QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of a child, Faith**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Cairns
FILE NO(s):	2011/4075
DELIVERED ON:	27 June 2014
DELIVERED AT:	Cairns
HEARING DATE(s):	16 June 2014 to 20 June 2014
FINDINGS OF:	Jane Bentley, Coroner
CATCHWORDS:	Coroners: inquest, child death, child protection, Department of Communities, Child Safety and Disability Services, Department of Education, Training and Employment, child notifications, truancy, Centrelink, information sharing.

REPRESENTATION:

Counsel Assisting:	Ms Stephanie Williams
Department of Communities, Child Safety and Disability Services (The Department):	Ms Karen Carmody, Counsel
Department of Education, Training and Employment (DETE):	Mr Kevin Parrott, Solicitor, Crown Law
Team Leader 1:	Neil Lawler, Solicitor

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Section 45 of the Coroners Act 2003 provides that when an inquest is held the written findings of the Coroner must be given to the family of the person who died, each of the persons or organisations granted leave to appear at the inquest and to officials with responsibility over any areas the subject of recommendations. These are my findings in relation to the death of Faith. They will be distributed in accordance with the requirements of the Act and posted on the web site of the Office of the State Coroner.

The scope of the Coroner's inquiry and findings

An inquest is not a trial between opposing parties but an inquiry into a death. The scope of an inquest goes beyond merely establishing the medical cause of death.

The focus is on discovering what happened - not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred and, in appropriate cases, with a view to reducing the likelihood of similar deaths.

As a result, a coroner can make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future.

A coroner must not include in the findings or any comments or recommendations, statements that a person is or may be guilty of an offence or is or may be civilly liable.

Proceedings in a coroner's court are not bound by the rules of evidence. That does not mean that any and every piece of information however unreliable will be admitted into evidence and acted upon. However, it does give a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its origin or source when determining what weight should be given to the information.

A coroner should apply the civil standard of proof, namely the balance of probabilities. However the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, then the clearer and more persuasive the evidence needs to be for a coroner to be sufficiently satisfied it has been proven.

If, from information obtained at an inquest or during the investigation, a coroner reasonably suspects a person has committed an offence, the coroner must give the information to the Director of Public Prosecutions in the case of an indictable offence and, in the case of any other offence, the relevant department. A coroner may also refer a matter to the Criminal Misconduct Commission or a relevant disciplinary body.

These findings and comments:

- confirm the identity of the deceased person, the time, place and medical cause of her death;
- consider the circumstances surrounding her death including how she died; and,
- consider whether any changes to procedures or policies could reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice.

Introduction

Faith died on 28 November 2011, shortly after her eighth birthday. She was beaten to death by her mother.

Police Investigation

Family History

Faith was born on 15 November 2003 in Tauranga, New Zealand. No father was listed on her birth certificate. She was born at 36 weeks gestation, following antepartum haemorrhage and meconium aspiration with a low birth weight. She was diagnosed with transposition of the great vessels of the heart and underwent corrective surgery on 16 November 2003.

When Faith was about ten months old, her mother gave her into the care of her maternal grandparents (the grandparents). They migrated from New Zealand to Australia on 9 March 2005 and brought Faith to Australia with them.

From September 2007 until August 2010 Faith and her grandparents resided in a house with her maternal aunt and uncle.

Faith's grandparents remained her primary carers until they left Australia to return to New Zealand on 28 July 2010. At that time Faith was returned to the care of her mother and her stepfather. From then until her death she resided with her mother, stepfather and her two step sisters who were aged two years and 11 months respectively at the time of Faith's death.

Faith was enrolled at a primary school in the Cairns area (school 1) on 27 January 2009. She transferred to another school in the Cairns Area (school 2) on 17 August 2010. She didn't attend there or at any other school from 10 December 2010. In the four month period that she attended at school 2 there were 34 unexplained absences recorded in relation to her attendance.

Faith's mother was born in New Zealand. She migrated to Australia on 28 January 2006. She gave birth to a daughter on 1 February 2008 and gave her into the care of a pastor of a church. She married Faith's stepfather on 25 September 2009 and they had two children.

The mother lived with the grandparents from her arrival in Australia until they returned to New Zealand. At that time she took over as the primary carer of Faith and she, the stepfather and Faith moved into a caravan park. In about September 2010 they left the caravan park and moved into a unit at Manoora. In June 2011 they moved into the unit at Westcourt where Faith was killed.

Faith's Death

At 9.21pm on 28 November 2011 Faith's mother called 000 and was put through to the Queensland Ambulance Service. She reported an unconscious child at her address. Ambulance officers arrived at 9.28pm and found Faith unconscious and not breathing. She was unresponsive and cool to touch. She was lying on her back on a mattress on the floor of the second bedroom. She was wearing a pink long-sleeved shirt and long black flannelette pyjama pants.

Paramedics commenced CPR and removed her shirt to allow for the placement of defibrillation pads. They observed extensive bruising to her arms, torso and legs. Faith's mother told them that some of the bruises were from her but said that Faith had been unwell and she kept falling over.

Police arrived at the unit soon after the paramedics and declared the premises a crime scene.

Faith was pronounced deceased by the paramedics at 9.46pm.

Autopsy

A Senior Staff Specialist Forensic Pathologist conducted an autopsy and found that Faith died from the combined effects of blunt force injury of the head, trunk and limbs and congenital heart disease.

At the time of her death Faith weighed 24 kg and was 127 cm tall. She had the following signs of recent injury:

Head and Neck

- bruise 40 x 25mm over left temple/cheek
- bruise 45 x 15mm over right side of face in front of ear
- hair loss over the right parieto-temporal scalp
- 15mm diameter bruise on left side of chin

Trunk

- Bruise 150 x 150mm over left upper abdominal wall including mid abdomen, umbilicus, central and left lower anterior and lateral abdominal wall
- Bruise 160 x 80mm over upper left back
- Abrasion 10 x 5mm in left hypochondrium surrounded by reddish area 60 x 50mm
- Multiple red and blue bruises 100 x 50mm over right upper back
- Area of abrasion and bruising 170 x 40mm over central back
- Series of multiple roughly vertically orientated linear abrasions in an area 60 x 15mm over central and lower back
- Extensive area of excoriation, scarring and discolouration involving skin of small of the back and most of the buttocks
- 45mm long abrasion over left buttock

Upper Limbs

- Extensive area of confluent bruising, in excess of 200mm across, extending from central and left upper anterior chest wall, over the left shoulder and involving the mid left arm and within this area multiple healing abrasions up to 20 mm in length which appeared to be associated with days old healing changes
- Pair of healing abrasions, 5mm long and 6mm apart, over the right shoulder tip region surrounded by reddish bruising
- 10mm long linear healing abrasions over the right arm
- Extensive confluent purplish bruising on right arm
- Purple and brown bruise 70 x 40mm over right forearm
- Extensive confluent bruising in area 260 x 80mm over dorsal aspect of right forearm, right wrist and right hand
- Multiple healing areas of abrasion individually up to 10mm in dimension over right hand and fingers
- Abrasion on tip or right middle finger
- Lacerated wound over base of left index finger
- 5mm healing linear abrasion on left finger
- Prominent swelling and bruising of tissues of left hand
- Extensive bruising 210 x 90mm over left axilla, left shoulder, left arm, elbow and proximal left forearm
- Bruising over left elbow region
- Old bruising on right elbow

- Area of bruising 80 x 60mm over posterior aspect of mid right arm within which was a pair of roughly parallel red lines

Lower Limbs

- Extensive area of near circumferential confluent red and purple bruising up to 260mm along the left thigh and situated within this numerous curved and linear abrasions, some showing signs of healing
- 120 x 80mm area of bruising over lateral aspect of left calf
- 15 x 5mm healing abrasion over lateral aspect of left foot
- 40 x 15mm abrasion on mid right thigh
- Pair of parallel abrasions, 35 to 40mm long, over right thigh
- 15mm long abrasion on right foot
- 10mm healing ulcer on right knee beneath a bandaid
- 10mm healing ulcer on left knee beneath a bandaid
- Extensive confluent area of bruising up to 160mm across over mid right thigh within which were parallel abrasions
- Reddish bruising on left leg

Subcuticular bruising was found over the right frontal, left frontotemporal and left occipital areas.

Overall, the pathologist noted over 50 separate areas of bruising, some of which was described as extensive, and abrasion on Faith's body. Some of those had begun to heal.

The skin of the arms, forearms, wrists and hands, thighs and legs was reflected and showed extensive confluent additional areas of subcuticular bruising and liquefaction of subcutaneous fatty tissues, most prominently over the shoulders, upper limbs and left thigh.

Faith's body was re-examined on 2 December 2011 and further bruising and abrasions were observed on her right foot, left middle finger, left palm and left elbow.

She had an acute fracture of her left second finger and healed fractures of her right second and fourth fingers.

The pathologist noted:

> *Post mortem examination showed extensive bruising over the upper and lower limbs, trunk, buttocks and face, associated with large amounts of blood and damaged fat under the skin surface, paleness of the body organs, and an enlarged heart with changes in keeping with corrective surgery for great vessel transposition. Some of the injuries appeared recent whilst others showed features in keeping with healing of at least some days. Some of the injuries showed features in keeping with blunt contact with a rod-like structure. X-rays showed a recently broken left index finger and healing breaks of two of the right fingers.*

The pathologist could not be certain whether Faith's death was contributed to by her congenital heart disease.

A specialist in Paediatric Medicine reviewed the autopsy report and the evidence obtained by police in relation to the circumstances of Faith's death.

The specialist concluded:

- Faith had a common congenital heart defect and had a very successful repair and outcome. She was last seen by a cardiologist when she was aged 2 ½ years and was expected to have a normal lifestyle.
- It is unlikely that the heart defect contributed to her death given her good prognosis and that no abnormalities or damage were identified at autopsy.
- Faith would have been in significant pain prior to her death.
- The injuries which caused her death were caused over a period of at least several days.
- Faith would have been unable to walk without considerable pain.
- The fractures of her fingers would have caused Faith considerable pain and she would have had significantly reduced movement of her hand.
- The acute fracture to her left second finger showed healing. Healing is not seen before 7 to 10 days after the bone is fractured. Faith would have had pain and reduced movement in her left hand for a week or more prior to her death.
- It would have been obvious to an adult, at least several days before Faith's death, that she was in pain and reluctant to walk and play as expected for a normal eight year old.
- The excoriation observed on Faith's buttocks is suggestive of the development of pressure sores the formation of which would require a period of immobility of several days i.e. lying on her back and buttocks.
- Faith died from combined effects of the haemodynamic consequences of extensive cutaneous and subcuticular blood loss, and systemic fat embolism, from multiple blunt force trauma contacts.

Criminal Proceedings

Faith's mother was interviewed by police on 29 November 2011. She stated that she became angry with Faith on 22 November 2011 when Faith told her that she wanted to return to New Zealand to live with her father. She slapped her on the face as hard as she could and then hit her with the metal pole of a vacuum cleaner. That metal pole was recovered from the unit. It was bent and broken. The mother stated that on that day, "I flogged her with the vacuum pole in her room and I kept hitting her and hitting her."

The mother stated that she repeatedly hit Faith on the arms and legs, especially the thighs, whilst she was lying on the mattress. Faith was moving around trying to protect herself with her arms. She hit her for several minutes. When she stopped she could see bruises all over Faith's arms and blood on her pants.

Faith's mother told police that she went to Faith's bedroom on 23 November 2011 to apologise for hitting her but again became angry with her and slapped her across the face again. She then hit her again with the vacuum pole. She said that the cuts on Faith's legs were caused by the pole which had become crushed due to the force with which she hit Faith. The pole bent resulting in sharp points along its length. The sharp points cut Faith when she hit her. She hit Faith harder on 23 November than she had on the day before.

Faith's mother said that Faith stayed in her room until 28 November 2011 and that morning the washed the dishes and was playing and dancing with her sisters.

About midday on 28 November 2011 Faith told her mother that she had a bad headache and felt dizzy. Her mother then went to her room and hit her with the vacuum pole again. She said she was hitting her anywhere and Faith was trying to block the strikes with her hands. She hit her repeatedly. She stopped for a couple of minutes and then hit her repeatedly again.

The mother told police that after the last episode of violence, Faith lay on her bed. She said she felt dizzy. Her mother helped her walk to the toilet and gave her a drink of water. Faith's mother went into her room to ask her if she was hungry but she was unresponsive. She turned Faith on her side and water ran out of her mouth and nose.

