ORDER:
Restriction on publication of reports:
The name of the deceased, and any other personal details identifying that person must not be published. The deceased can be referred to as Didbala. The name of the male CASPA worker who gave evidence at the Inquest on 11 November 2024 must not be published. He can be referred to as "the male CASPA worker" or "a CASPA worker" or "Carer". The non-publication orders dated 23 January 2023 and 11 November 2024 are revoked.

CITATION: *Inquest into the death of Didbala Anzac* [2025] NTLC 12

TITLE OF THE COURT:	Coroners Court
JURISDICTION:	Katherine
FILE NO:	D0235/2022
DELIVERED ON:	12 August 2025
DELIVERED AT:	Darwin
HEARING DATES:	11-15 November 2024
FINDING OF:	Judge Elisabeth Armitage

CATCHWORDS:	**Child Death in Care, Intensive Therapeutic Residential Care, Complex Case Management, Protocol for Police Contact with Children Living in Out of Home Care, Mental Illness**

REPRESENTATION:

Counsel Assisting:	Helena Blundell
Counsel for Department of Children and Families:	Michael McCarthy (Hutton McCarthy)
Counsel for NT Health:	Tom Hutton (Hutton McCarthy)
Counsel for NT Police:	Tina Tomaszewski (Mills Oakley)
Counsel for CASPA:	David Heilpern
Counsel for Family:	Kathleen Heath

Judgment category classification:	A
Judgement ID number:	[2025] NTLC 12
Number of paragraphs:	201
Number of pages:	58

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

No. D0235/2022

In the matter of an Inquest into the death of

DIDBALA (LIZZIA) ANZAC

ON: 3 OCTOBER 2022
AT: KATHERINE

FINDINGS

Introduction

1. Didbala[1] was born at Royal Darwin Hospital on 14 May 2005. She passed away in Katherine on 3 October 2022 between 03.22 and 04.19 am[2] at a CASPA operated care house. She was 17 years old at the time of her death.

2. Didbala was Bilinarra. She spoke Bilinarra, Ngaringyman, Mudburra and English. Her parents are Christine Anzac and Roger James. Her family from her mother's side are from Ntijpurru and Yarralin. Her father's family are also from Yarralin.

3. She was raised in a large extended family. Her siblings included Reanne Short, Francine Dann, Junior, Wayne Short and Rex Short. She also had half-siblings on her father's side who mostly reside in Kununurra. She had uncles on her maternal side including Andrew, Elmore, Peter, and Christoper Anzac.

[1] The cultural name "Didbala" has been used at the request of family.
[2] Coronial Brief, Folios 5 and 10D

4. Didbala mostly grew up in Nitjpurru and Yarralin but she also spent time with family in Timber Creek, Darwin, Katherine, and the East Kimberley. She was raised by her mother and her grandmother in her early years. Sometimes she was cared for by her sisters Reanne Short and Francine Dann, and her cousin Zara Bradshaw. Didbala also spent time with Elmore and Marjorie at Nitjpurru, with Andrew and Shirley in Katherine, and with her brother Jessie Deegan in Kunnunurra.

5. Didbala's family told me that she always wanted to be with them. She was connected to culture, and she loved going fishing and hunting when she was in community. Her family remember her love of sport, singing and dancing. One of her favourite things was Hip Hop and she was the star in a music video produced by the Indigenous Hip Hop Project at the Nitpurru school. The family shared the video during the inquest and it showed Didbala in her element, talented and vibrant.

6. However, Didbala's young life was not an easy one. She suffered serious mental illness which posed significant challenges for her and those who cared for her including family, health professionals and statutory carers.

Immediate circumstances surrounding her death

7. When she passed away, Didbala was under a Long Term Protection Order and was in the care of the Chief Executive Officer (CEO), Territory Families.[3] She was placed in a CASPA managed Intensive Therapeutic Residential Care (ITRC) house in Katherine (Katherine CASPA).

8. Didbala left Katherine CASPA on the night of 2 October 2022 and joined a group of female friends at around 10 pm near the United Service Station. The group of girls met an adult male not previously known to them, now identified

[3] Department of Children and Families formerly known as Department of Territory Families, Housing and Communities.

as C.[4] He asked the group if they knew where he could buy marijuana. They took him to buy marijuana and he invited them back to his cabin at a caravan park. Some of the girls, including Didbala, smoked gunja and drank beers that he provided.

9. One friend noticed a difference in Didbala after she had been smoking and drinking. Before this Didbala was cheeky and funny, but afterwards she was quiet and seemed sad. Two of her friends heard Didbala talking to herself saying, "*stop it, stop it, stop talking to me."* One friend said that Didbala wanted to go home to sleep. C gave them money for a taxi and the girls caught a taxi back into town.

10. The girls walked to the Katherine Information Centre and at about 1.00 am they waved down a marked police car. Probationary Constables (P/Cs) A and P were in the car. Didbala ran up and told P/C A that she had a curfew and wanted a lift home and one of the other girls said that Didbala was drunk. P/C A recalled that Didbala had red eyes and looked like she might have been mildly intoxicated.[5] P/C P, who had previous interactions with Didbala, said he did not really think she was intoxicated and she was calm. Neither P/C had any concerns about Didbala at this time[6] and there were no alerts on the PROMIS system about her being at risk of self-harm, though there were general mental health alerts. The P/Cs checked the police PROMIS system which confirmed Didbala was in breach of her bail curfew. They radioed the Shift Sergeant for instructions and he told them not to arrest her but to take her home, which I consider was the appropriate response. She was dropped off at Katherine CASPA around 1.30 am without incident.

The Carers at Katherine CASPA

[4] C provided some cannabis and beer to the girls, there is no evidence of any other involvement.
[5] Coronial Brief, Folio 9A, Statement of Const. A para 9 and Transcript 12 November 2024 pp 72-73
[6] Transcript at 75 (P/C A) and at 102 (P/C P)

11. The two Katherine CASPA workers (Carers) who were on shift on 3 October 2022 were both casual Carers. They both had other jobs working for other organisations and took the odd shift at the Katherine CASPA houses. Neither Carer was particularly familiar with Didbala. Overall, their evidence suggested that as casual workers they did not really get an opportunity to get to know the young people they cared for or to be overly familiar with each child's documented history.

12. The male CASPA Carer had a Certificate IV in Disability and a Diploma in Counselling. He had no youth specific qualifications but had completed the CASPA Induction and Therapeutic Crisis Intervention (TCI) training.[7]

13. He had worked 4-5 shifts with Didbala and had read Didbala's Safety Plan (but not on the day of this incident). He knew she had some aggressive behaviours and mental health issues, and that she was supposed to be taking medication for these issues.[8] He was not aware she had risks of self-harm.[9] He had attended one or two of the monthly CASPA clinical meetings but not more due to timetable clashes with his other job. He did not know about any Protocol regarding police attendances at ITRC houses.

14. The female CASPA worker, Carer 1, had considerable experience. She had worked in Western Australia as a youth residential care worker and youth justice worker for four years. She had a Diploma of Community Service and had completed the mandatory CASPA training which included Therapeutic Crisis Intervention (TCI). She told me that while she did do some role playing exercises as part of her TCI training, there was no scenario training on dealing with an assault, the continuing responsibility of care or communicating with police and did not know there was a Protocol with police[10] for this situation.[11]

[7] Transcript at 53
[8] Coronial Brief, Folio 8L at para 3
[9] Transcript 65-66
[10] Protocol for Police contact with children living in Therapeutic Residential Care (the Protocol) Additional Document Folio 12
[11] Transcript at 24 and 43

15. Carer 1 had met Didbala less than 10 times. She had tried to build a connection with Didbala, but had limited opportunity to do so because Didbala was mostly staying with her family.[12] Although she had not received any specific training in caring for Didbala[13] she knew Didbala was on medication for her psychosis and Foetal Alcohol Syndrome.[14] She did not know Didbala's full background history or the full extent of her mental illness, which she said she learned when sitting through the Inquest. She thought it would have been helpful to have had more detailed information about Didbala's history, than what was available in the documents she recalled reviewing.[15]

16. Carer 1 explained that updated information about the young people she was caring for was located in document form in the office at the CASPA house, (there was a folder of information for each child) and it was available electronically by email and on the work laptop.[16] She explained that her ability to review documents depended on how busy the shift was and that it was hard to find time to regularly review the documentation for each young person because "*when you started your shift you needed to be working*."[17] Although there was a half hour handover at the start and end of each shift which included signing relevant documents,[18] her evidence was that in the time available she was not able to absorb all the relevant information in the documentation for the children in her care.[19]

17. Given the passage of time, she was unable to recall how often she looked at any of Didbala's documents including Didbala's Safety Plan but accepted that she had signed an acknowledgement that she had read Didbala's Safety Plan.

[12] Transcript at 15
[13] Transcript at 14
[14] Coronial Brief, Folio 8M paras 4-5
[15] Transcript at 17 and 33
[16] Transcript at 15 and 17
[17] Transcript at 25-26
[18] Transcript at 45
[19] Transcript 46,48

18. Carer 1 did not attend any of the monthly CASPA clinical meetings where ongoing staff training is provided. She said she was encouraged to attend these meetings but they clashed with her other employment commitments.[20]

The events after Didbala was dropped back to Katherine CASPA

19. Carer 1 met Didbala when she was dropped off by the police. Didbala said that she was tipsy and asked for a broom. She took the broom into her bedroom and then returned it. Didbala went into her room at about 2.00 am and Carer 1 thought that she was behaving normally and assumed that she was sleeping.[21]

20. At 2.55 am Carer 1 heard Didbala screaming. Didbala came out of her room yelling that she could hear voices and she wanted to be taken to Darwin. Carer 1 understood that Didbala might be experiencing psychosis and tried to reassure her. However, Didbala escalated. Didbala came into the loungeroom and upended furniture. When Carer 1 tried to intervene, Didbala assaulted her by punching her and hitting her with a vase. Carer 1 ran into the office and called 000 at about 3.00 am.[22] In that call Carer 1 reported the assault and the damage to property but she did not mention that Didbala was hearing voices, or was otherwise mentally unwell, or at risk of self-harm.

21. P/Cs A and P were sent to respond. When they arrived at Katherine CASPA, Carer 1 told them that Didbala was hearing voices. The male CASPA Worker[23] asked "*Can you check on her in case we need an ambulance as well?*"[24] That request was very hard to hear on the police Body Worn Video and neither P/C recalled it being said. The police understood they were attending for an assault and property damage, more so than for mental health

[20] Transcript at 15 and 36
[21] Transcript at 19-20
[22] Additional Documents, Folio 4
[23] The name of this worker is the subject of a Non-Publication Order and he is referred to only as "the male CASPA worker."
[24] Body Worn Video Const A, Coronial Brief Folder 3, USB 4

concerns, but in any event their "*main priority was actually [Didbala]. We were trying to locate her and speak to her and sight her*."[25]

22. P/C A went almost immediately to Didbala's bedroom door and tried to speak to her through the closed door. When there was no response, the P/Cs tried to open her bedroom door, but it was locked. The CASPA workers gave them keys. They made repeated efforts to unlock the door but were not able to get it open. P/C A thought it was the wrong key. P/C P thought Didbala had somehow barricaded the door or was holding it shut. [26]

23. Carer 1 said that they keys she gave police were the ones she normally used to unlock doors in the house and she could not understand why they did not work. She gave police a second set of keys but they also failed to open the door. [27]

24. The P/Cs called the Shift Sergeant and he promptly came to assist. When he was told that the P/Cs had been talking to Didbala through the door he mistakenly (but understandably) assumed that Didbala had verbally responded to them, when this was not in fact the case. It is likely this (mistaken) belief reassured him, and he also tried to speak to her through the door. When he got no response he also tried to unlock the door without success. He also said that it felt like someone was holding the other side of the door. [28]

25. He went outside and looked through the window but could not see anything. When he then clarified that Didbala had not in fact spoken to the PCs, he forced the door.[29] About 5 minutes after he arrived, (and 24 minutes after the original attending police arrived) he kicked the bedroom door open and found Didbala hanging from the ceiling fan with an electrical cord around her neck.

