CITATION: *Inquest into the death of Deborah Leanne Melville-Lothian* [2010] NTMC 007	
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Darwin
FILE NO(s):	D0109/2007
DELIVERED ON:	19 January 2010
DELIVERED AT:	Darwin
HEARING DATE(s):	23 November – 11 December 2009
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	Child in Care of the Minister, reportable death of that child, care received prior to death, problems with relevant government agency.

REPRESENTATION:

Counsel:

Assisting:	Phillip Strickland SC
Instructing:	Fiona Hardy
Dept. of Health & Families:	Michael Maurice QC
Carers:	Louise Bennett
Mother:	Peggy Dwyer

Judgment category classification:	A
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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0109/2007

In the matter of an Inquest into the death of

DEBORAH LEANNE MELVILLE-LOTHIAN
ON 12 JULY 2007
AT ROYAL DARWIN HOSPITAL

FINDINGS

19 January 2010

Mr Greg Cavanagh SM:

INTRODUCTION

1. Deborah Melville was one month short of her thirteenth birthday when she died. She was a vivacious, fun loving young girl, who at an early age acted as a surrogate mother for her siblings, [redacted], [redacted], [redacted] and [redacted].

2. Three weeks earlier she had suffered a minor sporting injury. As a result of deplorable neglect over the next three weeks, Deborah was never taken to a doctor or a hospital to receive medical treatment. Deborah's upper thigh became infected. That infection led to septicaemia (blood poisoning) and pyaemia which caused all of her major organs to shut down.

3. I have more to say about the crucial facts immediately prior to her death later in these findings, however, in summary on 12 July 2007 at about 11am, Deborah's carer and great aunt, Denise Reynolds and her son had deposited Deborah in the back yard. Her brothers and sisters were told not to give her any food or drink. This unfortunate girl, who was near death at that stage, lay on her back on the dirt near a trailer in the back yard for the next 8 hours until she suffered a cardiac arrest. She was delirious, dehydrated and dying whilst her Aunt, who was entrusted with her care, was busy at work.

4. Her death was appalling and needless. The circumstances of her death are utterly shameful for the woman who was supposed to be her carer, Denise Reynolds and Deborah's other great Aunt, Toni Melville, who was living at 32 Zenith Circuit, Woodroffe at the time.

5. At the time of her death, Deborah together with her brothers and sisters was in the care of the Minister of Family and Community Services (FACS). She had been in the Minister's care since 2000. The Minister had authorised Denise Reynolds, Deborah's great aunt to be her foster carer.

6. The Community Welfare Act imposed on the Minister the same obligations as the parent of a child. Those obligations included the obligation to provide Deborah the necessities of life including accommodation and the obligation to provide medical health for the child.

7. The Inquest has heard considerable evidence about the serious deficiencies and systemic and individual failures of the Department in (a) failing to monitor and review the placement of Deborah in Denise Reynolds' care, and (b) failing to monitor the needs of Denise Reynolds and how she was coping, and to provide her with the support she required. Jenny Scott, speaking for the Department, has thoughtfully apologised for those failures. Although Denise Reynolds initially provided somewhat adequate care to the Melville children, as a result of an accumulation of pressures in her life from 2006, by the time of Deborah's death Denise Reynolds had almost completely abandoned her legal and moral responsibilities as a carer for Deborah Melville. These serious failures and deficiencies of the Department contributed to the death of Deborah Melville because they permitted that deplorable neglect by her carer Denise Reynolds to occur.

8. Deborah Melville's death is a reportable death within the meaning of section 12 of the *Coroners Act* because the death appears to have been unexpected or unnatural or resulted directly or indirectly from accident or injury and also because immediately before her death Deborah was a person held in

care within the meaning of the *Community Welfare Act* ("the Act"). I note that the Act was repealed in 2008 and was replaced by the *Care and Protection of Children Act*, which commenced operation in December 2008.

9. I am required to hold an Inquest into Deborah's death under section 15(1) of the *Act* because immediately before her death, she was a person held in care within the meaning of the *Act*.

10. The public inquest into Deborah's death was heard in Darwin from 23 November 2009 to 10 December 2009. Mr Strickland SC together with Ms Fiona Hardy appeared as counsel assisting. Mr Maurice QC appeared for the Department of Health and Families. Ms Dwyer appeared for Lynn Melville, Deborah's mother and Ms Bennett appeared for Deborah's carers at the time of her death, her great aunts, Denise Reynolds and Toni Melville.

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

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

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

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

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

"(1) A coroner may report to the Attorney-General on a death or disaster investigated by the coroner.

(2) A coroner may make recommendations to the Attorney-General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the coroner.

(3) A coroner shall report to the Commissioner of Police and Director of Public Prosecutions appointed under the Director of Public Prosecutions Act if the coroner believes that a crime may have been committed in connection with a death or disaster investigated by the coroner."

RELEVANT CIRCUMSTANCES SURROUNDING THE DEATH

14. Deborah Melville was born on 18 August 1994. Her mother is Lynn Melville (Hope Evlyn Lothian) and her father is Darryl Kevin Melville. Lynn was just 17 years old and Darryl was 16 years old when Deborah was born. Both her mother and father are indigenous Australians. Deborah was the eldest sister of five children: [redacted] born on 12 December 1995; [redacted] born on 15 December 1996, [redacted] born on 20 February 1998 and [redacted] born on 3 August 1999.

15. Deborah was a vivacious, fun loving young girl who acted as a surrogate mother for her siblings. She was an excellent runner. She did well at school. Her Great Aunt, Sylvia Jarrett said of her, "She was a good kid. She only complained when she was in pain."

16. Deborah's parents had a volatile relationship with numerous reports made to the Department of Family, Youth and Children's Services (the predecessor of Family and Children's Services) of drug use by their parents, severe domestic violence and neglect of the children. For simplicity, all references to the Department will be by the acronym FACS.

17. When Deborah was one month old, FACS received a notification probably from Deborah's grandmother that Lynn Melville "gets high and breastfed Deborah whilst she was on drugs".

18. When Deborah was fourteen months old, FACS received a notification alleging neglect and physical abuse of Deborah. The notifier reported that the behaviour of her father, Darryl was becoming more and more bizarre and that he was using more serious drugs than marijuana. Darryl had a serious criminal history involving offences of dishonesty, violence and drugs, breaches of domestic violence orders which occurred through Deborah's childhood.

19. When Deborah was two and a half years old Palmerston Police notified FACS that Deborah was found on the streets in Palmerston "distressed and naked". Just before Deborah's third birthday, FACS received notification of serious domestic dispute between her parents which resulted in Lynn Melville being taken to the Royal Darwin Hospital with suspected injuries.

20. Deborah and her siblings then lived for a short time at a refuge, Dawn House. When Lynn Melville was staying with her four children at Dawn House, the children were sent to carers for 14 days.

21. When Deborah was three and a half years old, Lynn Melville disclosed that Deborah had been sexually abused in the past when she was on an access visit to her father.

22. When she was almost four years old, FACS received another notification alleging neglect of the children. Deborah and her brother [redacted] were said to have wandered the streets every day often in dirty nappies or naked. This had gone on for some time. There were other notifications relating to other of the Melville's children concerning their neglect and concerning the use of drugs by Lynn Melville. By 1999, it became clear that the Melville children were "in need of care" as defined in the *Community Welfare Act*.

23. When Deborah was five years old Lynn Melville signed a temporary custody agreement with FACS for the children to be taken into temporary custody of the Minister for seven days. In 1999 and early 2000, Deborah and her siblings had periods when they went into temporary care of various carers. Initially only [redacted] and [redacted] went into care. They were later joined by Deborah and [redacted] and, after his birth, by [redacted]. Following a dog bite whilst in care, [redacted] was returned to her mother for a period. She rejoined her siblings in care in March 2000, following another incident of neglect by Lynn.

24. On 17 March 2000, FACS gave a report to the Family Matters Court. That Court heard applications under the *Act* for a child to be placed in the care of the Minister. Under section 49(1)(a) of the *Act*, the applications had to be reviewed at least every 2 years.

25. The report recommended that the five Melville children be declared in need of care under the Act and be placed in the sole guardianship of the Minister for three months. That order was granted was under s 43(4) of the *Act*. The order was extended for a further three months. On 12 September 2000, the order was extended for a further six months.

26. In June 2000, the children were placed with their maternal Aunt Michelle Fermanis. This placement broke down in July and the children were separated. Deborah, [redacted] and [redacted] were placed with one foster carer, [redacted] and [redacted] with another.

27. FACS commenced to investigate a more permanent placement for the children. One of the potential foster carers for the Melville children was Denise Reynolds, Deborah's great aunt. Denise presented as a very confident, friendly woman with a strong personality. At that point in their lives, the Melville children did not have a relationship with Denise.

28. During the early stages of the process to find a foster carer, Denise requested that she should be the last resort as a carer because she had seven children of her own. Denise had been with her de facto partner, Roberto Reynolds (Bert) for 17 years, but they were separated. However, it was reported to FACS that they still shared a good relationship with each other. Roberto used to visit Denise's property at Bees Creek regularly to help her look after their seven children.

29. There were eight children born of the relationship between Denise and Roberto: Robert (born 9 December 1984); Ronald born 20 March 1986; Brendan born 5 July 1987, who is profoundly deaf; Cassandra born 1990 but who died in 1991; Casey born 7 August 1991; Vivianne (who has cerebral palsy) and Jacqueline born 18 December 1993, and Geoffrey born 19 January 1997, who is slightly deaf.

30. When FACS approved Denise, they did not know about the death of Cassandra, who died from immersion in a bucket of water in the back yard. Rigor mortis had set in, which suggested that she had been dead some time before she was discovered. Monica Warden, a FACS worker involved in the initial placement said that if she had known about that death, she would have made further investigations about the circumstances of her death.

31. Denise gave evidence that she was reluctant to take on the Melville children. She said that Sadhi Ahmat, the head of KARU (an Aboriginal placement organisation), informed her that there would be a demountable set up on her Bees Creek property, and this promise was a factor in her decision to accept the children. In her record interview with Police on 1 August 2007, Denise was asked what motivated her to become a carer for the Melville children. She said:

> "There wasn't any motivation. We went to a meeting at Karu ... These children needed somewhere to stay all together because they were separated and I told them at the time of the meeting I would

have been the last person they wanted to give it to because I had seven kids of my own"

32. On 6 December 2000, the five Melville children were declared to be in need of care and the sole rights of guardianship were transferred to the Minister for a period of two years.

33. On 15 December 2000, FACS approved Denise as a foster carer for the five Melville children. FACS approved a care package of $2000 per month as foster payments for the 5 children. Denise received an additional $3941 per month from Centrelink being family payments and a sole parent pension. Her total payments in relation to the Melville children were $5941 per month.

34. For the next 6 years, the Melville children lived with Denise and her children at 50 Hunter Road Bees Creek, some 10 minutes drive from Palmerston. In an Addendum to the Care Assessment, FACS noted:

> "This situation [the placement of the Melville children with Denise] is not ideal given the large number of children involved. However the Department has a two year order on the children and are looking for a stable placement with family. Denise Reynolds is the only family member in Darwin that the Department is aware of and could potentially care for the children."

35. One matter which ought to have been of some concern to FACS is what a FACS worker described as the "huge conflict" between Denise Reynolds and Lynn Melville (which later extended to other members of the Melville family). Even before the placement commenced, Lynn Melville told Monica Warden that she did not have a good relationship with Denise; she did not know why Denise would want the children now when she had had no interest in them before, and she did not think the children would be 'treated right' by Denise.

36. In approving Denise's application as a foster carer, FACS officers were required to apply section 69 of the *Community Welfare Act*, which stated

that where a child in need of care is an Aboriginal, the Minister shall ensure that every effort is made to arrange appropriate custody within the child's extended family.

37. Adrienne Boucher, an experienced and articulate caseworker, who was the Melville children's caseworker for almost three years expressed the Department's view of the placement as follows: (transcript p.289)

> "Well, this is the best placement for the children, you know, they are with family and it's an Aboriginal family as well placing the kids there and if they weren't placed there then the kids would have to be separated into other families and quite highly - not an Aboriginal family."

FACS - A DEPARTMENT IN CRISIS

38. From March 2001 the management of the Melville children's foster care placement lay with FACS' Palmerston Out of Home Care Team. That team was one of about four teams managed by the Palmerston office of FACS. Patrick Dalton explained the role of the Out of Home Care team was to look after children who were in placements with foster carers, 'keep an eye on' the foster placements and meet the needs of the children in those placements.

39. Looking at a snapshot of May 2007, Dianne Eades explained that in the Palmerston and Casuarina offices the Out of Home Care team comprised a team leader, four professional staff and three family support workers. The latter assisted the professional staff by undertaking basic tasks such as taking children to appointments. Ideally the team leader would not have a case load.

40. During most of the period 2006 – mid 2007 the office manager in Palmerston was Jill Jackson. Miang Seah-Quenoy was the nominal team leader during that period, and was the acting manager at the time of Deborah's death.

41. From late November 2006 until mid-May 2007, Seah-Quenoy was acting in other roles within FACS and advanced practitioners, Anthea Motter and Patrick Dalton 'swapped' the position of acting team leader. They maintained a caseload during their periods as acting team leader. Although the idea of 'swapping' was intended to be fair and give both Motter and Dalton the opportunity of acting as team leader, FACS has acknowledged that this was unsatisfactory because there it did not provide any consistent supervision for the caseworkers.

42. A number of witnesses described the situation in the Palmerston office as one of 'crises' or 'madness'. Motter described it as 'imploding' and 'constantly putting out fires'. Crises included placements breaking down or children absconding or notifications involving sexual abuse. Other priority matters included where people had made a complaint to the Minister and the Minister demanded an answer from the Department and issues around access visits. Motter agreed that the situation was like that in the Alice Springs office during 2005, the period investigated in the [redacted] inquest. In such circumstances, it was difficult to plan for the orderly management of cases. Team leaders were required to both supervise caseworkers, and manage their own cases.

43. Motter helpfully detailed some of the issues that contributed to the office 'imploding'. She described an office where staff were 'running from one thing to another' and not having lunchbreaks. She said the phones were 'going crazy' and at the same time people were in the administrative area waiting to see staff. It was a situation of 'chaos' where members of staff were often stressed. She worked long hours and felt under pressure. Quenoy also described working such long hours that her 'flex hours' got so high she gave up adding them up. There was, in any event, no opportunity to take them.

44. Motter explained that it was difficult to keep staff. She described a 'revolving door' of caseworkers, which led to a lack of consistency both for carers and the children in care. Seah-Quenoy and Jackson also commented on the problems associated with high staff turnover. In the critical period from January 2005 to July 2007, the Melville children had five different caseworkers including Barbara Murray, who did not like her job and did not have a rapport with the children, Anthony Barnes, who had a caseload of 25 to 30 children and who could not find the time to make any home visits; Annette Mageean, who had just graduated from university; and Sarah Deery, who had come from Ireland and had no experience with Aboriginal families.

45. There were difficulties in recruiting and retaining good quality caseworkers. As Quenoy said: (transcript p.655)

> "sometimes we just have to grab whoever comes on the scene to fill the gap".

46. Jenny Scott detailed a number of measures that have been taken, such as recruiting from overseas, talking to undergraduates in interstate universities, having a stall at conferences, looking at relocation packages, and introducing a market allowance for working in the NT. Scott described these initiatives as having 'kept our head above water'. During the 2008-2009 financial year there was an attrition rate of professional staff of 32%. This figure is comparable to other jurisdictions across Australia.

47. A number of witnesses considered that there was inadequate training, for example in relation to statutory obligations, how to conduct home visits and in how to use the Policy and Procedure Manual. Adrienne Boucher said she was not given any orientation in relation to use of the Manual when she started. She felt she was thrown in the deep end and had to learn on the job.

48. In 2006-2007, there was low morale in the office. Industrial action was threatened. One of the reasons for this threat was concerns about caseloads.

There was obvious tension between the Out of Home Care team and the Placement Support Team.

49. There were also chronic staff shortages. The child protection team would call on staff from the Out of Home Care team to help out with child protection investigations. This took staff away from their day to day case management responsibility.

50. The result was that placements, which were considered to be 'low priority', such as the Melville children were 'put aside'.