Faith's mother called the stepfather and then called 000.

The stepfather told police that Faith had obvious bruising from being hit on 22 and 23 November 2011. The mother said that she tried to keep Faith away from the stepfather to conceal her injuries.

On 27 August 2013 in the Supreme Court at Cairns, Faith's mother and stepfather both pleaded guilty to unlawfully killing Faith. Faith's mother was sentenced to imprisonment for seven years. She had been in custody for 639 days at the date of sentence.

Faith's stepfather was sentenced on the basis that he failed in his duty to protect Faith, to whom he was in loco parentis. He was sentenced to imprisonment for three years with a parole release date of 27 May 2014.

Faith's Extended Family

Police investigations revealed that there were a number of family members who had regular contact with Faith and her immediate family in the period prior to her death.

Faith's maternal aunt (the aunt), her maternal uncle (the uncle), her stepfather's father (step grandfather) and his mother (step grandmother), his brothers (step uncle 1 and step uncle 2) and sister-in-law (step aunt) saw Faith and her family in the period before her death.

The step grandfather visited Faith's family at their unit every day, usually in the evening. When he was there Faith was usually (about 95% of the time) in her bedroom and she was not allowed to come out. She was usually laying on the bed dressed in long sleeve shirts and long pants. He would play with her sisters in the lounge room.

After Faith stopped going to school the step grandfather started to notice injuries on Faith. The step grandfather saw bruises on Faith's chin and face. He saw her with cuts on her lips and it appeared to him that she had been punched. He saw bruises on her upper arms and it appeared to him that she had been "beaten" rather than smacked.

He saw these bruises for about 12 months before her death. He knew that the mother was supposed to get some kind of counselling after Faith was returned to her care and he also knew that she did not receive any counselling.

In about June 2011 the step grandfather saw that Faith had "a busted lip" and it looked like she had been punched in the mouth. He asked the mother about it and she said that she punished Faith for hurting her little sister. He told the mother that she needed to get counselling.

A couple of days later he saw the aunt at a local shopping centre. He told her that she should go and see her sister as she was hitting Faith again.

About two weeks before her death the step grandfather saw bruising on Faith's left cheek and chin, her hands were swollen and she had bruises on her arm.

He spoke to the mother about Faith's injuries. She told him that she did it. She said that Faith would say things to her, such as that she wanted to return to New Zealand and it would "set her off".

The step grandfather had numerous conversations with the mother about hitting Faith. He gave her the numbers for Lifeline and offered to give her money to make the calls.

The step grandfather also spoke to the stepfather about the mother hitting Faith. The stepfather said that he had tried to talk to the mother but she wouldn't listen.

The step grandfather last saw Faith on 25 November 2011. She was watching the television. She had bruises all down her arms and her hands were swollen. He visited again on 26, 27 and 28 November 2011 and Faith did not come out of her room. It looked like she was asleep.

The step grandfather saw Faith, her mother and siblings on numerous occasions at the local shopping centre. When he saw Faith there she was always wearing a wig and makeup including black eyeliner, pink lipstick and powder on her face.

After the step grandfather spoke to the aunt at the shopping centre in June 2011 and requested that she speak to Faith's mother about the way in which she was treating Faith the aunt went to Faith's home. She saw that Faith was lying in bed with bruising to her face. Faith's mother told the aunt that she had hit Faith with the vacuum pole. She said, "I just grabbed whatever I could see."

The aunt asked the mother what would happen if their parents found out what she was doing to Faith. She did nothing else.

About two months before her death, Faith and her family attended at the aunt's residence. Faith had a shower there and when she was finished showering she came out of the bathroom and asked her mother for a towel. The aunt heard a loud slap and saw that Faith had a bruise on her face. She asked the mother what happened and she replied that she hit Faith as she didn't like her coming out of the bathroom naked.

The aunt said to the mother, "Sis, this is not on, you need to stop."

The mother replied, "I know, I know."

The aunt then observed Faith's mother apply make up to Faith's face to cover the bruising.

About three weeks before Faith died the aunt saw that she had a bruise on her face. She asked the mother about the bruise who said, "It's just a smack."

Faith's uncle first noticed bruises on her when she moved into the Manoora unit with her mother and stepfather. He saw that she had black eyes and bruises on her arms.

He heard the mother slapping Faith in the bedroom on occasions and heard Faith screaming and saying, "Sorry Mummy, no Mummy."

The uncle was aware that Faith's mother would make her stand in the corner and make her hop, sometimes for about an hour.

The uncle was also present when Faith was slapped by her mother after coming out of the shower at his house and he saw that afterwards she was wearing make-up to cover her bruises.

In November 2010 the mother visited the uncle and she was crying. She said she thought her kids were going to be taken from her because Faith had told a teacher at school that the mother hit her. The uncle was aware that Faith did not attend school after this.

After Faith was returned to the care of her mother they stayed with the aunt and uncle for a few weeks and then went back to the unit at Manoora. In about June 2011 they moved into the unit at Westcourt. After this the uncle saw that Faith had a bruise on her cheekbone. The uncle stated that Faith would look after her sisters. If the mother asked Faith to do something she would run to do it.

The uncle said that when the mother was angry, Faith would twirl her hair. This annoyed the mother so she cut Faith's hair short. From then on she made her wear wigs when she went out.

The uncle said that in November 2011 Faith's mother was talking about sending her back to the grandparents in New Zealand. The aunt phoned the Department and asked if Faith was allowed to return to New Zealand. She told them that Faith was not attending school.

The uncle thought that the mother would not hit the sisters as the stepfather and step grandfather would not let her.

Step uncle 1 often visited Faith's residence. He noticed that Faith was always in her room when he visited the house and she always wore long sleeved tops and long pants. She frequently wore a wig and had makeup on her face. He was aware that Faith was not attending school. He said that Faith did everything for her sisters and she was, "Just a good little girl."

Step uncle 1 asked the stepfather why Faith didn't go to school and he said that the mother wouldn't let her go. Step uncle 1 offered to take Faith to live with him and said that he would arrange for her to go to school. The mother would not discuss the idea.

In about August 2011 he became concerned that mother was being cruel to Faith because she was always in her room when he went to the house but he did not say anything to his brother as he didn't think it was his business.

Step uncle 2 told police that he rarely saw Faith and her family as they lived some distance away from each other. His wife (step aunt) told police that she saw Faith wearing makeup but never saw any bruises on her.

The step grandmother was told by the step uncle 2 and step aunt that they had seen bruises on Faith.

About a month before Faith's death, the step grandmother attended the house and saw that Faith had thick makeup on one side of her face. She could see that Faith had a black eye and the makeup was an attempt to cover it. She asked Faith what happened but before she could answer the mother pushed her into a bedroom. After about ten minutes Faith and the mother came out of the bedroom and Faith had more makeup on her face. The step grandmother asked the mother what had happened and she replied that Faith had hurt herself.

The step grandmother phoned the step father and said, “What’s wrong with this little one, she’s always having black eyes?”

He said, “Mum, that’s [the mother].”

The step grandmother said she thought that the step father never stepped in to protect Faith because she was not his biological child.

About a month before Faith died, the stepfather phoned the step grandmother and said that he had to hit the mother as she had nearly killed Faith. He said he came home from work to find the mother bashing Faith and she wouldn’t stop. He asked her to come over and talk to the mother about how she treats Faith.

The step uncle rang the stepfather who told him they were all going out to a BBQ so he told the step grandmother she would be wasting her time if she went over to the stepfather’s place.

From 31 October 2011 to 13 November 2011 the step grandmother stayed at Faith’s residence after undergoing surgery. She knew that Faith was not attending school. She believed that the mother kept Faith at home so she did not get into trouble for hurting Faith. When Faith tried to speak to the step grandmother the mother would send her off to bed. The step grandmother stated, “It was like Faith could never have any interaction with anyone.”

Whilst she was staying there she heard the mother hitting Faith in the bedroom. They came out of the room and the mother said to Faith, “Don’t cry or you know what will happen.” She then made Faith stand in the corner for an hour. The step grandmother left the unit “in disgust”.

On 26 November 2011 the step grandmother went to Faith’s residence to collect some belongings. The mother said she couldn’t let her in as the stepfather had taken the key to the door and she didn’t have a spare key.

The step grandmother said that she did not like the way the mother treated Faith. She treated her like a slave. Faith looked after her two sisters. She thought that the mother was cruel to Faith. She knew that the mother made Faith wear wigs and makeup. She assumed that the Department would be looking into the matter.

Notifications to Government Departments

Procedures for Notifications of Suspected Child Abuse

The Child Protection Investigation Unit (CPIU) of the Queensland Police Service (QPS) receives advice of suspected child abuse from agencies which are mandated to report and non government agencies involved with children and families.

The Department receives information at Regional Intake Services where officers take calls from the public, government and non government agencies. The information is recorded as a Child Concern Report (and no further action is taken) or a Child Protection Notification (which is referred to the Investigation and Assessment Team where child safety officers (CSO) assess that information). If the assessing CSO believes a criminal offence has been committed the CSO forwards the information to the CPIU.

DETE forwards information to CPIU and the Department where grounds exist to reasonably suspect that a child has been harmed or is at risk or harm. This advice is forwarded by way of a document known as an “SP4” – report of suspected harm.

All reports received by CPIU are assessed by a senior officer who decides on the level of intervention required. The assessment includes consideration of the report, QPS databases and, possibly, contact with notifiers.

The Department and CPIU are involved in a partnership known as the Suspected Child Abuse and Neglect (SCAN) team. SCAN also includes DETE and Queensland Health employees.

Teachers and School Employees

In May 2009 a teacher aide at school 1 was approached by Faith and her cousin in the playground. At this time Faith was a prep student. Faith and her cousin told the teacher aide that they were hit at home. The cousin told her that they all got smacked but that Faith's mother hit her with metal things on the arms and face. Faith showed her a mark on her abdomen that looked like a large bruise, another that looked like a cigarette burn and bruises on her back.

The teacher aide advised the guidance officer who took responsibility for reporting the matter and submitted the SP4 notification.

The teacher aide noticed that after that day Faith's behaviour changed. She became withdrawn and she missed school, sometimes for three or four days at a time. The teacher aide asked Faith sometimes whether anybody was hurting her at home but she always became very withdrawn and said, "No".

Faith left school 1 and enrolled at school 2 on 17 August 2010. As part of the enrolment process the mobility support teacher employed at school 2 contacted school 1 to obtain information about Faith. Faith's previous teacher emailed a report in which she raised concerns about low level neglect such as attendance issues, lateness, limited resources and inadequate lunch.

The teacher aide to whom Faith had confided at school 1 started working at school 2 in July 2010. Soon afterwards she saw that Faith was attending there. Sometimes she saw her in the playground. On 1 November 2010 she sat down next to Faith and talked to her. She noticed that Faith was wearing a long sleeved top. She asked Faith how she was and Faith pulled up her sleeves and showed her that she had welts all over her arms. They were red and raised and looked like cuts that had begun to heal. Faith told her that her mother had hit her.

The teacher aide called a teacher over and showed her the marks and told the teacher Faith's history as she knew it from school 1. The teacher phoned the guidance officer. In the office of the guidance officer Faith showed them a large bruise on her upper back. It was about 10cm wide. Faith said that her mother had hit her with a wire coat hanger.

The teacher aide later signed an SP4 notification to police in regard to Faith's injuries.

The guidance officer from school 2 reported Faith's disclosures to the principal of the school and completed an SP4 notification. On 2 November 2010 she was advised by Faith's teacher that Faith had been taken into care and later she was told that Faith had been returned to the care of her mother.

On 16 November 2010 the guidance officer was told that Faith was absent from school. She and the deputy principal went to Faith's residence but nobody was home. She then called the Department and reported that Faith had been absent since 8 November 2010 and that she had unsuccessfully attempted a home visit.

When Faith did not return to recommence school at the beginning of the 2011 school year the mobility support officer and the deputy principal of school 2 conducted a home visit to ascertain the reason for her absence. They spoke to a man who identified himself as Faith's uncle and he told them that Faith would not be returning to the school as she and her family were relocating to New Zealand. They did not enter the dwelling. After the visit Faith was recorded as "left" on the school records.

In early 2011 the teacher aide saw Faith at a local shopping centre and asked her where she was going to school. Faith said that she was staying at home. She said that she was moving to New Zealand.

