CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Yakamurro
Hearing dates:	6-16 June 2022
Date of findings:	15 December 2022
Place of findings:	Coroners Court, Lidcombe
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	CORONIAL LAW – suicide of 15-year-old First Nations boy in out-of-home-care; out-of-home care for First Nations children; out-of-home care involving interstate relocation of child; cultural safety of out-of-home care for First Nations children; kinship care arrangements; interstate cooperation of child protection services; significance of Country for First Nations children in out-of-home care; detection of suicide risk of children in out-of-home care; support for foster parents; Territory Families; Department of Communities and Justice; CASPA Services Ltd.
File Number:	2018/000393286

Representation:	1. Counsel assisting: Dr P Dwyer instructed by Ms L Nash of the NSW Crown Solicitor's Office 2. Amala (a pseudonym), mother of Yakamurro: Ms K Heath, instructed by Ms G Maginness of the North Australian Aboriginal Family Legal Service 3. Territory Families Housing and Communities: Mr T Hutton, solicitor 4. I (a pseudonym), Naarah Rodwell and CASPA Services: Mr D Heilpern, solicitor 5. Department of Communities and Justice: Ms H Bennett instructed by Ms T Howe of the Department of Communities and Justice 6. G and H (pseudonyms), foster carers for Yakamurro: Ms N Evans
Non publication orders:	**Non-publication orders were made during the inquest protecting the identities of various persons and restricting the publication of a limited amount of evidence. A full copy of the orders may be obtained from the Court Registry.**
Findings	**Identity** The person who died was [redacted], also known as [redacted] (Yakamurro). He is referred to in these findings by Yakamurro, out of respect and in recognition of his culture. **Date of death** He died on 20 December 2018. **Place of death**

	He died at 821 Jiggi Road, Jiggi NSW. **Cause of death** He died from neck compression due to hanging. **Manner of death** Yakamurro's death was intentionally self-inflicted. At the time of his death he was under the parental responsibility of Chief Executive Officer (CEO) of Territory Families, Housing and Communities, the child protection agency of the Northern Territory.
Recommendations:	1. Where Territory Families, Housing and Communities becomes aware of a significant incident relating to a family member of a child or young person who is in care and placed with an Agency, and it is considered that incident is likely to significantly affect that child or young person, Territory Families, Housing and Communities must notify the Agency with responsibility for the day-to-day care of that child or young person and collaborate with the Agency to develop a plan to support the child or young person. 2. That Territory Families, Housing and Communities further revise its Interstate Case Transfers from the Northern Territory to Other Jurisdictions (including New Zealand) Procedure to provide that, before the Interstate Transfer Panel is convened to formally discuss a proposed interstate relocation: a) Practitioners must hold a family meeting, wherever practicable and in the best interests of a child b) Where a meeting is not held, reasons for this decision must be recorded and signed off by a senior officer

	c) Where a meeting is not held, reasonable efforts must be made to consult with individual family members including parents and others who have ongoing involvement in the child's life d) Practitioners should update a child's genogram prior to the family conference where practicable or otherwise before the decision is considered by the Interstate Transfer Panel e) Best Interests Mapping should be conducted no more than three months prior to an interstate panel meeting and the documented outcomes from the Best Interests Mapping be included in the information considered by the Panel 3. That Territory Families, Housing and Communities introduce a policy that when there are significant changes to a child's placement, health or wellbeing, or a significant event occurs in the child's life, parents must be notified and consulted on future planning for the child. Where for some reason a decision is taken not to notify parents the reason for that decision must be recorded. 4. That Territory Families, Housing and Communities amend relevant out-of-home care policies and procedures to include a direction that practitioners are required to consider expectations around the frequency with which Territory Families will contact families and update them on the progress of their children at the initial care meeting, and as reasonably necessary and agreed thereafter. 5. That Territory Families, Housing and

	Communities continue to explore options for Intensive Therapeutic Care to be provided on or close to country for Aboriginal children who have complex or extreme needs and are unable to be placed in family-based care.

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Introduction

1. This inquest concerns the death of Yakamurro. Although it is necessary in the formal findings to have a written record of the name that Yakamurro was given at birth, orally and in the body of the findings, this Court will refer to him as Yakamurro, in accordance with his family's wishes and out of respect for his family and culture.

2. Yakamurro was a 15-year-old First Nations boy who died at a residential care home at Jiggi, in Northern NSW, on 20 December 2018. His death was the result of ligature compression of the neck due to hanging.

3. At the time of his death, Yakamurro was a child under the care of the Chief Executive Officer (CEO) of Territory Families, Housing and Communities ("Territory Families"), the child protection agency of the Northern Territory ("NT"). After moving to Northern NSW with his NT foster carers, G and H, the placement broke down. The NSW Department of Communities and Justice ("DCJ") had some involvement with Yakamurro at this stage, before CASPA Services Ltd ("CASPA"), a local child support service, assumed day-to-day care of Yakamurro.

4. Yakamurro was a charismatic and affectionate young man. He was greatly loved. At the time of his death, he was a teenager with good friends who loved playing and watching sport. He played basketball, AFL and soccer and was passionate about his ALF team, the 'Swannies'. He was gifted at art. He had hopes for the future. One of his carers at CASPA, K, gave evidence that he had a "*big heart*". He obviously loved his family in the Northern Territory and was particularly close to his siblings. He also had a strong bond with his former carers, G and H, and with those who had come to care for him in the NSW, including Maxine Fromm (Mumma Max, who tragically passed away in a car accident), case worker J, and Naarah Rodwell, CEO of CASPA.

5. Yakamurro's mother, Amala, travelled from the Northern Territory with an interpreter and support person to attend the NSW Coroners Court. Her counsel explained that she participated in the inquest in the hope that no Aboriginal child in similar circumstances will experience the pain and loneliness that Yakamurro felt at the end of his life, and that no other mother will experience the grief and suffering that she now feels. I acknowledge her profound sorrow and thank her for attending. I know she will never stop loving her child. The courage and grace that Amala showed in terrible and unfamiliar circumstances is astounding.