[25] Transcript at 78
[26] Transcript at 99
[27] Transcript at 27
[28] Transcript at 167
[29] Transcript at 167

CPR was immediately commenced and an ambulance was called and attended. Didbala was unable to be revived and was formally declared deceased at 4.19 am on 3 October 2022.

26. At the inquest P/C A said that if she had understood there were self-harm concerns she would have called the Shift Sergeant straight away and probably forced the door open immediately.[30] However, this information was not available to her and no-one, including the CASPA workers, appreciated that the circumstances gave rise to an elevated risk of self-harm.

27. None of the attending police were aware of a Protocol (considered later in these Findings) which sets out how police should interact with young people in out of home care (OOHC). And none of the police knew that an ITRC house or the children living in it were different to other forms of Out of Home Care, or that it was used for children with the most complex needs.

Post-mortem examination

28. On 4 October 2022, the Chief Forensic Pathologist, Dr Marianne Tiemensma, conducted a CT scan and external post-mortem examination of Didbala. A ligature abrasion was visible on her neck and there were no other suspicious injuries. Toxicology revealed a femoral blood alcohol reading of 0.052%, the presence of paliperidone which is an antipsychotic medication used in the treatment of schizophrenia, and findings consistent with cannabis use.

29. It was the forensic pathologist's opinion that the cause of death was hanging in the context of known complex mental health and behavioural problems.

Formal Findings

30. Pursuant to section 34 of the *Coroners Act*, I make the following formal findings:

[30] Transcript at 79

(1) The identity of the deceased is Didbala Anzac, born on 14 May 2005 in Darwin in the Northern Territory.

(2) The time of death was approximately 03.22am on Monday 3 October 2022. The place of death was Katherine, Northern Territory

(3) The cause of death was self-inflicted hanging in the context of known complex mental health and behavioural problems.

(4) The particulars required to register the death have been provided to the Office of Births, Deaths, and Marriages.

Background

Early Notifications to Territory Families

31. Territory Families received nineteen notifications concerning Didbala commencing from when she was a 1-year-old. The first notification, on 2 November 2006, raised concerns of neglect. Territory Families investigated and opened a Family Support Case. They developed a safety plan with Didbala's mother, Christine, and Didbala's maternal uncles, who were all caring for Didbala. The case was closed in August 2008 on the basis that the plan had been complied with and no ongoing risks were identified.[31]

32. In 2012 there were two notifications, relating to possible neglect and behavioural issues at school. Both were screened out without further action.

33. There were two notifications in 2013; the first reported neglect due to parental alcohol use; and the second reported an alleged domestic violence incident, which was subsequently unsubstantiated. Didbala was referred to Wurli Wurlinjan Well Being Unit for psychological services and her case was closed.

[31] Additional Document, Folio 16, [81-82]

34. Between 2015-2018 there were six notifications. Two related to anti-social behaviour by Didbala and four were about Didbala being exposed to domestic violence. It does not appear that anything of substance was done in response to these notifications.[32]

35. On 3 January 2019 Territory Families received a notification about Didbala's mental health when she was admitted to the Youth Inpatient Unit (YIP) in Darwin for a few days. Her psychiatrist told Territory Families he had concerns about her safety in the community. Territory Families had an open case and attempted a home visit in Katherine, but Didbala had gone with her grandmother to a community. The community clinic reported that Didbala was an elevated risk of suicide if her social situation was not addressed. She was later located in Katherine in the care of a family member and she was receiving visits from the Katherine Mental Health team.[33]

36. On 23 January 2020, Territory Families were notified that Didbala was in Palmerston with a group of girls involved in criminal activity, and police could not find a responsible adult to care for her. Territory Families enacted a Temporary Protection Order and placed her with a Foster Carer. Didbala immediately ran away from the Foster Carer and Territory Families did not know where she was. She was found on 2 February 2020 back in the care of a cousin in Katherine. The cousin was deemed to be a suitable carer, even though there was no real assessment of her personal circumstances or of her capacity to care for Didbala.[34]

37. On 5 February 2020 Territory Families were notified that Didbala had been exposed to domestic violence. Territory Families spoke to her aunt and determined that the aunt appeared to have appropriate supports, but again, no real efforts were made to investigate her capacity to care for Didbala.[35]

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[32] Additional Document, Folio 16 [95]
[33] Additional Documents, Folio 16 [107-117]
[34] Additional Documents, Folio 16 [118-123]
[35] Additional Documents, Folio 16, [124-127]

38. On 9 April 2020 it was reported that Didbala was intoxicated, emotional and abusive towards police and others. Apparently, she was in the care of a family member, MB. This notification was screened out because there was no evidence that MB had harmed her. However, again there was no proper assessment as to who was caring for Didbala or of their capacity to do so.

39. Territory Families provided an Institutional Response prepared by Leonie Warburton, Executive Director NT Wide Services.[36] Territory Families accepted that its responses to these early notifications were inadequate and that it should have been done much more to support family members to care for Didbala. In its closing submissions Territory Families accepted "that during this period it should have taken more steps to partner with Didbala and her family to develop a clear plan for Didbala to be cared for by strong, stable and suitable family, and to ensure that people identified to care for Didbala were aware of her needs and engaged in her care."[37]

Engagement with Mental Health Services

40. I was provided with extensive written statements and heard oral evidence from psychologist, Kelly Dhaemer, and psychiatrists, Dr Maree Ploetz and Dr Robert Parker. I was also provided with Didbala's health records as part of the Coronial Brief.

41. It is clear from all of the material before me that Didbala's mental health issues were complex, and her treatment was far from straightforward. This is reflected in the duration of her involuntary admissions to the Youth In-Patient Unit (YIP).[38] It is also reflected in the fact that she underwent two separate programs of Electro Convulsive Therapy (ECT) which I heard was extremely rare for a young person.[39] I note that the ECT treatment Didbala received

[36] Additional Documents, Folio 16 [130]
[37] Territory Families closing submission on 16 December 2024, [8]
[38] Additional Document Folio 21, Dr Parker, [40(a)(i)(e)]
[39] Additional Document, Folio 21, [35]

complied with all protocols and was approved by the Mental Health Review Tribunal (MHRT).[40]

42. Didbala's first admission to YIP was on 3 January 2019 when she was evacuated from Yarralin with delusions, escalated agitated behaviour and suicidal thoughts. She was discharged on 4 January 2019.

43. Thereafter, Didbala had several involuntary admissions to the YIP. However, I will focus on the two lengthy admissions from 20 October - 29 December 2020 and 10 February – 5 May 2021 as being the most relevant to the issues in this Inquest.

YIP Admission October- December 2020

44. On 20 October 2020 Didbala was care-flighted to Darwin and admitted into the YIP. Her behaviour and symptoms were described as "*aggressive, delusional and possibly psychotic*." Her medical records describe an acutely unwell young person. Her presentation was consistent with psychosis, but she also presented with behavioural issues that her treating psychiatrist, Dr Ploetz, considered were attributable, at least in part, to childhood trauma. She was also suspected of having FASD.

45. Her treatment proved extremely challenging. She was prescribed a range of medications and underwent ECT. Didbala's medical team sought expert advice from a range of interstate health specialists. They also investigated other possible physical/organic causes for her illness and identified limbic encephalitis as a possible organic cause. Treatment for this commenced.

46. Didbala's mother, Christine, and a cousin, provided support throughout this admission. Christine boarded with Didbala at the YIP and did everything that was asked of her.

[40] Additional Document Folio 21, [174] and Coronial Brief Mental Health Records

47. The health team convened discharge planning meetings which included Dr Ploetz, her treating paediatrician, a Social Worker, an Aboriginal Mental Health Worker (AMHW), Territory Families staff, Christine and her partner. The aim of the meetings was to "*explore supportive discharge planning to allow for the best chances of recovery and to minimise the risk of relapse after very severe illness*."[41]

48. The meetings were held at the YIP on 14 and 16 December 2020. Dr Ploetz felt that the discharge planning was done quite well.[42] Dr Ploetz said that given Didbala wanted to be discharged into the care of her mother, and as Christine was engaged and willing, the decision to discharge her to the care of her mother was appropriate. Dr Ploetz did not minimise the challenges Christine would face in caring for Didbala and so an Aboriginal Mental Health Worker (AMHW) and Social Worker were working with them both.[43]

49. The plan was to discharge Didbala on 21 December into the care of her mother under a Community Management Order (CMO). Health workers secured accommodation for Christine and Didbala at Dr Helen Phillips Cottages (located near the hospital) from 21 December 2020 to 21 January 2021. Christine was then to enter residential alcohol rehabilitation at CAAPS and Didbala was to board with her. [44] However, there were some delays arranging the required support and ultimately Didbala was not discharged until 29 December 2020 (on the same plan). I accept that keeping her as an in-patient for longer than was necessary was not considered to be in Didbala's best interests from a therapeutic perspective and so it was appropriate that she be discharged. Didbala's discharge summary stated, "*No evidence of risk of harm to self*."[45]

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[41] Additional Document 21 [69]
[42] Transcript at 142
[43] Transcript at 143
[44] Transcript at 303
[45] Additional Documents, Folio 21 [128]

50. Territory Families opened a 'Strengthening Families Case' on 24 December 2020[46] and Christine understood that whilst Didbala was not the subject of any Child Protection orders, Territory Families had agreed to provide necessary supports including accommodation, and social and parental supports after her discharge. The family was referred to Catholic Care, which was to organise and provide the practical support. Dr Ploetz noted that on 24 December Christine said she felt very supported.[47]

51. Because it was the Christmas period, Didbala's case was being temporarily managed by a Territory Families 'Team Leader' until her assigned 'Senior Child Protection Practitioner' (SCPP)[48] returned from leave on 14 January 2020.[49] A health worker called Territory Families on 29 December 2020 to advise of Didbala's discharge but the call was not answered, and a message was left requesting a return call, which was not responded to.[50] In those circumstances, Territory Families claimed it was not aware of Didbala's 29 December discharge until the Team Leader visited the YIP for another child on 4 January 2021.[51] That Territory Families were not aware of the discharge is hard to reconcile with their undertaking to support Didbala and Christine on discharge.