Queensland Police Service

On 11 May 2009 QPS received the SP4 submitted by the guidance officer from school 1 and commenced an investigation into the allegations.

Police from CPIU interviewed Faith at the Cairns police station. Faith said that her mother had hit her on the chest with a stick and hit her on the stomach with a spoon.

Police attended Faith's home and spoke to her aunt and uncle. They said that Faith had a skin condition which caused her to scratch her abdomen and denied that it was bruising.

Police also spoke to the mother who denied hitting Faith and said that she suffered from a rash and was obtaining treatment for the rash from a local medical centre.

Police concluded that the marks on Faith were not bruising but the result of a skin condition. They noted that Faith's family were cooperative and helpful.

Police finalised the report and recorded the allegation as being unfounded.

On 1 November 2010 police received a further SP4 in relation to Faith.

Officers of the CPIU and the Department jointly investigated the notification.

Police obtained a statement from Faith in which she said that her mother had struck her on the back and arms with a wire coat-hanger. Police saw three welts on her arms and five welts on her back.

The mother attended the school and was interviewed by police. She denied hitting Faith and said that Faith was hit by her cousin. Police spoke to the mother about the boundaries of physical discipline and warned her that if there were any other similar incidents she could be charged with a criminal offence.

No criminal prosecution was commenced in relation to the alleged assault and the CPIU investigation was finalised.

QPS received no further notifications in relation to Faith prior to being called to her home on the night of her death.

The Department

On 14 May 2009, in response to the SP4 notification from school 1, a child safety officer (CSO1) commenced an investigation and assessment in relation to Faith.

The SP4 summarised the concerns as:

- Faith's behaviour was out of character and she was hitting other children;
- Faith said that her mother had come home to live with her grandmother;

- The cousin stated that Faith gets hit all the time, sometimes with sticks and spoons, sometimes metal ones and get scratches;
- Faith showed the teacher an "enormous bruise" that covered the width of her pelvis;
- In addition to this a possible "cigarette burn" was observed just above the bruise;
- The cousin stated, "Mum and Dad hit us all the time because they love us"
- The cousin stated, "We all get a good hard smack on our bottoms if we don't go to bed, but Faith gets hit with sticks and spoons."

CSO1 attended school 1 with the CPIU officers. She was present when Faith was interviewed by police officers. Faith disclosed the following:

- Faith said that her mother was called "Ipu" (in fact, her aunt) and her "dad" was called "uncle";
- Faith showed the officers a mark on her stomach and said, "Mum smacked me with a stick";
- Faith then said her mother was [name of mother];
- Faith said her mum hurt her when she was outside and her nose was bleeding.

CSO1 interviewed Faith's grandmother who said that the mark on Faith's stomach was a skin condition for which she had been treated at a local medical centre. CSO1 contacted the medical centre and staff there advised they had no record of Faith receiving treatment for a skin condition.

CSO1 concluded that the allegations were false and unfounded and assessed that Faith was safe and a "child not in need of protection."

In November 2010 Team Leader 1 was the acting Team Leader of the Investigation and Assessment team at Cairns North Child Safety Service Centre.

Team Leader 1 was advised by the Far North Queensland Regional Intake Service that they had received a child protection notification in relation to Faith. The notification outlined that Faith had been beaten by her mother. Team Leader 1 organised two Child Safety Officers (CSO2 and CSO3) to attend Faith's school that day.

CSO2 and CSO3 were present when police interviewed Faith and she told them that her mother had hit her with a coat hanger. She said she was usually smacked with spoons and belts on her arms, legs and shoulders. They saw welts on her arms and back and bruising on her back.

Faith's mother attended at the school. CSO2 and CSO3 were not present for the interview she had with the police in which she denied hitting Faith.

CSO2 and CSO3 then interviewed the mother. She admitted in this interview that she had hit Faith. She said that she was emotionally detached from Faith and she said that her husband was in control of all their money and spent it on gambling. She said that she usually hit Faith across the mouth. She said she loved her other daughter and would never hit her.

CSO2 then contacted Team Leader 1, who advised her to complete a safety plan with the mother.

The mother then told CSO2 and CSO3 that Faith would not be safe at home that night and she would put Faith in her room with no dinner.

CSO2 again contacted Team Leader 1 and conveyed the new information and Team Leader 1 advised CSO2 to obtain a care agreement and complete a safety plan which involved the mother voluntarily agreeing that Faith be placed in the care of the Department for up to 30 days. Team Leader 1 decided that a medical examination of Faith was not required.

The mother agreed to a voluntary care arrangement and Faith was placed in the care of the Department on 1 November 2010. Faith was placed with foster carers.

CSO2 completed the safety assessment forms the following day and submitted them to Team Leader 1 for approval.

On 4 and 8 November 2010 the mother phoned Team Leader 1 and said that she was sorry for hitting Faith and wanted her returned. She said she would not hit her again and she agreed to a referral to the organisation ACT for Kids. Team Leader 1 also spoke to Faith who said she wanted to go home.

Faith was returned to the care of her mother on 9 November 2010.

Team Leader 1 made the decision to return Faith to the care of her mother on the ground that the risk of further harm to Faith was minimal. Her decision was based on the following factors:

- The family was supported by their church;
- There was a large extended family network including a grandfather who visited daily;
- The school would monitor Faith;
- There was no child protection history of the mother being a perpetrator of abuse;
- The mother's remorse and acknowledgement of concerns;
- The mother was willing to work with ACT for Kids who would visit the residence at least once per week
- The mother wanted Faith home.

Team Leader 1 decided to return Faith to her mother's care and refer the family to ACT for Kids. She believed that ACT for Kids would report back to the Department if there were any child protection concerns. She did not receive any further advice from ACT for Kids.

On 16 November 2010 the Department was advised by the guidance officer from school 2 that Faith had been absent from school since 8 November 2010 and they had unsuccessfully attempted a home visit.

The guidance officer phoned the Department and advised that she was concerned because Faith was absent since her return to the care of her mother. The phone call was taken by an officer of the Regional Intake Service which is a separate team to that which investigates and assesses notifications.

The notes of that conversation indicate that the officer was told that the guidance officer was concerned because the child had not been at school for the past week, that attempts to contact the mother had been unsuccessful, the previous abuse issues and that the mother had said that she was feeling that it (the abuse) could happen again.

He noted that ACT for Kids was engaging with the family and that the service would be going out to check on the family. He recorded the notification as a Child Concern Report rather than the more serious Child Protection Notification which would have resulted in a further investigation and assessment by the investigation and

assessment team. He did not advise Team Leader 1 of the further information although he reviewed the records and noted that there was a recent investigation carried out in relation to Faith.

That officer's team leader (Team Leader 2) said that Regional Intake Service officers do not have time to read through the historical information on the system. He would have only looked at the outcomes of the previous notifications. Team Leader 2 said such officers would only consult with a case worker if there was ongoing intervention for the family. In relation to the events surrounding the failure to notify Team Leader 1 of the new information Team Leader 2 said in her interview with the Ethical Standards Unit investigator:

> *There's a high risk that any of these things will be repeated for exactly the same reason because nothing's changed. In fact it's probably deteriorated in the fact that we have less staff and the incoming is high and I have a real genuine fear that this will happen again.*

Team Leader 2 said that if a family do not engage with [ACT for Kids] the Department, "don't ever know and … [there is] no way of checking".

ACT for Kids

ACT for Kids is one of a number of external agencies to which the Department can refer families for support and intervention with the goal that the family do not become involved with the child protection system. The Department refers to such external agencies as Referral for Active Intervention Services.

The case referral for Faith's family was sent to ACT for Kids, via the Department's database, Community Sector Information System (CSIS), by Team Leader 1 on 11 November 2010. It was accepted by the program manager at ACT for Kids on 16 November 2010 and she assigned the matter to a family coach.

The referral outlined that there were issues concerning child wellbeing, domestic and family violence, family relationship issues and parenting skills.

The referral noted that Faith had welts and bruises from a beating from her mother. It stated that both Faith and her sibling had limited protective capacity due to their young ages – 1 and 7 years. It stated that the mother had said that there were issues with her attachment to Faith and this may pose a risk for Faith. It also said that the mother had said that the step father spends his money at the TAB and the children had previously gone without food and the children maybe at risk of neglect.

The program manager noted on CSIS that she would follow up with the Department in regard to the child protection concerns. There was no follow-up conducted.

On 17 November 2010 the family coach sent a letter to the mother requesting she make an appointment with the service.

On 29 November 2010 the family coach had not received a reply to that letter so she phoned the mother who said that she did not receive the letter as she had been living with her sister for a couple of weeks. She said she may not need any support as she was sending Faith to live with her grandparents in New Zealand. The mother told the family coach that she was upset with Faith for wanting to go to New Zealand. She said they were waiting for her passport to come, that it should be there in four days, and they were intending to leave before the Christmas Holidays. The family coach said that she would phone back on 3 December 2010.

The family coach did not phone the mother on 3 December 2010 but on 6 December 2010 attempted unsuccessfully to make phone contact with the mother.

On 13 December 2010 the family coach and another employee visited Faith's residence for an unannounced visit. There was a baby in a pram and the mother was pregnant. They entered the residence and saw Faith washing dishes at the sink. The mother said she had just sent away for Faith's passport so that she could send her to New Zealand. The mother said that she had been staying with her sister for almost a month. She said that her partner was hardly ever around and that she was receiving counselling from Lifeline. As the mother was busy with the housework it was agreed that she would phone the family coach during the week to schedule another time to meet or the family coach would phone her on 19 December 2010.

The family coach didn't phone the mother on 19 December but attempted unsuccessfully to phone her on 4 January 2011 and sent her a text message. She received no answer to that text message. On 7 January 2011 she sent a letter to the mother. The letter stated that she had attempted unsuccessfully to call the mother on several occasions and therefore assumed that the mother did not wish to engage with the service. It stated that engagement is completely voluntary but ACT for Kids was obliged to inform the Department of non-engagement. It said that if the family coach did not hear from the mother by 14 January 2011 she would assume the mother did not wish to engage.

On 21 January 2011 the program manager approved the closing of the file on the basis that the mother did not wish to engage.

No further action was taken by ACT for Kids. The Department was not advised of the mother's failure to engage with the service.

Reviews of the Department's Actions in Relation to Faith

Systems and Practice Review Report

This review was an external departmental process led by Ms Gwenn Murray. Its purpose was to review the practice decisions and practice issues in the Department's service delivery to Faith.

The Committee determined that the death of Faith was not the result of actions or inactions of the Department.

The report identified the following issues:

- The first investigation commenced on 14 May 2009 was limited and resulted in an outcome of "Unsubstantiated – Child not in need of Protection". The outcome should have been "Substantiated."
    - There was little focus on probability and risk and little engagement with Faith;
    - The QPS position was relied upon for child protection assessment rather than just criminal proceedings;
    - It was considered that Faith's allegations were "random" although she had only been in prep school for three months and this was the first external source in her life.
- The process and analysis that commenced on 1 November 2010 was limited and not holistic and resulted in an outcome of "Substantiated – Child not in need of Protection". The outcome should have been "Substantiated – Child in need of Protection."
    - Depleted staffing levels meant that the assessment was undertaken by seconded Regional Intake Service officers and there was no CSO to assign to the case in the investigation and assessment team;
    - Faith should have been medically examined;

    - The stepfather and other members of the extended family should have been interviewed;
    - There was no assessment of the mother's mental health, her attachment issues and her anger management issues;
    - There were no checks conducted of child care history in New Zealand.
- The decision to return Faith to her mother's care on 9 November 2010 was premature – the investigation should have continued before any such decision was made:
    - The arrangement for the referral to and reporting by ACT for Kids was unclear;
    - It was assumed the family would engage with ACT for Kids and that Faith would attend school;
    - The focus was on the mother and her stated intentions.
- The decision making that resulted in the recording of a Child Concern Report on 16 November 2010 was inappropriate and based on an unrealistic reliance on mitigation of risk by external agencies. It should have been recorded as a Child Protection Notification and a more holistic consideration of past history was warranted.
- There were missed opportunities to refer the case to SCAN.
- There was very poor engagement with Faith by all agencies concerned:
    - ACT for Kids employee saw the child once but did not speak with her;
    - Faith was kept home for a year without anyone knowing where she was.

The Committee commented that the large volume of work had been an ongoing problem since at least 2009 and it resulted in the notification of 1 November 2010 in relation to Faith not being responded to properly.