51. At the same time the Palmerston office was 'imploding', there was a significant increase in the number of children in foster care. There were 73 children in foster care managed by the Casuarina and Palmerston offices in July 2006. This figure had grown to 122 in May 2007. There were between 300 and 350 children in foster care in the Darwin area. For the Northern Territory, there were about 590 children in care in 2003/2004; about 690 in 2006/2007 and about 880 in 2008/2009. This dramatic increase in numbers was probably caused in part by increased public awareness about abuse and neglect issues arising from the 'Little Children are Sacred' report and the child abuse task force set up by FACS and the NT police, and then the Federal intervention in the Northern Territory. There were 116 staff (excluding administrative and policy staff) employed in Child Protection and Out of Home care in 2005; 150 in 2007 and 196 staff in 2009.

SYSTEMATIC BREACHES OF THE LAW BY FACS

52. The Act imposed clear statutory obligations on the Minister and delegated FACS officers to ensure the safety and wellbeing of children in the care of the Minister. Key provisions of the Act were routinely breached to the knowledge of middle and the most senior managers at FACS. The basic reason for those breaches was the lack of staff resources. Another reason is that even the most senior bureaucrats in FACS did not appear to be aware

before Deborah's death about the extent of the legal obligations placed upon the Minister or the significance of breaching those obligations. There was no dedicated legal officer providing legal advice or offering legal opinions to Jenny Scott, the director of Family and Children's programs, or to her professional staff. That situation has now changed.

53. There were five key breaches of the *Act*:

- The requirement to visit the children at least once every two months: section 53(1);
- The requirement to provide a report to Minister after each visit concerning the child and his or her welfare: section 53(3);
- The requirement to provide a written review of the circumstances of the child every three months: section 56;
- The requirement to renew the registration of the carer every twelve months: section 63;
- The requirement to be satisfied every 12 months that the children were receiving an adequate standard of care as specified in the Act: section 63;

54. Section 52 of the *Community Welfare Act* provided that, when a child was placed in the care or "guardianship" of the Minister:

> "the Minister shall, subject to any limitations the court imposes, have the same rights, powers, duties and obligations and liabilities as a parent of a child."

55. That included the obligation to provide for the child the necessities of life, including accommodation, maintenance, education and recreation, and the obligation to provide medical care.

56. Section 53(1) of the *Community Welfare Act* provided:

> "The Minister shall cause an authorised person to visit a child to whom this part applies and who is residing in the Territory at least once in every two months."

57. Section 53(3) of the *Act* required that an authorised person, as soon as practicable after such visit, must furnish to the Minister a report in writing concerning the child and his or her welfare.

58. The 1999 Policy and Practice Manual stated that the best practice was for a child to be visited once every three weeks. The Manual stated that "monitoring the placement of a child in care is an essential part of case management." All FACS officers echoed this sentiment. Jenny Scott acknowledged that visiting a child was a core obligation or responsibility of FACS in monitoring care. As Anthea Motter, a FACS team leader put it: (transcript p.594)

> "[With visits], you get to see people face to face. You get to see where they reside. You get to see [them] in their own environment. You get to make an assessment about, you know, children and carers in - within their own environment."

59. Dianne Eades, who was the Senior Manager for Darwin Urban gave important evidence, embraced by Jenny Scott, about the vital importance of visits in the context of long term placements which appear to be stable can start to drift: (transcript p.779-780)

> "EADES: Children who are in long term Out of Home Care, particularly where placements are seen as 'stable', there may be some issues at times throughout that placement, those issues are usually dealt with in the context of that specific issue and the issue is usually resolved but over time a case that appears to be 'stable' can actually start to drift so children are not visited as often and the rigorousness of an initial placement and an initial registration of carers declines over time.
>
> THE CORONER: Madam, I think - and I may be wrong, but I think there's another reason too - kids generally are loyal and loving to their carers and their substitute parents as they are to their parents aren't they?---Yes, your Honour.

> And that loyalty and love would grow from year to year the longer you're with a substitute carer doesn't it?---Yes, your Honour.
>
> And if there are things that should concern the authorities about the care that is received or the performance of carers, kids who have grown and bonded are happy enough for those carers, being loyal kids, and are more likely to try and cover up for their carers, aren't they? That's the nature of kids, isn't it?---Yes, your Honour.
>
> Which would make it, therefore, more - make it important, even for what's called – important, not even, important for stable long - what is thought to be a stable long term arrangement that there be some objective assessment by carers turning up at the house and looking into the situation, don't you think?---Yes, your Honour.
>
> I just don't want you to agree with me because it's me. Am I making some sense to you?---Absolutely, your Honour. I'm aware of current research, both nationally and internationally, around the term cumulative harm."
>
> Accumulative harm?---Yes. And it's harm or episodes or certain events over a period of time that when you treat those events in isolation don't appear to be that serious or they're dealt with at the time and things improve. What jurisdiction under debate and people are struggling with is, how does a system respond to events of accumulative harm."

60. This evidence is a succinct summary of what happened in the placement of the Melville children.

61. FACS repeatedly breached the legal requirements to conduct visits at least once every two months and to provide a report in writing after those visits. The consequence of that breach of the *Act* was that the children's needs were not adequately monitored.

62. Section 56 of the *Community Welfare Act* required the Minister to review the circumstances of child under her guardianship every three months. The purpose of the review was to ensure that the placement continued to be suitable and desirable or to consider changes to the placement.

63. This statutory obligation was repeatedly breached in relation to the Melville children. Adrienne Boucher did only one case review during the two and half years she was the case worker for the children. She did not know that it was mandatory. She said the office was very understaffed: (transcript p.303)

> 'it was a general understanding ... it was just another bit of paperwork, you know, that wasn't a priority.'

64. Barbara Murray was aware that each child had to be dealt with individually in the case review, but did not do this. Jenny Letchford did one case review in June 2006. Her successors, Barnes, Mageean and Deery did not do any. At the time of Deborah's death a case review had not been completed for over 13 months.

65. Anthea Motter considered the case reviews were 'another competing need'. She would let caseworkers know which reviews were overdue, but said 'you were also aware that that was just added pressure and extra pressure to their already pressurised lives'. Miang Seah-Quenoy was aware that the office was not compliant with section 56 but, in her view, it was a written summary of the work done in the last three months. It was not a priority because the work was already done.

66. Jill Jackson said it was not unusual for case reviews to be overdue. She would pass the information on to the team leader (who had the information in any event) and just ask the team leader for some idea when the reviews would be done. She was concerned about the breach of statutory duty and thought she would have relayed these concerns to her superior, Dianne Eades.

67. The percentage of overdue case reviews for the Casuarina and Palmerston offices in the period July 2006 – May 2007 varied from a low of 34% to a high of 70%.

68. The registration of carers was an essential component of the Act in ensuring that an adequate standard of care of children in need of care was provided and maintained during the whole period of a child's placement in foster care.

69. Section 63(2) of the *Act* provided that in considering an application for registration, the Minister should, as far as practicable, be satisfied of a number of matters including that the applicant:

> "a. will have adequate interest in, and affection and respect for, a child placed in their custody;
>
> b. Will provide a stable environment for the child and will treat the child in a manner consistent with establishing a stable and secure environment;
>
> c. [omitted]
>
> d. Will be capable of providing adequate accommodation and material requirements necessary for the welfare of the child;"

70. The registration could be renewed from time to time for such period, not exceeding twelve months that the Minister thought fit. Each time a carer was re-registered, the Minister was required to be satisfied of the matters specified in section 63. The Minister had the power to delegate the approval of registrations and re-registrations to a senior manager. The Minister exercised that power and delegated his authority to senior managers, who had the rank of P3 or above.

71. The system of the administering the registration of carers was fundamentally flawed. First, the registration of carers often did not occur every 12 months. Secondly, and more importantly, the statutory criteria for re-registration were not complied with. Both Dianne Eades and Jenny Scott accepted that the failure to re-register carers in a timely and proper manner was not merely a failure to do administrative work because re-registration was a central feature of the administration of foster care for children. The

provisions in the Act concerning registration and re-registration were designed to ensure that children in the care of the Minister were provided with an adequate standard of care by carers and continued to receive an adequate standard of care on an ongoing basis.

72. Denise Reynolds was initially registered in December 2000. Her re-registration was finalised, slightly overdue, in January 2002. Her next registration did not take place until July 2004. She was re-registered again in April 2005 and for a final time in December 2006. The delays in re-registering Denise were not an isolated case. Dianne Eades, the Senior Manager for Darwin Urban, reported that in the Palmerston area, at any given time, one in five or one in four carers, and sometimes 40 per cent were not registered. Eades attributed that to the perennial issue of staff not having time to do fulfil their statutory duties.

73. None of the caseworkers were aware that the matters specified in this subsection needed to be satisfied. The FACS re-registration template was deficient in that its headings did not reflect the statutory obligations under section 63(2). Accordingly, FACS did not address itself to the matters which section 63(2) formulated. The state of satisfaction of the Minister in relation to the section 63(2) matters was a jurisdictional fact without which FACS has no power to register or re-register the carers. The re-registration of Denise Reynolds as the carer of the Melville children was not done on a proper legislative footing. Given the deficient re-registration template, this was presumably so of other registered carers.

74. In any event, the re-registration reports were generally perfunctory. This was particularly so for the report of 19 December 2006 (see below).

75. FACS made a distinction between how general carers and specific carers, including kinship carers (carers who were related to the children placed in foster care), were assessed. The assessment process for kinship carers was less rigorous and had fewer checks and balances than the process for

assessing general carers because it was assumed that kinship carers had a greater natural affinity for the children under their care.

76. General carers were re-registered by the Placement Support Team in FACS, who had expertise in this area whereas specific and kinship carers were generally re-registered by the Out of Home Care team, which meant that caseworkers were assigned yet another task in their already overloaded work schedule. This dichotomy arose out of historical considerations. It was not a logical or helpful distinction, as was conceded by FACS. That situation has now changed.

77. Kinship carers were assumed to require less support and monitoring by FACS. This was one of the reasons why the placement of the Melville children in the care of Denise was perceived as a 'low priority' in terms of the monitoring and supervision required by FACS. FACS properly conceded that this was a serious error on its part. Seah-Quenoy said that it was not unusual for there to be overdue re-registrations of specific carers.

78. Apart from not understanding the statutory requirements for the registration and re-registration of carers, there was virtually no guidance in the Policy and Procedures Manual relating to an appropriate standard of care.

79. The requirement that a carer must be "capable of providing adequate accommodation and material requirements necessary for the welfare of the child" requires some objective criteria (even if not overly prescriptive) to assist FACS officers in making appropriate recommendations.

80. The Manual provided "it is important that all services comply with common standards of service delivery." The "Northern Territory Out of Care Service Standards" outlines the standards and the way in which they are to be monitored and enforced. The NT standards are consistent with the National baseline standards for out of home care services approved by all States and Territory Community Services administrators in 1995. The Resources

Manual which was supplied by FACS for this Inquest had a section entitled "NT Out of Home Care Standards". The card simply said that such standards were "to be inserted".

81. In January 2007 there was a document printed "Out of Home Care Standards". The evidence is that none of the case workers or indeed any other FACS officer was aware of the existence of this document as at the time of Deborah Melville's death. If they were aware of the document, they certainly were not trained in it nor did they make use of it. Part 15.3.5 of the Manual deals with Assessment Criteria. But there is nothing to indicate that this should be done for re-registration. No FACS worker knew about this document or used it.

82. The caseworkers reported their inability to fulfil their statutory obligations to their team leaders. The team leaders reported this failure to their superiors the Office Manager who in turn conveyed this to the Senior Manager at of the Darwin office, Dianne Eades.

83. Dianne Eades' evidence is that she and Jenny Scott had access to monthly reports regarding overdue case reports and re-registrations. Eades did everything she could to bring these problems to the attention of her superiors. Scott was also aware in general terms about the failure to comply with section 53 of the Act (the visit provision) although there was no statistical data because there was no field in the CSIS system to report "visits". It is unsatisfactory that compliance with the requirements under section 53 regime could not be monitored without doing a full manual audit on each case file (a task which was not possible due to resources issues). Dianne Eades has said that this problem has now been rectified because there is a field in the CSIS system, which permits the recording of "visits".

84. Jenny Scott in turn discussed these matters in general terms with her superiors including the CEO of the Department, David Ashbridge before Deborah's death on 12 July 2007. Scott's evidence: (transcript p.934)

"CORONER: Do I take from that that amongst other things that you discussed with Mr Ashbridge, was that you informed him that the requirements of the Child Welfare Act weren't being met by the department?---He wouldn't have been receiving those monthly reports that I was but in the broad discussion about the pressures, we would have had that discussion from time to time."

85. Nothing appears to have been done by the Dept to rectify the serious problem of systematic breaches of statutory duties until after the death of Deborah Melville and an internal audit was carried out in August 2007.

THE PLACEMENT OF THE MELVILLE CHILDREN AT THE BEES CREEK PROPERTY: 2001- JUNE 2007

86. Jennifer Scott, who was authorised to speak on behalf of the Department of Health and Families, prepared a thoughtful and comprehensive statement for the Inquest. A section of the 'apology' part of her statement read: (Exhibit 41)

"The Department of Northern Territory Families and Children (NTFC) accepts responsibility for its part in the tragic death of a child removed from her natural mother and placed in our out-of-home care program. We failed to properly monitor and review the placement of the child with her foster carer, to recognise ongoing risks associated with placing five very young children with a foster carer already responsible for a large number of children on her own, and living in difficult circumstances. We failed to adequately monitor the needs of the foster carer, and how she was coping, and to provide her with the counselling and support she required. Our failure contributed to the circumstances in which the foster carer failed to obtain urgently needed medical attention for the child.

NTFC apologises to the family of Deborah Melville for our part in her death. ...

However, it is the system, not the case workers, which failed Deborah. All of the case workers involved in the placement of Deborah and her siblings acted in good faith, and to the best of their abilities given the training they had received, the policy and procedures in place at the time, their case loads, the resources at their disposal, and the limited alternatives available to them. They were not aware of any abuse or neglect on the part of the foster carer, or by those who looked after the children when the carer was away

from home. All believed, based on the carer's conduct over the previous six and a half years, that she would not fail to obtain medical treatment for a child in her care when and if it was required, and to notify FACS of any problems relating to the children's health or wellbeing."

87. This gracious apology is entirely appropriate. I do not entirely agree with Scott's statement that it is the system, not the case workers which failed Deborah. The Inquest has revealed that the failures were a combination of systemic individual failures. I accept that any criticisms of individual failures should be seen in the context of a system in crisis. There was an attitude widely held at FACS that there was no alternative but to continue the placement of the Melville children with Denise Reynolds. I do not believe that the alternatives were as limited as I discuss below.

88. There is conflicting evidence about the standard of care provided to the Melville children whilst they were living at the Bees Creek from 2001 to 2006. [redacted], [redacted] and [redacted] Melville have all provided statements to the Inquest. Their statements describe a harsh and generally unhappy existence whilst they lived with Denise Reynolds. The parties represented at the Inquest elected not to cross-examine the Melville children. The statements are therefore unchallenged.

89. [redacted] Melville says that Denise regularly hit the Melville children with a 1 metre long stick. He said they were hit hard and this type of punishment happened the whole time the children were in Denise's care. He said he always wanted to run away and that he did once run away into the bush with [redacted], got scared and came back. He said that the Bees Creek house was not clean and that there were cockroaches and rats, holes in the walls and no doors except in the toilet and bathroom. [redacted] Melville did report to the Bees Creek Primary School in 2002, when he was seven years old, that "*Aunty Denise keeps smacking me*". This matter was never investigated by FACS even though it came to their attention via a letter from the Assistant Principal of Humpty Doo Primary School to Adrianne Boucher.

90. [redacted] Melville also described getting hit with a stick and seeing [redacted] get smacked with a stick. [redacted] said that things were a bit better when Bert was around and that when he stayed at Bees Creek he did the cooking. [redacted] Melville said that her bedroom in Bees Creek was disgusting. The beds were ripped up and didn't have any sheets on them. She said it was cramped and that there was no privacy.