52. Regrettably, the remainder of Didbala's discharge plans unravelled within days for a range of reasons.

53. The Territory Families referral to Catholic Care was a 'cold' referral and Catholic Care were expected to contact Didbala and Christine after she was discharged from the YIP. While cold referrals seem to be the norm, Ms Warburton readily conceded that a 'warm' referral would have been better.[52]

[46] Transcript at 301
[47] Additional Document 21 [114]
[48] The term CPP and Case Manager are used interchangeably
[49] Additional Documents, Folio 16 [139-140]
[50] Additional Documents, Folio 21, Annexure MP2
[51] Additional Documents, Folio 16 [142]
[52] Transcript at 305

I understood that Ms Warburton was readily conceding that it would have been better if an allocated Catholic Care support worker had met Didbala and her mother in person whilst she was still in the YIP, perhaps even more than once, to build trust and rapport to support a therapeutic working relationship. But this did not occur. Sadly, and predictably in my view, by 7 January 2021 Catholic Care had made repeated unsuccessful phone calls to Christine, and reported to Territory Families that the case would be closed if Didbala's family could not be located. Catholic Care closed its case on 28 January 2021 and none of the supports it was supposed to provide on behalf of Territory Families, were ever delivered to Didbala and Christine.[53] Territory Families accepts that steps should have been taken to ensure services were commenced by Catholic Care before Didbala was discharged from YIP.[54]

54. Meanwhile, Dr Ploetz said that Headspace, who had initially accepted the referral for Didbala to provide out-patient care, reversed that decision at the 11th hour, despite being funded to care for complex cases such as Didbala. Nonetheless, she said that this setback was mitigated by the fact that she was planning to provide follow-up in the community and Didbala was referred to the Child and Adolescent Mental Health Service (CAMHS) for out-patient care in Darwin.

55. On 3 January 2021 Didbala was brought in by police under her Community Management Order (CMO) and was reviewed by CAMHS who were providing out-patient support. She was again reviewed on 8 January by her medical team and the CMO was revoked. However, despite extensive follow up by health staff, Didbala was thereafter unable to be located and her scheduled review on 15 January did not proceed.[55]

[53] Additional Documents, Folio 16 [143]
[54] Closing Submissions Territory Families 16 December 2024, [13]
[55] Additional Documents, Folio 21 [152-153]

56. On 14 January 2021, Didbala's SCPP spoke to her Aboriginal Mental Health Worker (AMHW) and learned that Didbala was now living with her mother in Palmerston. The SCPP and AMHW appear to have jointly agreed that they should remain living there until Christine's intake appointment with CAAPS. The AMHW said she would arrange transport for both Didbala and Christine to attend the in-take appointment on 19 January. However, when the SCPP phoned the AMHW on 21 January for an update she learned that Didbala and Christine were now either in Katherine or Yarralin.[56]

57. Since Didbala had missed her scheduled medications and medical reviews the clinicians caring for her were seriously worried about her mental health and the possibility of a relapse.[57] She was eventually located and assessed by psychologist Kelly Dhaemer in Katherine on 21 January 2021 and on 25 January 2021 she was taken by Katherine CAMHS to Katherine District Hospital due to concerns that her mental health was again declining.

58. On 9 February 2021 Ms Dhaemer phoned Didbala's SCPP and reported that she had been seeing Didbala almost daily, and she was presenting with mania and psychotic symptoms even though she was taking her medication. It is not clear to me who was looking after her at this time, possibly her cousin, as her mother had reportedly remained in Darwin.[58]

59. On 10 February 2021 Didbala expressed suicidal ideation to Ms Dhaemer and police were called to take her to hospital. Police records indicate that at Katherine District Hospital she assaulted staff and damaged equipment.[59] Health records suggest that her threats of self-harm related in part to feeling unsafe in the community.[60]

YIP admission 10 February – 5 May 2021

[56] Additional Documents, Folio 16 [144-148]
[57] Additional Documents, Folio 21 [163]
[58] Additional Documents, Folio 16 [149]
[59] Additional Documents, Folio 5
[60] Additional Documents, Folio 21 [169]

60. On 10 February 2021 Didbala was evacuated to Darwin and admitted into the YIP. Two days later Psychiatric Registrar, Dr Tranter, called Territory Families to advise that Didbala was again very unwell and involuntarily admitted.

61. Didbala presented as acutely unwell. She is recorded to have had a manic relapse of bipolar affective disorder. She was assessed, medicated, treated with ECT, and provided with therapeutic supports.

62. During this admission it was determined that Didbala required a stable community setting and Territory Families needed to play a greater role in her care. Referrals for a FASD assessment were made in February and NDIS forms were commenced by health staff.

63. All the evidence shows that Didbala was extremely frustrated by her long admission and the restrictions imposed on her in the YIP. I note that efforts and plans were made to reduce these restrictions where it was safe to do so.[61]

64. By April 2021 Dr Ploetz was concerned that Didbala was suffering significant 'containment distress' and that her frustration with being admitted into a high acuity mental health unit was exacerbating her unacceptable behaviours. Dr Ploetz was actively advocating for a suitable discharge location as soon as safely feasible.

65. During this admission, Territory Families staff attended seven Care Team meetings and obtained a Long Term Protection Order on 13 May 2021. By this time Christine had acknowledged that she was unable to care for Didbala due to her daughter's complex issues and her own poor health.[62] Although Territory Families were aware of other extended family members, none were considered suitable to care for Didbala due to her severe mental health issues,

[61] Additional Documents, Folio 21 [242-243]
[62] Additional Documents, Folio 16 [167]

related challenging behaviours and the need for her to remain in Darwin close to mental health supports.

66. Dr Ploetz said that Didbala's risk of self-harm/suicide was not overly prominent during either of her two long hospital admissions.[63] She said that her risk of self-harm/suicide was anticipated to increase in the context of a deterioration of her mental state or mood depression and substance abuse. She also said that this risk would sharply escalate if Didbala felt abandoned or left alone.[64] Dr Parker's evidence was largely consistent. He agreed that the level of risk was dynamic and that it changed over time depending on a range of factors but said that psychosis in adolescents was always a significant risk factor.[65] I note that neither of Didbala's discharge summaries from her long admissions referred to an elevated risk of self-harm/suicide.

67. As to her diagnosis, Dr Parker explained that limbic encephalitis was the likely explanation for her presentation. He said that towards the latter part of her illness she received very irregular Depot (anti-psychotic) injections but her base psychotic condition had settled because her limbic encephalitis had been treated.[66]

Discharge to CASPA placement and post discharge movements

68. CASPA is a not-for-profit charitable organisation that provides Intensive Therapeutic Residential Care (ITRC) for young people in NSW, QLD, and the NT. They have operated in the NT since May 2020. I received affidavits and heard evidence about how CASPA cares for young people from Mr Michael Manning, CASPA Executive Director Allied Health, and Ms Naarah Rodwell, CASPA CEO.

[63] Additional documents, Folio 21 [241] and Transcript at 153
[64] Transcript at 153
[65] Transcript at 182, 204-208
[66] Transcript at 183-184

69. CASPA first became involved with Didbala when Territory Families requested an ITRC placement for her as part of the discharge planning from the YIP.

70. CASPA had concerns about accepting Didbala into their care due to her level of complexity and mental illness. CASPA was initially of the view that, as Didbala required specialist disability knowledge and supports, the ITRC model that CASPA delivered was insufficient to meet her needs and Section 5.2 of the ITRC contract with Territory Families could be relied on to refuse the placement request. Mr Manning considered that NDIS Specialist Disability Accommodation was the most appropriate accommodation option for her. However, I heard no evidence to suggest that this option existed in the Northern Territory.

71. Ms Rodwell expressed similar concerns but said that CASPA was under pressure from Territory Families to take Didbala. I understood that this was because the appropriate level of care (as identified by Mr Manning) was not available in the Northern Territory and that for complex young people, like Didbala, CASPA offered the highest level of available therapeutic care.

72. Ms Rodwell also shared the health team's concerns that Didbala's ongoing inpatient status was detrimental to her and a discharge placement was becoming urgent. CASPA staff visited Didbala at the YIP to try and build rapport and to inform themselves as to their capacity to care for her. That included visits from the House Co-ordinator who tried to build a relationship with her prior to her discharge (and on one of those visits the House Co-ordinator was assaulted by Didbala). Even so, in consultation with the health team at YIP and CAMHS who supported the placement, CASPA accepted Didbala.[67]

[67] Additional Document, Folio 19 paras 20-21

73. Mr Manning considered that appropriate funding and resources needed to be allocated to CASPA to meet Didbala's extremely complex needs, including NDIS funding. As it turns out, he correctly predicted that without these specialist supports the "*placement would break down as it would be high risk for the health and wellbeing of the young person and the staff supporting*" the young person. [68]

74. Ms Rodwell said that notwithstanding the recommendations from CASPA and her health team that Didbala required additional supports, specific funding for these supports never eventuated. She explained that the current funding model did not include a 'complex needs' funding stream. The only provision for children with complex needs was an additional 'funded vacancy' allocation. This funding increases the staff/child ratio in a house (which occurred in Katherine in August 2021). But this did nothing to meet Didbala's needs particularly in light of her refusal to stay in placement. Ms Rodwell was of the view that a more flexible model of funding was needed to address Didbala's significant mental health issues, which could support her needs whether she was residing in or out of her placement.

75. However, having accepted Didbala, CASPA worked with her multi-disciplinary team in preparation for her discharge from the YIP. With the support of Didbala's YIP team, Didbala was discharged from the YIP to a CASPA ITRC residence in Darwin (Darwin CASPA) on or around 5 May 2021.

76. Drs Ploetz and Tranter prepared an extensive 'Master Plan'[69] which was shared with CASPA, CAMHS, Territory Families and the hospital Emergency Department (ED) (in the event Didbala presented at ED in the future). Dr Ploetz gave evidence that it was intended to be a "*live*" document that could

[68] Additional Documents, Folio 19, Affidavit Naarah Rodwell Annexure C
[69] Additional document Folio 23 Annexure RP5

be added to and followed by the people tasked with caring for her.[70] I note that this was a detailed and practical document that was prepared specifically to address the complexity of Didbala's case. Dr Parker said this type of document is not a usual or standard discharge document.[71] Dr Ploetz also attended the Darwin CASPA house to facilitate Didbala's move and to help mitigate risks.[72] The main risks were identified as absconding and a resultant relapse in her mental health. Self-harm and suicidal ideation were not identified as specific risks by the YIP clinical team.[73]

77. Despite efforts to build rapport and establish a smooth transition, the discharge plan almost immediately unravelled. Didbala did not stay at Darwin CASPA for long and she effectively self-placed with family in Darwin and Katherine within two weeks of her discharge. Even though she was not in placement, the CASPA staff worked hard to stay connected with Didbala and her family.

78. By 14 May 2021 Didbala was located by police sniffing inhalants and arrested on various criminal charges. She was bailed and Territory Families lost contact with her. By August she was believed to be in the Katherine area planning to travel to Yarralin. The Darwin CASPA placement was terminated and a new placement was arranged for her in Katherine.[74]

79. By 25 August 2021 Didbala was only occasionally visiting her Katherine CASPA house but she rarely stayed there. However, the Katherine CASPA staff did their best to stay connected with her.

80. On 22 October 2021 Didbala was assigned a new Katherine based Territory Families Case Manager.[75] However, by this date, she had travelled to Yarralin

[70] Transcript at 150
[71] Transcript at 198
[72] Additional Documents, Folio 21 [264]
[73] Additional Document, Folio 19 [22-24]
[74] Additional Documents, Folio 16 [250-266]
[75] Additional Documents, Folio 16 [281]

and her Katherine CASPA placement was terminated. Her Case Manager (by phone due to Covid travel restrictions), local police and the local clinic all checked in on her in Yarralin and she was provided with a food voucher.

