.[15] In part, it states:

> "The aim of aftercare is to help the person return to their home environment and to prevent or reduce risk of relapse or repeated high-risk VSU incidents. People who use volatile substances experience significant disadvantage and need continued assessment and care during recovery. After treatment for substance use, people will still face situations that make them want to start using again (e.g. stressful situations or contact with friends who are still using

[14] Inquest into the deaths of Kumanjay Presley, Kunmanara Coulthard and Kunmanara Brumby [2005] NTMC 086 at para 64
[15] Chapter 14

volatile substances). Structured long-term aftercare … is important to support the person and help them gain the skills they will need to avoid returning to VSU or other substance use, including high-risk alcohol use." [16]

178. Where treatment is not completed, the National Practice Guidelines say:

> "Dropping out before completion of treatment is a major problem reported in case series. To minimise early discontinuation, residential rehabilitation programs should use strategies to encourage long-term participation, such as appropriate cultural content and geographic location."[17]

179. It is relevant that the rehabilitation was generally at BushMob in Alice Springs, more than 1600 kilometres from their home communities. In these cases, there was no indication that being expelled from rehabilitation was seen as an additional risk factor and there was no support or additional support put in place. In fact, nothing that was of benefit to these children was undertaken.

Inability to assist

180. On 26 February 2018 Master W was expelled from rehabilitation at BushMob. From that point the involvements of the government agencies were as follows:

- 1 March 2018 - VSA assessment team arranged for the return of Master W to Gapuwiyak.
- 1 March 2018 – Email sent to Health clinic and police at Gapuwiyak requesting update of any VSA in the community.
- 15 March 2018 – Email from school principal saying bottles containing petrol were being located around the community.

[16] Page 121
[17] Page 115

The nurse said there were anecdotal reports of VSA. PCIS was searched and confirmed no recent episodes of care relating to VSA.

The uncle of Master W was spoken to and he said there had been no VSA since his return and he had dropped him at school that morning.

- 21 March 2018 – VSA assessment team sent an email to the Health Clinic and Police asking for any recent information on VSA.

- 26 March 2018 – VSA assessment team spoke to his uncle who said he was going well, there had been no VSA and he was attending school regularly.

- 5, 6 April 2018 – VSA assessment team travelled to Gapuwiyak. They were told that over the Easter weekend (30 March 2018 – 2 April 2018) Master W had engaged in VSA and was said to have forced a 5 year old to sniff petrol with a group of others. On that visit they did not see Master W. It was thought he was either not at home or sleeping.

  The family was spoken to about sending Master W to reside in an area he wouldn't have access to solvents and his grandmother said she would speak to him about forcing the 5 year old to sniff. The note says 'currently no positions available at rehab'.

- 17 April 2018 – VSA assessment team spoke to his grandmother. She said he had been sniffing overnight and was fed up with his behaviour. She was told there were no rehabilitation spots. She said Master W would go and stay with his father.

  VSA assessment team spoke to police, they said he had been forcing 5 – 7 year olds to sniff.

  VSA assessment team made a notification to Territory Families.

- 18 April 2018 – Territory Families received the notification that Master W had forced two younger children to sniff petrol and that they needed medical treatment.

  Territory Families spoke to his grandmother who said that he had been sniffing regularly since his return from BushMob and that he had been sniffing last night.

  The notification was screened in with a priority response time of 3 – 5 days. Nothing further happened.

- 30 April 2018 – 1 May 2018 – The VSA assessment team travelled to Gapuwiyak. They met family who told them Master W had left a day or two before and was with his father on an island.

  The plan was to monitor.

- 9 May 2018 – the VSA case was transferred to another clinician because Master W was on the island.

- No contact was made with any person until his death on 21 May 2018.

181. That chronology indicates that at least one person in his family understood that he was sniffing petrol from the time of his return to the community, that no agency sighted Master W after his return and that the 'monitoring' did not detect use until more than six weeks after his return.