The Committee stated:

> *Elements of this case are deeply disturbing, such as the fact that [Faith] did not attend school for one year, she was kept at home by her mother in order to conceal her injuries and so she could care for her young half-sisters. Her family visited the home, witnessed her abuse and injuries and, at times, concealed them by applying makeup. However none of her family contacted [the Department] or the Queensland Police Service.*

Upon completion of the review Ms Murray arranged an urgent meeting with the Acting Minister and Acting Director General of the Department and raised the following issues:

- backlog and workloads within the Department;
- the whereabouts and safety of Faith's siblings;
- poor communication between schools and the Department;
- concerns for Team Leader 1.

The Committee identified two further concerns that it considered to be risk factors for all children:

- The lack of a register or system to track whether and where children are attending school. No one investigated Faith's absence from school for one year.
- Poor community attention to Faith – although her family knew Faith was being abused by her mother none of the family members reported the abuse to the Department or to police.

The Committee recommended the following:

- The Department locate Faith's sister (the first child born to the mother) to ensure her safety;
- The Department consider the decision to place Faith's sisters with family carers when extended family failed to protect Faith;
- Support be provided to Team Leader 1;
- A second Investigation and Assessment team be deployed to the region to address backlog and intake volume;
- A meeting be convened with DETE to consider
    - better communication between schools and the Department including placement of children and systems for liaison when the Department expect that schools will monitor a child's safety or attendance at school;
    - the establishment of a register and system to track children when they leave one school and are not enrolled in another.

In January 2012 the Acting Director-General and Deputy Director-General advised the Committee that the following had been undertaken as an immediate response to the concerns raised by the Committee:

- the placement of the sisters had been investigated and was considered appropriate;
- a second Investigation and Assessment team had been deployed to Cairns;
- discussions were underway to
    - investigate a longer term solution to workloads in the region;
    - consider the establishment of a register to track enrolment and transfer of children between schools; and,
    - consider better communication between the Department and schools.

Child Death Case Review Committee Report

The Department conducted a Child Death Case Review (the original review) in relation to the death of Faith. That review was provided to the Child Death Case Review Committee (the Committee). The original review concluded that the death of Faith was not the result of any action or inaction by the Department. The Committee disagreed with that conclusion and concluded that the actions and inactions of the Department were linked to Faith's death.

The Committee noted that in November 2010 Faith presented with bruises and welts and disclosed that her mother had beaten her with a metal coat-hanger. The mother admitted to assaulting Faith and stated that she may do it again. Faith was removed from her mother's care but only nine days later the Department returned her to her mother. The investigation and assessment was finalised as "Child not in need of Protection" and the Department referred the case to ACT for Kids.

Seven days after she was returned to her mother's care the Department was notified by an employee of Faith's school that Faith had not been back at school and the notifier was concerned because the mother had stated that she may hit Faith again. The Department recorded the matter as a Child Concern Report rather than a Notification which meant that no further action was taken and the Department had no further contact with Faith.

The original review found that the following decisions adversely affected Faith:

- the assessment that she was not in need of protection;
- the decision to return Faith to her mother
- the decision to record a Child Concern Report (rather than a Child Protection Notification) upon receiving advice that Faith had been absent from school.

The Committee found the above decisions resulted in Faith being returned to her mother and remaining in a harmful environment that led to her death and that, in making each of those decisions, the Department failed to acknowledge the evidence of physical harm to Faith, her disclosures, the mother's admissions and the cumulative harm experienced by Faith. The Committee found:

- The Department knew about the significant child protection concerns present for Faith;
- The Department did not act adequately to ensure Faith's safety;
- The significant level of risk to Faith continued and escalated until her death;
- There was no reasonable excuse for failing to protect Faith;
- Faith may not have died had the Department discharged its obligations.

The Committee identified the following risk factors as being relevant to Faith's death:

- Faith's isolation:
    - Had Faith been sighted by other agencies (including attending school) or people within the community, her injuries may have been detected and her death averted.
- The Department's poor service delivery to Faith:
    - The decision to knowingly return Faith to a harmful environment despite evidence of severe harm and the mother's admissions that she may assault her again, was a risk factor relevant to Faith's death.

The Committee concluded that the Department minimised the extent of harm to Faith and did not thoroughly consider the ongoing risk of harm to her following her return to her mother. The decision to return Faith was premature and consideration should have been given to further intervention at the end of the voluntary agreement.

The Committee identified the following service systemic issues as adversely affecting Faith:

- A high backlog of cases between 2009 and 2011 which impacted on practice;
- The decision not to interview the mother and stepfather in May 2009;
- A lack of child focus and comprehensiveness of the investigation and assessment in May 2009;
- The decision to record the matter as unsubstantiated and Faith not in need of protection in May 2009;
- A lack of identification of the need for a referral to support the family in May 2009;
- The reallocation of the investigation and assessment from CSO2 and CSO3 to Team Leader 1 in November 2010;
- The quality and extent of the information gathered to inform the decision of 1 November 2010;
- The lack of comprehensiveness of the investigation and assessment of 1 November 2010;
- The lack of assessment undertaken during the period of the care agreement in November 2010;
- The decision not to re-interview Faith prior to her being returned to her mother in November 2010;
- The decision to record the outcome of the investigation in November 2010 as Faith not being in need of protection";
- Insufficient information to support the outcome of the Safety Assessment as "Safe" on 9 November 2010;
- The decision to return Faith to her mother on 9 November 2010;

- The decision to record the information received on 16 November 2010 as a child concern report.

The Committee found that the following service system issues did not adversely affect Faith:

- lack of feedback provided to notifiers;
- the decision to refer the family to ACT for Kids.

The Committee did not identify any recurring risk factors.

At the time the Committee finalised the report a second Investigation and Assessment team and another team leader had been deployed to Cairns to address the backlog and plans were underway to restructure the region and increase staffing levels.

The Committee noted that the original review focused on resourcing problems in the region rather than consider individual officer accountability. The Committee noted that no referrals had been made to the Ethical Standards Unit or the Crime and Misconduct Commission (CMC), which is a legislative obligation, and referred the matter to the CMC.

The Committee made the following recommendations:

1. The Department provide training to all staff of the region in relation to
   a. Assessment and consideration of cumulative harm during intake and Investigation and Assessment processes;
   b. The importance of testing and corroborating evidence when making decisions at the intake and I&A phases;
2. The Department provide an updated action plan which includes:
   a. details of actions taken and proposed to implement recommendations; and,
   b. how the Department intends to measure the success of any training provided and or action taken to implement recommendations.

Ethical Standards Investigation Report

The Ethical Standards Unit conducted an investigation into the actions of individual officers of the Department in relation to Faith's death. The investigator concluded that the evidence obtained was capable of substantiating the following allegations:

- the investigation and assessment conducted between 14 May and 9 September 2009 was inadequately conducted;
- the investigation and assessment conducted between 1 and 10 November 2010 by Team Leader 1 was inadequately conducted as:
  - the duties performed by Team Leader 1 were not in accordance with legislation, policy and/or procedure in that:
    - a medical examination was not arranged for Faith;
    - there was a lack of information gathered during the investigation and assessment to inform the outcome;
    - there was a lack of information gathered and an insufficient assessment made to support the "Safety Assessment" (dated 9 November 2010) outcome of safe.
- Between 1 and 10 November 2010 Team Leader 1 made inappropriate decisions that potentially contributed to ineffective service delivery to Faith, in that:
  - The investigation and assessment was reallocated to another person;
  - Faith was returned to the family home prematurely;

- Faith was not considered to be a child in need of protection.

Implementation of the Recommendations arising out of the Reviews

Kirstin Hall was the Manager of the Case Review Unit within Complaints and Review section of the Department. Ms Hall gave evidence in relation to the implementation by the Department of the recommendations of the reviews which were held as a consequence of Faith's death.

Three recommendations were made by the Systems and Practice Review report writer:

- Consultation is undertaken within the Department to explore strategies to better respond to the geographical and demographical demands impacting on the Cairns office;
- The review report be provided to all staff who participated in the review to allow critical discussion and reflection on learnings and a consideration of the training required for staff about practice identified in the report;
- A de-identified copy of the report be provided to Child Safety Directors' Network for discussion and reflection on learnings, specifically in relation to the example that this case provides around a child being able to be "invisible" and the poor engagement with the subject child by all agencies.

Ms Hall stated that these have been translated into a Far North Queensland Action Plan.

The Child Death Case Review Committee made the following recommendations:

1. The Department provide training to all staff of the region in relation to
   a. Assessment and consideration of cumulative harm during intake and investigation and assessment processes;
   b. The importance of testing and corroborating evidence when making decisions at the intake and investigation and assessment phases;
2. The Department provide an updated action plan which includes:
   a. Details of actions taken and proposed to implement recommendations;
   b. How the Department intends to measure the success of any training provided and or action taken to implement recommendations.

Ms Hall advised that in regard to the first recommendation the Far North Queensland Action Plan was devised. In relation to the second recommendation the Committee has been advised of actions which have been taken in regard to training.

The inquest

A pre-inquest conference was held on 7 March 2014. The parties were given leave to appear. Counsel Assisting advised that the issues to be explored at the inquest were the circumstances surrounding the death of Faith, including:

- the involvement of government and non-government agencies in the period preceding Faith's death; and
- the involvement of, and interplay between, the Queensland Police Service, the Department of Child Safety, Education Queensland and ACT for Kids.

The inquest commenced on 20 June 2014. 155 exhibits were tendered at the commencement of the inquest. 14 witnesses appeared and gave evidence.

The evidence

Step Grandfather

The step grandfather said that he went to the unit where Faith and her family lived nearly every day. Faith was always in her bedroom lying down or asleep. He saw bruises on her face, arms and chin. The mother told him that she'd hit Faith. He told the mother to stop it on at least a dozen occasions.

He said that he was very concerned about Faith. He told the aunt that she should speak with the mother. He discussed the matter with his son who said that the mother wouldn't stop. The step grandfather said that he took the mother to the doctor, got her the phone numbers for counselling services and gave her money to make the calls.

The step grandfather, when asked why he didn't report Faith's abuse, said that he didn't know why he didn't report it – maybe because he was too busy working. He said that he considered calling the police but he was scared that if he reported the abuse the mother may stop him from seeing the other children.

The step grandfather said that the Department never contacted him – if they had he would have told them what he knew.

He said that if Faith's siblings had been abused he would have reported it to the Department. He agreed that he was probably worried that, if he reported the mother for abusing Faith, the other siblings would be removed from the family.

The step grandfather was aware that Faith was not attending school but did not report that to anyone. He said that he didn't think about it.

Step Uncle 1

Step Uncle 1 said that he thought the mother was being cruel to Faith.

He knew that she wasn't going to school and he thought she should go to school so he told stepfather and mother she could live with him so that he could send her to school. The mother and stepfather weren't interested in his offer to help Faith – he said the mother just glared at him.

He didn't visit the unit often but when he did Faith was in her room.

He said he didn't report his concerns that Faith was being abused because he didn't want to interfere as he didn't think it was his business. However, he said that if Faith's siblings had been abused he would have reported that to the authorities. He said that if the Department had contacted him he would have told them what he had seen in regard to Faith.

The step grandmother

The step grandmother was an unimpressive witness. She had a selective memory when it came to recalling her knowledge of the mother's abuse of Faith. She downplayed any first hand knowledge of Faith's mistreatment but it is clear that she was told by her son that Faith's mother almost killed her.

The step grandmother was forthright and honest when she adamantly stated that she would never make a report to or contact the Department due to her own experience of being removed from her family as a child.

Teacher Aide, Schools 1 and 2

The teacher aide worked at both schools Faith attended. She developed a rapport with Faith. She noticed that Faith withdrew after the first complaint was made and that her attendance was sporadic after that.

The second notification of harm came about after Faith came and sat next to her at the second school and surreptitiously rolled up her long sleeved shirt whilst looking at her. The teacher aide saw the welts on her arms.

When the teacher aide saw Faith at the shopping centre Faith told her she was not at school as she was moving to New Zealand. Faith seemed well and happy at that time.

The witness stated that it would have been useful for her to know of the outcome of the SP4 notifications. She was told by a teacher that Faith had been taken into care and then returned to her mother but no further details.

Guidance Officer School 2

The guidance officer made the SP4 notification on 1 November 2010. She was not present when police and CSO's arrived. She was not advised of the outcome of the investigation. She was told by a teacher on 2 November 2010 that Faith had been taken into care.