81. On 6 December 2021, Didbala called her Case Manager to advise that she had moved to another family member's house in Yarralin; she needed bedding and there was no electricity. She was provided with a power card, mattress, and bedding. She was given another power card and food voucher on 30 December. Health practitioners confirmed she was receiving her medication and attending the clinic.[76]

82. On 28 February 2022, her Case Manager discussed ongoing care options including telehealth and face to face therapy sessions with the CAHMS psychologist. In early March it was reported that Didbala was sniffing deodorant and suffering from delusions and Police reported that her family could neither control nor support her and there were insufficient resources in Yarralin to manage her complex needs.[77]

Re-admissions to the YIP and return to CASPA

83. Didbala was re-admitted to the YIP between 2-14 March 2022. She was care-flighted from Yarralin with concerns her psychosis had relapsed. Medical staff were of the view that admitting her to YIP for any length of time would re-traumatise her and she was released to be managed in the community.

84. Didbala's Case Manager travelled to Yarralin on 8 March 2022. The Case Manager organised a case conference with her health team to try and put in place supports for her and met with her carer, RS, to progress a kinship carer assessment.

[76] Additional Documents, Folio 16 [282-297]
[77] Additional Documents, Folio 16 [300-303]

85. It was determined that Yarralin remained the best option for Didbala and it was where she wanted to be. On 14 March 2022 Didbala was discharged from the YIP and her Case Manager and a Mental Health Worker escorted her back to Yarralin. However, later that day Didbala attended the clinic requesting "Ice" and spat at a clinic worker.

86. RS remained in contact with Didbala's Case Manager and on 22 March reported that Didbala "*had gone mad again.*" The Case Manager travelled to Yarralin on 24 March 2022 to speak to family.[78]

87. On 25 April 2022 Didbala was flown to Darwin and re-admitted to the YIP. She was discharged on 29 April to a CASPA house in Darwin.

88. On 6 May 2022, a new Katherine based CPP was appointed as Didbala's Case Manager, and she was placed in a CASPA house in Katherine.

89. Didbala continued to regularly be out of placement. She stayed with various family members and had several police involvements from July to September 2022. She returned to her Katherine CASPA placement on 1 October 2022 just 2 days before her passing.

Comments and Discussion

90. According to the NT Health Root Cause Analysis (RCA) Didbala was one of the most complex young people ever encountered; she could be agitated and extremely aggressive, she suffered from psychosis, mania, mood and perception disturbances, suicidal ideation, and self-harm.

91. Her need for family and community connection was clear from her constant returning to her home communities and her cultural needs were never adequately addressed in her care plans. CASPA CEO, Ms Rodwell, acknowledged that CASPA's engagement and support strategies were largely

[78] Additional Documents, Folio 16 [325-328]

ineffective due to Didbala's deep drive to be with her family. She said that Didbala's movement between families and community was deep seated.[79] On reflection, Ms Rodwell insightfully explained Didbala's behaviour this way, "*I see her level of absconding [as] underpinned by her deep feelings of neglect… [But her] need to be with her family was the very thing that thwarted our ability to provide a consistent medication regime and a consistent care environment*" both of which were "*key to her recovery*."[80]

92. Despite the efforts of dedicated individuals, the services and care provided by Territory Families was rarely sufficient to meet Didbala's needs, and in particular Territory Families failed to properly accommodate Didbala's drive to be with her family. In making this finding, I acknowledge that providing care and services to Didbala was highly challenging. Barriers to effective service delivery included multiple changes in her overworked Case Managers and Covid 19 travel restrictions which combined to made it difficult to build trust and rapport with Didbala or her family. This in turn likely contributed to Didbala's frequent intransigence and her refusal to engage with the limited services available in the Big Rivers Region. Flexible complex care funding or NDIS funding specific to her needs may have provided for more effective methods of intervention and engagement with her.

A Failure to Adequately Collaborate with Family

93. Didbala's determination to be with family, irrespective of the plans that were put in place for her, made it essential for Territory Families to work closely and collaboratively with her family but this was not reflected in their approach to her care. Territory Families now accepts that given her age and reluctance to remain in any placement, her Case Managers should have prioritised strengthening her natural family network and establishing a flexible family care arrangement.[81] Expanding on these concessions, Ms Warburton, in both

[79] Additional Document, Folio19 at para 9
[80] Additional Documents, Folio 19, Affidavit Naarah Rodwell at [42]
[81] Department of Children and Families written submissions 16 December 2024 at para 62

her affidavit and her oral evidence, conceded that Territory Families did not work with Didbala's extended family to the extent they should have whilst she was in the care of the CEO.

94. In its Institutional Response, Territory Families belatedly recognised the strength of Didbala's extended family and frankly conceded their failure to:
    (a) proactively support Didbala's family in her early years when there were early warning signs of neglect, exposure to harm and her developing behavioural issues;
    (b) develop clear case plan goals or co-ordinate her medical care or her educational needs while she was in Yarralin from August 2021 to April 2022;[82]
    (c) conduct kinship assessments of family members or to meaningfully assess whether family members had capacity to care for Didbala, possibly inconsistent with the Aboriginal Child Placement principles enshrined in s 12(3) of the *Care and Protection Act 2007 (NT)*;
    (d) develop and update a family tree and lists of family contacts. While Territory Families did some family mapping for Didbala[83] it is not clear when this was done and it was incomplete; it missed key people in Didbala's family, including family members who provided care in Yarralin, such as RS. Despite having a partnership in place, Territory Families failed to engage the Kalano Community Association to assist with identifying and recording her family members.[84]

95. Discussions about kinship care only belatedly commenced on 9 March 2022 by which time there were notifications from police and Katherine West Health workers that her family were struggling, and her mental health was spiralling. Given the family's documented willingness to engage in family planning

[82] Additional Documents, Folio 16 para 316, Transcript at 323
[83] Additional Documents, Folio 16 Annexure LW3
[84] Transcript at 297

meetings and the reports from police and the clinic that they were not coping, more ought to have been done earlier.[85]

96. When she was discharged in May 2022, after her second long YIP admission, Didbala was the subject of a Long Term Protection Order. The decision to place her in ITRC with CASPA was well founded on the health team's advice that she needed a stable community placement, and her mother's acknowledgement that she could not care for her. However, there was no active review of this decision when it became clear that Didbala was not staying at her placement and was instead staying with her extended family. Territory Families did not engage an Aboriginal Community Worker for Didbala and her family and this should have been done[86] and little or no effort appears to have been made to formally assess whether her family had capacity to care for her in Katherine in the months prior to her death. Didbala's Katherine based family said that they had little contact with Territory Families when Didbala was in Katherine and Territory Families records support that assertion.[87]

97. Didbala was placed in the following CASPA ITRC houses:

- 5 May 2021 – July 2021: Alawa, Darwin
- 12 August 2021 – 28 October 2021: R Court, Katherine
- 29 April – 5 May 2022: R Road, Milner
- 5 May 2022 – 19 May 2022: C Crescent, Katherine
- 19 May 2022 – 3 October 2022: B Court, Katherine

98. Despite these several placements with CASPA, Didbala spent relatively short periods of time in CASPA's direct care as she frequently chose to stay with her extended family instead of in her placement. And, with the exception of the House Co-ordinator at the Alawa house, there is little evidence that

[85] Additional Documents, Folio 16 paras 73-74, 312-313, 381
[86] Additional Documents, Folio 16 para 498
[87] Transcript at 297

Didbala formed any real connection with any of the CASPA staff who were looking after her. Each placement broke down or was terminated because she was internally driven to be with her family.

99. Similarly to their complaint concerning Territory Families, Didbala's family said that the CASPA workers did not sufficiently engage with or include family members in Didbala's care. In particular, they were unhappy that they were not contacted when Didbala was out of placement and felt they could have assisted CASPA in finding her and encouraging her to return to care. They felt excluded by those caring for her and they did not know that they could visit her at her CASPA residences.

100. Ms Rodwell acknowledged that CASPA did not engage with Didbala's family to the extent that she thought should have occurred. However, Ms Rodwell explained that CASPA was hamstrung because responsibility (and funding) for family engagement primarily sits with the Territory Families Case Managers. Ms Rodwell considered that this 'neglect' (my word) of Didbala's family was substantially due to the Big Rivers Case Managers being overwhelmed by excessive caseloads (discussed in greater detail later in these Findings). Ms Rodwell explained that in NSW case management is delegated to the Out of Home Care (OOHC) provider and CASPA Case Managers have a caseload of just 5 children.[88] It was her view that if CASPA had been delegated case management for Didbala, much more would have been done to work with and include her family in her care.

101. A flexible care arrangement that included family may well have been a more successful model for caring for Didbala. It is possible to imagine that Didbala may have settled into a placement if she and her family had understood that her family were welcomed and valued for the significant role they had to play in her continuing care. Alternatively, Ms Rodwell raised the possibility of an

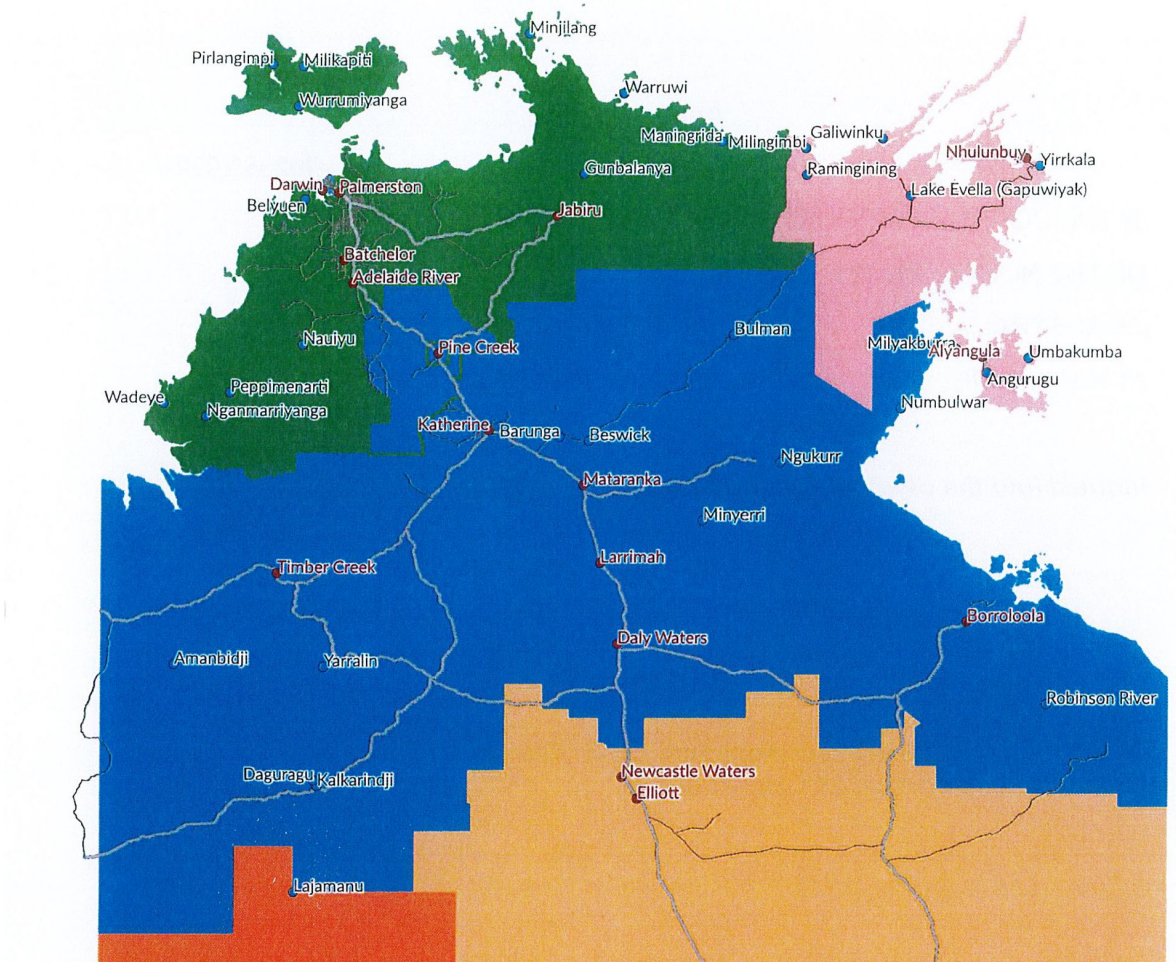
[88] Transcript at 255-257

outreach type model for young people who refuse to stay in out of home care placements.[89]

Overwhelmed Case Mangers and Case Management neglect

102. The Territory Families Big Rivers region stretches over one thousand kilometres across the Northern Territory between Western Australia and Queensland and covers over seven hundred kilometres from North to South.