6. Prior to commencing the inquest, members of the assisting team travelled to Katherine to visit Amala, Yakamurro's siblings, his grandparents, aunts and uncles. They met and visited Yakamurro's grave in the Katherine cemetery, where the traditional lands of the Jawoyn,

Dagoman and Wardaman peoples converge. I thank members of Yakamurro's family and community who attended including Nicole Limmon, Stella Hall, Andrew Lansen, Malcom Mumbin, Trent Ashley, Nelly Hall Guyula and Victor Junior. Video footage of that visit was played simultaneously at the Coroners Court at Lidcombe. I thank the family for their generosity and warmth in including the Court in that ceremony at the grave site and for giving us an insight into important aspects of culture.

7. I acknowledge the importance of country to Yakamurro and his family.

The role of the coroner and the scope of the inquest

8. The role of the coroner is to make findings as to the identity of the nominated person and in relation to the place and date of their death. The coroner is also to address issues concerning the manner and cause of the person's death.[1] A coroner may make recommendations arising from the evidence in relation to matters that have the capacity to improve public health and safety in the future.[2]

9. The medical cause of Yakamurro's death was not in dispute. However, the circumstances that led to his decision to end his own life required significant exploration. An issues list[3] prepared before the proceedings commenced guided the work of the inquest. The Court focussed on the care Yakamurro received after he was removed from his parents and tried to understand what went so terribly wrong. The inquest was not directed towards personal blame, but rather focussed on an investigation of the systemic failures that occurred.

10. The inquest took place after each agency involved had conducted their own extensive internal review, and for this reason the issues for investigation were somewhat narrowed. I commend the agencies involved for their willingness to conduct extensive internal reviews.

11. I note that Territory Families acknowledged and apologised for the deficiencies in the care it provided Yakamurro. Its Practice Review following Yakamurro's death indicates its real commitment to improvement and this Court was referred to changes that have subsequently been made to its policies and procedures. I also acknowledge that the care landscape has changed significantly since the *Royal Commission into the Detention and Protection of Children in the Northern Territory*, which was established in August 2016 and delivered its final report in November 2017.

12. Similarly, DCJ conducted an Internal Child Death Review which acknowledged that it played a very passive role in caring for Yakamurro when more was required. It acknowledged the need for greater clarity of its responsibility in relation to interstate transfers.

[1] Section 81 *Coroners Act 2009* (NSW).
[2] Section 82 *Coroners Act 2009* (NSW).
[3] The issues list is attached at Annexure A.

13. These acknowledgements and related reforms have greatly reduced the work of the inquest. I acknowledge that senior members of both Departments attended the inquest and appeared committed to learning from the tragedy of Yakamurro's death. I commend their apparent willingness to grapple with the difficult task of institutional change.

14. It should also be noted that many of the issues touched upon in this inquest have been substantially explored in the Independent Review of Aboriginal Children in Out of Home Care ("OOHC") chaired by Professor Megan Davis, resulting in the report "Family is Culture". However, most of the broader systemic issues that were explored there are beyond the scope of this inquest, which focuses necessarily on Yakamurro's life and his interaction with child protection systems across two jurisdictions.

15. These findings have drawn from the important work done by other Government and non-government organisations, and I hope that they will play a role in identifying the way in which individual children can fall through the cracks of the child protection system, despite the commitment of good people who want to provide good care.

16. The journey towards better, safer, more culturally appropriate care for First Nations children is ongoing and must be a priority for State and Territory governments charged with such an important responsibility. To that end, I note the important lessons that have already been learnt as a result of Yakamurro's death and at the conclusion of proceedings I make a number of recommendations that flow from the evidence I heard.

The evidence

17. The court took evidence over seven hearing days. The court also received extensive documentary material in a 28-volume brief of evidence. The documentary evidence included statements, expert reports, medical and care records, and photographs.

18. While I am clearly unable to refer specifically to all the available material in any detail in my reasons, it has been comprehensively reviewed and assessed.

Fact finding and chronology

19. Counsel assisting provided the Court with comprehensive submissions which summarise much of the evidence which was before the Court, including a brief account of Yakamurro's early life. Where appropriate I have relied on those submissions as the basis of the chronology below. I have also taken into account submissions made by all interested parties and note, where relevant, their objections to matters of fact and interpretation. Nevertheless, to summarise such a huge volume of material is not an easy task and I accept that opinions may differ in relation to which matters should be emphasised. I greatly appreciate all the care and effort that was put into the submissions by those appearing before me during the inquest.

The context to Yakamurro's journey into state care

20. It is necessary to place Yakamurro's life in its wider social context prior to a close examination of the particular facts leading up to his untimely death. In this task the Court was assisted by Professor Megan Davis's report, "Family is Culture", outlining the findings of her extensive review into Aboriginal out-of-home care in NSW. While the review is state focussed, her careful analysis of the impact of colonisation and inter-generational trauma is both profound and highly relevant to practises well beyond NSW. It is important to understand the context of Aboriginal mistrust of the child protection system and to face Australia's long history of removing Aboriginal children from their parents, of condoning assimilation policies, of disrespecting or paying lip service to Aboriginal culture and the overuse of institutional care for First Nation children.

21. This is not just history - Professor Davis's report sets out the scope of the current crisis. According to her report, the latest government statistics released in January 2016 show 39% of children in foster care in NSW were Aboriginal, 54% of children in NSW residential care homes were Aboriginal and 50% of the average daily detention population of children and young people aged 10-17 years of age in NSW was Aboriginal. The Aboriginal population of New South Wales as a proportion of the total population in the state in 2016 was 3%.[4]

22. There are similarly concerning figures in NT. As at 30 June 2021, there were 966 children in out-of-home care in the NT. This was a decrease in the number of children in care for the fourth consecutive year, down from 1,026 as at 30 June 2020, and 1,054 as at 30 June 2019, but it is still a very concerning number. Of the 966 children in care, 879 were Aboriginal. Approximately 33% of those children were placed with Aboriginal carers. In 2020/21, 227 children entered out-of-home care, 86% of whom were Aboriginal children. It is also important to note that 289 children exited out-of-home care, which was 22 more children than the previous year. 156 of the children who exited care were returned to their families, and 150 of those children were Aboriginal[5].