91. Apart from [redacted] complaint to the school, none of the children ever made a complaint that they were regularly beaten by Denise let alone with a piece of wood. Denise Reynolds admitted to smacking the children when they misbehaved, but denied ever using a stick to beat them. Some members of Denise's extended family have said that they were intimidated by Denise. She was a large woman and they felt scared of her. It is not necessary to make a finding about the level of physical discipline inflicted on the Melville children.

92. I accept the evidence of the Melville children about the poor physical condition of the Bees Creek property because it is corroborated by a large amount of evidence. I also find on all the evidence that the standard of care provided to the Melville children between December 2000 and 2006 fluctuated between adequate to below adequate.

93. A number of FACS caseworkers observed Denise Reynolds and the Melville children together. They paint a positive picture of the placement of the Melville children with Denise Reynolds. Sarah O'Regan observed in 2001 that the Melville children appeared to be settling well; [redacted] appeared to have a very close bond to Denise. Deborah and [redacted] told her that they were happy in their placement and happy with their carer. O'Regan did note that Denise had problems with managing her budget, which was a constant theme during FACS' dealings with Denise. Margaret Wilson, who was the caseworker between October 2001 and July 2002 stated that Denise interacted well with the children and appeared to be genuinely fond of them.

94. Annette Mageean, who was the caseworker between January and May 2007 did not spend much time at all with the children, but from her limited observations, she told investigating police that the Melville children got along well with Denise and with her children, and that Denise had positive strategies to deal with [redacted] Melville's behavioural problems. Denise also demonstrated appropriate concern about some behavioural problems with Deborah. This is consistent with other evidence at the inquest. Patty Raymond, an Aboriginal and Island Education worker, who worked at Humpty Doo primary school and regularly saw the Melville children from 2003 until mid 2007 observed that the children regularly attended school. She said that Denise was always available to discuss issues about the children. She was proud of the way that Deborah and [redacted] were developing. She said they were normal happy children. She never heard them make any negative comments about Denise.

95. However, over the years, there were a number of signs indicating patterns of neglect of the Melville children or indications that they were at risk. The evidence at this inquest is that FACS paid insufficient attention to the cumulative weight of these risks and signs.

96. In 2001, FACS was notified that [redacted] Melville then aged 4 or 5 had been sexually assaulted or interfered with by Darryl Melville Snr. Denise Reynolds assured O'Regan that Darryl Melville Snr would not have unrestricted access to any of the Melville children. From time to time, Denise's sister, Toni Melville, her husband and her children Shaun, Adrin and Shaneeka lived in the caravan on the Bees Creek property. FACS was notified in June 2002 that Adrin had allegedly sexually interfered with two male children.

97. Denise had a meeting with FACS officers where she assured them that she would not permit Adrin or Darryl Melville Senior unsupervised access to the Melville children. Those assurances were breached in that both men lived at

the Bees Creek property and later the Zenith Circuit property from time to time, and after Denise commenced working full time in March 2006, she did not ensure that the children were left unsupervised with those adults.

98. In early 2002 Natalie Hunter, the Director of Karu, visited the Bees Creek property. Hunter thought that the Bees Creek property was "a dump....just totally unsuitable". The house where they lived was made of galvanised tin. There were lots of bunk beds everywhere, some of the floor was dirt and some was concrete. Hunter told Miang Quenoy of her concerns that Denise may be gambling, which might have explained the lack of money being spent on the Melville children's material needs.

99. During 2001-2002, FACS workers did a lot of work on the placement. Sarah O'Regan visited the children more than once every two months and Margaret Wilson did 16 face to face contacts with the children including 10 home visits in the space of 10 months. Margaret Wilson candidly conceded that it was difficult to establish a rapport with each child when she was caseworker for only 10 months, particularly when there were five children, and some of them were young and easily distracted. Wilson regarded the placement as an "intense" one – there were lots of tasks to do on the placement. O'Regan said she considered the placement needed extra support.

100. On 16 September 2002, the Deputy Principal of Humpty Doo primary school wrote a lengthy letter to FACS case worker, Adrianne Boucher reporting that [redacted] and [redacted] came to school on a number of occasions late, with no shoes, dirty face, hands and feet. They complained that they were hungry and had no breakfast. They smelled of urine and were made to take a shower and change their clothes. They reported that Denise did not have enough beds and the children had to share them. [redacted] reported that Aunty Denise had thrown her in the shower while she was fully clothed and she came to school wet from head to toe. They had blisters on their feet from wearing sandshoes without socks. Their shoes were too small. Both [redacted]

and [redacted] displayed attention seeking, defiant behaviour. [redacted] had also reported that Denise's boys were bullying and teasing him, pinching and punching him and that Aunty Denise "keeps smacking me".

101. In 2002, Territory Kidz child care sent a letter about the two younger Melville children, [redacted] and [redacted] also referring to irregular attendance at school, unhealthy food brought to school, lack of shoes lack of hygiene.

102. On 27 September 2002, Heather Matthews, one of FACS' team leaders between 2001 and April 2004 noted the following in a report after her home visit to the Bees Creek property: poor standards of cleanliness at the home; inadequate lunches for the children and inadequate clothing; overcrowding - up to 19 people resided at the house. She stated that Denise responded to crises by demanding FACS take the children. These threats occurred frequently. The records for the period up to December 2002 also disclose occasions when Denise made such threats. The making of these threats contributed to FACS backing off on investigating any sensitive matters with Denise.

103. She wrote that Denise received a considerable amount of money in benefits but had a history of asking for advances in payment and neither her home nor the children displayed evidence to suggest she spent "even half her payment on the children". She noted that Adrienne Boucher had suggested Denise might be a gambler and this had been confirmed by Sandra Kitching from Karu.

104. Matthews also stated that "the kids seem settled and are happy and Denise seems to love them and want to keep them". However, Matthews gave evidence at the inquest that she had a gut feeling throughout her whole period as team leader that Denise Reynolds did not have a strong attachment to the Melville children as she claimed to have and that the children were more of a chore than a joy to Denise. Heather Matthews said that she had

concerns about whether the physical and emotional needs of the Melville children were being met. Matthews also said, presciently, that if FACS did not broach the subject of where the money was going with Denise, FACS would be in breach of its duty of care to the children.

105. Matthews raised almost none of these concerns in the Family Matters Court Report she wrote on 20 December 2002:

> "The family lives on a five acre block at Bees Creek, sharing a four bedroom house and a large caravan. The accommodation is basic, and somewhat crowded, but adequate for the family's needs. Mr and Mrs Reynolds have successfully integrated the Melville children into their family unit and the placement appears to have met all the children's needs for stability, security and affection."

106. The report also noted that Denise was concerned about Deborah Melville and that she seemed to be very flat emotionally and did not respond in the same way in similar circumstances to other children her age. This was put down to the impact of separation and it was said that FACS would facilitate a psychosocial assessment of Deborah early in the New Year. It is not clear if this was done.

107. The report noted that there had been episodes of great stress for Mrs Reynolds during the placement, "but she has always maintained her commitment to the children and to keeping them together". However, the report also noted: (transcript p.227)

> "Mr and Mrs Reynolds have recently advised FACS that as their original time commitment was for two years, to give the children a family based home whilst Ms Melville worked out - towards reunification. As this has not happened and it now appears the children will be in substitute care for a significantly longer period, they have decided that a more appropriate option is for the children to be placed elsewhere with carers who have no other children... FACS with the help of Karu Aboriginal and Islander Child Care Agency are actively recruiting a new and permanent placement for the Melville children."

108. In fact, FACS did not appear to make much of an effort in looking elsewhere for other carers, which may reflect both the difficulty in finding another carer who would take all five children or the view in FACS that Denise was the only real option for the children. FACS told Denise that they did not have a placement which would take the five children. Denise agreed to continue as the carer because she did not think it was fair that the children should be separated again.

109. Matthews defended her report by stating that a court report is required to be objective and behavioural, and not a place for recording opinions and gut feelings. The court report was a misleading document both for the court and for future caseworkers who relied on such court reports as one of the most important sources of information they referred to. The perfunctory and glib nature of this court report was a feature of all future court reports, which often appeared to be cut and paste jobs.

110. Matthews was criticised by Karu for raising the concerns she did and was told not to import her white middle class values on Aboriginal families. She was told that by raising those concerns she was contributing to the development of a second stolen generation. Such criticisms, which were entirely misplaced and worked against the children's best interests, had the desired effect of producing a form of self-censorship in Matthews.

111. On 5 February 2003, Virginia Child Care Centre sent a letter to Adrienne Boucher about inappropriate and disturbing behaviour by [redacted] and [redacted] including sexualised behaviour. [redacted] was trying to touch other children inappropriately, she was hurting them and also calling them "niggers", a word she said they used at home. Both children used phrases such as "lick your willy" and "let's go sex". [redacted] did not wear underwear and her clothes, which were too big and fell down.

112. Jill Lake, a family support worker with FACS, drove [redacted] and [redacted] to crèche between October 2002 and February 2003. She observed that the

children did not have underwear and their clothes were too big. She also noted that they usually did not have breakfast or ate donuts. She provided daily reports of her observations to Adrienne Boucher.

113. In September 2004, Deborah's Aunt Colleen Melville complained to FACS that she was concerned about the general care of the children. She was concerned that they were often unclean, and not attending school regularly, and not taking school lunches to school. Although Colleen Melville exaggerated the frequency she saw the Melville children, her complaint is consistent with other reports about the Melville children including the report from Humpty Doo Primary School.

114. On 8 September 2004, the Coordinator of Student Services at Humpty Doo Primary School wrote a letter in similar terms to the 2002 letter noting:

> "great deterioration in hygiene and cleanliness over the last two terms... their feet were in poor condition, dirty and lots of sores and they often came to school dirty".

115. Most of the "red flag issues" occurred whilst Adrienne Boucher was the case worker between July 2002 and February 2005. Boucher gave evidence at the Inquest and impressed me as a dedicated and skilful case worker. She was the only case worker whom the Melville children spoke of and they spoke of her positively. However, her view that Denise was the only appropriate carer for the children also blinkered her to the problems of the placement. One of the problems faced by Adrienne Boucher and other FACS workers was that the documentation system in FACS at the time was not adequate, which gave her limited capacity to distil or analyse critical information, which would have alerted Boucher to the issue of the cumulative evidence of neglect.

116. FACS keeps hard copy files and computer records (CCIS) in relation to each client. Entering information into CCIS was time consuming and was not always done. For example, home visits were not always recorded.

Sometimes events were not recorded contemporaneously. Some caseworkers did not make records in the "progress notes" part of CCIS but rather made file notes which they uploaded, for example, monthly. Not all of the information on the hard files is uploaded on to CCIS. The hard files themselves were poorly organised and did not contain any summary document to flag important issues. A new caseworker would not have been able to ascertain from reading either the hard files or interrogating CCIS, what matters were important, unless that caseworker had many hours to spend poring over the files and CCIS.

117. The problem was exacerbated with a sibling group. There was no facility on CCIS to upload data on to more than one file. To keep all CCIS records for a sibling group up to date would involve cutting and pasting on to all files. For the hard files, where a matter related to all siblings, photocopies of documents would need to be placed on each file.

118. The poor organisation of the hard files and the deficiencies in the CCIS system, coupled with the absence of a summary document for either system, meant that there was no effective means of communicating corporate knowledge or highlighting "red flag" issues. The communication of such information was dependent on a handover from the previous caseworker. With frequent turnover of caseworkers, the problem of obtaining a clear picture of the history of a placement was exacerbated.

119. These very same concerns with CCIS and the hard copy files were noted in the [redacted] inquest, which related to events in 2005. CCIS now has a frame to record "face to face" contact but there is still no facility to cross-reference between members of the same sibling group and there is no summary document, which flags issues either on the hard file or on CCIS.

120. Boucher said that she could only vaguely recall reading the September 2002 letters from the school. Nothing in the records noted that she had done

anything about this letter. She did not recall the 2002 letter from Territory Kidz Child Care.

121. On 15 September 2004 Adrienne Boucher had a meeting with Denise Reynolds and Leanne Melville. Denise had an answer to each of the matters raised by the school. However, Boucher conceded that she had treated the September 2004 letter from the school as an isolated incident whereas this in fact was not the case: (transcript 298 & 299)

> "Just how serious you'd think the 2004 complaints were, you would take them much more seriously if you had the context of the 2002 complaints as well, wouldn't you?---Yes.
>
> And that would affect wouldn't it, whether you accepted Denise's explanations or not, wouldn't it?---That's correct."

and

> "Strickland: So if you put all the school records together, the records in 2002 from the school, pre school in 2002 and then again in 2004, they paint a picture over a pretty long period of time of matters that you have described as raising serious concerns --- Yes."

122. Boucher candidly admitted in hindsight she should have been more proactive in "searching out things" with Denise.

123. Between January 2006 and the time Deborah died, the Melville children changed caseworkers four times. That was particularly unfortunate because from 2006, due to a combination of factors in Denise's life, her willingness and capacity to provide an adequate standard of care for the Melville children declined dramatically.

124. On 12 May 2006, Cyndia Henty-Roberts, who was working at the FACS Placement and Support team visited the Bees Creek property to do a physical home check. She was very critical about the state of the property, in particular the bathroom and the toilet which she described as very dirty.

She described seeing very old, worn mattresses with no sheets, a bare kitchen where it appeared no-one lived, and no toys.

125. Although Denise and Bert had clearly had a volatile relationship for years, which included long periods of separation, up to 2006, Bert was around for considerable periods of time to help with the care of the Reynolds and Melville children. By 2006, the relationship was in its terminal phase. Bert was out of Australia for all but one month in 2006 returning in February 2007 to arrange for the sale of the Bees Creek property, which took place in April 2007.

126. Denise's sister, Sylvia Jarrett, spoke of the pain the breakdown in her relationship caused Denise. She became aware that Roberto had been unfaithful in the marriage. Denise gave evidence about the emotional turmoil this caused her. She said that Bert told her that Denise had to make a choice between the Melville kids and him. Adrianne Boucher believed that Bert was an important factor in the stability of the placement.

127. In March 2006, Denise said she began full time work – five days a week as a base operator for a taxi company. She did not work Wednesday or Sunday. Denise said that she took up full time employment because it was an "outlet" – from sitting at home doing nothing. At that time, according to the credit union statements, she received a total of $10, 129.72 monthly, which comprised FACS payments, Centre-link payments and Family allowance payments, in addition to her salary.

128. These two important events barely registered with the Out of Home care team at FACS, who persisted in viewing the placement as a stable one during 2006. However, Henty-Roberts and Rosalee Webb at the Placement and Support team both appropriately expressed concern at the ability of Denise to care for the children when she was working full time. Webb thought the Melville children seemed to be living in poverty. Anthea Motter, a team leader at the Out of Home Care team expressed anger at Roberts and

Webb's interference. Motter told them to 'butt out'. This bureaucratic infighting was counterproductive to FACS principal task of ensuring the welfare of the Melville children.

129. On 14 June 2006, the case review completed by Tara Murray stated that "the caseworker is unaware of any changes in family circumstances ... the current placement is meeting the needs of the children". Although Murray knew that Bert was in the Philippines during 2006 and knew that Denise began to work for a taxi company in March 2006, her case review made no mention of either fact. The case review was both misleading and inaccurate.

130. Murray had also heard that Denise was gambling at the casino. She did not even raise this matter with Denise because she considered this to be an invasion of Denise's privacy and she did not feel she had the confidence or skills to approach Denise on that issue. Murray also thought that in relation to home visits, it was too intrusive to actually inspect the bedrooms. The notion that it was too intrusive to carry out the most basic checks necessary to ensure that the children under the Minister's care received an adequate standard of care demonstrates the failure of FACS to fulfil its most basic obligations towards those children.

131. It must have been obvious at the time that a woman with 9 children whose partner had left her and, who had now taken up full time work, would have a serious impact on the standard of care being provided to the children. No-one at FACS ever bothered to make proper enquiries about who would look after the children when Denise was away from home – in particular when they returned from home and during school holidays. Denise said that after she began working, FACS arranged for all five children to be in a school care program during holidays between 8am and 6pm, and that her 18 year old son Ronald looked after them from 6pm until she came home from work.

132. Jenny Letchford was the case manager between May 2006 and 28 September 2006. When she took over from Murray as the caseworker, she said that no risk factors or warning signs were identified in the placement.