ATTACHMENT A - DCM Regions



[89] Transcript at 269

103. Due to staffing shortages in the Big Rivers Region, Territory Families did not provide the level of case management that a young person with Didbala's complex needs required. To be clear, when we are discussing unmanageable caseloads what we are actually talking about are highly vulnerable children in care (and their families) not getting the consistent support and attention that their situations deserve. The real impact of this is children missing out. For example, Didbala never received NDIS support even though all the evidence indicates she would have been eligible.

104. Territory Families conceded in its Institutional Response that Didbala experienced a high turnover of Case Managers resulting in inconsistent engagement with her. Territory Families attributed the high turnover to their overall high staff turnover and because Didbala moved between Darwin, Katherine, and other communities.[90] Ms Rodwell said that at one point Didbala had three Case Managers in three weeks. Although Ms Warburton did not accept that figure, Territory Families' records revealed three Case Managers between June and October 2022. It would have been exhausting for Didbala to try and keep track of her changing Case Managers (if she ever met them) and almost impossible to develop trust or rapport. The turnover must have been frustrating and was not conducive to the delivery of quality care.

[90] Additional Documents, Folio 16 [389-390]

105. While Ms Warburton considered that a manageable caseload was about eight for complex, high needs, young people like Didbala; she said that in the Big Rivers Region the average caseload for Case Managers is a whopping thirty-six children, compared with caseloads of around twelve for the Darwin and Central Regions. In other words, all Territory Families Case Managers' caseloads are higher than ideal, but the Big Rivers caseloads are simply unachievable.

106. Ms Warburton gave evidence that of the thirty-eight professional positions based in Katherine, ten were unfilled. She said that there were long standing vacancies in the Big Rivers Region, and more generally, across Territory Families.[91]

107. The consequence of staff vacancies and excessive caseloads in the Big River's Region is that vulnerable children in the CEO's care do not receive the case work they need or deserve. The child protection system in the Big Rivers Region is suffering a chronic crisis of Case Management neglect.

108. The variation in Case Management across regions was noted by Ms Rodwell who described Territory Families' case management of Didbala as excellent when she was initially discharged from the YIP in Darwin; but from May 2022 to the date of her death in Katherine, it was almost non-existent, and she gave it a shockingly low 1 out of 10 rating.[92]

109. Ms Rodwell described the day-to-day impacts of the current overly bureaucratic model. Carers are unable to respond quickly to the most basic requests of young people in their care, for example, to engage in sporting activities. Simple activities require separate approvals and sometimes separate funding from Territory Families. Given Territory Families workloads there are unacceptable delays. I understand that when the Carers are not

[91] Transcript at 332-334
[92] Transcript at 271, 275

responsive to children's needs, trust breaks down and therapeutic relationships are strained. I expect it leads to feelings of frustration and hopelessness on the part of children and Carers alike, but it is the child that suffers and is let down once again.

110. As I have already touched on, I heard evidence from Ms Rodwell that for children in CASPA care in NSW, most case management functions are delegated to CASPA and CASPA Case Managers typically have a caseload of five children. If case management were funded and delegated to CASPA in the Big Rivers Region, Ms Rodwell gave evidence that she could fill the positions with caseloads of five. Alternatively, Ms Rodwell explained that that, if funded, CASPA could provide 'case support workers' who could work with Territory Families Case Managers. She was clear that a different model would deliver better outcomes for children in out of home care in Katherine.[93]

111. However, Didbala's family were not convinced that a model that transferred case management to CASPA was the best model for Aboriginal children. Family were of the view that given 90% of children in care in the NT are Aboriginal, long term solutions should focus on transferring more responsibility, including delegation of case management functions, to Aboriginal Community Controlled Organisations (ACCOs). This model is said to be in line with the Victorian child protection model.[94] However, I did not hear any evidence about the willingness or capacity of ACCOs in the NT to take on case management responsibilities for children in the care of the Territory Families.

112. What is clear is that there are insufficient Case Managers for complex children in care in the Big Rivers Region and the result is that children and families are suffering Case Management neglect. Didbala's family submitted that Territory Families should urgently explore innovative strategies to meet

[93] Transcript at 261
[94] Written submissions on behalf of the Family, 16 December 2024.

unmet case management needs in the Big Rivers Region and I fully agree with that submission.

NDIS

113. A stark example of Case Management neglect was the failure of Territory Families to progress Didbala's NDIS application in a timely fashion.

114. Territory Families established the Disability Development Team (DDT) in 2020 to support its staff to access funding for children with disability and developmental delay, in particular, NDIS. The DDT works with the Territory Families Medical and Allied Health Specialist Services (MAHSS) panel to access assessments and interventions for children and monitors the quality of NDIS plans and supports.[95]

115. As early as 19 February 2021 it was identified that Didbala was likely to need NDIS supports and Territory Families were to begin the NDIS application.[96] On 24 February 2021 her treating psychiatrist, Dr Ploetz, advised Territory Families that the YIP team would start a FASD assessment.[97] And in March 2021, Ms Dhaemer, psychologist, told Territory Families that a PATCHES assessment for FASD might be useful.[98]

116. During March and April 2021, the DDT emailed Didbala's various Team Leaders, Case Managers and health team professionals concerning the completion of NDIS assessments and the application.[99] On 28 April 2021, Dr Tranter sent the DDT an unsigned document outlining evidence in support of Didbala's NDIS application. The DDT requested that the document be signed but when this was not done the NDIS application stalled and was not progressed.

[95] Additional Documents, Folio 16 [66-67]
[96] Additional Documents, Folio 16 [163]
[97] Additional Documents, Folio 16 [166]
[98] Additional Documents, Folio 15 [137]
[99] Additional Documents, Folio 16 [185, 195]

117. On 7 April 2021, the DDT advised Didbala's Case Manager that she should be referred for a Specialist Behaviour Support Intervention and on 29 April 2021 SAL Consulting were engaged to do a Specialist Behaviour Supports Assessment. SAL Consulting enquired whether a FASD assessment was required but were advised that Territory Families were waiting on a diagnosis from Dr Fancourt.[100] SAL Consulting were not successful in contacting Didbala and on 15 September 2021 the referral was closed without the assessments being completed. Again, the NDIS application was not progressed.

118. On 2 June 2022, a Services Australia Social Worker contacted DDT and the Didbala's CPP as they had been trying to assist Didbala to access a Disability Pension. The Services Australia Social Worker requested DDT's help to get NDIS support. On 24 June 2022, the DDT drafted a NDIS application and sent it to the Case Manager who completed it and sent it back to the DDT on 9 September 2022.

119. While a FASD diagnosis would have qualified Didbala for NDIS funding in the 'disability' stream, I accept that there were genuine difficulties in having her complete a lengthy and multifaceted FASD assessment due to her intransience and her unwillingness or inability to participate in the assessment process. However, there was also evidence to support an application for funding in the 'psychosocial disability' stream. The Services Australia Social Worker, who was supporting Didbala to obtain a Disability Pension, was of the view that sufficient evidence of a 'psychosocial disability' was available. All potential applications for NDIS should have been identified and progressed much earlier by the Territory Families DDT team rather than leaving it to another organisation to prompt the application.

[100] Additional Documents, Folio 16 [199]

120. Having identified in February 2021 that Didbala was likely eligible for and would benefit from NDIS supports, an application for NDIS was not submitted until 12 September 2022, over 18 months later.[101] During that period, Ms Rodwell expressed frustration that CASPA was routinely expected to provide supports that should have been funded under an NDIS package and that CASPA did not receive 'complex needs' funding to provide the NDIS type supports.[102]

121. Ms Rodwell gave evidence that CASPA is a charity which is running at a loss in the NT. In other jurisdictions where CASPA operates, increases in Federal Awards for staff are covered in the contract, but this is not the case in the Northern Territory and CASPA is expected to absorb these cost increases within their existing funding.[103] I have heard similar evidence from not-for-profit enterprises in other inquests.

122. Given how critical NDIS funding is to the wellbeing and development of children who are eligible, it is alarming that Territory Families does not have benchmark timeframes for the completion of NDIS applications.[104] Ms Rodwell said that if a CASPA Case Manager had not completed an NDIS application within 3 months of the intake of the child, the staff member would be performance managed.[105] Territory Families has acknowledged that benchmark timeframes for preparing and submitting NDIS applications should be introduced.

Limited effective therapeutic engagement

123. Without NDIS or 'complex needs' funding, CASPA delivered therapeutic supports to Didbala as best it could. As to CASPA's efforts, Mr Manning said that the CASPA clinical staff each managed a caseload of three houses and

[101] Additional Documents, Folio 16, [222, 364]
[102] Transcript at 254, 255, 271
[103] Transcript at 284-285
[104] Transcript at 291-294
[105] Transcript at 266-267

there was one Therapeutic Specialist based in Katherine. That specialist worked directly with the young people in care, including Didbala, and also supported her Carers. Mr Manning said that each month information was collected regarding Didbala's support needs and shared at monthly clinical meetings where the therapeutic specialists would provide three hours of training and workshops to Carers. However, as already noted, the casual Carers on the fateful night never, or only rarely, attended these meetings.

124. Didbala's first Therapeutic Support Plan was not completed until 13 September 2022 and relevantly included a Functional Behaviour Assessment, Positive Behaviour Support Plan, and Incident Crisis Management Plan. The completion of these plans was delayed because Didbala was not residing in her placements and refused to engage in assessments. These delays flowed through to the level of targeted support that was provided. In spite of these delays and considering the limits of their funding arrangement, I was not overly critical of the care that was provided by CASPA.

Family concerns about Casual Staff and Non-Aboriginal work force

125. Didbala's family were upset that the casual Carers on 3 October 2022 did not really know Didbala. Ms Rodwell acknowledged that utilising casual Carers to staff IRTC houses was neither optimal nor in line with CASPA's organisational goals. She explained that the normal rostering procedure is to roster a core staff member with a casual Carer but at times this does not happen due to leave requirements and staff shortages.[106] Ms Rodwell explained that in an endeavour to improve core staffing levels (and reduce reliance on casuals) CASPA had offered increased salaries and other incentives to attract and retain fulltime workers in Katherine. I acknowledge these efforts and I heard evidence from all agencies in this Inquest as to the challenges of recruiting and retaining staff in the Big Rivers Region.