23. Sadly, some children are not able to remain with their birth families for their upbringing and they do need to be removed, at least for a period of time. The reasons for that can be complex but are often related to the trauma that generations of Aboriginal people have experienced since colonisation displaced them from country and family.

24. At the time of Yakamurro's passing, he was in the care of the CEO of Territory Families,

[4] Vol 2, Tab 31, p. 7.
[5] Vol 18, Tab 467.

and was case managed by the Northern Region, which comprises Arafura, (the North-Western corner of the Territory, including Wadeye, Adelaide River, Jabiru, Maningrida, Wurrumiyanga and Warruwi but excluding Darwin and Palmerston); Arnhem (the North-Eastern corner of the Territory, including Milingimbi, Galiwinku, Nhulunbuy, Yirrkala, Gapuwiyak and Groote Eylandt and Big Rivers, extending to the eastern and western borders of the Territory, south of Arafura and Arnhem, and north of Barkly and Central, which together comprise the Southern Region. Big Rivers includes Pine Creek, Kalkarindji, Katherine, Ngukurr, Beswick, Borroloola, Robinson River, Lajamanu and Timber Creek.

25. Yakamurro has family members who are or were previously based in Ngukurr, Badawarrka, Minyerri, Urapunga, Jilkminggan and in Katherine, each of which are within the Big Rivers catchment[6].

26. I accept the submission of Territory Families that the challenges it faces in the delivery of child protection services in the Northern Territory, particularly in remote communities, are unique and significant. The Court heard evidence about the difficulties in finding appropriate professional staff to assist in some remote areas. Other challenges referred to included providing appropriate housing, educational and therapeutic opportunities. The court accepts these challenges exist and is somewhat heartened by evidence that change is occurring, although it will continue take time, commitment and additional resources.

27. I was informed that *"[s]ince late 2016, and the establishment of Territory Families, there has been a sustained expansion of the focus and activities of child protection services to include early and preventative measures, as well as family support in circumstances where safety concerns are identified, however entry into care is not considered necessary*[7]". Expansion of early support and prevention strategies must remain the priority going forward.

28. These factors form the relevant background to my specific inquiries. Yakamurro's death can only be understood in this context.

Background and early family life

29. Yakamurro was born on 7 May 2003 in Katherine District Hospital, Northern Territory. As a young child, Yakamurro lived on Ngalakan country at Badawarrka Community, a small community made up only of family and no service providers.

30. Yakamurro's mother, Amala, is a Waguluk woman who grew up in Badawarrka community. Yakamurro's father, N, was from Minyerri.

31. Yakamurro's skin name is Ngarritj and his totem is Baru, the Crocodile.

[6] Vol 18, Tab 467, at [33].
[7] Vol 18, Tab 467, at [21].

32. In statements provided to the Court, Amala described that when Yakamurro was a young child she would tell him stories passed down by the ancestors and teach him traditional bush ways of living. Yakamurro learnt how to fish, hunt on land, gather bush foods and then cook it all up for a good feed. Yakamurro enjoyed eating bush foods around a fire surrounded by family. The adults would sometimes catch buried turtles and snakes while the children would collect water lilies. Amala taught Yakamurro how to catch fish with no line and using traditional practices.

33. There is no doubt that Amala loved Yakamurro and never stopped, even when they were separated and he was far from his own country. Ms Naarah Rodwell of CASPA put it eloquently: *"Amala…never stopped wanting to know where he was, how he was. She was consistently sending messages of love. She, even when transient for periods of time, she carried so many things with her: she didn't lose them; she would always have photos…"*[8] Ms Rodwell also noted that despite Yakamurro's significant trauma, he had *"layers of empathy and kindness"* which *"indicated that somebody was doing something right for him"* in his early years.[9] I found her comments particularly insightful and acknowledge the protective power of a mother's love even during periods of great disruption and trauma.

34. Despite his access to culture, Yakamurro's early life was far from idyllic. There is no doubt that Amala's own trauma affected her ability to protect her children. It is a matter appropriately acknowledged by Amala's counsel and a matter about which Amala has shown great insight. I reject entirely the submission made by G and H that the court proceeded with "*an obvious intention to exonerate Amala*."[10] The submission demonstrates a lack of familiarity with coronial proceedings where the purpose is not to apportion blame but to seek understanding. It also fails to appreciate the extensive and undisputed material before the Court in relation to the dire circumstances Yakamurro and his siblings experienced early in their lives, including exposure to domestic violence and [redacted].

Involvement of Territory Families, Housing and Communities (Territory Families) in Yakamurro's early life

35. Yakamurro first came to the attention of Territory Families on 12 January 2004 when it received a report regarding Yakamurro's exposure to domestic violence, emotional and physical abuse.[11] Prior to Yakamurro's birth, Territory Families had also received reports of concern in relation to Yakamurro's older sister, C.[12]

[8] Transcript 14/6/22, p. 24, l. 32 and following.
[9] Transcript 14/6/22, p. 24, l. 23-25.
[10] Submissions of G and H.
[11] Vol 3, Tab 33, p. 1.
[12] Vol 3, Tab 33, p. 1.

36. On 21 January 2004, Wurli Wurlinjang Aboriginal Health Service were engaged to work with Amala to monitor the weight and general wellbeing of the children.[13]

37. On 9 July 2004, Yakamurro (then aged one) and C were taken to Katherine Hospital by Amala. They were admitted to Katherine Hospital for failure to thrive, extensive scabies and skin sores.[14] Territory Families were notified the following day.

38. On 16 November 2004, orders were made for Amala and N to have guardianship of the children under the direction of Territory Families and medical staff at local clinics in Katherine for three months. These orders were in effect until 10 June 2005.