133. On 7 August 2006 there was a serious fire at the Bees Creek property. There is conflicting evidence about where the children lived from that time. There is no doubt that immediately after the fire, Denise and the children moved to 32 Zenith Circuit, Woodroffe where her sister, Toni (also known as Leanne or Lil) Melville's lived. According to Denise's other sister, Sylvia Jarrett, the Reynolds family and the Melville children moved to Zenith Circuit after the fire and stayed there until Deborah's death. On 25 January 2007, police attended the Bees Creek property because of a call from a neighbour. They located two dead and one surviving dog. The police recorded their belief in a PROMIS record that it appeared that no-one had lived at the property for some time. The children were staying with their Aunt in Adelaide for some time in January 2007.

134. Denise stated that after the fire, they moved to Zenith Circuit for a while because Bees Creek became uninhabitable. Denise said that she and the children then moved back to the Bees Creek property until Bert returned from the Philippines and said he wanted to sell the property in April 2007. Denise said that after the sale of the property, they then returned to Zenith Circuit for a few months before Deborah died. Ultimately, I cannot resolve exactly where the children lived because FACS did not comply with their legal obligations and make the necessary checks. I am satisfied that after the Bees Creek property was sold in April 2007, Denise and the children lived at Zenith Circuit until Deborah died.

135. Other people living at Zenith Circuit at that time included Denise's sister, Sylvia Jarrett (who helped look after Toni), and Toni's two young adult sons, Shaun and Adrin, both of whom had significant intellectual disabilities. Toni Melville's nephew, Christopher, who had significant

mental health problems, also lived at the house from time to time. On 5 May 2007, when the Melville children were present, it was reported to the police that Christopher Melville:

> "[was] walking around carrying a knife and making threats to harm others in the house – also making threats to get a gun and telling persons not to go to sleep or they may not wake up. Currently four adults and three children were in the house. Not sure if Police attend male will be aggressive towards them. Nothing in particular has set things off but things have been getting worse over the last two weeks".

136. Denise did not report this incident to FACS because "I didn't think of it at the time. I didn't think – it meant nothing to me." The police did not know that the Melville children were in the care of the Minister.

137. The living conditions at Zenith Circuit, Woodroffe were clearly inadequate for the children's needs. More importantly, the loss of the Bees Creek property was yet another misfortune that befell Denise, which significantly impacted on the level of care she gave the Melville children. Her relationship with Bert had ended. She said (transcript p.859 & 871):

> "I lost my relationship with my husband because I chose them [the Melville children] over him."

and

> "[Bert said that the] kids were more important than he was and unfortunately I [Denise] chose the wrong way"

and

> "I gave up my husband for them".

138. As a result of the final separation from Bert, she also lost her home at Bees Creek and was forced to move into Zenith Circuit, Woodroffe in conditions she described as very hard and very cramped. No-one had any privacy. Ten people including the Melville children slept in the lounge room. The Melville children sometimes slept on the lounge or on the floor with a

blanket. Brendan Williams, a program officer with Youth Works, became a support person to Deborah and [redacted] in 2007. He noticed that Deborah's behaviour got worse during the course of the first half of 2007; that she was withdrawn, tired, moody, sullen and irritated, even angry. She did not tell him why she was feeling that way. He also noticed that [redacted] was often tired because he did not get a good night sleep at home. [redacted] sometimes came to school in dirty clothes because Deborah had not time to wash them, which he felt was a 'shame job'.

139. Denise said that her mood worsened after she moved to Zenith Circuit, Woodroffe, and she was unhappy with her life. Furthermore, there was a history of animosity between Denise and the Melville children's mother and their aunt, Colleen. Deborah had also reached puberty. Denise conceded that she may have been more difficult to deal with. Deborah was also probably close to her mother, and she had written a note to Denise in 2006 that she was going to live with her mother and it was time to 'move on'. Deborah reported to Anthony Barnes on 28 December 2006 that she was having arguments with Denise in December 2006. Mageean noted in April 2007 that there was some conflict between Deborah and Denise and that Denise had told her that Deborah was pushing the boundaries with her. In all of those circumstances, although Denise denied it, it would be unsurprising if Denise had felt some resentment towards the Melville children, or at least towards Deborah.

140. [redacted] Melville gave a graphic description of Deborah's life to Brendan Williams after they moved to Zenith Circuit, Woodroffe. That is significant because [redacted] told this to Brendan Williams before Deborah died so it cannot be said that [redacted] was coloured by her death: (transcript p.800)

> "HARDY: And what did [redacted] tell you about life at home?---Basically [redacted] just said Deborah was mum.
>
> Did he elaborate on what he meant by Deborah was mum?---That – from what [redacted] has told me, is that Deborah used to do the

> washing, make the meals, get the kids out of bed in the morning, wash clothes and get them off to school and basically they were her responsibility.
>
> Did he tell you anything about the sleeping arrangements at home?--- Yeah, [redacted] used to – told me that the sleeping arrangements was there was a lot of people at the house; that sometimes he had a bed, sometimes he didn't. But it was first in best dressed and sometimes they slept on the floor, sometimes they didn't."

141. Denise thought that Deborah aged 12 was like an adult. FACS was critical of that belief. The children often cooked meals for themselves or they had take-away food. According to Sylvia Jarrett when Denise was not working, she (Denise) would 'go out'. Denise admitted to going to the casino a lot as an 'escape'. She denied that she was a problem gambler. Denise also claimed that she was looking to buy another house and that she had money to pay for a deposit on the house.

142. Although Letchford gave evidence that she visited Zenith Circuit, Woodroffe property three times and Bees Creek once, there are no record visits in CCIS for the time she was case manager. She did not see the children on the first occasion and saw only three of them on the second occasion. She did not know where they slept. Letchford claims that she visited the Melville children at after school care about ten to fifteen times during her period as case worker. There wasn't a single record of any of those visits. She was not able to recall anything of substance of what the children told her other than that "things were going okay". She knew that Denise was working full time and that Bert was not in the country. Nevertheless, Letchford made no inquiries and knew virtually nothing about the people who Denise had nominated as the substitute carers for the Melville children, namely Denise's eldest son and Toni Melville. Toni Melville had serious health problems herself and could not even walk to the bus stop to take the children to school. Letchford said that she was not worried that Denise would not be able to provide essential care for the children outside of school hours.

143. She also knew nothing at all about the living arrangements of the Melville children: (transcript p.373)

> "Did you know if the children - you didn't know if the children were sleeping in the bedroom or not?---No.
>
> Did you know, in fact, that all the children, the Melville children were sleeping in the lounge room?---No.
>
> Do you know that none of them had beds?---No.
>
> Is that something you should have known as their case worker?---Yes."

144. It appears that Letchford was not concerned by the overcrowding at the Zenith Circuit property because she believed there was always a lot of overcrowding in the Aboriginal culture and she believed the stay at Zenith Circuit was only temporary. Letchford, like some other caseworkers, did not appear to have turned her mind to a number of relevant matters, which should have raised concern about the level of care the Melville children were receiving. Letchford unsuccessfully tried to help Denise try to get some demountables onto the Bees Creek property.

145. Anthony Barnes commenced as caseworker on 28 September 2006 and finished on 6 February 2007. Barnes was the author of two documents which were closely scrutinised in this inquest – the Family Matters Court report dated 11 December 2006 and the Carer Re-registration form dated 19 December 2006.

146. I find, and it is accepted by FACS, that both reports contained serious deficiencies. The Family Court report stated:

> "Mrs Reynolds has provided the Melville children with appropriate care during this period that has met the children's physical, emotional and psychological needs.
>
> It has also been observed by FACS that the children have developed a healthy attachment to Ms Reynolds and her children which has

resulted in the Melville children integrating into Ms Reynolds' family and are now considered to be an integral part of Ms Reynolds' family."

In conclusion..... the five Melville children have resided with Denise Reynolds from 2000 and have received positive care and nurturing from Mrs Reynolds. It recommends the children continue to be declared in need of care and that FACS will continue to support Mrs Denise Reynolds in caring for the Melville children.

147. Key excerpts from the Re-registration form are as follows:

"**Issues/Difficulties from placement:**

No issues or difficulties identified at this time

Family/Home atmosphere:

Ms Reynolds is the Melville children's Great Aunt. Ms Reynolds has cared for the six Melville children for the past five years and provided the children with appropriate care during this period.

Motivation to continue fostering:

Ms Reynolds has stated that she identifies [the five children] to be her kin and considers the children to be part of her own family. Ms Reynolds has stated that she is happy to continue to care for the five Melville children until they are 18 years of age or older.

Ability to deal with stress

Ms Reynolds has demonstrated a high level of stress management. Ms Reynolds has also demonstrated that if at times of stress she requires assistance she will contact the children's FACS Case manager for support.

Summary and Conclusion

Ms Reynolds is the Melville children's Great Aunt. She has cared for these children for the past 6 years and has provided excellent care for the children during this period and considers the children to be part of her natural family."

148. Barnes made no reference in either report to where the children lived, or to the fact that on his understanding they were living for the majority of time

at Zenith Circuit, Woodroffe or to the fire at Bees Creek or to the fact that Bees Creek house was unsuitable for habitation. Barnes thought it would have been "useful" but not essential to know where the children were living each night. He did not mention his concerns at the overcrowding at Zenith Circuit. There is no mention of the fact that since the last court report in 2004, Denise had begun working full time or that she had separated from her partner. He made no mention that Bert had spent all but one month in the Philippines. He did not mention that Denise had on a number of occasions asked FACS to take the children back, which was obviously relevant to her motivation to continue fostering. There was no mention of Denise's gambling even though he had heard rumours about it because he considered the gossip was not serious enough to investigate it. Barnes did not provide any valid reason for omitting this essential information in his reports.

149. Denise gave evidence that she told Anthony Barnes before she went to court in December 2006 that another carer should be found for the children in 2006. She was told that the children should stay with her because there was no-one else to take the children. Given my doubts about other parts of her evidence (see below), I cannot be sure about the truth of this evidence although it is consistent with Denise's previous efforts to ask FACS to find another carer. By December 2006, her life had become appreciably more difficult.

150. Barnes admitted cutting and pasting material from previous reports. That sloppy approach meant that facts recorded in previous reports became out of date and misleading when included in current reports.

151. A more fundamental flaw of Barnes' approach to his work as caseworker was his failure to investigate the most basic facts about the children's lives for himself. Barnes accepted assurances from Denise about the Melville children without checking out those statements for himself. Even at the inquest he did not appreciate that it was essential to know facts such as

where they lived or how many people lived in their house. This flawed approach was not confined to Barnes. Seah-Quenoy properly conceded that FACS "did not look into the situation [with the Melville placement] enough" and attributed that failure to case overload, and the lack of continuity in caseworkers. She also agreed that one lesson she had learnt from this case was the importance of checking facts or allegations not just with the carer, but with other people.

152. Another example of FACS' failure to investigate important facts concerns information received about Denise's gambling (including from apparently reliable sources) which was conveyed to FACS team leaders and caseworkers. Those 'rumours' were never investigated even though there was a steady stream of reports over several years that Denise was often at the casino. Indeed, police investigations revealed that Denise had gambled more than $1.6 million in a little over 4 ½ years. Anthea Motter had heard these 'rumours' but they were not investigated because they were never substantiated. Such an argument is circular. The casino is not going to contact FACS to tell them that a particular person was a problem gambler. A carer is unlikely to make admissions themselves. Accordingly, the only way to check whether the rumour has substance is to do at least some elementary investigations – at the very least to enquire of the carer or her family. This was not done. One of the reasons it was not done was an unnecessary sensitivity on the part of FACS about intruding into the private lives of the carers. Gambling, however, had a direct impact on the welfare of the children, who are the Department's clients, both in terms of ensuring that taxpayers' money is spent on the children and not on gambling and to ensure that the carer is spending the time on caring for the children. Motter eventually conceded that the best way for FACS to discover about problem gambling is to check up when other people tell them about that information.

153. In certain respects, I found Barnes' evidence to be less than candid. He was asked a number of questions about his court report and re-registration from

concerning his statements which were to the effect that the children were provided with adequate accommodation: (transcript p.506)

> "STRICKLAND: It was impossible for you to ascertain whether they had adequate accommodation unless you actually went there yourself and assessed that accommodation. Do you agree or disagree with that?---I would partially agree with you, sorry.
>
> Why only partially agree?---Partially because where that would've been done really thoroughly would've been the physical safety check of the home and I was not required to do that.
>
> You re-registration report was misleading in that respect, wasn't it?---No, it wasn't.
>
> It was misleading because you made no reference to where they were living; correct?---I made no reference to where - their home address, no.
>
> And you made no reference to the fact that you had never visited it?---I - I didn't say that I had visited it.
>
> And you made no reference to the fact that what the nature of that accommodation was, whether there was 19 people living in it or less than 19?---All right, no, I didn't say that.
>
> Don't you think it was essential to at least record that in a report which is to look at whether there was adequate accommodation?---As I said, I wrote this report believing it was adequate because it should've gone in comparison with a physical safety check which I did not do. I was informed it had been done previously or it was in the process of being done by others. I wrote this report. I provided it to the then manager of the office who was also very much aware of the accommodation situation and this report was accepted by that person.
>
> In re-registration isn't a physical safety check required?---Yes, it is.
>
> And were you aware that the very last physical safety check which was in May 2006 deemed it to be - their accommodation to be unsatisfactory?---No, I wasn't." (my emphasis)

154. However, Annette Mageean, who took over from Antony Barnes as the caseworker for the Melville children gave evidence, which I accept, that

Barnes had told her the Bees Creek property should never have passed the Departmental safety check. That evidence contradicts Barnes' evidence that when he wrote the report, he believed that the accommodation was adequate: (transcript p.534)

> "HARDY: If we could move on, you had a handover with Barnes and Anthea Motta, some time after you'd received the files. Was that a verbal handover or was there some kind of written document?---It was a verbal handover, your Honour, and that was when the stuff about the house came up.
>
> Could you explain what the stuff about the house was?---The Bees Creek property apparently according to Anthony Barnes was a five acre block and it was like a bush type living. He was talking about the Departmental - at some point, the Departmental safety check, and he was saying that he really, it shouldn't have passed the Departmental safety check, because of the conditions out there. I never was privy to see the conditions, but it didn't sound very good.
>
> THE CORONER: He told you it shouldn't have passed the safety check?---That's right, your Honour."(my emphasis)

155. My criticisms of Barnes and the other caseworkers are tempered by the fact that at the time of the Melville placement, they received no or inadequate training in their legal obligations under the *Community Welfare Act*. They were shown the voluminous Practice and Procedures Manual, but were expected to wade through it themselves. Caseworkers complained about the lack of adequate supervision and, at time, lack of support from management. However, team leaders could not provide adequate supervision because of their own heavy caseloads.

156. The lack of proper supervision was certainly evident in the December 2006 re-registration document. Patrick Dalton, who was acting team leader at the time the re-registration was approved, supported Barnes' recommendation to re-register Denise. He provided no proper oversight at all and relied completely on Barnes' judgement. He gave no guidance as to the legislative preconditions for re-registration – indeed he did not seem to know them himself. Jill Jackson was a senior manager, who was delegated under the Act

to approve the re-registration. She too was totally reliant on the information provided to her by Barnes. She expected that the gambling issue concerning Denise was not noted on the re-registration form because she had discussions with Seah-Quenoy on that issue. Nevertheless she signed off on that form although the form recorded "No issue and difficulties identified at this time". Furthermore, no physical safety check of the Zenith Circuit property or referee checks for the carers or medical checks were done. Eades confirmed that such documents should have accompanied the re-registration document. Once again, the statutory forms were given a perfunctory or rubber stamp treatment. Jackson was too busy to properly review the re-registration of Denise in December 2006. This was not primarily a resources problem. There is no reason why these important documents were not treated with appropriate care. Furthermore, the Placement and Support team were willing to assist with the re-registration, but the Out of Home care team rejected that support probably because they knew that Placement and Support did not support the placement of the children with Denise. The checks that were built into the *Act* in order to safeguard the welfare of the children in the Minister's care broke down. This was acknowledged by Jenny Scott: (transcript p.926)

> "STRICKLAND: And this re-registration form was also authorised by Anthony Barnes; do you understand that?---Yes.
>
> However, it was approved by the team leader, Mr Dalton; correct?---That's what it says here, yes.
>
> And then it was further approved by the case work supervisor, Jill Jackson?---Yes. I can see that, yes.
>
> Aren't those two – Dalton was the – Barnes reported to Dalton, correct?---Yes.
>
> And Dalton reported to Jackson?---Yes.
>
> Isn't the whole purpose of having two superiors to actually provide a check on the case worker to make sure that he's doing the right thing,

that he's ticked off the relevant boxes?---That is the purpose of an organisational structure with different levels of responsibility, yes.