182. After it was known to the agencies that he was sniffing again the VSA assessment team told the family that there were no rehabilitation spots available. The family then sent him to his father to be cared for on an island away from volatile substances. The VSA assessors travelled to Gapuwiyak two weeks after being told that he was sniffing but were not able to see Master W. Territory Families having received a notification and triaged it for a response of 3 – 5 days did nothing further.

183. There was no checking with the school to see if he continued to actually attend. There was no checking to see whether he would be available to be seen when the VSA assessors visited the community. There was no multi-agency communication to discuss what might be done to assist Master W and his family.

184. That is just one example, but it can be readily seen that there was no aftercare plan, indeed there was no care plan at all. There was no real effort to engage with Master W. Even when visiting the community the assessors did not call family to determine whether he would be available to see them. There was no communication between agencies to seek a solution. The family was told there were no further options.

Failure to comply with the law

185. In the Northern Territory the *Volatile Substance Abuse Prevention Act 2005 ("Act")* provides the framework for the prevention of volatile substance abuse and the protection of persons from harm resulting from volatile substance abuse.

186. The scheme of the Act was set out in my findings into the death of Mr Laurie.[18] At the time of that inquest the Top End Health Service were not following the scheme in an important aspect. As indicated above the Act and the guidelines require an assessment to be conducted expeditiously (within 2 weeks if practicable) and if the person is at risk of severe harm the assessor **must** make an assessment of the person, **must** prepare a report, **must** give it to the CHO and **must** recommend an appropriate treatment program.

187. Rather than follow the Act the assessors instead case managed and monitored these children until there were no reports of sniffing for two

[18] Inquest into the death of Edward James Laurie [2017] NTLC 015

months and then found them not to be at risk and closed the file.[19] Apart from the failure to follow the law, the issue with that approach is that there was never a care plan put in place and the seriousness of the issues was not elevated to the CHO. They were the same issues sought to have been addressed in the Laurie inquest and findings.

188. Mr Richard Campion was the General Manager of the Mental Health Alcohol and Other Drugs portfolio. He gave evidence at the Laurie inquest. The findings in Laurie were handed down on the morning of 15 June 2017. One of the recommendations was:

> That the Top End Health Service provide such training and supervision as may be necessary to ensure their processes and procedures are in accordance with substance and intent of the *Volatile Substance Abuse Prevention Act.*

189. The same day those findings were handed down I was running another inquest into the death of Mr Munkara[20] and Mr Campion was giving evidence once again. The issue again was that the provisions of an Act (although a different Act in that case) were not being followed. The following questions were asked and answers given:

Q. So in either case, those with control in this situation acted unlawfully, didn't they?
A. Yes.
Q. Have you read the findings his Honour handed down this morning?
A. As much as I could, yes.
Q. Even without reading them, from sitting through that inquest as you did, you would understand that things weren't done lawfully there, wouldn't you?
A. Absolutely, yes.
Q. Do you think there's an issue with those, at least that you manage, in complying with the Acts of parliament?

[19] Assuming that children addicted to the use of solvents are not sniffing just because a report is not made seems to be a very dangerous assumption and proved to be so in these cases.
[20] Inquest into the death of John Benedict Munkara [2017] NTLC 016

A. That would be hard to dispute in the area of Alcohol and Other Drugs, that certainly needs to be my – our focus moving forward from here, yes. I wouldn't dispute that.