39. Yakamurro was referred to Sunrise Medical Centre in February 2005, however there appears to have been limited engagement from outreach workers at the medical centre, though the children had on occasion presented at the clinic for medical reviews.[15]

40. On 5 May 2005, Territory Families made an application seeking for the care of Yakamurro and C to be placed with the Minister for Territory Families for a period of 12 months[16], however, on 10 June 2005, the care application for Yakamurro and C was withdrawn.[17] File notes indicate this decision was taken on the basis of a court-ordered paediatric report.

41. Between 8 March 2006 to 20 August 2009, Territory Families received nine reports of concern in relation to Yakamurro's exposure to emotional and physical harm and neglect,[18] however these reports did not appear to trigger a statutory response.

42. The Internal Practice Review noted that, prior to 2009, family support services delivered to the family were "*too little too late*".[19] It highlighted the fact that had earlier intervention services been delivered to Yakamurro and his family, this may have reduced the trajectory of Yakamurro's needs and could have given him a much better start in life.[20]

43. Ms Karen Broadfoot, the General Manager of Territory Families for Greater Darwin, provided extensive oral evidence to the court in addition to providing lengthy and extremely helpful written statements.

44. In her oral evidence, Ms Broadfoot was asked about the level of support that Amala and N received. Ms Broadfoot told the court:

    "I think there were significant supports actually put in. So I don't agree that there were no supports. I think that in the [sic] *what the reviewer is attempting to say there is that there is*

[13] Vol 3, Tab 39, p. 1.
[14] Vol 20, Tab 476, p. 2.
[15] Vol 3, Tab 51, p. 78.
[16] Vol 3, Tab 50.
[17] Vol 3, Tab 55.
[18] Vol 20, Tab 475, p. 4.
[19] Vol 19, Tab 467, p. 332.
[20] Vol 19, Tab 467, at [16] – [18].

some early indications when we were first involved back in 2004 and we certainly did take that matter to court then and subsequent notifications where we, where significant concerns were coming up again we certainly did put supports in around that."[21]

45. The significant supports referred to are carefully set out in the comprehensive and very helpful statement of Ms Broadfoot. Ms Broadfoot nevertheless conceded that the initial supports given to Amala and N regarding Yakamurro and C were "*predominantly focused on the health requirements of the child[ren]"*[22], and that the supports offered were largely referrals to local health clinics.

46. During this initial period of involvement in Yakamurro's life, there appears to have been a lack of supportive proactivity when engaging with Amala and N. The Internal Practice Review found that casework would often only occur after Amala and N made contact with Territory Families. There were missed opportunities to support the family. As the Internal Practice Review notes, Amala and N initiating contact with Territory Families was a reflection of their maintained interest in the children.[23] There was a willingness to ask for help.

47. The Internal Practice Review further noted:

"*Parenting programs for [Amala] and [Yakamurro] were first recommended by a Paediatrician in 2004 at the outset of the Agency's engagement with the family. However, a parenting program such as Good Beginnings was not engaged until 2011. Good Beginnings would have been a generalist parenting skills program and would not have been to the level of education required in 2011, to support [Yakamurro's] parents respond to a young boy with established challenging and* [redacted]*. But a program such as Good Beginnings would have had optimum benefit when the children were first reported with failing to thrive."*[24]

48. In his expert report, forensic psychologist Stephen Ralph agrees that more should have been done by Territory Families during this time. I accept his view. Mr Ralph expressed concern at the lack of contact from Territory Families with Yakamurro's family between 2005 and 2009.[25] In Mr Ralph's opinion, following the withdrawal of the care application in 2005, Yakamurro should have been identified as a vulnerable, 'at risk' child, warranting the delivery of appropriate support services. In oral evidence he indicated that even though the care application had been withdrawn, the family were clearly struggling and in need of assistance.

[21] Transcript 9/06/22, p. 37, l. 15-19.
[22] Transcript 9/06/22, p. 38, l.12-13.
[23] Vol 19, Tab 467, p. 332.
[24] Vol 19, Tab 467, p 332.
[25] Vol 26, Tab 561, p. 3.

He stated "*to leave it and allow it to continue on just allows the issues to fester and become even more complex and more pressing*…"[26]

49. Mr Ralph notes there was no indication that Territory Families followed through with providing the family with appropriate support and assistance, and the situation deteriorated. He noted that by 2009, five years after concerns were initially expressed about Yakamurro's failure to thrive, medical neglect and living in an unsafe environment, the same concerns were still evident.[27]

50. In hindsight, it is clear that the children's health issues should have been an indicator that broader parenting supports and strategies were needed. The health needs of the children were a sign that Amala and N were struggling and more should have been done by Territory Families to support them in their roles as parents.

51. Territory Families has readily and properly conceded that, in spite of the best intentions of staff to provide care for Yakamurro, the approach taken, particularly very early in Yakamurro's life, was flawed.

52. It has acknowledged, *inter alia*, the following:

    a. Its early engagement with Amala and N was inadequate and it has accepted that it should have done more to engage with and support Yakamurro's family prior to 2009.

    b. there was a delay in the services which were offered to Amala and N, and the services that were offered were criticised for being generalist and failing to provide specialised support for children with challenging behaviours. There was also delay in the delivery of statutory services, most notably the failure to create an initial care plan for Yakamurro more than two years following his entry into care.[28]

    c. It could have made greater efforts to engage with Yakamurro's family at an early stage. Ms Broadfoot highlighted the fact that Territory Families could have tried to open a Family Support case to provide ongoing support to Yakamurro's family following the withdrawal of the care application.[29] This would have allowed voluntary support services to be delivered to the family and may have fostered a better relationship between Territory Families and Yakamurro's family. A Family Support case would have meant that casework would be undertaken without the need to rely on an open child protection case to create the platform for intervention.

[26] Transcript 16/6/22, p.9, l.13-15.
[27] Vol 26, Tab 561, p. 4.
[28] Vol 19, Tab 467, p. 332.
[29] Vol 18, Tab 467, p. 23.