That appears to have completely broken down in relation to this document, doesn't it?---Yes."

157. Barnes failed to visit the children at home during the entire time he was case manager. Barnes did not know where the children were living during the time he was the case manager other than they were sometimes living at Bees Creek and sometimes at Zenith Circuit. On 29 November, he visited the children at the Humpty Doo Village Green where he spoke to them for about 20 minutes. He did not know if the Bees Creek property was safe after the fire because "I hadn't been in there."

158. The Bees Creek property was only 10 minutes drive from FACS' Palmerston office. Barnes said he did not even have 1 hour to visit the children at their home. He explained his failure to visit the children by saying he had a case load of 25 – 30 children. There was a shortage of staff and they were caretaking other people's cases and constant crises. Barnes' recorded in his notebooks anything that he considered important. The notebooks indicate that many of the tasks Barnes was performing at that time were routine, and administrative – arranging access visits, and dealing with relatively trivial matters. Barnes thought it would have been "useful" but not essential to know where the children were living each night. He considered it only "useful" to know the number of people living in 32 Zenith Circuit.

159. Barnes maintained that he was justified in his view that the children were receiving an adequate standard of care because there were no signs of neglect or other signs of maltreatment being seen by other professional people in the community. There were abundant signs of neglect, but Barnes did not undertake the most elementary investigations to uncover them. Barnes reluctantly conceded that he had concerns that the Zenith Circuit house was overcrowded. Barnes knew that Denise was working full time and that her husband had left her. He did not ask whether either of these

factors were causing her any stress. Denise had told him her 18 ½ year old son, Ronald looked after the Melville children, but he never spoke to the son because of his caseload and he accepted what Denise told him. A basic check would have established that due to his own work commitments and his lack of interest in the Melville children, he almost never saw them. Deborah complained to Barnes about arguments she had with Darryl Melville Senior who had slapped her on the back of the head Barnes did not know of the allegation of sexual interference made against Darryl Melville Senior in relation to [redacted] Melville. Had he known about that, he would have been "extremely concerned" if Deborah was not being supervised by her carer. Deborah was not being properly supervised. Again, all this information was available to FACS, but no-one was joining up the dots. This essential problem was candidly conceded by Anthea Motter: (transcript p.609)

> "STRICKLAND: Because what I want to put to you is that certainly after the Bees Creek fire the department failed to put the various pieces of the puzzle together, namely new accommodation, partner's left, nine children, working fulltime, rumours of gambling, you failed to put those pieces together, do you agree with that?---Sure, we didn't – yes.
>
> And in retrospect that was an error, wasn't it?---On reflection, yes."

160. Barnes repeatedly referred to his contacts with the school where the children were residing. There was no record of such contact and Barnes has only the vaguest recollection about the information the school was providing him.

161. Barnes has provided a statement to the inquest which stated that he does not know what else he could have done because it would have been too damaging to remove the children. This statement represents an assumption widely held by FACS officers in the Out of Home Care team. In one respect, the assumption was understandable because there was a chronic shortage of carers. However, the assumption developed an almost talismanic quality, which distracted FACS from its duty, which was to ensure that the children received an adequate standard of care. Most FACS officers concluded or

were told that there was no alternative to Denise and therefore either shut their eyes or did not bother to investigate matters that may have disturbed the status quo. The law and good practice required FACS to determine whether Denise was providing an adequate standard of care and if not, to ensure she did provide an adequate standard of care or find an alternative placement for the children.

162. After Deborah died, the Melville children were removed from Denise without the disastrous consequences predicted by some. Natasha Tenholder, who is neither Aboriginal nor related to the children, has been the children's carer for some time. Anthea Motter stated that the four Melville children have a good relationship with Natasha, and she provides good care for the children. They are happy well adjusted children.

163. The failure by FACS officers to abide by the statutory criteria of ensuring that the children under the care of the Minister had an adequate standard of care led to this erroneous attitude.

164. In early 2007, Denise's niece, Shaneeka died in a car accident. That death was stressful for Denise and the whole family.

165. Annette Mageean was the caseworker for the Melville children from 6 February 2007 to May 2007. She was advised during handover that it was a low priority case and it would not involve much work. She did not conduct a home visit until 26 April 2007, almost three months after she had become the caseworker. There was no valid excuse for this failure to comply with the Act. She had previously expressed concern to her team leader, Anthea Motter, about not having seen and spoken to the children, and she felt there was a breach of duty of care. Motter told her to go and see the children.

166. On 26 April, she and team leader Patrick Dalton (who accompanied her for 'moral support') went to Zenith Circuit to deliver a letter about getting criminal record checks done of the inhabitants of Zenith Circuit. This was

being done as part of the re-registration process. Although FACS had not conducted a home visit for many months, neither Mageean nor Dalton entered the house because the focus was on "delivering the letter". Dalton obtusely said "there was nothing there to indicate to me that I should be going inside." She did not ascertain who was living in the house or where the children were sleeping. Dalton did not even speak to the children. It was never adequately explained why in such an overworked office, two FACS workers were needed to deliver a letter to Denise, but could not take the elementary step of actually entering the house where the Melville children lived. Mageean did not receive any training in how to conduct a home visit.

167. On 30 May, Mageean did a home visit. She saw how overcrowded the house was. She saw that the children were all sleeping on one big mattress, which took up the whole of the lounge room floor. Mageean was told that sometimes Denise and her children did not stay overnight at Zenith Circuit. Mageean said she was dissuaded by her superiors in the Department from doing a physical safety check on the property (which was required for the re-registration process) because FACS knew that the overcrowded house would not pass the check. Denise kept assuring FACS that the accommodation was only temporary. However, as the months dragged on, there was no concrete sign that they were going to move. Scott acknowledged that FACS did not make a sufficient effort to ensure that the Melville children had adequate accommodation after the Bees Creek fire.

168. At no stage did FACS ever properly assess the adequacy of either the Bees Creek property after the fire or the Zenith Circuit house. The excuse for the latter was that it was only temporary accommodation. That excuse may have been valid if Denise's stay at Zenith Circuit, Woodroffe was only for a matter of one or two weeks. However it ceased to be valid after it was obvious that she and the children were staying there for a period of months not weeks, and there was no concrete sign they were going to move.

22 JUNE 2007 – 12 JULY 2008: THE LAST THREE WEEKS OF DEBORAH'S LIFE

169. It is difficult to provide a precise chronology of events of the last three weeks of Deborah's life. However, such difficulties are not unique to this inquest. Memories fade. Some witnesses have sometimes changed their stories between when they first gave a record of interviews to investigating police to the committal hearing and the criminal trial, and then this inquest. Other witnesses have given an essentially consistent version throughout. I bear in mind that when giving evidence at this inquest, witnesses did so without the spectre of serious criminal charges hanging over the heads of Denise Reynolds and Toni Melville, which may have enhanced the candour of their evidence. Denise and Toni Melville were each charged with manslaughter. Each was acquitted by a jury in February 2009. It is inappropriate to go behind those verdicts and I do not do so.

170. Having carefully assessed the demeanour of each witness who gave evidence before me, and having analysed all the witnesses' statements made to investigating police and their evidence at the criminal proceedings, I may make the following findings about the sequence of events, which led to Deborah's death on 12 July 2007.

171. There is no dispute that on the last day of school on Friday 22 June 2007, Deborah attended a sports day at Humpty Doo Primary School. She had a limp. Deborah told her school friend Ricky Kelly at about 12.30pm that she had a really sore left leg and it felt like she was going to collapse.

172. What is in dispute at this inquest is the course Deborah's injury took over the next three weeks, the signs and symptoms she exhibited over those three weeks of being injured and then ill, and how obvious those signs and symptoms must have been to anyone who bothered to pay Deborah any attention.

MEDICAL EVIDENCE

173. The starting point in answering those questions is the medical evidence. Dr Terrence Sinton, who performed the autopsy on Deborah, concluded that Deborah died from acute septicaemia or blood poisoning which had arisen as a result of a bone infection (osteomyeletis), which had developed in her upper left thigh. The septicaemia was a direct result of the infection in Deborah's thigh. Dr Sinton had performed two and a half thousand autopsies and about six of those involved osteomyelitis, but none in a child. He said that this was "by far the worst case he had seen". He said the internal soft tissue of the thigh had "basically rotted away effectively from the buttocks down to the knee joint".He found about 1500 mls of pus present inside the left thigh, an amount he described as "extraordinary". Dr Sinton was of the opinion that as the infection developed and got worse the pain would have become excruciating and there would have been increased immobility. The infection would have spread to the whole body rather than just a specific area.

174. Dr Peter Sharwood, an experienced orthopaedic surgeon, who was deployed with the Australian Army, gave evidence at the inquest. He described the course of Deborah's injury, illness and death. He said that Deborah developed a blood clot in the upper part of her left thigh, which having become infected, developed into an abscess. The abscess expanded causing pain, redness, swelling and difficulty in walking. This onset of symptoms is often mistaken for a minor trauma. He said Deborah would have experienced severe pain from day 2, which would be worsened by movement of her leg including any exercise of the leg. Dr Sharwood said that during this period (between days 2 to 10), Deborah would have an elevated temperature, became lethargic, lose her appetite and object or refuse to move. She would develop a build up of pus.

175. At about day 10, the abscess would have burst and the pus would discharge out into Deborah's buttocks. This opinion is consistent with Dr Sinton's autopsy, which noted a collection of thick pus surrounding the femoral shaft from the left buttock to the knee joint. Dr Sinton observed a 10cm cavity in the buttock, which would have been full of pus.

176. Every doctor agreed that the 1500 millilitres of pus would have taken at least one week to develop after her initial injury.

177. Because the pus had broken out of a confined space, Deborah appeared go get a little bit better. However, she then accumulated an abscess in her thigh and her infection (the emboli of pus) began to spread throughout her body, including her heart and lungs. By then, Deborah had developed septicaemia. Probably at between days 18 to 21, the pus got into the blood stream and the lungs causing lung abscesses. Dr Sinton found abscesses on Deborah's lungs and tongue and pleural effusions (an accumulation of fluids in the lungs). These are all classic symptoms of pyaemia.

178. By day 21, there was less blood flowing around her heart, her lungs were not working properly and she was hypoxic from the pleural effusions, and her kidney was failing. The absence of fluid in the last 8 hours of her life also caused dehydration, which was probably the final straw. All of those conditions caused her cardiac collapse.

179. Dr Pozzi, a specialist orthopaedic surgeon practicing in Cairns, gave evidence that, in his opinion, based upon certain assumptions put to him by senior counsel for FACS, Deborah had entered into a phase of progression from an acute stage of the osteomyelitis to an acute chronic stage. Dr Sharwood disagreed with that opinion and found that Deborah never progressed beyond an acute stage. I accept Dr Sharwood's opinion that if there was any progression towards a chronic stage, there would have been signs that Deborah would have got better immediately before her death (and there were no such signs), and the autopsy report did not record the presence

of the sequestrum (dead bone) and involucrum (the new bone that forms around the infected mass), which are the classic features of chronic osteomyelitis.

180. Deborah's treating doctor, Dr de Souza said:

> "there was no doubt in my mind that this girl would have had significant pain, significant difficulty walking and would have had fevers, on and off, or constantly for a period of time. I think this girl would have been very, very unwell at some point and recurrently throughout the course of this illness developing."

EVIDENCE OF LAY WITNESSES

181. Denise's evidence was that on 23 June, Deborah had told Denise that she had "sprained" her muscle at sports day. Sylvia rubbed Deborah's leg and Denise rubbed it on day three. Denise said she did not take Deborah to a doctor because: (transcript p.852)

> "I just thought that it had pulled a muscle that was it. I didn't think anything else. That's what she told me. And that's what I believed".

182. Denise said on the Sunday before she died, Deborah told Denise that her leg appeared to get better. Denise's evidence is that she continued to believe until the day Deborah died that her only problem was that she had pulled a muscle in her leg. She had heard that Deborah could not walk and asked the other kids to get her a drink or something to eat, but Denise thought that was just attention seeking behaviour.

183. Toni Melville told police in a record of interview on 1 August 2007 that she saw Deborah come home from school on Friday and she was limping. Deborah complained to Toni that the teacher made her run around oval today and my leg feels a bit sore. She pointed to the top of her thigh muscle. Toni told her to walk to the lounge and massage herself. She then stopped limping. Toni said that Deborah was just walking around doing everything

with the kids. Deborah was out in the yards, playing with the kids, screaming, but only if other kids touched her toys.

184. Deborah allegedly told Toni after about 2 weeks that her leg felt better and she was walking around, running around –she didn't give any indication that she was feeling sick and then she said she wanted to go shopping on Sunday 8 July. Then she said that she did not feel like going. Toni said:

> "I just don't understand how she died mate. I see her walkin' around and then the next minute I'm just ringing the ambulance I dunno."
>
> "That's why I can't understand hey, she was walking around, she didn't even look sick, she didn't give us any indication that she might be in pain or anything at all and then the kids came in and said to me 'Aunty Lil Deborah's on the ground outside' and that's when I went outside and I rang the ambulance and it was too late for her."

185. She told police that she could not remember which leg Deborah was limping on.

186. I accept that if Denise Reynolds or Toni Melville had known that Deborah was seriously ill, they would have taken her to a Doctor. There has been no cogent evidence to suggest that Denise or Toni had any ulterior motive not to take her to a doctor. Their failure to take her to a Doctor or a hospital was not malicious or done with deliberate cruelty to prevent her from obtaining medical treatment. Denise did not seek any medical treatment for Deborah because she did not bother to turn her mind to Deborah's needs. It appears that as a result of the combination of pressures on Denise Reynolds' life at that time, she was totally preoccupied with her problems and her issues. She wanted to go to work because she did not want to sit at home doing nothing. She thought being at home was doing nothing. She gave Deborah Melville's problems either no or virtually no attention. She was hardly ever at home. She was either at work or at the casino. Denise's daughter, Jacqueline Reynolds said they did not take Deborah to the doctor when her leg got sore "because Mum was too busy at work."

187. Denise clearly had a serious gambling problem, which she continued to deny. By 2007, Denise was spending considerable sums of money and time at the casino. In March 2007, she withdrew $1680 from the ATM at the casino; $5500 in April 2007 and $13,000 in July. In the last three weeks of Deborah's life, she spent a lot of her night time hours at the casino. For example, on 26 June 2007, she was at the casino between 8.40pm and 4.25am; on Friday 6 July, she was there between 9.37pm and 4am; on Sunday 8 July between 9.17pm and 3.12 am, and on Wednesday 11 July between 8.19pm and 12.36am. Denise could not possibly have fulfilled her responsibilities as a carer to the Melville children if she was working full time and gambling as much as she did.

188. Toni Melville did not give evidence at the inquest because she was too unwell to attend. Her reasons for not taking her to a doctor are not entirely clear. The most likely explanation is that Denise had laid down the law that Deborah was not to be taken to a doctor and she did not want to cross or contradict Denise.

189. On certain critical points, Denise's evidence at this inquest and her statement to interviewing police was dishonest and designed to conceal the extreme neglect and inattention she gave Deborah in the last three weeks of her life. I make the same finding in relation to the statement Toni Melville made to the police.

190. Denise gave this evidence: (transcript p.876-880)

> "STRICKLAND: Did you – when was the next time you noticed anything about Deborah?---About three or four days later.
>
> What did you notice?---That – well, it wasn't a notice, it was – it was mentioned to me by the children that Deborah kept getting them to get her water and food and everything. So I told her if she didn't exercise her leg her muscle was going to be no good.
>
> But did you ask Deborah what was wrong three or four days later?---No, I didn't.

Why not?---Because she had already told me that she pulled a muscle at sports.

But that was three or four days ago. What I'm asking you is why didn't you say to her three or four days later if there was anything wrong with her?---Because I just thought it was the same injury.