The guidance officer stated that, had she been aware of the outcome of the Department's investigation she would have been more mindful of the need to monitor Faith and her attendance at school.

When Faith had not attended school and her home visit was unsuccessful she was concerned enough about Faith's wellbeing to contact the Department. She doesn't recall who she spoke to there but she got very little response. She explained to the person on the phone that Faith had been absent from school since returning to the care of her mother – they just said, "Thanks."

The guidance officer is the person responsible for reporting child abuse concerns to the Department. She stated that she needs to be advised by the Department whether children need to be monitored for absenteeism, changes in behaviour etc.

Team Leader 1

Team Leader 1 gave evidence of her workload as at November 2010.

At that time she was an acting team leader. She was supposed to have four CSO's in her team but she had only two due to leave and resignations and one of those two was extremely inexperienced.

Her case load included 235 open investigations (193 of which were classified as backlog being more than two months old) and 109 reports of additions concerns. In November 2010 alone Team Leader 1 received 33 new child protection notifications. In effect, Team Leader 1 had the safety and welfare of more than 250 children to assess and investigate.

On the day Team Leader 1 received the notification about Faith she received three other urgent cases all of which required a 24 hour response.

Seven children had been removed from one family – those children were in her office and she was attempting to find a placement for them. She also had to deal with a mother with an intellectual disability who had absconded from New South Wales Department of Community Services and was trying to remove her newborn baby

from the hospital. The other urgent matter involved a mother with extensive child protection history trying to leave hospital with her baby which had been born that day.

She said that to say she was "drowning in work" would be an understatement.

Team Leader 1 said that she made the best decisions that she could, on the information available to her then, and taking into account the amount of time that she was able to spend assessing Faith's case considering the other cases that were competing for assessment and investigation.

Team Leader 1 made the decision to return Faith to her mother based on her belief that the family had protective factors in place. Those included:

- The family was engaged with the church;
- Faith had an extended family network who would monitor her wellbeing-
    - Faith and her mother identified family members including aunts, uncles and grandparents and Faith's mother told Team Leader 1 that she was being helped by the step grandfather;
- ACT for Kids would monitor Faith and provide assistance to the mother and family;
- Faith would be monitored by the school;
- The foster carers didn't advise of any further disclosures by Faith or raise any concerns about Faith being returned to her mother.

Team Leader 1 believed that ACT for Kids would notify the Department if the family failed to engage.

In relation to the findings of the reviews, including the Ethical Standards Unit investigation, Team Leader 1 agreed with the following (with the proviso that she did the best she could at the time):

- The process and analysis that commenced on 1 November 2010 was limited and not holistic and resulted in an outcome of "Substantiated – Child not in need of Protection". The outcome should have been "Substantiated – Child in need of Protection."
- The decision to return Faith to her mother's care on 9 November 2010 was premature – the investigation should have continued before any such decision was made.
    - Team Leader said that if she had more time she would have interviewed family members including the step father.
- The decision making that resulted in the recording of a Child Concern Report on 16 November 2010 was inappropriate and based on an incorrect reliance on mitigation of risk by external agencies. It should have been recorded as a Notification and a more holistic consideration of past history was warranted.
- There was very poor engagement with Faith by all agencies concerned.
- A large volume of backlog and incoming cases meant that the investigation and assessment of 1 November 2010 was not appropriately responded to.

It was the opinion of Team Leader 1 that the factors which contributed most significantly to the poor outcome for Faith were:

- Lack of engagement by ACT for Kids with Faith's family;
- the Department was not notified of that non-engagement;
- Faith was not returned to school and she was not made aware of that fact;
- There was no notification recorded on 16 November 2010 and she was not advised of the further information received;

- Faith's extended family did not report that Faith was being abused by her mother.

Team Leader 1 was concerned that the procedures should specify that Referral for Active Intervention Services must report back to the referring case officer rather than the Regional Intake Service team so that the information doesn't fall into a "gap" and is actioned appropriately.

Team Leader 1 said that since Faith's death the workloads in the region have been greatly reduced by restructuring and also because a team was sent to the region to address the backlog of cases. The restructure has meant that work is spread much more equitably across teams in the region.

Louise Carroll

Ms Carroll gave evidence that the Ethical Standards Unit investigation report was sent to the Crime and Misconduct Commission which advised that it is satisfied with the action taken to date and requested to be advised of any further action taken.

The report was also sent to the Regional Executive Director and actioned, in that officers referred to have been sent "Show Cause" notices in relation to the allegations which were found able to be substantiated.

Kirstin Hall

Ms Hall, at the time of inquest the Acting Director of the Case Review Unit of the Department, gave evidence of the implementation of the recommendations of the various reviews by the time of inquest.

Ms Hall stated that the Child Death Case Review Committee has endorsed the Department's actions in regard to the recommendations and it is considered by the Committee that they have been implemented.

Ms Hall stated that when the recommendations of the recent Queensland Child Protection Commission of Inquiry (the Carmody Inquiry) are implemented non-government organisations will be taking a greater role in alternative intake pathways.

Ms Hall identified that the lack of communication in relation to Faith's case file by ACT for Kids has been addressed at a local level but could not comment on whether similar procedures have been implemented on a wider basis.

Ms Hall stated that the Department is now exploring procedures and policies detailing the actions required to implement the Carmody Inquiry recommendations and that those implementing the recommendations would take into account the issues raised by Faith's case in regard to the lack of communication between the Department and ACT for Kids.

Gwenn Murray

Ms Murray was the external reviewer led the Committee which authored the Systems and Practice Review Report. She has much experience in such matters having reviewed the deaths of over 20 children in care and thousands of other cases.

Ms Murray gave evidence that at the time she completed the investigation she was so concerned about the systemic issues in the Cairns region that she asked to have an urgent meeting with the Director-General and the Minister. She met with and appraised them of her concerns and asked them to investigate:

- The location of Faith's step sisters;

- The backlog of notifications concerning 300 children that hadn't been assessed;
- The fact that teams were depleted with insufficient, traumatised and stressed staff;
- The poor communication between school personnel and the department (in relation to the failure of anyone to identify that Faith hadn't attended school for one year)

During her review the staff in the region told her they had been raising staff issues at regional level at least since 2009 and nothing had been done about it – their concerns had "fallen on deaf ears".

She said the staff in the Cairns office were relieved when action was quickly taken after her meeting with the Director-General and the Minister but Team Leader 1 conveyed her distress that it had taken so long for things to change and that it had taken the death of a child for action to be taken.

In regard to the referral of Faith's family to ACT for Kids, Ms Murray said that she could understand why it was done as they are a good service but really only suitable for low risk families and Faith's family was not low risk. She said that this was illustrated by the fact that the mother didn't engage.

Ms Murray said that she considers that a proper assessment was not carried out between 1 and 9 November 2010 as there were a number of gaps along the pathway that was followed. She considered there was an over-reliance on ACT for Kids to mitigate the risks to Faith and the decision to return Faith to her family was premature.

Ms Murray said that it was of concern that the Department relied on school attendance as a protective factor for Faith but when the school notified that she was not attending the Department then relied on ACT for Kids to monitor the family. She said that the notification by the school should have resulted in a more holistic assessment of Faith's situation.

In regard to the assessment that took place in early November 2010 Ms Murray said that there was no proper handover between CSO2 and CSO3 and Team Leader 1. She said they should have met and discussed the case and the fact that they didn't constituted a breakdown in communication. She said that CSO2 and CSO3 should have been able to continue the investigation and that Team Leader 1 didn't "appreciate the real and present risk to Faith at that time."

Ms Murray said that Team Leader 1 didn't know enough about Faith's family and circumstances to make an appropriate decision as at 9 November 2010 as she had not been to Faith's home and she hadn't spoken to any of her family members.

Ms Murray noted that her investigation revealed that when the guidance officer notified of her concerns about Faith's absence on 16 November 2010 CSO2 or CSO3 overheard the conversation and spoke to the receiving officer and told him that a Child Concern Report wasn't sufficient because of the concerns about Faith. He told Ms Murray he couldn't recall that conversation– he recorded the information as a child concern report instead of the higher level child protection notification.

Ms Murray said that there was no formal obligation on the Regional Intake Service officer to forward the new information to Team Leader 1 and it would be quite difficult to mandate that procedure given the high numbers of notifications that are received.

Ms Murray said that it was unacceptable that Faith was able to fall off the radar for a whole year – as a society we need to know where our children are. She said it was

also of great concern that nobody in the community or family reported any concerns in relation to Faith.

Ms Murray said that she identified the following areas that needed to be addressed and improved in regards to Faith's case:

- The Department has to be clear about the role of Referrals for Active Intervention Services and how they communicate with the Department when a file is closed to due non-engagement;
- There needs to be better communication between the Department and schools – principals in this case reported poor communication – schools need to know the outcome of the Department's investigations and who the child is with and if the Department is relying on the school to be a protective factor for the child;
- As a society, we need a better tracking system for children in regard to their attendance at school;
- If Centrelink has information that would identify the whereabouts of a child then that information should be shared.

Ms Murray considered that the Department should consider a public awareness campaign in relation to the obligation of everybody to report concerns about the welfare of children and to stress that child protection is everybody's business.

Arna Brosnan

Ms Brosnan is the Regional Director, Child Safety Services, Far North Region of the Department.

Ms Brosnan stated that in May 2009 staff in the Cairns office were working under very difficult conditions in that there was a high number of complex cases, a number of children from the Cape had been moved to Cairns and their files transferred to Cairns and new cases were coming in. Staff were advising that they were under resourced and there was a high turnover of staff who were leaving due to the workloads. Because of these resignations staff who were employed were generally inexperienced. There was a large backload of cases across the regions and there had been since 2005. In addition, case officers were suffering assaults and verbal abuse from client families.

Ms Brosnan and staff met with union representatives and discussed the issues that were being faced by staff. The result of these meetings was that some vacant positions were filled and there was a recruitment drive interstate and internationally to locate suitable staff. However, the changes did not significantly reduce the workloads and the Cairns office remained overworked, under staffed and under extreme pressure.

Ms Brosnan said that in November 2010 Team Leader 1 was having a very difficult time with an inexperienced team. The backlog was very distressing for the staff – everyone was concerned about it and matters had to be re-prioritised constantly.

Team Leader 1 had reduced the backlog but it was still a cause of concern.

Ms Brosnan said, "Professionally, everyone felt compromised because of workloads."

This state of affairs continued into 2012 but subsequent to Faith's death and particularly after the Child Death Case Review Committee Report was received and Ms Murray met with the Director General and the Minister, a restructuring of the region occurred. This resulted in workloads being spread more equitably across the region and a reduction in the caseload in the Cairns office. A team was sent up from

Brisbane to reduce the backlog which they managed to do in a six month period. Investigations and assessment work was allocated to a centralised unit.

Ms Brosnan stated that she agreed with the decision of Team Leader 1 to return Faith to her mother but said that if Team Leader 1 had less cases she might have been able to spend more time on assessing Faith's case.

Ms Brosnan described Team Leader 1 as very organised, very good at asking for assistance, committed, professional, well-regarded and extremely hard-working.

Ms Brosnan said that, although there is no requirement to do so, it would be best practice for a Regional Intake Service team member who received information in regard to a recently closed investigation and assessment to forward that information to the CSO.

Ms Brosnan said that there are now routine meetings between the investigation and assessment team, the Referral for Active Intervention Services (such as ACT for Kids) and parents. She said that the Department meet with services to which children or families are referred and discuss the child protection concerns, the expectations and goals of intervention.

Ms Brosnan thought that such discussions should be mandated and that failure to do so would pose a risk for children who were referred to such agencies.

Ms Brosnan stated that ACT for Kids was loading case closure information onto CSIS database but the Department's officers could not access that information. Ms Brosnan was of the belief that Referral for Active Intervention Services would notify the Department of case closure on the basis of non-engagement via the Regional Intake Service.

Ms Brosnan said that post the Carmody Inquiry implementations more cases will be referred to external agencies such as ACT for Kids. Ms Brosnan is of the opinion that employees of those agencies and officers of the Department need more training about non-engaging families and working to engage those families. Ms Brosnan said that the Department should ensure that agencies to which cases are referred are competent and are engaging families and that they are aware that if further concerns are identified they have to notify the Department of those concerns.