[106] Transcript at 249-250

126. Didbala's family were also concerned that she was being cared for by workers who were not Aboriginal. Ms Rodwell accepted this is a genuine concern for Aboriginal families and recognised the need to have Aboriginal staff at all operational and management levels. She explained that CASPA do actively recruit Aboriginal staff, including people from the Big Rivers Region, but that recruiting and retaining Aboriginal staff is also challenging. Ms Rodwell explained that in a genuine effort to address the cultural needs of Aboriginal children in its care, CASPA has entered Memoranda of Understanding with the Kalano Community Association and the Larrakia Nation Aboriginal Corporation, to develop cultural support plans for Aboriginal children in CASPA care.

Safety Planning

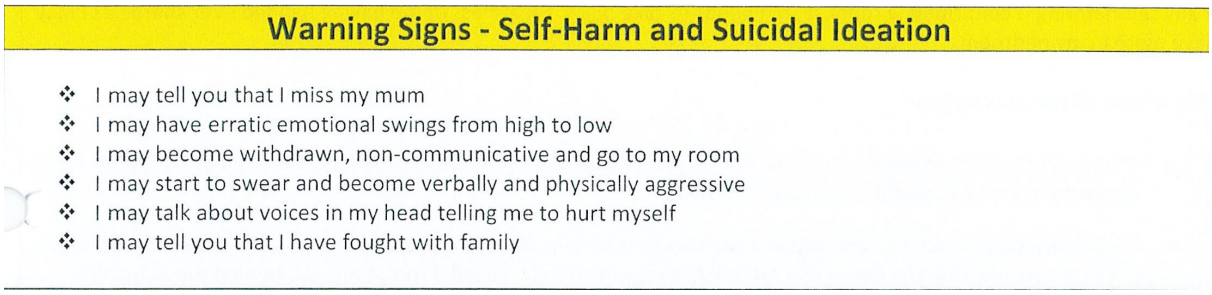
127. Territory Families knew of, and recorded, Didbala's risk of self-harm/suicidal ideation in a document titled 'Essential Information Record' (EIR).[107] Under the heading 'Health and Wellbeing' are several boxes. One of these boxes is for "*Has a history of self-harm, suicidal attempts or ideation, or mental health concerns*" and this was ticked. However, Ms Warburton agreed that separating mental health concerns with self-harm/suicidal ideation in this document would provide better clarity concerning these risks.[108]

128. When Didbala first came into CASPA care a Safety Plan based on the intake information provided by CAMHS and the YIP was prepared and this was regularly updated. Although Didbala had not displayed any form of suicidal ideation since February 2022, the section titled 'Suicide and Self-Harm' remained in the Safety Plan to ensure staff were aware of the risk and trained to respond. Her most recent Safety Plan was dated 30 September 2022 and was specific to her Katherine CASPA residence.

[107] Additional Documents, Folio 19, Annexure H
[108] Transcript at 326-327

129. Although both casual Carers were aware of the Safety Plan neither had recently reviewed it and neither adequately understood Didbala's significant history of acute mental illness and trauma or how that elevated her risk of suicide or self-harm even in the absence of recent threats or attempts. CASPA acknowledged the importance of procedures which ensured that staff read and understood each young person's Safety Plan and have amended its 'changeover' (handover) forms to document this.

130. The 'Suicide and Self-Harm' section in Didbala's Safety Plan included the following warning signs.



131. Albeit with the benefit of hindsight, some of these Warning Signs were present or partially present when Didbala came out of her room on 3 October 2022 at 2.55 am. For example, she became verbally and physically aggressive, she said she was hearing voices (but not that they were telling her to self-harm) and she withdrew to her room and became non-communicative. These were all acute/recent changes in behaviour and I accept that she was not exhibiting any earlier warning signs in her Carers' presence. Didbala's outburst was significant and unexpected and these potential suicide behavioural warning signs were in the context of Didbala damaging property and physically assaulting Carer 1. Carer 1 was in shock and fearful for her safety. In those circumstances I do not criticise her for not immediately identifying Didbala's behaviour as a possible warning of self-harm. In all the circumstances, Carer 1's response of withdrawing to safety and calling 000 for assistance was appropriate.

132. However, as Ms Rodwell acknowledged in her evidence, after appropriately addressing the immediate risk of harm to themselves (by placing themselves in a place of safety and calling 000), neither of her Carers turned their minds to the possibility that Didbala's acute change in behaviour also gave rise to an elevated risk of self-harm.[109] With the benefit of hindsight, having retired to a place of safety it is regrettable that, as they waited for police to arrive, neither Carer accessed or considered Didbala's safety plan. If they had reviewed Didbala's safety plan they may have been reminded of the suicide behavioural warning signs and specifically these directions concerning what to do if a risk of self-harm is identified and Didbala locks herself in a room:

Prompt me with 3 times when I am in the bathroom/bedroom and not responding to you.

, can you hear me?"
, I need you to respond"
, we are coming in as we are worried about you"

IF after the 3rd prompt I have not responded, you will have to come into the room and sight me.

- Don't let me go off on my own, I would like you to stay close-by so you can see me and support me to keep myself safe.
- Don't let me lock the bathroom door as this is a sign that I am not in a good headspace and that I may self-harm.

- If I lock myself in a room or am stopping workers to open the door, I understand that you will enter the room to check on me and that the Police and Ambulance may need to be called. Prompt me and remind me about this but please do not threaten with police or yell at me.

133. That was a solid plan which, if actioned, would likely have resulted in a swifter entry into Didbala's room. However, I accept that the circumstances of this case were confusing. While Didbala was not responding verbally, the Shift Sergeant genuinely (though mistakenly) thought she had been speaking to the P/Cs, and the police and CASPA staff genuinely believed that she was actively holding the door to her room or was otherwise actively preventing their entry. In other words, they genuinely believed, in spite of her silence, that she was responding to their efforts. Given those genuine beliefs, it is understandable that the police and Carers did not immediately force the door.

[109] Transcript at 264

134. The Safety Plan also provided guidance concerning alcohol or other drug use. On this night Carer 1 identified that Didbala was tipsy (which in her mind meant mildly affected by alcohol) but the responses set out in the Safety Plan, such as calling the poisons hotline, the mental health access line or 000, appeared directed at dangerous AOD use and did not seem relevant or proportionate to mild or normalised use. I accept that Carer 1's assessment that Didbala was tipsy did not warrant the kind of response listed in the Safety Plan.

135. The Safety Plan also contains this prompt:

- Please ask me about the amount and what kind of substances I may have mixed so you can inform ambulance or poisons hotline

136. Although Carer 1 was not concerned by Didbala's level of intoxication it would not have been inappropriate to attempt to clarify precisely what, and how much, she had consumed. Given Didbala's serious mental health issues, any information gained may have been relevant to: a) an immediate risk assessment noting that "mixing (poly-use) AOD" is identified as a risky behaviour on her Safety Plan for self-harm; and/or b) the information may have been relevant to inform a harm minimisation conversation which is also recommended in the Safety Plan. While such an enquiry could have occurred when Didbala got home, I accept that it was late at night and there was no apparent urgency. As there were no alarm bells about Didbala's behaviour it was the kind of enquiry which could also usefully occur the following morning and I am not critical of the decision to defer this conversation.

Engagement with Police

137. I am satisfied that the response by NT Police was appropriate based on the information they received and had in their possession and I was impressed

that in both interactions with Didbala, the two probationary constables appropriately sought advice from their Shift Sergeant.

138. Ms Rodwell explained that when CASPA commenced operations in Katherine it made efforts to formally contact local police to try and provide information about ITRC and raise awareness of a Territory Families "Protocol for Police Contact with Children Living in Therapeutic Residential Care" (the Protocol).[110] I have considered the Protocol. It is a high level document that speaks to various principles, commitments, and strategies. However, it provides a little in the way of practical advice for Carers or police. Of the nineteen page document approximately one page (the next to last page) contained information directed to incidents involving a police attendance at an ITRC house. The sections speaks for itself so I will extract it in full.

Strategies during and following an incident – Police involvement

MAIN CONSIDERATIONS:

- Children and young people are supported to correlate their actions to the impacts and consequences, and guided to learn from their experiences.
- Children and young people will receive timely access to legal support and responses that focus on their needs and reduce the risk of re-occurrences.
- Children and young people will live in a safe and supportive environment that uses a considered approach to managing group dynamics.

WHEN POLICE HAVE RESPONDED TO AN INCIDENT THERE ARE ADDITIONAL STRATEGIES THAT APPLY:

Therapeutic Residential Care services at the time of an incident:

- Ensure the safety of all involved before the arrival of Police.
- Where possible, when contacting Police or upon their arrival, provide members with advice about the child or young person that may inform their response, i.e. known triggers, likely response to the attending Officer and any known strategies to best approach and communicate with the child or young person.

[110] Additional Document Folio 12

Therapeutic Residential Care services strategies following an incident:

- Ensure an appropriate independent adult support person is available for the child or young person who is alleged to have committed an offence. This may be another member of the Therapeutic Residential Care staff, or arrangements may be made through the Territory Families Case Manager depending on the circumstances. A support person cannot be a Therapeutic Residential Care worker involved in the incident.

Shared strategies for successful outcomes following an incident:

- Provide information to children and young people about their rights and facilitate contact for them with a legal service provider immediately, or as soon as practicable after the incident.

POLICE RESPONSE

- When police receive a request for immediate (000) or non-immediate (131 444) assistance, attending Officers will initially focus on the safety of all people involved prior to determining if any criminal offences have occurred.
- At incidents attended by Police involving children and young people living in Therapeutic Residential Care, consider the most appropriate response to the situation, which will include the following:
  - Safety and wellbeing of children, young people, staff members and victims; and
  - Relevant legislation.
- Where a criminal investigation occurs a child or young person will be considered for pre-court diversion unless excluded by the severity of the offence or prior relevant criminal history.
- Police will work with Territory Families to determine if there may be a need for alternative options to ensure the ongoing safety of involved people. Police will take appropriate action for all parties, dependant on the circumstances.
- Where an interview is sought with a child or young person, Police will work with the Therapeutic Residential Care service provider and the Territory Families Case Manager to ensure the child is provided with legal representation and has a responsible adult present.

139. I consider that there were two important pieces of practical advice for the Carers, namely: a) to ensure safety; and, b) to provide police with relevant information about the young person to inform their response. There was an important piece of practical advice for the police, namely, to focus on the safety of all people involved.

140. I am satisfied that the evidence demonstrates that the safety of Didbala and the Carers was at the forefront of everyone's mind. However, her elevated risk of self-harm was not recognised by the Carers and so it was not communicated to the attending police. The attending police were not told of her serious behavioural and mental health issues, or her associated heightened risk of suicide, or the specific responses/approaches devised in her safety plan.

141. When the police arrived, the Carers seemed relieved. Accepting that the Carers fully cooperated with the police, they failed to appreciate that they had vital information about Didbala (as distinct from the incident itself) that they should have proactively provided to the police. Equally, although the attending police said they would have liked additional information, they did not make effective enquires to elicit further relevant information from the Carers about Didbala's circumstances.

142. The Protocol provides that Behaviour Support Plans should be discussed with police who attend incidents at out of home care residences so that police are alerted to specific behaviours and triggers for behaviours that might be challenging or dangerous. P/C P said he had never seen a Behaviour Support Plan or a Safety Plan and even though he had been to both the CASPA Katherine houses a number of times.[111] P/C A had seen one since this incident. It was provided to her by the Watch Commander when she was conveying an "At Risk" youth. The evidence points to the Protocol being neither widely known, understood nor applied.