53. Ms Broadfoot's frank and helpful concessions included a summary of what she considers to be the key deficiencies, a number of which are interrelated. That summary (at [647] – [666]) includes, *inter alia*:

- *First*, upon Yakamurro's entry into care, it was vital that the Agency facilitated an assessment of his health and medical needs, or what is commonly referred to as a 'baseline assessment'. There were known concerns for [Yakamurro's] development at the time of his entry into care, on account of his child protection history, including for failure to thrive. However, it does not appear that an appropriate assessment of his medical needs was undertaken at that time, which then limited the Agency's ability to understand why [Yakamurro] presented in the manner he did, to identify interventions to assist his development, to inform the responses of others.

  When Paediatric and other assessments were subsequently completed for [Yakamurro], particularly once he had relocated to NSW, a greater understanding of [Yakamurro's] developmental challenges and delays was obtained, and they were shown to be significant. This information would have been beneficial for all those involved in [Yakamurro's] care in the Northern Territory, including the foster carers, his parents, those endeavouring to engage with him at school, CAT investigators, among others. Not obtaining that information at the outset was a fundamental oversight.

- *Second*, the Agency did not conduct its own investigations into notifications concerning [redacted], and therefore did not conduct an adequate risk assessment with respect to that exposure.

- *Third*, [Yakamurro's] placement with his grandmother and his subsequent reunification with his parents appear to have occurred without appropriate consideration being given to the safety of those placements, and whether or not those family members were equipped to meet Yakamurro's needs. The Agency was compromised by the earlier failure to appropriately assesse Yakamurro's needs when he entered care or having completed the investigations referred to above, insofar as the reunification with his parents was concerned.

- *Fourth*, the behaviour of the long-term foster carers should have been scrutinised more closely throughout the period of Yakamurro's involvement with them. Ms Broadfoot was of the view that Department staff appear to have been too deferential to the foster carers and accepting of behaviour that should have sounded alarm, including "their ongoing equivocation about caring for the children, their frequent contacting of the Agency in distress or when heightened,

their unwillingness to accept support or to participate in training, and their failure to provide timely or detailed information regarding the children". Ms Broadfoot acknowledged that the desire to keep the children in the Katherine area, near family, and the acute shortage of other potential foster carers in the region would likely have motivated the Agency to strive to maintain the placement, despite its fragility.

It was not clear to Ms Broadfoot that the Placement Unit, which was responsible for re-authorising G and H, and for the decision to place Yakamurro's younger siblings into that household, was aware of the full extent of the difficulties being experienced by the Case Manager in engaging with the carers. Ms Broadfoot did not think that the decision to place Yakamurro's younger siblings with the carers would have been made, had they have been aware. This reflects a concerning breakdown in information sharing within the Agency.

Once the decision to place the children with the foster carers had been reached, including after the attempted reunification of Yakamurro with his parents, I consider that greater effort should have been made by the Agency to support the carers, and targeted training provided on how to respond to issues that were arising in the placement, including [redacted]. Although offers of support by the Agency, including for training and counselling, were declined by the carers, we should have been more proactive in the assistance provided, and in upskilling the carers, earlier on in the life of the placement.

- *Fifth*, the steps taken by the Agency to explore kinship placements for Yakamurro, beyond his placement with his maternal grandmother and reunification with his parents, and placements in compliance with the Aboriginal Child Placement Principle, were insufficiently documented, and are therefore unable to be properly scrutinised.

- *Sixth*, the Agency failed to meet Yakamurro's cultural needs once he was residing in NSW. This was an inherently difficult task for the Agency to achieve, and the original intention of having Yakamurro return to community twice a year was a reasonable starting point, however more should have been done. In particular, the Agency should have developed a detailed Cultural Care Plan for Yakamurro, and sought to link him with people of cultural significance for him in community, not only from within his immediate family, and with his language.

- Ms Broadfoot stated that encouraging relationships with positive male Aboriginal role models could have been of real benefit to Yakamurro, including to discuss appropriate and respectful behaviour, given the behaviours Yakamurro was

exhibiting. If appropriate, those individuals from community could have accompanied Amala when visiting NSW, to engage further with Yakamurro. Further, more should have been done by the Agency to link Yakamurro in with Aboriginal people in NSW, to assist him to develop a positive understanding of what it is to be an Aboriginal person and foster a greater sense of pride in his culture.

- *Seventh* (and what she considered to be the most significant failing), the Agency too readily allowed the decision-making role for Yakamurro to be influenced or performed by external parties, including the foster carers and CASPA, despite him being in the care of the CEO, and the fact that the NT Agency had statutory responsibility for him.
- Ms Broadfoot explained that in her view, the Agency did not establish a meaningful relationship with Yakamurro, during his time in care, so as to be able to seek information from him on what he was experiencing, and his views on future care arrangements. They were left largely reliant on the information and views of persons who were caring for Yakamurro at different times. While those views are important, they did not replace the Agency's own responsibility to bring an independent judgment to bear on Yakamurro's behaviour and trajectory.

54. Ms Broadfoot then identified a number of reasons why Yakamurro's case was one of the more challenging and complex that she had seen in her long and distinguished career in child protection, that would have made it challenging for any case manager. They included:

a) the nature of the notifications received, which alleged [redacted] and domestic violence, which are generally difficult to investigate;

b) lack of information provided in relation to certain notifications;

c) the identity of the alleged perpetrators of harm, which included [redacted], as well as alleged physical harm on the part of his foster carers;

d) reports of conflict within Yakamurro's immediate and extended family, and the long-term transiency of his parents

e) the availability of relevant services in communities frequented by Yakamurro;

f) the inexperience of Yakamurro's foster carers, at the time of his placement with them, and the lack of alternative foster carers within the Katherine area;

g) untimely or insufficient communication from those involved in caring for Yakamurro,

h) the dynamics between those involved in caring for Yakamurro, and the strained relationship between Yakamurro's Case Managers and Yakamurro's foster carers, in particular;

i) the ongoing tension between maintaining placement stability for Yakamurro, where he was reported to be progressing scholastically, for example, and ending his placement due to concerns that it was not fully meeting certain of his other needs, including cultural connection; and

j) the difficulties presented by distance, following the foster family's relocation to a jurisdiction that had a higher level of service offering to meet Yakamurro's high needs

55. My function is forward-looking and it is important to consider what, if anything, has changed since Yakamurro's death and to examine the early intervention programs that may be available to families today.