Ms Brosnan stated that, since the recommendations of the Child Death Case Review Committee there had been discussions with principals of schools 1 and 2. The principal of school 2 had identified concerns about information he received from the Department when a notification had been made about a child by his school. It was agreed that there would be a five day feedback to schools which would include the outcome of the investigation (whether recorded as a child concern report or a child protection notification). Ms Brosnan agreed that the feedback could also include the name and contact details of the case officer so that the school could contact that person if they had further concerns about the child.

Ms Brosnan agreed that if a case had been closed by the Department and one of the bases for making that decision was that the child would be monitored by the school then the school should be provided with that information.

Family Coach, ACT for Kids

The family coach said that she had been a family coach for about one year as at November 2010. She was a cadet in 2009, then a trainee and then a family coach. She has a Certificate IV in Community Services. In 2010 she was studying for her diploma. Her training took place on the job.

The family coach said that it was not her role to speak to children and she had never received any training as to how she should deal with issues of child abuse. When asked she was unable to say how she would go about ascertaining if a child was in need of protection or at risk of abuse.

The family coach said that she was assigned Faith's case on 16 November 2010 and she sent an initial letter to Faith's mother on 17 November 2010. She said that there were no procedures as to how initial attempts to engage families should be made. She could have phoned or sent a letter and she chose to send a letter.

She said if the families don't engage she advises her practice manager and sends an email to the CSO.

The family coach stated that on 6 January 2011 when she received no reply to the letter she sent to Faith's mother she did not advise the Department of that by email or phone. She wasn't sure whether she was supposed to do so – she asked some of the other family coaches whether she should and they said she could do so but wasn't required to do so.

Upon closing the file the family coach completed an assessment of Faith's mother. In doing so she recorded "adequate" against all criteria. Those included family safety, child wellbeing, health, parenting and family interactions. She said she made the assessment based on her 15 minutes with the family and her 10 minute phone conversation with the mother.

In relation to current procedures, the family coach said that they now get two different types of referrals from the Department – non-consent and consent. The non-consent families do not know that they have been referred to ACT for Kids and they are sent an initial letter advising them of that. She said that she doesn't often get a reply to those letters so she sends a second letter advising that she will visit the family. A high number of families also don't respond to the second letter and then ACT for Kids send an email to the referring officer from the Department advising of that.

In relation to consenting families i.e. those who have had contact with the Department and advised that they will consent to engagement, the practice is to make initial contact by phone, and if there is no answer, visit them at home. She said that sometimes the families don't engage and then she tells the practice supervisor of that and closes the case in CSIS and then sends an email to the referring CSO.

The family coach stated that CSIS is the database for sharing information with the Department and that the Department can access the information which is input by ACT for Kids.

When asked at which stage of the process Faith's mother stated she did not want to engage with the ACT for Kids the family coach was unable to identify when that occurred.

Regional Director, ACT for Kids

The current Regional Director of ACT for Kids appeared at the inquest. He gave evidence that he has worked for that organisation since 2007 and has a good knowledge of the services provided. Mr Smith said that ACT for Kids is a non-government organisation that works to prevent and treat child abuse and neglect. He said that ACT for Kids in Cairns offers a case management service for families at risk of entering child safety services. It works with families to support them.

Mr Smith said that the referrals from the Department have changed and that the organisation has modified how it tries to engage families. He said that family coaches are trained in engaging families.

Mr Smith said that families are initially contacted by letter which is sent within seven days of receipt of the referral from the Department. After engagement the family coach assesses the needs of the family and develops a case plan. Services provided can include financial assistance to purchase items that the family needs, counselling services and regular visits. He said that weekly visits would be ideal but that does not usually occur.

He said that it is the practice that the family coach should contact the Department if they identify any further concerns regarding the family. Mr Smith said that notification would occur by the family coach contacting the Regional Intake Service by phone or email. The CSO would not be contacted with further concerns. He said that sometimes ACT for Kids receives feedback in relation to these notifications but not always. Mr Smith considers that such feedback would be useful especially where the service is still engaged with the family.

Mr Smith said that family coaches or team leaders may seek further information from the Department in regard to referrals but there are no formal meetings held to discuss cases which are referred.

Mr Smith said that it was only in the past few weeks that he became aware that the Department staff could not access the information that ACT for Kids placed on the CSIS database.

Mr Smith stated that if, at the time of Faith's death, family coaches were under a misapprehension that they did not have to report non-engagement to the referrer, that misapprehension has now been addressed.

In regard to Faith's family Mr Smith said that the family coach had attempted a number of different ways to engage Faith's mother. However, he agreed that on the records of the family coach, it was not clear that Faith's mother did not want to engage.

In regard to possible recommendations Mr Smith said he thought there was room for more collaboration between the Department and ACT for Kids at the beginning and end of the process but there were no formal structures in place for that currently. He said that meetings that were once held were very relevant and useful but that practice had dropped off along the way and in light of the Carmody Inquiry recommendations, more formal interaction is needed between service providers.

Brett O'Connor

Mr O'Connor represents DETE at the Director's Child Safety Network meetings. He said that DETE has good procedures in place for tracking children, managing student absences and the protection of students. In Faith's case those procedures led to the notification to the Department and police of the allegations of abuse by her mother and the notification of her absence from school.

In preparation for the inquest Mr O'Connor had considered the procedures that were in place at the time of Faith's death and the actions of DETE employees and he concluded that the principal and other school staff had followed the DETE procedures and acted appropriately in relation to Faith.

Mr O'Connor said that the procedures did not change significantly following Faith's death. He was not aware of any consideration of the recommendation in relation to the introduction of a register to track students who are not enrolled in school.

He is aware that the Department have undertaken to provide feedback to the school within 5 days, when the school makes a notification about a child protection concern.

Mr O'Connor stated that information sharing with Centrelink would be useful as it would assist DETE in locating families of children who are not enrolled at school. He said that in the case of Faith he would expect that had the principal of school 2 become aware that Faith's family was still in residence in the catchment area the school staff would have made further efforts to ensure her attendance.

Principal of School 2

School 2, in central Cairns, has the highest rate of mobility of students in Australia apart from schools in indigenous communities. In 2014, since day 8 of the school year, (the final day for counting students for purposes of funding and staff numbers) there have been 107 students enrolled and 91 students have left the school. In 2013 400 students left the school and enrolled at the school during the school year.

It also has a high level of disadvantaged students with the lowest socio-economic index of any school in Australia outside of indigenous communities. Out of 712 students, only 2 families have a mortgage with the remainder relying on rental accommodation, public housing or, at the worst extreme, sleeping "rough". Only 9% of the students have English as a first language. Seventy percent of the students are aboriginal or Torres Strait Islander, 10% are Cook Islander, 11% are refugees and 8% are Caucasian.

It is a constant challenge to get children enrolled at the school and to maintain their attendance. Staff frequently report to the Department and QPS. The concerns vary from neglect to all types of abuse – physical, emotional and sexual. So far in 2014 the school has submitted 52 SP4's and in 2013 there were a total of 80 submitted.

When children are enrolled at the school the mobility support teacher looks up the child's history on the OneSchool database and considers the assistance that is needed to keep that child safe and at school. The school provides basic school necessities that can be paid off by parents over the year and also refers children and families to external agencies for support.

Because of the challenges faced by this school in ensuring student attendance, the principal has given much consideration to methods of tracking and finding children and ensuring that children are enrolled in school. He has also given consideration as to procedures which would assist him in these endeavours and also, help him to monitor his students in relation to their safety and welfare.

He stated that when notifications are made of serious abuse allegations he gets a very good response from both QPS and the Department. Officers from both departments generally respond quickly and attend the school on the day of the notification. His officers are provided with immediate responses from QPS as to whether the child is to be removed from their family. He sometimes get the same response from the Department but stated that the information he was receiving at the time of Faith's death could vary.

The principal stated that the Department currently provides feedback within 5 days and advise whether the notification was recorded by them as a child concern report (in which case the file is closed) or a child protection notification (the matter is investigated and assessed).

The principal stated that it would be helpful if he was also provided with the name of the case officer assigned to the case and their contact details. He said that he has been advised that he should contact the Regional Intake Service team if he has any further concerns about a child who has been the subject of a notification. He said that when he phones the Regional Intake Service team he is often placed on hold, sometimes for up to 20 minutes, and he can be put through to an officer in another

city such as Ipswich or Townsville. The person he speaks to has no direct knowledge of the child he wishes to discuss. He does not then know whether the information he imparts reaches the appropriate officer.

The principal said that he was always advised of the QPS officer responsible for child protection investigations and he could not understand why he could not speak to the case officer from the Department directly responsible for the investigation.

In relation to mobility of students the principal stated that funding for his school was dependent on the number of students in physical attendance on day 8 of the new school year. Of his 500 ATSI students, some 300 came from the Torres Strait islands. Many of these students returned to their home for the holidays. Their parents often had difficulties having them back at school in time for the start of the year due to a number of issues including finding the funds to purchase flights for a number of children. They often came back to school but may arrive 2 or 3 weeks late.

At the start of the year all the teachers at the school try to find students who have not returned. In 2014 teachers from the school conducted 60 home visits before day 8. The principal himself spent time walking the streets surrounding the school to find absent students. He spent a day at a local shopping centre looking for parents and students.

The principal said that if he had access to basic Centrelink information it would allow him to track children who should be, but were not, attending school. He would be able to access their address and from OneSchool would be able to ascertain whether they had been enrolled in any other school. He would also be able to ascertain if the family had any other school aged children who were not attending school.

The principal stated that if he was told by a parent or carer that a child was moving to another Queensland school he would keep them on his inactive role until he could be satisfied, through the OneSchool database and through receiving transfer applications from that school, that they were so enrolled. If they were not enrolled in any school he would continue to look for the child.

The principal also said that he thought that principals who were told that a child was moving overseas should advise Centrelink of that information. If payments continued to be claimed in relation to that child an alert could be triggered which would lead to the matter being reported to the Department or a suitable organisation and investigations could be carried out in relation to the whereabouts of that child.

The principal stated that he had contact with Team Leader 1 in relation to a number of his students and he found her to be very competent and they had a good working relationship.

Kelvin Laute

Senior Constable Laute was asked whether, if he had received information from Team Leader 1 that the mother had admitted to hitting Faith with coat hanger in the interview she had with CSO2 and CSO3 that would have altered his decision not to charge the mother with criminal offences. He stated that he doesn't consider that would have changed his decision not to charge. When he decided not to charge the mother he knew that the Department were going to be continuing with the family and he thought that was the best option.

Submissions

Counsel Assisting

Counsel Assisting submitted that I should make the following recommendations:

1. The Department respond to notifications from DETE with the following information:
   a. that the notification has been received;
   b. whether the notification has been assessed as a child concern report or a child protection notification;
   c. the name of the case officer who has been assigned to the investigation; and
   d. the direct contact details of that officer.

2. The Department consider updating its practice manual to mandate the practice that when a child concern report is recorded at a Regional Intake Service and relates to a notification which has been closed for less than 30 days to email the information to the appropriate CSO.

3. ACT for Kids update its practice manual to make it clear that an email is to be sent to the referrer advising of the case closure on the basis of non-engagement.

4. The Department include in its service agreements with Intensive Family Support Services the requirement that case closures on the basis of non-engagement are notified to the referrer.

5. Centrelink, DETE, the Department and QPS consider what is required to establish an information sharing system to allow agencies that have responsibilities relating to the safety, welfare or well-being of children access to customer information collated by Centrelink. In particular, the name, address and telephone details for school aged children, their nominated carers and school-aged siblings.

6. Any information sharing system would be supported by DETE requiring Centrelink Customer reference numbers to be provided on enrolment.

The Department

Ms Carmody for the Department submitted that one of the most significant factors in Faith's death was the reluctance of her extended family to report the abuse she was suffering. The Carmody Inquiry recommendations may go some way to addressing this issue as members of the community will be able to report to non-government organisations and perhaps they will be less reluctant to do so.

Ms Carmody accepted that there was an extreme under resourcing of the Department in 2010 and appropriate resourcing at that time may have resulted in a better outcome. There have been two significant changes since Faith's death – increase in resources for the region and intended implementation of the Carmody Inquiry recommendations.

Ms Carmody submitted that the issue in relation to ACT for Kids failing to notify the Department of non-engagement by families has been addressed as it is now required that they do so.

The Department agreed with the first recommendation suggested by Counsel Assisting but with the amendment that "Team Leader" be substituted for case officer. The Department agreed with the second, third and fourth recommendations.