Did you ask if it was getting better or getting worse?---No.

Why not?---It was just her – sorry, it was just – I thought it was an injury, a sporting injury and I know what it's like to try and move around with them, so I just left it at that.

Did you have time just to ask her a simple question, how's it going with your leg?---Of course, I had – of course, I had time. I asked her every day, every day I got home from work. She would come out to the car sometimes and then other times she was inside sitting at the table. She'd ask me how my day was, I'd ask her how her leg was.

.....

I'm sorry, go ahead?---And then on the Sunday [the Sunday before she died] that's when she told me her leg was feeling better.

That's the Sunday - - - ?---We woke up in the morning. Sorry, we woke up in the morning and I told all the kids to go and have a shower, get dressed, we were going to go shopping. And that's when she told me her leg was feeling better.

Are you saying that from the Saturday, which is the first day you noticed her injury, the day after her sports day, until the Sunday before she died, you asked Deborah every day how's your leg going or something like that?---Well, probably not every day but I did ask how her leg was. She would ask how my day was, I would ask how her leg was.

Did you do that everyday or not?---Well, probably not everyday, no.

Well, how often did you ask her?---Well, I don't know, I can't remember. This is like two and a half years ago.

But you said a moment ago you asked her that question everyday?---Sorry?

You said a moment ago you asked her that question everyday?---Well, it probably wasn't everyday.

Why did you say that then?---Well, it was just a misconception of the way that I put it I'm sorry.

Did you ask her once every couple of days?---Every couple of days maybe.

Well, did you or didn't you?---Well, yes, every couple of days.

And what was her answer every couple of days you asked her?---Well, every couple of days I asked her how her leg was, she would say it was good. Well, not it was good, it was better. And then on the Sunday she told me that her leg was better.

So it kept on getting better and better, is that right?---That's what she told me and that's what I believed.

That's not true, is it, Mrs Reynolds?---Well, it's not true now because we all know that.

No, what I'm suggesting to you is she never said to you every couple of days that her leg was getting better?---Well, yes, she did.

.....

Did you tell Deborah to exercise her leg?---Yes, I did.

How often did you tell her that?---Everyday I told her to exercise her leg everyday so it will get better.

And is it the case that she said words or by her conduct indicated she did not want to exercise her leg?---Said words by her conduct, what do you mean?

Did it appear to you from what she said or did that she did not want to exercise her leg?---Well, no, she didn't want to exercise her leg, no.

And how did you know that?---Well, she told me that it was sore and I told her that it's going to be sore because she's pulled a muscle and pulled muscles are sore.

So she told you the leg was sore but she was also telling you the leg was getting better, is that right?---Well, she didn't actually say her leg was better until the Sunday that she said that her leg was better.

I thought you said that you asked her about every second day how her leg was and her answer to you was generally it's getting better?---That's right, that's what she said to me but she didn't actually say to me until the Sunday that her leg was better. Not getting better, was better.

Do you remember an occasion when you asked Deborah to put her leg on top of the couch and leave it there?---Yes, I do.

And do you remember Deborah tried to do that?---Yes.

And do you remember grabbing her leg and putting it up high and putting it on the couch and she was yelling and screaming?---No, she wasn't yelling and screaming. I said to her that in order for her to get a stretch on her leg she's better off putting it on the lounge and I showed her. She wasn't yelling and screaming.

You were saying words to her like 'you can do it, you just need to put up your leg on the couch, that's all you need to do', correct?---Yes, that's correct.

And she was saying to you 'I can't do it, auntie Denise', wasn't she?---She was probably saying that, yes.

And she couldn't do it, could she?---Well, I helped her the rest of the way. She got her leg most of the way I just helped her the rest.

And I suggest to you whilst you were doing that she was yelling and screaming?---And I say to you she wasn't.

You see there was – [redacted] Melville was present when you did that and she said she heard Deborah screaming and yelling and screaming when you were doing that. You say that's incorrect do you?---Yes, I do.

.....

Do you remember – I'll ask you another question. Do you remember pressing on Deborah's shoulders to try and stretch her?---To make her do a squat, yes. Not pressing on her shoulders. I had my arms on her shoulders and I was trying to get her to come down with me to do a squat.

And she couldn't do it could she?---Well, not at that time, no.

> If I can just go back to the occasion when you were putting Deborah's leg on the top of the couch and you've admitted you did that?---Yes.
>
> And you've admitted that Deborah said 'I can't do it, auntie Denise'?---Yes.
>
> It was obvious to you, wasn't it, that she was in pain when she was trying to do that?---No. She said it was – she said it was sore, yes. She said that she couldn't do it, yes. But she never screamed and screamed and cried and carried on, no." (my emphasis)

191. This evidence is obviously internal inconsistent. It is plausible that after her abscess burst (which was on about day 10 according to Dr Sharwood), the pain caused by the build up of pus in her upper thigh would have eased and she may have told Denise that. However, if it were really the case that Denise had asked Deborah how her leg was going every couple of days and also told her to exercise her leg every day, she would have noticed, as did everyone else in the house, apart from Toni Melville, that Deborah's condition was worsening over time. I find that Denise was not telling the truth when she said she did not notice Deborah in pain when Denise put Deborah's leg on the couch. All the doctors agreed that any movement on her infected leg would have caused her severe pain. Denise also did not tell the truth when she said that she saw Deborah walking around the house during those final three weeks, but did not notice that her walking became more laboured and more difficult. Denise herself admitted that on Sunday 8 July she saw Deborah walk a few metres, stop and start to rub her legs. Denise knew that Deborah did not go shopping with her siblings because she could not walk more than a few metres. Denise lied when she said that Deborah told her that her leg was better on that day and she had no reason to disbelieve her. The overwhelming evidence discussed below is that Deborah's ability to walk deteriorated dramatically and that by the last week of her life, she could not walk unsupported.

192. Deborah's younger sister, [redacted] Melville told the police that she was present when Denise told Deborah to put her leg on top of the couch and leave it there. Deborah was trying to do that. Aunt Denise grabbed Deborah's leg and picked it up very high and put it on the couch. Deborah was screaming and screaming and yelling. Denise was saying to Deborah: "You can do it. You just need to put up your leg on the couch that's all you need to do." Deborah was saying "I can't do it Aunt Denise." Aunt Denise said "You can." Deborah said "I can't do it Aunt Denise." Aunt Denise then lifted up Deborah's leg and chucked it on the couch.

193. Denise's son, Casey Reynolds, told the police that after Deborah's initial injury he thought she got better for about a week or five days. After that Deborah couldn't really walk properly. Denise kept telling her to stretch her legs. After that "it started going up, real swelling up and up". Casey said he noticed that she could get around on her leg but like it hurt all the time. He said that Deborah was mainly lying or sitting down watching TV during the holidays.

194. Deborah's younger brother, [redacted], said that somewhere between one and two weeks before Deborah died, Deborah could not walk to the toilet herself so she urinated and defecated in her pants.

195. Sylvia Jarrett initially gave evidence at the inquest that Deborah came home one day from school complaining about a sore right leg. She was wrong about this – the complaint was about her left leg. Sylvia said she massaged the leg with Tiger Balm. After that, Sylvia did not notice anything wrong with Deborah apart from the fact on Wednesday 11 July when the FACS workers came to Zenith Circuit, Sylvia saw Deborah sitting on the floor having defecated in her pants. When reminded about what she told the police in her record of interview conducted on 13 July 2007, Jarrett "recalled" a lot more.

196. Sylvia said that from day 1 to 14, Deborah could walk "but you had to help her up off the lounge. And I just put my hand out and she'd pull herself up. And then I'd follow behind her in case she crumbled" as she accompanied Deborah to the toilet. Sylvia said that from day 7 to 21, Sylvia had to take her to the toilet. Sylvia said that Deborah complained a lot when she tried to move, that she cried in pain. She called out to Sylvia in the middle of the night when she needed to go to the toilet "and stuff like that" because Sylvia got up and helped her. Sylvia said that "Sometimes every night she would complain, but mainly if you touched her leg and that she'd complain." She said "my sister gave her something for the pain, Codeine or something". Sylvia said that on day 18, "you could not hold her up and the minute you let her go she would crumble to the ground" She also said Deborah's leg was shaking so badly. That is consistent with Dr Sharwood's opinion that by that day, Deborah had commenced to contract pyaemia – the pus had entered her bloodstream. Jarrett said that she thinks Denise was present when Deborah collapsed to the ground. Denise denied any knowledge of that.

197. Evelyn Nooks said she saw Deborah a few times from days 14 to 21. By this time Deborah was losing colour and could not bear weight on her leg. She said that Deborah's limp had gotten worse compared to the first couple of weeks of the school holidays. She said that Deborah was sitting on the couch and could not put weight on her leg. Her knee was more bent and she looked a little bit off colour.

198. Richard White, an Aboriginal Community police officer who lived across the road from Toni Melville, said that Deborah was unwell since around the time of the school sports day. On or about that day Deborah came over to his house and told him she had a sore leg. She had a slight limp and an abscess on her elbow. He told her she should tell "Aunty Leanne about getting antibiotics".

199. Richard White next saw Deborah about a week before she died when [redacted] and one of Denise's daughters carried her around to his house, one under each arm. Richard White described her as being very sick, very pale. Her left leg was tucked up so she could not stand on it. He saw her leg and could not see any injury, swelling and described her leg as having a blind boil. He told investigating police two days after Deborah died that on this occasion Deborah wanted to go and lie down as she was in so much pain. She was "pretty much crying" every time she tried to stand on her left leg and appeared to be in pain.

200. Denise denied she ever saw any bruising or swelling on Deborah's leg. Denise said that Deborah once told her she had a black mark on her. When she tried to show Denise, the black mark was gone "and that was the only time she'd ever mentioned she had any markings on her leg".

201. There was abundant evidence that there was at the very least significant swelling of Deborah's leg at the very least by 11 July. Casey Reynolds said that on Wednesday 11 July he saw that her legs and arms were puffy, swelling up. In fact her whole body was. Deborah wasn't able to talk properly, and he could see her veins sticking out from her left leg.

202. Vivianne Reynolds said that Wednesday 11 July that "everyone noticed [Deborah's leg] was swollen". "It was swollen from her ankle up to her knee".

203. Furthermore, Sylvia had told Denise about a purple bruise on Deborah's leg and Denise had looked at it. There was some conjecture whether the autopsy photograph of Deborah's upper leg showed any obvious discoloration. The photographs clearly show swelling on her left leg. Dr Sharwood said he believed that there was discoloration exactly where Dr Sinton described the abscess in the thigh, in the buttock. [redacted] Melville said she saw purple on Deborah's leg about four to six days before she died. Sylvia Jarrett told investigating police that Deborah was on the toilet and she showed Sylvia a

big dark purple colour bruise on her leg "like she'd been whacked on the leg or something" and "it was big enough to really notice it". Sylvia Jarrett unconvincingly stated at the inquest that she did not actually see the bruise, but that is not what she told police one day after Deborah died. On the other hand, after Deborah's death, Dr De Souza, who saw Deborah at Royal Darwin Hospital did not see any abrasions or anything on her body to indicate a skin infection nor any signs of trauma, nor did he see any signs of swelling. I am unable to make any finding about whether there was obvious swelling or bruising on Deborah's leg or upper thigh prior to her death.

204. Denise initially denied any knowledge that Deborah had defecated and urinated in her pants or on the family couch because she could not walk to get to the toilet or that Deborah needed assistance to get to the toilet. She then said that she remembered one occasion when Toni Melville had told her that Deborah had weed her pants, but that did not surprise her because Deborah had done that before.

205. [redacted] reported that Deborah had urinated on two couches on one occasion each and had defecated in the kitchen. After that people had to help her to the toilet. I accept [redacted] evidence because it is consistent with other evidence in the case including Sylvia Jarrett who told investigating police in her statement that after the second week of the holidays, Deborah sat on the couch and messed herself and then she had to be taken to the bathroom to have a shower and clean herself up. Sometimes other kids teased Deborah about this. I find that Denise and Toni knew that Deborah had on more than one occasion defecated and/or urinated in her pants, and that was an obvious sign for anyone who paid the slightest attention to her needs that she could not walk properly and that she required medical attention.

206. Toni Melville told police that no-one ever told her that Deborah should be taken to a doctor or hospital for medical treatment. Later she told the police that she did suggest to Denise when she was first injured that she take

Deborah to a doctor. She said Denise gave her some exercises and she was okay. Denise denied that anyone ever told her that she should take Deborah to a doctor or a hospital: (transcript p.886)

> "STRICKLAND: Now, did anyone during the three weeks that Deborah, from the time that Deborah got injured until the day she passed away, did anyone ever say to you that she should go to the doctor?---No.
>
> Or to a hospital?---No, not that I can remember.
>
> Well, if they had said it you would have remembered wouldn't you?---Well, I would have remembered, yes."

207. The evidence of both Denise and Toni on this point was deliberately untruthful.

208. A number of people gave evidence at the inquest or made statements to police that during this three week period they said to Denise and/or Deborah that Deborah should be taken to a doctor and she refused. [redacted] Melville said that she heard Casey Reynolds say to Aunt Denise "Can't you see that Deborah is on the floor, she's in heaps of pain. She needs to go to the hospital." Everyone was then saying "well she's your problem so you can do everything about it" and then he was really angry and upset and he left. [redacted] did not know when Casey said that to Denise but it was possibly on the day of her death. Casey did say it in Denise's presence because Denise said she does not need to go to a doctor's. Deborah only needed to walk around with that leg.

209. Evelyn Noakes saw Deborah shortly after the sports day and noticed she had a limp, like a "sprained ankle". She asked Toni if Deborah had been to the doctor. Toni said "no". On another occasion, Evelyn told Toni Melville that Deborah definitely needed to get her leg checked up because it didn't look like a pulled muscle. Deborah was lying down on the couch. Evelyn told Deborah that she needed to get up so her body didn't seize up. Evelyn said that she did not talk to Denise about Deborah's injury because Denise was

"rarely" at home. Greshima Noakes said to Toni Melville a few times that maybe Auntie Denise should take Deborah to a hospital. Toni said, "do you want to be arguing with Denise." I said "no". Toni falsely denied the statements made by the Noakes' sisters in her record of interview.

210. Richard White told [redacted] and her cousin when Deborah came around about 1 week before she died, "Look, you've got to tell Aunty Leanne [Toni Melville\ to take her to a doctor." They said: "When we take her back, we'll tell her."

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211. Jai White said that he went over to see Deborah on Wednesday 11 July. He was told by a cousin that she was in the shower and it was really annoying because they had to hold cups for Deborah because she was really shaky. He was also told that she could not come out because her leg was really sore, her arms were kind of sore and she was shaking really bad. Jai asked the cousin if they had taken Deborah to the hospital yet and they said "no".

212. Evelyn Noakes visited Toni Melville on 11 July 2007. Denise was at home because it was her day off. She saw that Deborah was on the couch. Evelyn helped Deborah off the couch by putting her arms or hands under Deborah's armpits. Deborah could not even wiggle to the front of the couch. Evelyn braced her so she would not fall. Evelyn said Deborah was in pain. She looked like "death warmed up". Deborah had urinated on the couch, and when Denise came home, Deborah was yelled at and screamed at that she should not be sitting down and she should be walking around.

213. Deborah was told to sweep the floor. Evelyn said that Deborah "couldn't stand up straight was putting her weight on the broom. Evelyn did not know how Deborah came to be on the kitchen floor crying. She noticed that that Deborah's lips were dried and cracked.

214. On 11 July, Denise was not at home. She did some errands and then went home because two FACS officers, Sarah Deery and Semia Truan were due to make a visit on that day. Denise denied noticing anything wrong with Deborah on Wednesday 11 July. She saw that when the FACS workers came to her house, Deborah was lying on the kitchen floor crying, but she attributed this solely to Deborah's fear that FACS was present to take her away from Denise: (transcript p.888)

> "STRICKLAND: But surely – surely you noticed something was wrong with Deborah on that day, surely?---No, I didn't. If she was pale or if she looked sickly or if she had any kind of those symptoms I would have taken her to the doctors. I would have taken her to a hospital. She would have been first in line. If there was any puffiness or anything like that I would have taken her to the doctors. I had no reason not to take her to the doctors at all. Oh my God.
>
> .....
>
> When the welfare workers arrived Deborah was lying on the floor in the kitchen, is that correct?---When I walked outside – when the welfare workers arrived she was standing up in the kitchen. When I walked outside to open the back door and we came back inside she was laying on the floor, yes.
>
> Do you know why she was lying on the floor?---No, I don't.
>
> Didn't that concern you?---Well, from what I understood was she threw herself on the floor and started crying and carrying on, she didn't want to leave, that's all I was told. She was crying. The welfare workers bent down and spoke to her, that's all I know."