143. I heard evidence that none of the attending police had received any specific training in dealing with 'at risk' young people and nor were they aware of the Protocol. Without this training they were not in a position to know that they could ask for documents such as a Behaviour Support Plan or a Safety Plan which would inform them of risks specific to the child, such as a risk of self-harm. Had they accessed these plans, or considered the critical information contained in them, they may have understood that leaving Didbala alone in her room was risky and they may have entered the room earlier. [112]

144. I am told that CASPA now ensures its staff are trained on the Protocol during their induction and CASPA also now participates in monthly meetings with

[111] Transcript at 101
[112] Transcript at 84

police and other stakeholders regarding 'At Risk' young people as a mechanism for improved information sharing.

145. While the Mental Health First Aid training all police are required to do equips police with skills they require on the road,[113] all the police who gave evidence at the inquest considered that specific youth training would assist them to do their job. CASPA submitted that all police should be trained about the vulnerabilities and causes of behaviours of children in care including that ITRC care is for those with the highest complexities. I agree with this submission.

146. The sad fact is that all young people in ITRC care will, as a result of their complexities and backgrounds, have a higher risk of suicide than the average young person (without complex needs and histories). Recognising this, CASPA has implemented a change to all Safety Plans, and staff are now directed to inform all first responders that the young person is a suicide risk. In addition, the inquest raised the idea that a short one page summary setting out critical information about a child in care could be developed and made available to all first responders. CASPA recognised the value of this and I am told that a one page critical summary now forms part of each child's Safety Plan and is provided to first responders.

The Keys

147. It is difficult to understand why the keys to Didbala's room did not appear to work that night, but it led the police and Carers to believe that Didbala was somehow preventing the door from being opened and this belief delayed their entry into her room.

148. CASPA readily acknowledged the keys should have been individually labelled to avoid confusion in an emergency and has implemented this change.

[113] Transcript at 90

Police PROMIS Alerts

149. There were two specific 'Mental Health' alerts for Didbala on the police PROMIS system. If opened (clicked on) for further information, the first one from 10 February 2021 recorded "*had recently been released from Cowdy ward and fresh report received of possible self-harm."* The Shift Sergeant recalled that this 2021 alert related to an incident he was involved in but it did not cause him to consider that Didbala was at risk of self-harm on the night of her death.[114] His understanding of the incident that gave rise to this alert is not entirely consistent with the medical records of this incident, which is not surprising given the different roles police and hospital staff play and the different information they can access. In circumstances where police are assisting with the transport or management of mental health patients I wonder whether it might be prudent for police to ask what the risk(s) for the patient are, so that the most appropriate alert(s) can be placed on the police system, which is currently SerPro. However, I am not suggesting that this Mental Health alert was in any way inappropriate.

150. The second entry from 2 March 2022 recorded "*she displayed symptoms of psychosis (constantly repeating that she was on ice and that there were other people talking to her)".* In both instances the police records reflect that she was care-flighted to Darwin and involuntarily admitted under the MHRSA.[115]

151. P/C A was shown a printout of the Police Alerts for Didbala with the alert heading 'Mental Health'. P/C A explained that to access the detail of the Mental Health alerts (on both the old PROMIS system and the current SerPro system) you must navigate to the narrative description of the incident.[116] There was no specific 'At Risk of Self Harm' alerts for Didbala, though such an alert does exist.[117] P/C A said that if there had been such an alert it may

[114] Transcript at 170
[115] Additional Documents Folio 5
[116] Transcript 87-88; 169
[117] Additional Documents Folio 5

have changed her response.[118] However, I did not receive any evidence that there were any incidents involving police where they were provided with information which would have warranted such an alert.

152. I am satisfied that there was nothing in the PROMIS alerts or her earlier behaviour with the P/Cs (when she was dropped home) that ought to have triggered a more urgent response from the police or caused them to consider that she was at an elevated risk of self-harm.

Delayed Entry

153. Twenty-four minutes elapsed between when police first arrived and when they forced entry into her bedroom and found her deceased. This was a devasting outcome for all those in attendance. I accept that the Carers and police officers were doing their best that day and if anyone had identified an elevated risk of self-harm entry would have been effected earlier.

154. I accept that the CASPA casual Carers were not as familiar with Didbala or her history as permanent staff may have been. They were shocked by her escalation which placed them at real risk of harm and they did not have sufficient knowledge of her or the benefit of scenario based critical incident training. Without that knowledge and training they did not re-direct their thought processes and did not identify the risk that also arose for Didbala. Because they lacked this insight, the risk was not communicated to the police and confusion about the urgency of the situation was compounded by misunderstandings as to whether Didbala had been communicating and/or was blocking entry.

155. As discussed earlier, in response to this misidentification of risk and communication failures, CASPA now requires Carers to inform first responders of the elevated risk of self-harm for children in their care and they

[118] Transcript at 87

are also required to provide first responders with the one page critical information sheet concerning each child. To cement these changes, I will make these recommendations and also one directed to scenario based critical incident training.

Interagency Co-ordination and Communication

156. There were several agencies directly involved in Didbala's care including NT Health, Territory Families and CASPA and multiple instances of poor inter-agency communication and co-ordination were identified. For example:
   a) When Didbala was discharged from the YIP at Christmas time, her Case Manager was on leave, Territory Families failed to respond to the health team about her discharge and did not become aware of her discharge date until 5 days after it had occurred.
   b) Although she was referred to Catholic Care for support, personal contact was not facilitated by Territory Families, contact was never established, and the support was never delivered.
   c) While Territory Families were heavily involved in her discharge planning from the YIP in 2021 and Child Protection Orders were in place after her discharge her care co-ordination was not proactively managed by her Territory Families Case Manager and devolved to Ms Dhaemer.
   d) Although all agencies considered her eligible for NDIS, Territory Families failed to take the lead or bring this to fruition in a timely way.

157. As the statutory parent, Territory Families had the overall responsibility for her care and was funded to provide her with Case Management. It ought to have been the proactive lead agency in co-ordinating her care and ensuring she received the care she needed.

158. This is not the first inquest to have identified the lack of co-ordinated care provided to highly vulnerable, 'at risk' children. In response to the former Coroner Judge Cavanagh's recommendation that a framework be legislated to "*ensure mandatory cooperation, co-ordination and information sharing in a*

timely manner"[119] (arising from an inquest which investigated the deaths of three young people who were known to various government agencies to be at risk of severe harm);[120] I heard that in March 2023 a Child Wellbeing and Safety Partnership (CWSP) Framework was incorporated into Part 5.1B of the *Care and Protection of Children Act* 2007(CAPCA),[121] and I heard that from 2024 the CWSP Framework has been operating in Yarralin.

159. I understand that the CSWP Framework is flexible in that it operates a little differently in each community depending on the available agencies in the community. However, its key members include Territory Families, NT Health, the Department of Education, the Department of Chief Minister and Cabinet and NT Police.

160. Agencies working in the CWSP Framework are tasked, inter alia, to identify children and families who have multiple unmet needs relating to their safety and wellbeing or who are 'at risk', to gather and share information, to develop action plans with families, to co-ordinate services, to commit to delivering on actions within agreed timeframes, and to escalate matters that require systemic change.[122] Anyone is able to refer a child or family to the CWSP Framework and a referral is likely to be accepted if the child's needs require collaborative action across multiple agencies.

161. I understand the CWSP Framework is located in remote communities and so issues with Didbala's care when she was living remotely may have been raised and addressed in a more timely manner if such a framework had been in place. However, it does not address what I consider to be the more pressing issue, namely the failure of her Case Management in the Big Rivers Region.

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[119] 2020 NTLC 022 [309]
[120] Additional Documents Folio 28, *Inquest into the deaths of F Yarranganlagi James, K C Mamarika and L Leering* [2020] NTLC 022
[121] *Care and Protection of Children Amendment Act* 2023
[122] Additional Documents, Folio 31 [41]

162. I am informed that Territory Families are developing a High-Risk Youth Panel to support "*rigorous multi-disciplinary case review, planning, decision making, service integration and collaborative problem solving and to provide support and direction to case management staff."*[123] While I do not doubt the potential of such a panel, it also fails to address or resolve the issue of chronic inadequate Case Management in the Big Rivers Region.

Death Notification

163. Territory Families policies require that parents and siblings be notified of a death. Territory Families contacted several members of Didbala's family by phone on 3 and 4 October 2022 (although it could not identify which family members were contacted). Certainly, Christine was contacted by Territory Families[124] and also by CASPA, who offered her support.[125]

164. However, Didbala's family remained concerned that some family found out about her passing through social media and this upset them greatly. Territory Families said that it would review its death notification procedures in light of these concerns.[126] As Territory Families already partners with various Aboriginal organisations to conduct family mapping, consideration could be given as to whether these partnerships may be able to assist with the sensitive and culturally laden task of death notification.

Engagement with NT Health

165. NT Health completed a Root Cause Analysis (RCA) following Didbala's death which concluded that, "Didbala's case was extremely complex and included her history of developmental delay, suspected ADHD, Suspected FASD, psychiatric conditions, alcohol use, drug use, VSA, suspected limbic encephalitis, complex trauma, complex psychosocial situation, and

[123] Additional document, Folio 16 at para 584
[124] Transcript at 327
[125] Additional Document, Folio 19 at para 57
[126] Transcript at 347

behavioural presentation. The RCA found that no single root cause contributed to her death but rather identified a series of contributing factors and key learnings.[127] I am satisfied that Didbala's health team made significant and committed efforts to care for Didbala whilst she was an in-patient at YIP and when she was out in the community and I am satisfied that the services provided by NT Health were appropriate to Didbala's complex health needs.

166. The RCA found that Didbala would likely have benefitted from: a full FASD assessment, a management plan for that condition and NDIS support; and trauma informed psychological counselling and support for her trauma history. I agree, noting the difficulties in achieving these outcomes given Didbala's lack of residential stability. While her location was stable when she was involuntarily admitted into YIP, I accept that during these admissions she was not well enough to engage in FASD assessments.

YIP

167. Didbala's family said that her two lengthy admissions were a source of significant distress to them and worried that its prison like environment was harmful to Didbala. Dr Ploetz agreed that there were aspects of the physical layout of the YIP that were not fit for purpose and should be improved. NT Health advised Didbala's family that money had been allocated to upgrade the YIP infrastructure and aesthetics such as: painting the YIP a more welcoming colour, a mural, furniture upgrades, a shade structure in the court yard, sensory room dimmer lights, music in common areas, sensory profiling and additional plants and greenery.[128] I am encouraged by this proactive response to the family's concerns and hope these improvements are beneficial for all the vulnerable young persons (and their families) who require assistance in YIP.

[127] Additional Documents, Folio 23 at 332 and Annexure RP3
[128] Closing Submissions, K Heath at para 97

168. Didbala's family worried about Didbala being placed in a 'Seclusion Room' and submitted that NT Health should eliminate the use of seclusion and restraints for young people in in-patient mental health wards. Dr Ploetz accepted that seclusion was used in Didbala's case, but said it was used sparingly and only as a last resort when her behaviours became dangerous to herself or others. All episodes of seclusion were appropriately documented and there was no evidence that Didbala was placed in seclusion regularly or for any period longer than was necessary. I accept Dr Parker's assessment that the extremely limited use of seclusion was a testament to the YIP staff's skills at de-escalating aggressive or dangerous behaviours. Even so, Dr Parker explained that NT Health is currently actively working towards the goal of eliminating seclusion and restraints in mental health facilities altogether, in line with National Policy. I will make a recommendation to encourage the finalisation of this work.