In relation to recommendations 5 and 6 the Department submitted that consideration should be given to page 94 of the Carmody Report which considers an integrated information platform:

> *[t]he development of a centralised data hub, or data-sharing system, whereby departments individually contribute information for the benefit of Child Safety, is a longer-term strategy that is likely to require considerable resources and time to develop. Should such a system be favoured by government, it will need to be funded and resourced to ensure it works as intended and has the desired effect. In the short term, the Commission is of the opinion that the most critical goal is to reduce demand on the intake system.*

The Department submitted that I make a further recommendation being:

- That the Department notify every party to a current Service Agreement which utilizes CSIS that:
    - The Department does not have access to personal client information or identified information on CSIS;
    - Information entered into CSIS by service providers is not accessible by the Department; and,
    - the Department is only able to view referral information for families referred by Child Safety Services

DETE

Mr Parrott, for DETE, submitted that I would find that no actions or inactions of the staff of DETE contributed to Faith's deaths and that all officers of that department acted appropriately and in accordance with relevant policies and procedures. He submitted that, after the actions of her mother and stepfather, it was the reticence of her extended family to report Faith's abuse that most greatly contributed to her death and that the next most contributory factor was a lack of communication.

Mr Parrott submitted that schools are the "eyes and ears" of society when it comes to protection and monitoring of children but without information those eyes and ears are partially blinded and deafened. The Department should provide the name and contact details of the case officer to the school principal. Mr Parrott submitted that the suggestion of the principal in relation to information sharing with Centrelink is simple but efficient.

DETE provided further submissions in regard to the recommendations of Counsel Assisting, being:

1. It is submitted on behalf of the Department of Education Training and Employment ("the Department") that recommendation 5 be amended to read as follows:

> *The Department of Communities, Child Safety and Disability Services engage at the earliest possible opportunity with Centrelink, The Department of Education, Training and Employment, Queensland Police Service, Queensland Health and representatives from the non-state school sector, to consider the feasibility of an information sharing system to allow agencies that have responsibilities relating to the safety, welfare or well-being of children to have access to customer information collated by Centrelink. In particular the name, address and telephone details for school aged children, their nominated carers and school-aged siblings. This consultation process should also consider, and take note of, those matters already recommended and accepted by the Queensland Government as a result of the Queensland Child Protection Commission of Inquiry*

(http://www.ccypcg.qld.gov.au/pdf/qg-response-child-protection-inquiry.pdf)

2. It is submitted that the changes to the proposed recommendation 5, as suggested above, are properly directed to that agency that carries the primary responsibility for the protection of children within the state. Further it is submitted that the recommendation is currently limited to students enrolling in state schools and therefore, the changes allow for a coordinated approach between all of the relevant stakeholders in which the relative legislative and administrative difficulties (refer below) may be addressed.

3. It is submitted that the Coroner not adopt the comment/recommendation in paragraph 6 for the following reasons:

   a. It would be premature to make such a comment/recommendation as the consultation process in recommendation 5 needs to be undertaken before the feasibility of such a comment/recommendation can be determined.

   b. There will need to be in depth consideration around the current legislative framework and changes/amendments that would need to be made to support such a comment/recommendation. As the *Education (General Provisions) Act 2006* (https://www.legislation.qld.gov.au/LEGISLTN/CURRENT/E/EducGenPrA06.pdf) is currently drafted, it does not provide the department with the authority to "require" parents to provide this information.

   c. Even if the Department had the authority to require this information, its usefulness hinges on Centrelink being able to disclose the information envisaged by the Coroner (i.e. name, address etc.). It is submitted that the legislative framework within which Centrelink currently operates contains very strict confidentiality provisions (as identified below) which would seem to currently prevent this disclosure of information (http://www.humanservices.gov.au/customer/information/privacy & http://www.humanservices.gov.au/spw/business/services/centrelink/information-for-agents/agent-declaration-of-confidentiality.pdf - refer particularly to page 8 onwards for relevant legislation). As Centrelink was not represented during the Inquest, the consultation process in recommendation 5 would allow them to provide input in relation to these matters before deciding on the specifics of any information sharing.

   d. Subject to there being an appropriate legislative framework in place, there are also further administrative and process related issues to be considered by the Department which would be best explored during the consultation process provided for in recommendation 5 (i.e. changes to the enrolment procedure, changes to OneSchool and information/education in relation to the changes to parents and staff). In this regard, it should be noted that:

      i. the comment/recommendation is currently limited to students enrolling in state schools;
      ii. there were 517,610 full time students enrolled in Queensland state schools as of February 2014.
      iii. the comment/recommendation as framed applies to students on enrolment. There were 46,719 full time enrolments in prep year in 2014. Not all new or indeed existing students would

have a Centrelink Client Reference Number ("CRN"), nor would individual schools need to be aware if they did so, so as to better protect children.

iv. a requirement that all students whose parents/guardians/carers had a CRN to provide such information, would impose, without the proper systems in place to record and share such information, a substantial administrative burden upon schools. Given the evidence before the Coroner about the mobility of students in this area, among others, as between family members there would also need to be a means of verification of the relevant numbers.

4. It is submitted that it is evident from the above that there is an in depth consultation process that needs to be undertaken (and which is provided for in **recommendation 5**) before there can be any comment and/or recommendation in relation to the specifics of the proposed information sharing.

Team Leader 1

Mr Lawler submitted that the actions of Team Leader 1 were the product of her working environment and there was no clear nexus between her actions and the death of Faith. There was a breakdown in communications. Many of the systemic issues have now been addressed.

The Department of Human Services (Centrelink)

The Department of Human Services, although not a party to the inquest, became aware of the issues raised in relation to information sharing and helpfully provided the following information:

1. The *Human Services Legislation Amendment Act 2011* integrated Medicare Australia, Centrelink and CRS Australia on 1 July 2011 into the Department of Human Services;

2. Information held by the department in the Medicare, Centrelink and Child Support programmes is subject to statutory secrecy provisions which prevent the communication or disclosure of certain information except in specific circumstances. Of relevance in these circumstances, the department may disclose certain information under specific provisions (including Public Interest Certificate Guideline) where the department has reasonable grounds for believing that the disclosure is necessary to prevent or lessen a threat to the life, health or welfare of a child. The Department of Social Services has policy responsibility for the Public Interest Certificate Guidelines and there is scope to amend these Guidelines to broaden the current set of circumstances where it is in the public interest and there is evidence of need.

3. In order to facilitate the sharing of information in the current set of circumstances, the department currently participates in "A Protocol for Sharing Information between the Commonwealth and Child Protection Agencies" (the Protocol). The purpose of the Protocol is to outline procedures on how the Commonwealth and child protection agencies can share information where possible (in accordance with the legislation) in order to provide more responsive care and protection services to children.

4. Under the Protocol the Queensland Department of Communities, Child Safety and Disability can request Centrelink, Medicare and Child Support information where the department has reasonable grounds for believing

that the disclosure is necessary to prevent or lessen a threat to the life, health or welfare of a child.

5. Nationally, the department responded to 12,933 requests for information in accordance with the Protocol in 2012-2013 and 17,492 requests between July 2013 and April 2014. Of those requests, there were 4.295 requests in 2012-2013 and 5,095 requests processed from July 2013 to April 2014 from Queensland authorities.

6. The department records do not indicate that a request was ever received or processed for Faith.

7. In relation to recommendation 5 of Counsel Assisting, the department proposes that requests for information could pass through the Queensland Department of Communities, Child Safety and Disability Services and utilise the existing arrangements under the Protocol. Our Department and the Department of Social Services would be happy to have further discussions with the Queensland Government about the avenues that currently exist to share information and any further improvements that could be made.

8. In relation to recommendation 6 of Counsel Assisting, the Protocol does not rely on the provision of the Centrelink Reference Number to identify information about a child and we do not believe the collection of these reference numbers would be of any assistance in processing requests for information.

Comments and recommendations

Comments

As was stated by Team Leader 1 at the inquest, Faith's death was caused by her mother and nobody else. However, there are a number of factors which significantly impacted upon the outcome for Faith and which resulted in Faith being left in the care of the mother who abused and ultimately, killed her.

The Inaction of Faith's Extended Family

It remains inexplicable that none of Faith's extended family reported the abuse she was suffering to the Department or to police.

Her aunt and uncle now reside in New Zealand and did not give evidence at the inquest but it is clear from the statements that they provided to police that they knew Faith's mother was mistreating her.

The step grandfather told the aunt that she had to speak to the mother about it. The aunt went to see the mother and saw Faith lying in bed with bruises on her face and the mother told her that she had hit Faith with the vacuum pole. The aunt said, "Sis, this has to stop" but did nothing further.

The step grandmother knew of the abuse and of its seriousness. She was told by her son that the mother nearly killed Faith and yet she took no steps to protect Faith. She was the only one of the family members who gave evidence who gave a convincing reason for not reporting Faith's abuse to the Department. She said she had been removed from her family as a child and she would never call the Department. She gave no reasonable explanation reason as to why she did not consider calling police.

The step grandfather visited Faith's home almost every day. He saw for himself the extent of her misery and mistreatment. She was bruised, battered, had "busted" lips and was not allowed (or at times, probably not able) to come out of her room. She lay on her bed nearly all the time. In spite of stating that he loved her as his own granddaughter he did not protect her. He told her mother that she needed help and tried to convince the mother to get counselling.

The step grandfather saw Faith on 25 November and saw that her hands were swollen and she had bruises all over her arms. It is likely that by this time she had broken fingers. When he visited on 26, 27 and 28 November 2011 Faith was in her room and it looked like she was asleep. It is clear now that she had been severely beaten at that time and by 28 November 2011 she was dying.

The step grandfather said that he loved Faith as his own grandchild but then stated he would have intervened if his biological grandchildren had been mistreated by the mother.

Step uncle 2, to his credit, offered to have Faith come and live with him. He knew the mother was cruel to Faith and she was not attending school and yet when his offer was declined he did nothing else to help Faith, deciding that it was none of his business.

Faith's extended family are not cruel people and they all were concerned about her wellbeing and the mistreatment she suffered and yet, they were willing to allow that abuse to continue rather than make a phone call to the Department or to police and report their concerns.

The only reasons for this refusal to help her that can be gleaned from the evidence were that firstly, she was not the biological child of the step father and therefore, it was not their business to interfere and, secondly, they were concerned that if they did report the matter Faith's sisters would be removed from the family.

Ms Murray suggested a public awareness campaign is needed to convey the message that child protection is the business of every person in our society.

Decisions by employees of the Department

The decisions made by the Department in relation to Faith were examined and analysed in detail by one internal review, two external reviews and an Ethical Standards Unit investigation.

The findings of those reviews were that decisions made by the Department's employees in relation to Faith were incorrect, premature and the result of inadequate investigation and assessment. I agree with those conclusions.

The decision to record the notification of May 2009 as unsubstantiated and that Faith was not a child in need of protection was made prematurely and without sufficient investigation and information. The assessing officer incorrectly concluded that Faith's allegations were false. The decision was made without interviewing the mother or obtaining any corroborating medical information as to whether she was suffering from a skin condition.

The investigation in November 2010 was insufficient and the decision to return Faith to her mother was premature and based on inadequate information. There had been no information obtained from extended family members and Faith was not interviewed sufficiently. The decision to return Faith to her mother was based only on the mother's assurances and her agreement to engage with ACT for Kids.

The school was not advised that Faith was to be returned to her mother and that one of the grounds for that decision was that she would be monitored at school.

However, it would be unfair to judge the decisions and those who made them, in particular Team Leader 1 who decided Faith should be returned to her mother on 9 November 2010, with the benefit of hindsight and without considering the surrounding circumstances.

At the time those decisions were made officers in the Cairns office were stressed and overworked because of the backlog of cases and the number of incoming cases. That had been the case since at least 2009. They were unable, given the competing demands on their time, to allocate enough time to cases to investigate them properly and thoroughly.

It is evident, as was said a number of times during the inquest and identified in the reviews, that in November 2010 the workload of Team Leader 1 was untenable.

Due to the position she was placed in by her huge workload, Team Leader 1 has had to deal with the distress of Faith's death, she has had her decisions analysed and criticised by four reviews, including an Ethical Standards investigation, and she is currently addressing a "Show Cause" notice from the Department.