215. Sarah Deery was the last FACS officer to be assigned as caseworker for the Melville children. Her visit to 32 Zenith Circuit was her first home visit. She and Truan stayed for 20 – 30 minutes. When Sarah Deery and Truan entered the kitchen, they saw Deborah lying on the kitchen floor crying and in distress. According to Jarrett, Deborah had "weed and shit herself" which was unusual. Sarah asked, "what was wrong?" Denise answered that the kids were usually like this when a new case manager came because they think the case manager is there to take them away. Like so many caseworkers before

her, Sarah Deery accepted Denise's explanation at face value. In fact, Deborah had never behaved in that way with any other case manager. Deborah was sufficiently confident with FACS that on 28 December 2006 she approached Antony Barnes with complaints she had about Darryl Melville Snr, Shaun Melville and Denise.

216. Sarah Deery got down on her knees next to Deborah said to her: "I'm not here to take you away. I'm Sarah. I'm your new case manager." There were no signs that Deborah had defecated or urinated in her pants. She was on the floor with Deborah for about one minute.

217. Sarah Deery and Truan then walked the short distance to the dining room and then noticed [redacted] Melville, Deborah's brother aged 8, standing in a corner with a blanket over his head. Sarah Deery, Michael and Denise then had a conversation about [redacted] allegation that he had been tied up in ropes and kidnapped. This distracted Sarah Deery's attention away from Deborah. However, Sarah Deery did get a glimpse of Deborah walking down the hallway to the bathroom. She was walking unsteadily and supporting herself by holding one hand on each side of the wall. Sarah Deery thought that the explanation for this was that Deborah was upset and distressed. She did not see Deborah for the rest of her visit. She did not think that Deborah needed medical attention. Truan saw that Deborah's legs were shaking when she walked. Sarah Deery and Truan said that Deborah did not say anything to them. Toni Melville said she saw Deborah walking around the furniture leaning on the wall. She asked Deborah if she was okay. Deborah said, "Yeah, Aunty Lil. I'm gunna stay here for a while. Everything's alright. My leg's fine." Toni said later in the interview that on Wednesday night, she saw Deborah walking unassisted.

218. It is difficult to understand why neither Denise nor Toni told the FACS workers that Deborah had a sore leg. I do not find that this omission was done for any sinister purpose. If Denise or Toni wished to actively conceal

Deborah's injury from FACS, they could easily have done so. However, Denise and her family were very guarded in their dealings with FACS. Sylvia Jarrett said that FACS was seen as a bit like the police, she described them as 'the Gestapo'. Denise's pattern was to keep any problems she or the children encountered to herself, and not to discuss them with FACS. She did not tell FACS about the serious outburst by [redacted] Melville in May 2007. She did not open up to FACS about the mounting problems she was facing in 2006 and 2007. It was consistent that she not tell FACS about Deborah's injury: (transcript p.889)

> "STRICKLAND: Can you just say again why you didn't tell the welfare worker about Deborah's sore leg?---Again I don't know. It didn't come up in the conversation so I don't know why I didn't tell the welfare worker about her sore leg. I just assumed that Deborah would have said something and I left it at that. They saw her walking down the corridor, they could have asked a question."

219. Sarah Deery and Truan cannot be blamed for not knowing that Deborah was critically ill. They saw and spoke to Deborah for only a minute. She had none of the prior knowledge that Denise had. She was not even told that Deborah had suffered a sports injury. Sarah Deery went back to FACS office later that afternoon and reported to Dalton that she had concerns about the placement. Dalton accurately said that there was nothing to indicate to him that the situation was as serious as it was. It was just another routine crisis. Sarah Deery told Mageean that Deborah could hardly walk or talk. Sarah Deery said to Mageean, "you didn't tell me that Deborah had a mental health condition." Mageean said to her, "Deborah doesn't have a mentall health condition." Sarah Deery, Mageean and Miang discussed returning to Zenith Circuit. Mageean wanted to return. However, they did not do so because it was late in the afternoon. Mageean thought or said that there were other carers in the house and if they were seriously concerned, they would know what to do. The notion that FACS could rely on the carers to do the right thing was the fatal theme underlying FACS approach to the care of the Melville children.

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220. On the day Deborah died, 12 July 2007, Denise left for work at about 10.30am. She had spent about 4 hours at the casino the night before. Before she left for work, Casey Reynolds heard Denise say to Deborah, "Oh get up and start walking around do your stretches and that." Denise said that she thought that Deborah needed to get outside because she needed some fresh air. She said that she and Sean carried her near the back stairs. She denied depositing Deborah near the trailer. Denise expected that she would only be outside for a short period of time, and that Deborah would go inside by herself. Denise says that she told Toni that if Deborah wants a drink or anything to eat, Deborah had to go in and get it herself, not send the other kids in because she believed that Deborah could walk perfectly well herself. Before she went to work, she thought Deborah was fine.

221. Toni Melville, in her record of interview with the police, said Deborah was taken outside because she asked to go and lie on a red bed frame outside. Toni said that at about 1.00pm or 1.30pm, she walked outside and asked Deborah if she wanted a drink or if she needed to go to the toilet or anything. Deborah allegedly said, "No, Aunty Lil. I'm fine. [redacted] been looking after me." Deborah then said to [redacted] in Toni's presence, "Oh yeah [redacted]. It's gonna be alright when we go back to school. We're gonna have a really good time." Toni said, "I was sure she was alright. She kept saying she was fine. She didn't ask for panadol and didn't say she was sick". All Deborah said to Toni was, "Aunty Lil. My leg's fine." Toni also made this patently false and cynical remark, "That's why I did everything for Deborah, you know, anything she needed. If, mate, she would have just told me she was sick."

222. Denise and Toni's evidence about they did and thought on the last day of Deborah's life was deliberately untrue. Denise deposited Deborah outside near the trailer on the dirt where she stayed for some 8 hours. Denise gave instructions that no-one was to give her any help, any food or drink.

Deborah became dehydrated and died an appalling and needless death. Greshima Noakes aptly said, "No one deserves to be treated like that." Denise gave no thought at all about how long Deborah would stay outside for. I have no doubt that when Denise went to work that morning, both she and Toni knew that Deborah was unwell, although they did not know that Deborah was close to death. Consistent with their behaviour in the last three weeks of Deborah's life, they demonstrated not the slightest care or attention for Deborah or her suffering.

223. Denise herself demonstrated some genuine guilt when she was travelling to hospital in one of the ambulances at about 7.15pm. She told ambulance officer, Deborah Downs, "She [Deborah] told me this morning that she was feeling off. I told her to get over it and went to work. I should've listened to her." When Denise was questioned by Dr de Souza shortly after Deborah died, she told him that Deborah had been complaining of a sore leg over three weeks and that she had attributed that to her having a calf sprain. Denise also told Dr de Souza Deborah had complained of her right upper limb and right shoulder being sore in the morning before she left. Denise also told the police in her record of interview that on Thursday 12 July, she noticed that Deborah's ankles were swollen. The evidence from other eyewitnesses, whose testimony I accept, indicates that Denise displayed a callous indifference to Deborah on that final day of her life.

224. [redacted] said that Aunt Denise was getting ready to go to work and then Sean and Aunt Denise grabbed Deborah and took her outside and left her there. Aunt Denise said to us kids, "If you go next to her – you'll get a smack". We all said "alright". Denise then left for work.

225. Sylvia Jarrett said that Deborah was really in pain on that day and she was given some more strong pain killers. She said that when she was helped to her feet she collapsed to the ground in pain. Denise's evidence was that she saw Deborah fall backwards to the ground and her head hit Denise's foot

when she fell down. According to Denise, Deborah told her that Deborah had a sheet caught around her foot, which caused her to trip.

226. [redacted] Melville gave a very different version of that incident. He told police on 13 July 2007 that on morning that Deborah died, Deborah was in front of the TV laying down when Shaun, Toni's son, reefed her up. Deborah was "screaming like she was going to be killed". Sean was reefing her up and he did not really care what he was doing. She was saying, "Please don't! Please don't". Denise then came and picked her up. Denise was trying to get Deborah to get up but she kept on falling over and hitting her head. She did this about three times. Denise said, "Hurry up Deborah exercise your leg I've got to go to work. No one help her or anything." Denise helped Deborah outside and then she let go of her. She was leaning on the walls outside and she fell next to the trailer.

227. [redacted] gave a second interview four months later. He said the last time he came to be interviewed he was scared and told a few lies but now he was going to tell the truth. [redacted] said that his aunt Denise picked up Deborah and forced herself back down. She picked up Deborah and then dropped her again and Deborah kept on hitting her head. He said that Denise picked her up and then dropped her down. She kept on doing it. Deborah kept on getting hurt. Denise then put her next to the trailer and said, "Stay there" and she told all of them "No one get her a drink or anything." Denise picked Deborah up by the armpits. Deborah was saying, "Stop it. Don't". Aunt Denise was saying to Deborah, "Get up. Get up. Stand on your feet and just walk." [redacted] said he watched this in silence because he believed if he tried to interfere, the same thing would happen to him. [redacted] also said that Sean tried to reef Deborah up by the hair five times.

228. [redacted] Melville, aged 9, said that on the day she died, Deborah couldn't walk at all. She said, "We wasn't allowed to go near her but we just went

near her. We weren't allowed to go near her because Aunty Denise does not want us to help her because she [Deborah] has to do it on her own."

229. I do not accept that Deborah's falling down happened in the way Denise described it. I find that Denise knew that Deborah fell down because she could not stand up. Denise heard her screaming in pain. Denise apparently still believed that the injury was muscular because she had told Deborah that she had to do her exercises. However, Denise did not care about Deborah's injury because she was hurrying to go to work. I do not find that Denise knew that Deborah was by then close to death. However, her indifference to Deborah's pain and suffering was deplorable and callous. She may have been tired after having left the casino at 12.40am that morning having spent 4 hours there the night before.

230. After Denise left for work, Evelyn Noakes went to the house on 12 July with her sister, Greshima. She saw Deborah lying on her back with her knees bent. Evelyn was very disturbed about seeing Deborah outside because "this kid's outside, I mean she couldn't get up, she couldn't walk." Toni told her that Denise had said, "if she wants to act like an animal she can get outside and act like an animal." Evelyn understood this to be a reference to the fact that Deborah could not get off that couch and had been soiling herself. Toni also said that Denise had said that no one was to go near Deborah or give her anything to eat or drink.

231. Greshima Noakes also saw Deborah lying on the ground near the trailer "like a piece of rag on the ground". She was as pale as a ghost. She said that Toni told her and Evelyn that Deborah was outside because "she peed and shit all over my couch so if she wants to act like an animal we'll treat her like one." Greshima told Toni they should call an ambulance to take Deborah to hospital but Toni said they would have to wait for Denise and added that Denise had told the children that no one was to go near Deborah or give her anything to drink or eat.

232. During the day, some of the children kept Deborah company and brought her water. Vivianne said that Deborah needed to wash her mouth out as she had not brushed her teeth for ages. [redacted] said her teeth were bleeding.

233. [redacted] said on the day she died we put her out in the fresh air and her leg started to go purple. They all realised that Deborah needed a drink and so [redacted] went to get her a drink. Deborah said "I'm really thirsty." Deborah then began to talk in a delusional way. [redacted] said that Deborah was next to the trailer and her leg was getting stuck under the trailer and [redacted] kept pulling it out. She said that Deborah was hungry so [redacted] got her a chocolate yoghurt and then "we got her a drink of water and it spilt all over her". She could not talk properly. She had dry lips and a dry mouth. [redacted] said that she could not really understand what Deborah wanted. Deborah became delusional. She said to [redacted], "I've got fairy friends. There are a few on that tree over there. The witches are catching all the fairies and locking them up."

234. [redacted] said that Deborah was near the trailer and ants were going through her mouth and her nose and her eyes but "we got it off her". [redacted] said that Deborah was lying next to the trailer as if she never wanted to get up. [redacted] later went out and saw Deborah next to the trailer to see what she was doing. She asked [redacted] for a drink and he got her one. Because she was so weak she tried to get up and she spilled the drink all over herself. She was dehydrated. Toni Melville was present when Deborah spilt the drink over her. Toni put her hand out and Deborah said "No, no, no I don't want you to help me you're too too scary". Toni said "I'm not going to help you up you're going to help yourself up. I'm just putting my arm out for you" and then she helped her up.

235. Vivianne Reynolds told Toni Melville that Deborah was talking about witches, which "freaked me out". She saw that Deborah's leg around her toe was getting light purple. Toni said "Well I don't know what to do." She said

this because Denise was at work. I said "Aunty Lil she can't get up." She said "Well you'll have to call your mum". Vivianne said she had not wanted to call her mum because her mum was so busy. This was a telling comment. I accept that Toni was not prepared to take any initiative in providing assistance to Deborah or getting her urgent medical attention because Denise had instructed Toni that she was not to see a doctor.

236. Casey came home and at about 5pm saw Deborah and noted that her leg started to swell up really, really bad. He saw her having a fit and was shaking like she was really cold.

237. Toni Melville said that she went outside to see Deborah, who was screaming and howling that she needed the light on. Toni told [redacted] to turn the light on and she did. Jacqueline said to her, "well Deborah the light's on, look up there you can see the light and Deborah looked up and said: 'Yeah – yeah I can see the light" and then after that she died."

238. Casey went to see his neighbour, Richard White, to see if he could take Deborah to hospital. Casey checked her pulse and could feel nothing. Richard White then arrived and said that Deborah looked dead. Richard White, who had a senior first aid certificate, could not feel any pulse. He started doing CPR. When he was doing CPR, he smelled something which was "probably urine." He could not see the abscess on the leg he had seen earlier.

239. At 6:52pm an emergency call was received by the St John Ambulance. By the time the ambulance arrived two fire trucks were already there. At about 7pm the NT Fire Service received an emergency call. About five minutes later they arrived at the premises. It was obvious that Deborah was not breathing. Shortly thereafter an ambulance arrived. Ambulance officers commenced basic life support on Deborah. They found her in cardiac arrest and commenced cardiac compressions or mouth to mouth resuscitation. A second ambulance arrived at 7.15pm. Deborah was not breathing and no

pulse. She had no eye movement, reflex movement and while doing compressions there did not seem to be any life or movement.

240. At about 7:45pm on Friday 12 July 2007, Deborah arrived at the Royal Darwin Hospital in full cardiac arrest. Dr Sharwood was of the opinion that the girl was dead by the time she arrived at the hospital.

241. She was certified as having died at 8.30pm on 12 July 2007 at Royal Darwin Hospital.

242. The failure by Denise and Toni Melville to take the elementary step of taking Deborah to a doctor or to a hospital was directly responsible for her death. The medical evidence establishes that Deborah's death was completely preventable.

243. Both Dr Sharwood and Dr Souza were of the opinion that without medical intervention, there was no chance of Deborah recovering. Dr de Souza said that if she had been brought in some three weeks before her death the proper treatment would have been antibiotics and surgery would not have been necessary. She would have needed a long protracted course of antibiotics to completely eradicate the infection within the bone.

244. If she had been brought in a week before her death, he would have expected the infectious process to have been well established by then and escalating given where it was located and the degree of severe pain. He would have expected her to have had fever because the pus was well established by then and he would have expected her to have signs of developing renal failure because her kidney blood tests were massively deranged. If Deborah had been treated within the first two weeks of her illness her prospects of success would have been excellent. The treatment would have been to destroy the organism by using intravenous antibiotics. Surgical draining may have been necessary.

245. Had she been treated seven days before her death it is likely that blood tests would have picked up the location of the pain and infection and the blood test would have probably picked up her developing kidney failure and she may not have had such a high potassium level.