169. Didbala's family were also concerned that the YIP was a non-therapeutic environment. Dr Ploetz disagreed noting that Didbala received a range of medication, therapy and behaviour management which positively improved her mental health.[129] The YIP practice of allowing family members to board with young patients, which Didbala and her family accessed and benefitted from, is one example of therapeutic practice. While Dr Ploetz considered that a revised model of care with an emphasis on staff with paediatric experience and training could be useful,[130] she explained that it was a model that was not really practical or achievable within funding constraints and in the context of a five bed unit which was not always occupied.[131]

Community Management Orders

[129] Transcript at 154
[130] Transcript at 156
[131] Transcript at 204

170. Part 7 of the *Mental Health and Related Services Act 1998* governs the use of Community Management Orders (CMOs). It provides that involuntary treatment is to be for brief periods, is to be regularly reviewed and is to cease when the person no longer meets the criteria. It embodies the fundamental principle of least restrictive practice.

171. I considered whether a greater use of CMO's may have improved Didbala's compliance with her medication regime but, according to Dr Ploetz, the evidence concerning the efficacy of CMOs for young people is equivocal. In addition, CMO's were of limited practical use in Didbala's circumstances. They could compel her to take her anti-psychotic medication but not her limbic encephalitis medication. Doctors Ploetz and Parker both considered that under the model of 'least restrictive practice' collaborating with Didbala rather than over-utilizing CMOs was the preferred option.[132] Their evidence satisfied me that a greater use of CMOs would not have improved the health outcomes for Didbala. I was satisfied that CMOs were appropriately used when she was affected by severe mental illness and appropriately withdrawn when her clinical presentation improved.

Provision of Mental Health Services in the Big Rivers Region

172. Didbala received outpatient care from a range of organisations including Darwin CAMHS, Katherine CAMHS, Wurli Wulinjang Health Service, Yarralin Health Clinic and Katherine West Health Board Aboriginal Corporation (KWHB). These organisations supported her by providing her medications, following up compliance with medications and with counselling and support where possible. There were attempts at co-ordination and cooperation between these numerous services in caring for Didbala, largely dependent on heroic efforts by individuals such as Kelly Dhaemer, the child psychologist at Katherine CAMHS, but this inevitably failed when individuals were on leave.

[132] Transcript at 147, 148, 183, 184

173. Ms Dhaemer provided quality care for Didbala within the resources available. Ms Dhaemer was proactive in locating Didbala when she moved to family in the community and she provided Didbala with therapy, counselling, and support both in-person in Katherine and in Yarralin via tele-health. Didbala's family acknowledged and appreciated the care that Ms Dhaemer provided.

174. Ms Dhaemer frequently took on the *de facto* role of co-ordinating the numerous services involved in Didbala's care including her multiple health providers, Territory Families and CASPA. For example, on 10 February 2021, the day after Didbala's second long admission, she initiated inter-agency meetings and continued to do this to try and ensure appropriate supports were in place in the community.[133] But as the only child psychologist at Katherine CAMHS, the role of inter-agency case co-ordinator should not have rested with her and she believed this role should have been performed by Didbala's Territory Families Case Manager.[134] It was clear from her evidence that Ms Dhaemer was at times frustrated by the lack of multi-agency co-ordination in the care of Didbala and she identified three areas where improvements could be made for young people like Didbala: a) improved inter-agency communication; b) greater emphasis on building connection with families and friends; and, c) an expanded CAMHS team in the Big Rivers Region.

175. Dr Parker gave evidence that notwithstanding the care provided by the Katherine West Health Board and Ms Dhaemer, there were and still are significant gaps in service delivery to young people in the Big Rivers Region, compared to the standard of care that is available in Darwin. He agreed with Ms Dhaemer and said that a fully funded multi-disciplinary CAMHS team

[133] Additional Documents, Folio 15 at para 124
[134] Transcript at 125

with funding to travel to remote communities was needed to bridge the gaps in service delivery.[135]

176. Concerning the lack of inter-agency co-ordination and information sharing between the various agencies caring for Didbala, Dr Parker considered that a Complex Case Co-ordination Team was necessary to address this issue. Similarly to Dr Dhaemer he considered that for someone like Didbala (who was in the care of Territory Families) this team would be best co-ordinated by or sit within Territory Families.[136]

177. The NT Health RCA similarly found that governance structures and responsibilities for the provision of mental health support to children in the Big Rivers Region were not clear or well understood. It also identified that: the delivery and coordination of services was left to individual practitioners, like Ms Dhaemer, who were not supported by a clear framework of responsibilities; and there was no clearly defined model of care or multi-agency approach to meet the needs of a young person, such as Didbala, with multifactorial challenges.

178. The key recommendations of the RCA were:

(a) Top End Region and Big Rivers Region work collaboratively to ensure child and adolescent mental health services are appropriately governed and resourced to reduce individual risk and meet community based need. This may include a review and redesign of service delivery to ensure it is flexible, evidence based, culturally safe and family inclusive, informed by active participation of First Nations patients and health workers.

(b) For patients with a substantive risk of mental health deterioration in the context of complex care needs, a standardised multi agency process should exist, with the explicit aim of reducing risk. Amongst other things,

[135] Transcript 195-196
[136] Transcript 188-189

this process should include defining relevant risks and key thresholds for action, identifying an appropriate decision maker in each agency or unit involved in the care of the patient, ensuring the patient and their family are empowered to participate in care team meetings and decision making, elevating the cultural needs of the child and family as central to their treatment plan, and developing an agreed implementation along with monitoring and evaluation framework.

179. Dr Parker agreed with those recommendations and I endorse them. I am told an NT Health taskforce has been established to ensure the recommendations are implemented.

Conclusion

180. Didbala was well known to Territory Families from a young age and in the care of the CEO when she passed away. She suffered from complex trauma and serious mental health issues which resulted in highly challenging and aggressive behaviours. Her complexity required the best of co-ordinated care and an individualised response. Sadly, the systems and agencies she was connected with ultimately failed to deliver the care she required.

181. In the care of the CEO she was subjected to an array of Case Managers, when she would have benefitted from consistency. In addition, in the Big Rivers region her Case Managers carried such high workloads they could never hope to properly consider and address her needs and there was no flexibility within Territory Families' funding arrangements to consider any other source of Case Management. Consequently, she suffered from Case Management neglect. The starkest example of this was a failure by Territory Families to efficiently progress a NDIS application even though all the professionals engaged with her believed she was eligible, and in circumstances where there was no other specific 'complex needs' funding to compensate or otherwise meet her needs.

182. An active equal partnership between family members and Territory Families and CASPA would likely have benefitted Didbala. However, Territory Families failed to accurately identify and document Didbala's extended family even though they remained heavily involved in her care. Territory Families failed to assess family members capacity to provide care, and they often failed to proactively support her family to provide care. Family members felt excluded and ignored by Territory Families and CASPA alike. Didbala's family want this to change.

183. Although Didbala received high quality mental health interventions, this was not well co-ordinated, particularly in the Big Rivers Region. She often lost contact with her mental health practitioners resulting in repeated mental health relapses necessitating traumatic crisis interventions involving evacuations and hospitalisations. These crises may have been reduced or avoided if her mental health care had been better co-ordinated and more consistent.

184. Didbala's mental health gave rise to a chronic elevated risk of suicide and self-harm. Her consumption of gunja, alcohol and the acute changes in her behaviour shortly before she took her life, pointed to an elevated risk of suicide or self-harm that day, but this was not identified by her Carers and it was not communicated to attending police. Neither the Carers nor the attending police were aware of a Protocol which might have alerted the police to the chronic risk of children in ITEC care and might have caused the Carers to more fulsomely communicate with the police about Didbala's complex mental health concerns. The Carers did not have the benefit of scenario training particularly on how to engage with first responders, and the police did not have the benefit of youth specific training on children 'at risk', in care, or behaviours associated with complex trauma. A failure to appreciate her level of risk, and a mistaken belief that she was preventing their entry,

contributed to a delayed entry into her room. Her Carers and the attending police are devastated that they could not save her.

185. Her family suffer the trauma of her death and mourn the passing of their dear Didbala.

Recommendations

1. **I recommend that CASPA** ensure that its workers inform first responders (for example, 000 call takers, police, fire, or ambulance officers) that "A Risk of Self Harm or Suicide" exists for all children in their care due to their inherent vulnerabilities.

2. **I recommend that CASPA** ensure that there is a current (up to date) one page summary of critical information for each child in their care which its workers are to provide to all first responders.

3. **I recommend that CASPA** review their existing mandatory staff training to ensure that it includes scenario-based training on dealing with emergency and crisis scenarios (including, for example, scenarios involving calling 000 and the attendance of police or ambulance).

4. **I recommend that CASPA** review its procedures to ensure that all staff are provided with sufficient time to read and review all critical documents in relation to each child in their care, on a regular basis, and that this is recorded and monitored.

5. **I recommend that NT Police, Territory Families and CASPA** take steps to review, update and implement the "Protocol for Police Contact with Children Living in Intensive Therapeutic Residential Care," including through training staff in relation to the Protocol or its equivalent.

6. **I recommend that NT Police** maintain clear alerts in police systems which identify the risk of suicide and/or self-harm for children where such a risk is known to police, including circumstances where Territory Families, CASPA or another service provider informs police that a child is at risk of suicide and/or self-harm.

7. **I recommend that NT Police** ensure all frontline police receive expert training on the circumstances, behaviours, and risks of vulnerable children in OOHC and ITRC care, including on strategies and approaches for engaging with this cohort safely.

8. **I recommend that Territory Families** review the funding model for ITRC to:
   (i) provide for/off-set legislated award wage increases for the duration of the contract; and
   (ii) provide for complex needs funding for children in ITRC where the supports are not provided for or funded under a NDIS plan.

9. **I recommend that Territory Families** ensure each child in its care is provided a Case Manager with a realistically manageable case load (noting that the Case load for CASPA case managers is 5). Where this is not achieved, Territory Families should consider the feasibility of out-sourcing Case Management to, for example, the child's ITRC service provider where that provider is able to provide a Case Management service.

10. **I recommend that Territory Families** urgently address the chronically unfilled Case Management needs in the Big Rivers Region and identify innovative strategies to ensure these needs are actually met. (By way of example only, by considering the feasibility of interstate models of Case Management including, the NSW model of care where Case Management is delegated to CASPA (for children in their care) and the Victorian model where Case Management is delegated to ACCOs where the child in question is Aboriginal).

11. **I recommend that Territory Families** set benchmark time limits for completion of NDIS assessments and applications for children in care who are identified with this need.

12. **I recommend that Territory Families** amend the Essential Information Record form to separate Mental Health and Suicidal or Self Harm risks.

13. **I recommend that Territory Families** review and up-date its Death of a Child in Care Policy concerning how families are contacted about the death of a child in care.

14. **I recommend that Territory Families** urgently establish a High Risk Youth Panel and evaluate and monitor its effectiveness in addressing the needs of the high risk youth cohort.

15. **I recommend that NT Health** take all necessary steps to implement a Child and Adolescent Mental Health "*Remote Area Team*" in the Big Rivers Region to provide community based mental health support in conjunction with Aboriginal Controlled Community Health Organisations.

16. **I recommend that NT Health** set a benchmark time within which it will have eliminated the use of seclusion and restraints for children in in-patient mental health facilities.