56. In her first statement, Ms Broadfoot notes:

"*Since late 2016 and the establishment of Territory Families there has been a sustained expansion of the focus and activities of child protection services to include early and preventative measures as well as family support in circumstances where safety concerns are identified".*[30]

57. This was confirmed by Ms Broadfoot during her oral evidence. She agreed that "*there's been a substantial expansion of the focus and activities of child protection services to the early phases so that the hope is that [Amala, and parents in her situation] can be supported to raise her own children rather than being taken away"*.[31]

58. Another focus since Yakamurro's death has been on the importance of housing within the context of child protection and parental supports. Ms Broadfoot told the court:

"*We've actually come together now as Territory Families, Housing and Communities. So for my responsibilities, for example, I cover off on child protection and housing. Therefore what we're working towards is and we've already seen is a significant cross over both with our clients being able to communicate with each other far more effectively and being able to target resources far more effectively*"[32]

59. Although Ms Broadfoot gave evidence that there are no simple fixes regarding housing and that the provision of housing in the Northern Territory is very difficult, she also told the court:

[30] Vol 18, at [21]
[31] Transcript 9/06/22, p. 38, l. 28.
[32] Transcript 9/06/22, p. 39, l. 2-9.

" *What we are [now] able to do is make some prioritisation around who is allocated housing on the priority list, those sorts of things and that's where some of the communication happens. It's also happening where people are residing in social housing and they're experiencing difficulties in maintaining the tenancy and potentially having difficulties in relation to child protection. What we're finding is that having child protection workers go or family support workers go out and actually working alongside tenancy officers is allowing us to have - intervene more early, get support services in and, and make an effect that way. That doesn't address of course the broader limitations around housing across the territory which is a very real thing".*[33]

60. Child protection is complex at all junctures. However, the honest reflection that was displayed by Territory Families regarding its involvement in Yakamurro's early life suggests a willingness to ensure better delivery of service. The willingness to engage with the inquest process suggests that Territory Families is keen to work towards better outcomes for First Nations families and children, however there remains much to be done.

Re-engagement of Territory Families with Yakamurro in 2009

61. In 2009, Territory Families began engaging with Yakamurro's family again. At this time, the family were spending time living in Minyerri. The re-engagement was triggered by the receipt of a child protection notification on 12 June 2009, raising concerns of failure to thrive for Yakamurro and C. Following this notification, Territory Families conducted interviews with Amala and N, Yakamurro and C, with their maternal grandmother and with staff from the Women's Crisis Centre where Amala had stayed with the children. A Territory Families caseworker also conducted home visits. Territory Families arranged some specialist appointments for the children, including hearing and paediatric appointments.[34]

62. Following the interviews with family members, Territory Families contacted various support services, to identify which services the family wished to access.[35] Territory Families workers also contacted Wurli Wurlinjang Aboriginal Health Service and the Minyerri Clinic to obtain information about the children's health.

63. There was a subsequent child protection report made to Territory Families concerning the children's health.

64. On 20 August 2009, a temporary protection order was made for Yakamurro and C and their care was placed with the Chief Executive Officer of Territory Families.[36] Yakamurro and C were placed into temporary care due to malnourishment and the failure of Amala and N to

[33] Transcript 9/06/22, p. 39, l. 19.
[34] Vol 20, Tab 476, p. 23.
[35] Vol 18, Tab 467, p. 27.
[36] Vol 20, Tab 475, p. 4.

meet their basic needs.[37] That day, the children were flown from Minyerri to Katherine to receive medical treatment.[38]

65. Territory Families had numerous visits with the children's maternal grandmother, to discuss arrangements for her care of the children. On 28 August 2009, a Mobile Child Protection team transfer report was completed. It concluded that family members needed to be assessed, however in the opinion of that writer, the grandmother and the parents did not appear to have the "*ability or motivation*" to provide adequate care.

66. However, on 20 October 2009, Yakamurro and C were moved to a kinship placement with their maternal grandmother. Ms Broadfoot concedes that there is a lack of documentation as to how Territory Families satisfied itself that the children would be safe in their grandmother's care.[39]

67. The Internal Practice Review notes that Territory Families failed to adequately assess the proposal to place Yakamurro in his grandmother's care. The decision to place Yakamurro with this grandmother lacked any meaningful assessment of her capability and suitability to provide for Yakamurro and to protect him from family violence. The report also noted that there was inadequate planning to provide for the children's safety once they were placed with their grandmother.[40]

68. During the placement with their grandmother, Amala and N continued to have informal contact with the children and lived with her at different times.[41] From January 2010, Territory Families was made aware of child protection concerns relating to the children whilst they were in the care of their grandmother. Family meetings and interagency case conferences were convened to discuss safety concerns relating to the children. The child protection concerns arising from notifications to Territory Families were substantiated.

69. Consequently, on 7 April 2010, Yakamurro's grandmother was deemed unable to provide a safe environment for the children and to fulfil their basic needs.[42] The children were placed in a temporary foster care placement in Katherine and it became evident to Territory Families that the children had high needs.

70. Territory Families acknowledge that more could have been done to proactively pursue other kinship placement options at this time.[43] This understandably still causes Amala great heartbreak. In my view it is a significant turning point in Yakamurro's life.

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[37] Vol 20, Tab 475, p. 4.
[38] Vol 19, Tab 467, p. 327 at [113].
[39] Vol 18, Tab 467, p. 31.
[40] Vol 19, Tab 467, p. 333.
[41] Vol 20, Tab 476, p. 26.
[42] Vol 3, Tab 33.
[43] Vol 19, Tab 467, p. 369.