246. If she had presented forty eight hours before her death, Deborah would have been extremely unwell. There were signs forty eight hours before her death that she was suffering delirium. Two days before her death there would have been established septicaemia present and established high potassium and established renal failure and this would have made her extremely unwell. "We could have categorised her in the resuscitation room and had a whole team working on her two days before." However if she had arrived two days before her death her prospects of survival would have been eminently greater as compared to when she had the cardiac arrest about an hour before her death.

247. If she had arrived six or eight hours before her cardiac arrest, she may well have survived although she may have died in intensive care some days down the track from overwhelming infection and they may not have been able to "catch up with her kidney failure" but she may have survived.

248. Dr Sharwood gave similar evidence at the inquest. He also said that the incidence of death from osteomyeletis is less than 0.0001% of the population. A study published in the last decade examining admissions at the children's hospital at Westmead showed the incidence of acute osteomyelitis was 0.08%.

POLICY REFORMS

249. The protection of children in the care of the State is one of the most important obligations of government. A constant refrain in the inquest was that FACS has not been properly resourced to meet the increasing demands placed on it by the growing number of children who are in the care of the

CEO or who fall under FACS' administration. If governments do not provide the necessary financial resources to fund more caseworkers, more administrative support for caseworkers and better, more user friendly information systems, the dysfunctional nature of the child protection system in the Territory will continue or get worse.

250. There was consensus amongst the experienced child protection witnesses in this case that case workers need to spend more time with children rather than be burdened with administrative tasks. However, as Jennifer Scott stated, child protection systems operate in a legal environment and there is a need to keep high quality records. It is therefore difficult for caseworkers to find a balance between doing the necessary administrative work, which includes proper record keeping on the one hand, and, on the other hand, devoting attention to the core responsibility of spending time with, building a relationship with and gaining the trust of children in care. As I pointed out during the Inquest, it has taken many years for Police Officers to be properly resourced with administrative staff so that they can carry out their core duties. There is no reason why child protection workers whose jobs are equally important to Police should not be similarly resourced.

251. The inquest has also highlighted the need for legislative reform. The *Care and Protection of Children Act 2008* ("the 2008 Act") is deficient in that it weakens the statutory obligations on the part of the Minister (or relevantly the CEO) to provide the protection needed for those children.

252. The 2009 Policy and Procedures Manual Version 2.0 ("the 2009 Manual") under the heading "Monitoring Children in Care" provides:

> "When a child is in the care of the CEO, the Department is required to ensure their safety and wellbeing. This is achieved by setting minimum standards of case worker contact with a child in care."

253. This inquest has amply demonstrated the point made in the Manual that it is essential to set and, I interpolate, enforce minimum standards on a range of

matters to meet the Department's obligations to ensure the safety and welfare of children in the care of the CEO. Although the 2009 Manual provides a comprehensive policy statement requiring that, at a minimum, a worker should have face to face contact with each child in care at least once every four weeks, such policy statements have no legal force or effect. There is nothing in the 2008 Act, which contains a similar provision to section 53(1) of the *Community Welfare Act* requiring an authorised person to visit a child in the care of the Minister at least once in every two months and to require the person to furnish a report concerning the child and his or her welfare. In my opinion that section, or a similar provision, should be reintroduced in the 2008 Act. Such was also the guarded view of Jenny Scott.

254. One of the critical deficiencies identified in this Inquest was the absence of any benchmarks by which case workers could determine whether a carer was providing an adequate standard of care to the children. Annette Mageean gave evidence that it was difficult to judge whether a carer met any particular standard of care when there was no standard to be measured against. What constituted an adequate standard of care was left to the individual judgment of the case worker. Section 63 of the *Community Welfare Act* set out some basic standards, with which the Minister was required to be satisfied, before registering a carer. In my opinion, it is important that certain minimum benchmarks be set out in Regulations, which have a legal force. Such benchmarks would provide some objective guidelines in determining whether the basic standards were met. More importantly, they would afford proper protection for children in care. The Out of Home Care Standards 2007 would is a good starting point for any such Regulations.

255. The 2008 Act does not even contain the minimum standards contained in the *Community Welfare Act*. Section 77 of the 2008 Act provides that the CEO must enter into a placement arrangement with other persons or bodies for a

child who is in the CEO's care and provides that the CEO may cancel the arrangement and replace it by another placement arrangement at any time. However no standard of care is specified for that placement arrangement. Section 78(3) provides that the regulations may specify the conditions for a placement arrangement including for example the standards required of facility for the arrangement. However no regulation had been enacted under that section. Jenny Scott gave evidence that the Department's opinion was that the 2008 Act should have at least the minimum standards of the *Community Welfare Act*: (transcript p.944)

> "STRICKLAND: Have any regulations been enacted under s 78?---They've not been enacted but there's drafting occurring.
>
> But it is actively under consideration?---Yes.
>
> But to your knowledge the draft regulations which are under consideration do not incorporate any standards of care for carers similar to the old Act, do they?---There are some broad references but it is still in draft form.
>
> Yes, but those broad references don't meet even the standards stipulated in s 63, do you agree with that?---Yes, they're less than that.
>
> Yes. So to that extent this new Act is regressive isn't it in that it contains lesser standards of care than the old Act. Do you agree with that?---It was drafted with the intention that the – that a number of matters would be dealt with in policy and others in regulation which is still under drafting, so in that sense it is not yet comparable in some areas to the old Act in legislative terms.
>
> But you've acknowledged even in the proposed regulations that have not yet been enacted, it doesn't contain the minimum standards that were contained under s 63 of the old Act. So there is in terms of legal force and effect it must follow then that the new Act contains less stringent standards of care legally for carers than the old Act, correct?---Yes, in the way you've just phrased it, yes.
>
> Do you think it is appropriate for the new Act or the regulations to reintroduce the minimum standards of care for carers that were contained in the old Act?---Yes, I think that it should at least – yes, it should at least have the minimum standards of the old Act. Now,

whether or not those are appropriate in the current – in this current day and age. They were developed in 1983, so whether they are still the most appropriate, that's within the drafting process."

256. Furthermore, the care plan, which is enshrined in section 70 of the *Act*, should refer to the basic standards of care as specified in the Regulations. Section 74 of the *Act*, which requires a six monthly review of the care plan should be amended to require the person conducting the review to assess whether the carer is meeting the basic standards of care specified in the Regulations.

257. Section 12 of the 2008 Act concerns the placement of Aboriginal children. It is similar to section 69 of the *Community Welfare Act*. A universal view at the inquest was that Aboriginal children in care should not receive a lesser standard of care than non-Aboriginal children in care. However, the application of that basic principle has caused confusion. For example, a number of caseworkers believed that the overcrowding experienced by the Melville children was tolerable because overcrowding was culturally acceptable. The experience of the Melville children fortifies my belief in the desirability of promulgating certain basic standards of care which have the force of law, and which would apply to all children in care. Section 12 of the 2008 Act should be amended to include a sub-section specifying that a person with whom an Aboriginal child is placed be required to meet the basic standards of care specified in the Regulations.

258. The *Community Welfare Act* provided that every two years, the Minister was required to return to the Family Matters Court for the Court to assess whether it was still appropriate for the child to be in the Minister's care. That provision has been repealed by the new Act. Under the 2008 Act, the CEO applied to the Court for a protection order for a child. One common type of protection order made under section 123(1)(b) of the *Act* was the daily care and control direction, in which a child was placed under the daily care and control of the CEO. The Court can make a determination about the

length of a daily care and control direction, but is not required to do so. The CEO could then enter into a "placement arrangement" with a carer which was similar to the foster care placements under the *Community Welfare Act.*

259. There is no provision in Part 2.2 of the *Act* which deals with children in the CEO's care for a Court review of a daily care and control direction. Furthermore, under Part 4.7 there is no provision for the CEO's decision to place the children in the care of a particular carer to be reviewed. In short, there is no external review of certain important decisions concerning the ongoing care of children. Given the systemic problems in FACS, this is disturbing.

260. Jenny Scott gave evidence that it was important that there be a regular external review of the administration of the 2008 Act. Such regular external review is essential in terms of transparency and public accountability. Part 5.1 of the 2008 Act creates the position of a Children's Commissioner and establishes the functions of the children's commissioner. Section 260(1)(c) of the *Act* provides that one function is to monitor the administration of this *Act* insofar as it relates to protected children. Section 261 confers powers on the Commissioner to do all things necessary or convenient for the performance of the commissioner's functions. However, there is no provision in the Act which guides or controls the Commissioner in how to exercise his functions. No specific powers are conferred on the Commissioner to obtain documents, examine persons or carry out any type of investigations. This is contrast to detailed provisions about the Commissioner's powers to investigate complaints. The *Act* should be amended to remedy those significant omissions.

261. This Inquest has highlighted the inadequacies of a child protection system which does not focus on the issue of patterns of neglect over a period of

time or what has been referred to as cumulative harm. Jenny Scott stated: (transcript p.927-928)

> "STRICKLAND: Now, Diane Eades has given evidence, at a level of generality, that one of the problems of treating a long-term placement as having a low priority is that you don't give sufficient attention to what she called the cumulative risks?---Yes.
>
> And is there a wider dimension of that problem; namely, that the model of the child protection system upon which the Act was based and upon which practice was based, was a forensic incident based approach?---That's right, yes.
>
> And can you just develop that to his Honour?---The child protection system has largely, over decades, been based around a system where a report is made about harm to a child and the issue is then investigated to determine what caused that harm, so that's where the term 'forensic approach' comes in. So generally an incident, so the child's got a bruise or there's an allegation of sexual abuse; you investigate how did the bruise occur, who did the sexual abuse. So a very incident and sort of in some ways blinkered approach. Practice over time has developed to try and guide staff who are doing that work into thinking a bit outside that square and a bit outside that incident to look at all the other impacts that might be occurring. So is the family one that's also where there's substance abuse or family violence occurring, those sorts of things, that might be impacting on that incident. Do you want me to go on to talk about cumulative harm?
>
> I do want you to. So is there now a growing recognition throughout Australia and, indeed, internationally of what is described as cumulative harm, is that correct?---Yes, there is."

262. In the Victorian legislation the concept of cumulative harm is defined in the Act as referring to "the existence of compounded experience of multiple episodes of abuse or layers of neglect". Jennifer Scott was of the view that the concept of cumulative harm "is one that has real importance in the Northern Territory context" given the issues that are prevalent with families in the Territory.

263. Section 15 of the 2008 Act which defines "harm to a child" should be amended to include cumulative harm. The 2009 Practice and Procedure Manual should be amended and professional staff should be trained to become aware of, identify and deal with issues of cumulative harm.

264. Another deficiency identified in this Inquest is the loss of corporate knowledge from one case worker and one team leader to the next. The Victorian Ombudsman's Report into the Victorian child protection system reported "information is not carried over from one notification or report to the next and therefore information is lost over time". That succinctly identifies the problem with FACS that there at least needs to be a formulised written hand over system whereby new case workers are provided with a short succinct summary identifying any risk factors or areas of concern to do with the children in care. Another more complicated matter is to remedy the multiple problems with the computerised information system (CSIS). A task force has been set up to deal with this problem.

265. Anthony Barnes made some useful comments about the need for a better, user-friendly alert system on the FACS information systems so that when FACS officers open up a particular file can immediately see if there are any 'red flags' or issues of concern pertaining to the placement.

266. Sergeant Anne Lade, who was the officer in charge of this investigation, sensibly suggested that FACS notify police of the name and address of carers of children in the care of the Minister (now CEO). That would permit the police to notify FACS if an issue arose in relation to that carer or at that particular address, such as the one which arose with [redacted] Melville on 5 May 2007. It would not be difficult for the police and FACS to develop a simple protocol to share information on such matters.

267. The inquest also heard evidence about the carer application forms. Jenny Scott believed that such form should include questions about all the children that have ever been in the care of the applicant carer. That would increase

the chances of picking up any information about children who have died under the applicant's care.

268. The investigation by Sergeant Anne Lade was an exhaustive, detailed and completely transparent examination of the circumstances of Deborah Melville's death. It is the finest coronial investigation in which I have been associated with in my years as the Coroner in the Territory.

269. In my view, the chaotic and dysfunctional nature of the office environment and professional workings of FACS as outlined in this Inquest (and mirrored in the [redacted] Inquest) must reflect adversely on the senior management of the Department of Health and Families.

RECOMMENDATIONS

270. I make the following recommendations pursuant to my powers under section 34(2) of the *Coroners Act*.

1. The *Care and Protection of Children Act 2008* be amended to include a requirement that a child under the care of the CEO and who is residing in the Territory must be visited by a person authorised by the CEO at least once every 2 months.

2. Regulations should be promulgated under section 78(3) of the *Care and Protection of Children Act 2008* which specify certain basic standards of care that must be provided to a child at the placement arrangement.

3. Section 70 of the *Care and Protection of Children Act 2008* be amended to include that a care plan must refer to the basic standards of care specified in the Regulations. Consequential amendments should be made to section 76 of the Act.

4. Section 74 of the *Care and Protection of Children Act 2008* should be amended to require the person conducting the six monthly

review of the care plan to assess whether the carer is meeting the basic standards of care specified in the Regulations.

5. Section 12 of the *Care and Protection of Children Act 2008* should be amended to include a sub-section specifying that a person with whom an Aboriginal child is placed be required to meet the basic standards of care specified in the Regulations.

6. Consideration should be given to amending the *Care and Protection of Children Act 2008* to permit a regular court review of protection orders made under Subdivision 3 of Division 4 of Part 2.3 of the Act.

7. Part 5.1 of the *Care and Protection of Children Act 2008* should be amended to provide for a regular 2 yearly review of administration of the Act in so far as it relates to protected children and to confer more specific powers on the Children's Commissioner to enable him or her to conduct such a review.

8. Section 15 of the *Care and Protection of Children Act 2008* should be amended to include a definition of "cumulative harm" to a child.

9. Professional staff at FACS should receive specific training concerning issues of identifying and dealing with issues of cumulative harm to children in the care of the CEO.

10. FACS should develop a written handover system when one caseworker takes over a new case. Such a system should include a short succinct summary identifying any risk factors or areas of concern pertaining to the child in care.

11. FACS should enhance its computerised information system to ensure that caseworkers can easily identify 'red flag' issues or issues of concern in respect of each child in care.

12. FACS notify the NT police of the name and address of a carer with whom the CEO has entered a placement arrangement, and develop a protocol for the police to notify FACS in relation to any matters of interest relating to that carer or that address.

13. The carer application forms be amended to include information about all the children that has ever been in the care of an applicant for care.

14. FACS provide sufficient administrative support in terms of administrative personnel and equipment for caseworkers to enable caseworkers to focus on their core responsibilities of protecting children in care.

FORMAL FINDINGS

271. Pursuant to section 34 of the *Coroner's Act* ("the Act"), I find, as a result of evidence adduced at the public inquest, as follows:

(i) The identity of the deceased person was Deborah Leanne Melville-Lothian born on 18 August 1994 in Darwin.

(ii) The place of death was at Royal Darwin hospital, at 12 July 2007 between 7pm to 8.30pm.

(iii) The cause of death was acute septicaemia as a result of osteomyelitis of the left femur.

(iv) Particulars required to register the death:

1. The deceased was Deborah Leanne Melville-Lothian.

2. The deceased was of Aboriginal Australian origin.

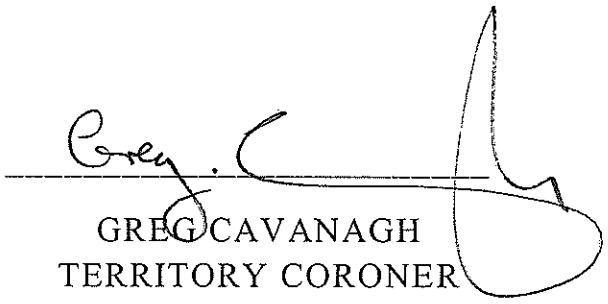
3. The cause of death was reported to the Coroner.

4. The cause of death was confirmed by post mortem examination carried out by Dr Terence Sinton on 13 July 2007

5. The deceased's mother was Hope Evelyn Lothian and her father was Darryl Kevin Melville.

6. The deceased resided at 32 Zenith Court, Woodroffe. She was not employed at the time of her death as she was at school.

Dated this 19th day of January 2010.



GREG CAVANAGH
TERRITORY CORONER