The evidence revealed that Team Leader 1 was at the time, and remains, a dedicated, committed and extremely hardworking employee. She was responsible for making decisions which could have a devastating impact on children and she had to make those decisions in an environment which was characterised by understaffing and under resourcing. Team Leader 1 and the rest of the staff in the region had been battling for some time to address a huge backload whilst the new files continued to come in.

Team Leader 1 did her best under very trying circumstances. I am satisfied that had she had more time to assess Faith's case she would have made further investigations. Those investigations may have resulted in a decision not to return Faith to her mother.

The inadequacies in the response of the Department to Faith's circumstances were a direct result of the under-staffing that characterised the Cairns office of the Department at the time.

Lack of Communication and Information Sharing

The Department and the School

One of the grounds on which Team Leader 1 returned Faith to her mother was that the school would be a protective factor. However, this information was not relayed to the school. Neither the guidance officer nor the principal of school 2 were given any formal advice as to the outcome of the Department's investigation into Faith's family.

The principal highlighted the difficulties faced by him and his staff in attempting to monitor the wellbeing of children when they do not receive appropriate feedback from the Department. This has now been addressed to some extent – the school are notified if the matter was recorded as a Child Concern Report or a Child Protection Notification.

It is vital that schools be advised if the Department is relying on the school to monitor the child. The principal or responsible officer at the school should also be provided with the name of the case officer who is responsible for the child's case and their contact details, so that they can contact that person directly if they have further concerns or need further information to protect the safety of that child.

Centrelink and Schools

The Systems and Practice Review Committee identified that the lack of a register or system to track whether and where children are attending school was a risk factor for all children.

The evidence before the inquest was that no such register has been established although the matter was first raised in April 2012.

Mr Hansen, who is at the coal face of the search for children who are not enrolled in school, and who has given the matter much consideration, is of the opinion that the provision of some basic information by Centrelink would go a long way to addressing the problems he faces when trying to find students. If he was able to access the address at which children were living he would be able to determine whether they should be enrolled at his school and then ensure that they attended school. He could also ensure that children who had moved to another address in the state were enrolled at another school in their area, via the OneSchool database.

Faith was reported by the school to be absent on 16 November 2010. The Regional Service Intake officer was also that she had been absent since she was returned to the care of her mother. When Faith did not come back at the start of the 2011 school year teachers conducted a home visit to look for her. They were told by a person who identified himself as Faith's uncle that she was moving to New Zealand. The school then had no means by which to verify that this occurred.

Had the principal had access to Centrelink records he would have been able to monitor Faith's whereabouts and he would have known that Faith did not leave her address.

The Department and ACT for Kids

There was a concerning lack of information sharing between ACT for Kids and the Department. There were also misunderstandings between the agencies about the procedures for information sharing. Some of these misunderstandings continued after Faith's death and in the period leading up to the inquest and some persisted at the time of the inquest.

Team Leader 1 believed that she would be advised by ACT for Kids if the family didn't engage. That was incorrect.

The family coach from ACT for Kids input the case closure information on the CSIS database and was of the belief that officers of the Department could access that information. That was incorrect. Departmental officers could not access the information on the database that was input by ACT for Kids.

The Regional Director of ACT for Kids didn't know of that fact until a few weeks before the inquest. Ms Brosnan was of the belief that Referral for Active Intervention Services would notify the Department of case closure on the basis of non-engagement via the Regional Intake Service. This is also not correct, according to the Regional Director and family coach of ACT for Kids.

The family coach, according to her evidence, did not know that she was obliged to advise the child safety officer when a family failed to engage with ACT for Kids.

Team Leader 2 knew that the Department was not advised by ACT for Kids of non-engagement by families but Team Leader 1 believed that it was.

This breakdown in communication led to Team Leader 1 not being advised that one of the most important protective factors on which she had based her decision to return Faith to the mother (referral to ACT for Kids) had fallen down.

Team Leader 1 also believed that ACT for Kids would visit Faith's family at least once per week. The evidence of the Regional Director of ACT for Kids is that weekly visits with families are ideal but rarely occur.

At the time she gave evidence at the inquest, Ms Brosnan believed that case officers, ACT for Kids and referred families have regular meetings in relation to referrals. This is incorrect. The Regional Director of ACT for Kids said that, whilst he believes that meetings should occur at the commencement and finalisation of cases, such meetings are never held.

Ms Brosnan considered that such meetings should be mandated and the failure to hold such meetings would pose a risk to children who were referred to such agencies.

These breakdowns in communication and information sharing were significant to the outcome in Faith's case. It is concerning that they may still exist especially considering the impending implementation of the Carmody Inquiry recommendations which will see many more families referred to external agencies, from the Department and from other bodies.

Poor service delivery by ACT for Kids

The family coach spent a total time of 25 minutes speaking with Faith's mother – ten minutes on the phone and 15 minutes at home. She assessed the family as "adequate" in relation to family safety, child wellbeing, health, parenting and family interactions on the basis of that 25 minutes contact. This was in spite of the fact that Faith's mother told her that the step father was barely at home and that she was receiving counselling from Lifeline and the mother was pregnant and had a one year old baby at the time.

At no time did the family coach offer any assistance to Faith's mother or attempt to ascertain the mother's needs and/or explain to the mother how the service could be of assistance to her. The family coach did not phone the mother on two occasions when she said she would.

The family coach spent longer (40 minutes) closing the file than she did speaking to the mother. When asked what her case plan would be for the family had the mother engaged, the family coach could not give a satisfactory answer. She said she might find out whether Faith wanted to play a sport such as soccer.

When she closed the file the family coach did not know whether the mother had received her text messages or her letter. She had not been told at any time by the mother that she did not wish to engage. She appears to have concluded that this was the case on the presumption that the mother did not contact her as requested to do so in a letter but she did not know whether the mother had received that letter. In fact, the family coach did not know whether the mother was able to read the letters sent to her or whether she was still at that address. At no time after sending the final letter did the family coach make any further phone calls or attempt any other contact to find out if the mother had received that letter.

At no time did Faith's mother indicate that she did not wish to engage with the service.

The family coach said that she did not consider that she was obliged to advise the Department of the non-engagement and closure of the file however, her evidence on

this point was in direct conflict with the letter she sent to the mother which stated that she was obliged to advise the Department.

The service offered to Faith's mother by ACT for Kids was inappropriate to the circumstances of the family, insufficient and not of any assistance to the family in any way. Whilst I take into account that referrals to ACT for Kids are only for low risk families, the service provided to Faith's family would not have been of any assistance even to a low risk family. There was no real attempt by the family coach to have the mother engage or in fact, to ascertain if she had received correspondence.

Had the family coach made another visit at the end of the school holidays she should have realised that Faith was not at school. It is not evident however, that even that would have prompted any action on her part.

The lack of any real attempt to engage Faith's family is of great concern given that the implementation of the Carmody Inquiry recommendations will result in a much greater percentage of families being referred to external agencies, including ACT for Kids.

Actions of DETE

I am satisfied that all DETE employees acted appropriately and in accordance with that Department's policies and procedures. The principal and staff of school 2 could not have reasonably done any more to attempt to find Faith and notify the Department of her absence from school.

Had they been advised that Faith had been returned to her mother on the basis that the school would monitor her wellbeing they may well have made further attempts to ascertain whether in fact Faith had left the country and reported that to the Department.

Recommendations

Whilst much has been done to address the systems and procedures of the Department which were recognised as being inadequate in relation to the investigation and assessment of Faith's case, there are some issues which remain to be addressed in an attempt to ensure, as far as possible, that another child does not become "invisible" to the community, or "slip through the cracks" of the child protection system.

The submissions of the Department of Human Services indicate that information sharing is not inconsistent with the legislative framework.

The Department of Human Services submits that any information required by schools could be requested by the Department and passed onto schools. This is not a practical solution. The Department has insufficient resources to carry out its core functions and would be unable to take on the added responsibility of receiving requests for information, passing them on to the Department of Human Services and then relaying information to schools. Nevertheless, there is a clear need for schools to have this information. How that can practically be provided is a question that is best answered by those with detailed knowledge of the systems and processes involved in such information sharing.

I make the following recommendations, which all parties to the inquest have stated that they are in agreement with:

1. The Department respond to notifications from DETE with the following information:

a. that the notification has been received;
b. whether the notification has been assessed as a child concern report or child protection notification;
c. the name of the team leader who has been assigned to the investigation; and
d. the direct contact details of that team leader.

2. The Department consider updating its practice manual to mandate the practice that when a child concern report is recorded at a Regional Intake Service and relates to a notification which has been closed for less than 30 days to email the information to the appropriate child safety officer.

3. ACT for Kids update its practice manual to make it clear that an email is to be sent to the referrer advising of the case closure on the basis of non-engagement.

4. The Department include in its service agreements with Intensive Family Support Services the requirement that case closures on the basis of non-engagement are notified to the referrer.

5. That the Department notify every party to a current Service Agreement which utilizes CSIS that:
   a. The Department does not have access to personal client information or identified information on CSIS;
   b. Information entered into CSIS by service providers is not accessible by the Department; and,
   c. the Department is only able to view referral information for families referred by Child Safety Services

6. The Department of Communities, Child Safety and Disability Services engage at the earliest possible opportunity with Centrelink, The Department of Education, Training and Employment, Queensland Police Service, Queensland Health and representatives from the non-state school sector, to consider the feasibility of an information sharing system to allow agencies that have responsibilities relating to the safety, welfare or well-being of children to have access to customer information collated by Centrelink. In particular the name, address and telephone details for school aged children, their nominated carers and school-aged siblings. This consultation process should also consider, and take note of, those matters already recommended and accepted by the Queensland Government as a result of the Queensland Child Protection Commission of Inquiry (http://www.ccypcg.qld.gov.au/pdf/qg-response-child-protection-inquiry.pdf)

I further recommend that the Department consider launching a public awareness campaign, particularly in Far North Queensland, promoting the fact that child protection is the responsibility of every member of our community and the role of the Department in supporting families rather than removing children from those families.

Conclusion

Faith was a defenceless child. She was only 8 years of age at the time of her death. When she was 6 years old and started at prep school, she took the first opportunity offered to her to report the abuse she was suffering at the hands of her mother, to a teachers' aide with whom she had formed a bond. Her cousin corroborated her allegations.

The Department investigated her disclosures but concluded, after being told by her grandparents that she had a skin condition (a fact that was never verified) that Faith was not telling the truth and was not in need of protection.

Evidently Faith was punished for that disclosure because afterwards her behaviour changed - she was withdrawn and would not answer when asked how things were at home and she started missing school.

Faith's mother enrolled her at a different school. In 2010 Faith saw the same teacher aide at her new school. No doubt scared of being punished if she told of the abuse again, she sat next to the teacher aide and, whilst looking at her, rolled up her sleeves – displaying her injuries in a silent plea for help.

The Department and QPS immediately commenced investigations but the action taken was insufficient to protect her. Faith was removed from her mother but then returned only nine days later, after an investigation that was later found to be inadequate, determined she was not in need of protection.

From that time on Faith was removed from the only real protective factor in her life – her school. The staff at Faith's school did all they could to help Faith but they were hampered in their efforts by not having access to the information which was available to other government departments (the Department and Centrelink) and which they could have used to better monitor Faith's whereabouts and ensure her attendance at school and thereby, her safety.

ACT for Kids was not a suitable agency to assist Faith and made no real attempt to engage and/or support her family in any way.

Faith then became totally dependent on those around her – those who knew of the terrible abuse she was enduring and should have placed her safety above all other considerations – her extended family and her step father.

Rather than help and protect Faith those family members failed to act because of their fear that the Department would remove her sisters from the family and, perhaps, because they did not want to be seen to be interfering in matters they considered were not their business.

On the day she died, Faith asked her mother to give her some Panadol to ease her pain. Her mother didn't have any and told her there was nothing she could do for her. Faith asked her, "Well could you at least say a prayer for me?" Faith had nobody to help or protect her. She was left to die alone and in pain.

Findings required by s. 45

Identity of the deceased – an 8 year old girl named Faith

How she died – Faith died from multiple blunt force trauma injuries she sustained when her mother struck her repeatedly with a metal vacuum pole

Place of death – 97-101/3 Mann Street, Westcourt, Queensland 4870

Date of death– 28 November 2011

Cause of death –

Faith died from the combined effects of the haemodynamic consequences of extensive cutaneous and subcuticular blood loss, and systemic fat embolism, from multiple blunt force trauma contacts.

I close the inquest.

Jane Bentley
Coroner
Cairns
27 June 2014