71. Ms Broadfoot was questioned about kinship placements extensively. She accepted the key findings of the Internal Practice Review in this regard, namely that the efforts undertaken to identify Yakamurro's kin, including meaningful engagement with the family to assist with that task, was inadequate. The Internal Practice Review found that *"[m]ultiple documents in Yakamurro's case refer to no suitable family being available but the evidence to support this statement is lacking"*.[44]

72. However, Ms Broadfoot explained that since 2016, Territory Families has developed a framework to focus on child protection services in the early phases of interaction, which seeks to equip parents with the skills and resources to maintain care of their children. Ms Broadfoot described this preventative approach as a "*significant focus on the need to intervene earlier and to intervene with – in stronger ways to address parenting issues and to prevent children coming into care*."[45] Ms Broadfoot explained that Territory Families have "*expanded the footprint in remote communities but we have expanded the responsibility of staff in remote communities as well*", meaning that if a child is placed in the community and there are concerns for the child, a staff member who is also working and living in the community will be able to work alongside them.

73. Ms Broadfoot told the court that Territory Families has since *"funded seven Aboriginal organisations specifically for the purpose of undertaking family finding and to assist with the assessment and support of kinship carers*".[46]

Placement with G and H

74. On 1 August 2010, Yakamurro and C were placed with foster carers G and H. By 2010, G had been living in the Northern Territory for around 30 years and H had been living in the Northern Territory for around 10 years. G was working as a nurse and H was working as a teacher. Neither came from a First Nations background.

75. G and H attended part of the inquest and both gave evidence before me. It was clear that they remained angry, frustrated and devastated about their interactions with the care system. Their pain was palpable as they spoke in the courtroom. They told the Court they remain in a loving family relationship with Yakamurro's sister, C, and they spoke about their ongoing wish to regain care for Yakamurro's younger siblings, A and B. After giving evidence, G and H retreated from the inquest due to their extreme dissatisfaction with the process. They later provided written submissions which I have carefully reviewed.

[44] Transcript 9/06/22, p. 40, l. 1-4.
[45] Transcript 27/2/20, p. 38, l.30-40.
[46] Transcript 9/06/22, p. 40, l.11-13.

76. When Yakamurro and C first came into their care, G and H had the best of intentions for the placement. They clearly went above and beyond what was expected of them as foster carers and very quickly developed a dream of creating a family. One cannot help but wonder if from the start there was a lack of clarity around what their ongoing role would be and whether this issue was appropriately managed by Territory Families. At this stage, while Amala was hoping to re-gain care of her children, G and H appear to have been wanting to build a permanent blended family. I am concerned that these different expectations were not managed better from the start.

77. From the outset, it is clear that G and H wanted to build a relationship with Amala and N and wanted the children to maintain a connection to their parents. The Court heard evidence that outside of formal contact arrangements, Amala would visit G and H's home to see the children. The Court heard that the children came to refer to Amala and G as "black mum" and "white mum." Amala wanted contact with her children, but one wonders if the informal arrangement that developed assisted her in the longer term.

78. On 20 September 2010, Pine Creek Health Centre, where G was employed as a nurse, referred C and Yakamurro to mental health services, noting Yakamurro's "*very concerning behaviours*". This referral does not appear to have been brought to the attention of Territory Families at the time it was made.[47]

79. On 23 September 2010, G raised concerns with Territory Families about Yakamurro's violent behaviour, both at home and at school with other children.[48] Territory Families made a referral to Forensic Psychologist Stephen Ralph, who Yakamurro began to see in November 2010.

80. On 26 October 2010, Pine Creek Health Clinic advised that both children were below expected developmental milestones.[49] However I note in passing that it was not for another five years that investigations into a possible diagnosis of Foetal Alcohol Spectrum Disorder appear to have been formally considered.[50]

81. On 24 November 2010, Territory Families contacted Mr Ralph. During the discussion, it was reported that Yakamurro was exhibiting aggressive and rule breaking behaviour, and that he [redacted].[51]

82. During this time, it appears that G and H were in regular contact with Territory Families. It is evident from the material in the brief of evidence, and should have been evident to Territory Families at the time, that G and H needed more support to manage the challenging behaviours of the children at this time. This is something that Territory Families has now

[47] Vol 18, Tab 467, p. 33.
[48] Vol 20, Tab 476, p. 33.
[49] Vol 20, Tab 476, p. 34.
[50] Vol 4, Tab 110.
[51] Vol 20, Tab 476, p. 35.

acknowledged, noting that regular home visits should have been occurring so that Territory Families could have considered further training or supports to assist G and H.[52]

83. There are differing views between Territory Families and G and H as to the level of support that was provided to G and H at this time (and moving forward). The perceived lack of support provided to G and H led to considerable tension between them.

84. What the evidence suggests is that G and H were making considerable efforts to find adequate support services for Yakamurro. However, in parallel, Territory Families were also making efforts to assist Amala and N with housing, and to assist with facilitating their attendance at contact visits with Yakamurro and C.

85. Sometime prior to December 2010, Yakamurro disclosed to G that [redacted] This prompted G to make a further report of concern regarding Yakamurro's [redacted] behaviour.[53]

86. On 14 February 2011, Mr Ralph completed a report which concluded that Yakamurro's behaviour was consistent with [redacted].[54] This report was provided to Territory Families. Mr Ralph recommended that the children have therapeutic intervention. He also concluded that it was important that issues surrounding their further placement be resolved as soon as possible in order to provide the children with stability and certainty. He acknowledged that decision-making in relation to this issue was extremely difficult and that further investigation and assessment would be required to determine the best placement options.

87. On 24 February 2011, G notified Territory Families that Yakamurro had disclosed to her that [redacted] This was investigated by the [redacted] During the investigation, Yakamurro chose not to disclose his complaint to [redacted] and the police investigation did not proceed.