190. Although Mr Campion remained in that position until these inquests it is clear that the area of Alcohol and Other Drugs did not alter their practices so as to comply with the Act and guidelines. It is astonishing that the VSA assessment team appears to have had a written procedure to support their unlawful version:

1. *Assess applications of assessment*
2. *Determine risk status and plan of care:*
    a. *If no risk,*
        i. *Monitor the client for VSA via visits to community; correspondence (email, telephone, fax) with community members and organisations*
        ii. *While VSA continues, monitor client movements as per above, and provide interventions and support to both client and community*
        iii. *When no VSA for a period of two months, make a determination to the CHO to not recommend mandated treatment*
    b. *If at risk,*
        i. *Refer to appropriate community organisation for follow up*
        ii. *Monitor client VSA use and community organisation intervention as per above, and provide interventions and support to both client and community*
        iii. *After two months of VSA use/not, make a recommendation to the CHO re mandated treatment.*

191. That procedure is contrary to the Act and the guidelines. But appears to be so ingrained that when reviews were undertaken by the Top End Health Service into two of these deaths it was used as a benchmark. It was even said to be in the guidelines. It is not.

192. When Mr Campion prepared his affidavit for these inquests he did not utilise the Act and guidelines to judge the provision of services to these children. He likely used that same procedure. The result is that in his analysis, the services provided to the children were appropriate. He was critical of only a general lack of documentation.

193. During the course of this inquest however, he conceded once more that the Act and guidelines had not been followed, that the children were at severe risk of harm on multiple occasions but not assessed as such, that the assessments were not undertaken in a timely manner, that their cases were not elevated to the CHO, that there were no case plans or intervention plans developed and that the many failures may well have contributed to the deaths of these children. That those concessions were made many months after the deaths, and only during cross-examination under oath, is extremely unsatisfactory.

Response by government agencies at the inquest

194. The response by Territory Families and the Department of Education to the inquest was appropriate. There is no doubt that both those departments sought to assist in this inquest. I commend Ms Broadfoot and Mr Dexter for their forthright analysis of these cases and the evidence provided at the inquest.

195. The responses from the Top End Health Service were disappointing and only provided the day before the inquest, one at 5.47pm. The institutional response was not provided by a manager with responsibility for the VSA assessment team, or the line manager for Mr Campion, or indeed anyone in the Top End Health Service. It was left to a senior policy director from the Department of Health to attempt to explain why the unlawful practices continued.

196. One of the obvious issues was to understand why the issues were the same as those in an inquest three years earlier. In that inquest the recommendations were:

> I **recommend** that the Top End Health Service and the Department of Health conduct as soon as possible the review proposed in the Chief Executive Memorandum provided to my Office and dated 19 May 2017.
>
> I **recommend** the Top End Health Service provide such training and supervision as may be necessary to ensure their processes and procedures are in accordance with substance and intent of the *Volatile Substance Abuse Prevention Act.*

197. The response from the department to those recommendations addressed to the Attorney General and tabled in Parliament in part stated:

> *Top End Health Service (TEHS) Mental Health and Alcohol and Other Drugs Service has engaged a Risk and Review Officer within the service. The Terms of Reference associated with this activity requires the officer to focus on the application of risk management in consumer care, the application of appropriate risk escalation, the application of legislation into clinical practice, and the provision of consumer care in the context of patient centred care and the TEHS Organisational Charter. With the support of the Risk and Review Officer, an audit was undertaken of all notifications received to the Volatile Substance Abuse Team since January 2014. This enabled the service to action any outstanding work, evaluate the effectiveness of activity against previous notifications, and set a benchmark for moving forward.*
>
> *New processes have been established by which the assessors in the Volatile Substance Abuse team provide their recommendations to the Chief Health Officer. Following acceptance of a notification, the team endeavour to provide a recommendation to the Chief Health Officer within two weeks. If, for clinical reasons, this does not occur then the team will provide an assessment report to the Chief Health Officer after the initial two weeks and on a periodical basis until the recommendation is provided.*
>
> *The processes by which the team provide their recommendations to the Chief Health Officer has also been amended. This is to provide enhanced visibility within TEHS of decision making and team activity. All recommendations and update reports are now progressed through the General Manager for signing, and the opportunity to ask further questions or request clarification, prior to being sent to the Chief Health Officer. This process enhances governance and*

accountability within the service and provides an enhanced risk management framework."

198. On the basis of that response the Attorney General wrote to me on 9 November 2019 saying, "I am satisfied that the Department of Health has considered the recommendations of the Coroner and is taking necessary steps with respect to those recommendations". Unfortunately those "necessary steps" were, in fact, not taken.

199. The institutional response to this inquest by the Top End Health Service did not illuminate or attempt to illuminate why so little had changed. Indeed, there was no recognition that the same mistakes were being repeated. The institutional response characterised the problems as being, "lack of clarity of roles and service delivery that was not effectively integrated".[21]

200. It said that following the recommendations of the Laurie inquest and the review that followed, an online training package was developed for the assessors. The package was attached to the statement and was little more than slides of the sections of the Act. But even if it had been more, it is difficult to imagine anyone thinking that an online training package for four assessors was an effective means to align practice with the law. It was said that there was also an 'on demand' training session. But there was no audit of practice from that time or since.

201. It is tragic and frustrating that almost all of the issues and comments three years ago are equally applicable to these cases. In my view the refusal or inability of the Top End Health Service to change its unlawful practices contributed to these children's deaths.

202. The institutional response by the Top End Health Service indicated that the primary health network was now undertaking some of the initial interventions with young people who were found to be sniffing and that was

[21] Statement of Cecilia Gore paragraph 9

believed to be a better model for the future. Those interventions were said to avoid applications being made for assessment. Involvement of local organisations is obviously a better model, however simultaneously bypassing the Act, is likely to reduce assessments, care plans and treatment plans.

Recommendations

203. I have made suggestions and a recommendation in relation to the much touted Multi-Agency Community and Child Safety Framework (the Framework) in the earlier inquest into the other three children's deaths[22] and so will not repeat them here.

204. It was said that the Framework was necessary to ensure the protection of children in circumstances such as these. However, the main issue was not so much a lack of coordination and the sharing of information, although that is certainly evident. In my opinion, the primary issue for all agencies was their indifference to the evident plight of these children and their families.

205. The very model utilised, where a few people fly-in and fly-out is likely associated with that indifference. To expect the visit of a couple of days by a few workers from Darwin to change school attendance, wandering at night and volatile substance abuse in a remote community is not realistic, yet it continues.

206. Many recommendations have been made over the years to address such problems. One of the most notable was made in 1991 by the *Royal Commission into Aboriginal Deaths in Custody*. The Royal Commission looked at the problem of petrol sniffing. Recommendation 238 is in these terms:

[22] *Inquest into the deaths of Fionica Yarranganlagi James, Keturah Cheralyn Mamarika and Layla Leering* [2020] NTLC 022

> That once programs and strategies for youth have been devised and agreed, after negotiation between government and appropriate Aboriginal organizations and communities, governments should provide resources for the employment and training of appropriate persons to ensure that the programs and strategies are successfully implemented at a local level. In making appointment of trainers preferences should be given to Aboriginal people with a proven record of being able to relate to, and influence, young people even though such candidates may not have academic qualifications.

207. It is not permissible to just pay lip service, to agree, with recommendations and do little more than set up an implementation matrix. Such a matrix was set up following the review after the Laurie inquest. Three years on little has happened on many of the recommendations and those that are said to have been completed have made no detectable difference. I am distressed that the same issues and lack of action I witnessed in 2005 and 2017 are still so evident today.

208. It is not generally considered necessary to recommend that a government agency comply with their legal obligations. However, in my opinion it is necessary that I make such a recommendation for a second time.

209. I **recommend** the Top End Health Service provide such training and supervision such as may be necessary to ensure their processes and procedures are in accordance the *Volatile Substance Abuse Prevention Act*.

210. I **recommend** that government give consideration to funding a rehabilitation service in a regional centre in the top end of the Northern Territory.

211. I **recommend** that government implement recommendation 238 of the Royal Commission into Aboriginal Deaths in Custody.

Dated this 15th day of December 2020.

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GREG CAVANAGH
TERRITORY CORONER