88. Territory Families acknowledge that their responses to Yakamurro's disclosures of [redacted] were significantly lacking and that concerns regarding [redacted] were not suitably assessed to protect Yakamurro or his siblings from experiencing further harm.[55] Further, Territory Families acknowledge that their interventions were insufficient to assist G and H with developing skills to practice protective behaviours in the home.[56]

89. In March 2011, Territory Families were conducting casework with a view to restoration of the children to their parents. Territory Families had a meeting with Amala and N. By this stage N

[52] Vol 18, Tab 467, p. 35.
[53] Vol 20, Tab 476, p. 41.
[54] Vol 20, Tab 475, p. 5.
[55] Vol 19, Tab 467, p. 371.
[56] Vol 19, Tab 467, p. 372.

was employed, Amala and N had started counselling and there was no reported occurrence of domestic violence for a period of 9 months.[57]

90. On 20 March 2011, Amala and N had a further child, A. A was eventually also placed into the care of G and H.

91. Despite Mr Ralph's earlier recommendation, it was not until 8 June 2011 that Territory Families commenced a Therapeutic Services case for Yakamurro. During the first therapeutic services session, Yakamurro was described as being [redacted] by G.[58] He had weekly to fortnightly individual therapy sessions for a period of approximately one year. However, G gave evidence that she does not recall the therapeutic support provided to Yakamurro as being helpful in addressing his [redacted] behaviours.[59]

92. In July 2011, Territory Families received reports regarding Yakamurro's concerning behaviour including [redacted] behaviours and cruelty to animals.[60]

93. As part of the restoration process, Territory Families set goals for Amala and N. They had to have suitable housing, engage in parenting programs and there could be no reports to Territory Families concerning domestic violence or excessive drinking involving either parent. Assistance was provided to Amala and N from time to time, including in July 2011, for example by referring them to the Therapeutic Services Team, to assist them to deal with Yakamurro's disclosure of [redacted]. As I outlined earlier, Territory families has frankly conceded that the Agency did not conduct its own investigations into notifications concerning [redacted], once it was advised that [redacted] was unable to proceed with a criminal investigation or prosecution. It should have then commenced its own investigation, including by speaking with family members. Greater effort should have been made by the Agency to support the carers, and targeted training provided on how to respond to issues that were arising in the placement, including [redacted] behaviours[61].

94. On 30 August 2011, Territory Families enrolled Amala and N in a parenting program called Good Beginnings,[62] which they started attending on 11 October 2011. Unfortunately, they did not complete the parenting group sessions.

95. On 6 January 2012, Territory Families made an application to Katherine Court to extend the protection order for Yakamurro for a period of one year.[63]

96. On 20 February 2012, Amala and N were advised that Territory Families was satisfied that they had addressed the family violence and alcohol abuse issues. However, at that point in

[57] Vol 18, Tab 467, p. 40.
[58] Vol 18, Tab 467, p. 42.
[59] Transcript 10/06/22, p. 22, l. 40-45.
[60] Vol 20, Tab 476, p. 76.
[61] Vol 18, Tab 467, at [650] and [657].
[62] Vol 18, Tab 467, p. 46.
[63] Vol 18, Tab 467, p. 48.

time, housing and inappropriate discipline of the children were identified as outstanding issues to be addressed.[64]

97. Amala was still hoping for a speedy return of the children. At the same time it is clear that G and H made great efforts to assist with the children's immediate physical and emotional needs while building long-term relationships. It appears that from an early stage, G and H wanted to form a family and care for the children as their own, whilst still maintaining the children's connection to Amala and N. I accept that they gave Yakamurro's parents more access to the children than was legally required and that they tried to understand aspects of Yakamurro's culture. Nevertheless, being well intentioned and having the necessary skills to manage an extremely complex placement are very different things. Neither G or H had been parents or full-time carers before. Despite their professional backgrounds they were ill-equipped to deal with the issues they faced.

98. Yakamurro and C displayed extremely complex and challenging behaviours whilst in the care of G and H. Despite these challenges, I accept that G and H made great efforts to love and care for the children and to advocate for their wellbeing and development.

99. Territory Families admit that greater placement support for G and H was required from the outset and that Territory Families failed to meaningfully assess G and H's suitability to care for Yakamurro and C, who were evidently displaying challenging behaviours. The support offered to G and H was insufficient and not tailored to the needs of Yakamurro and C.[65] It may also be that there was a disconnect between what G and H wanted - to build a family - and what may have still have been possible at that stage if proper support had been provided– a permanent return to their birth parents or family.

100. On numerous occasions G told the court that she and her partner approached the care of these children in a unique way. She explained that she had a close bond with Amala and that they had always told the children: *" 'You got a black mum and dad and you got a white mum and dad' and that's the way it's always been. It's been black mum and dad, white mum and dad, they've always known that and it's really acceptable and we worked as a team. But it was – had never sort of been done. You know foster carers are there, and family is there and it's very …you know like...that might be because that's the way foster carers work or Territory Families, I don't know but it's not the way that we wanted our family to work. We were sort of out of the box."* G and H had never been foster carers prior to their involvement with the family. I am concerned that they may have misunderstand their role right from the beginning. Territory Families did not monitor the placement sufficiently closely to understand the manner in which G and H's control of the situation developed.

[64] Vol 18, Tab 467, p. 48.
[65] Vol 19, Tab 467, p. 372.

Restoration to parents

101. On 5 April 2012, Yakamurro was restored to his parents. By this time, Amala was pregnant with a further child, B. The date for reunification was chosen as Amala and N moved into a house that week and would have intensive in-house support from Mission Australia.[66]

102. Yakamurro's parents had new housing in Katherine and I accept that Yakamurro was supposed to have his own room. There was to be intensive in-house support from a Mission Australia caseworker. Territory Families record that there had been no reports of domestic violence for approximately 16 months and no known reports of excessive drinking for 12 months.

103. Territory Families had purchased a fridge for the new house. Good Beginnings was to offer the parenting plus program to Amala and N until 25 May 2012, with the option for extension upon request from Territory Families.

104. C remained with G and H after expressing her views that she did not wish to return to her parents' care. G gave evidence that it was not often that C would express her views, stating "*this was probably one of the first times that [C] was able to actually stand up in front of the Territory Families people and say 'I don't want to go'… I think the problem is the children are never listened to*."[67]

105. There appears to have been insufficient analysis at this time by Territory Families of how separating Yakamurro and A from C might affect the success of any placement back with family. Similarly, there appears to have been limited curiosity about exactly why C was refusing to go or what part, if any, G and H had in the decisions made.

106. Yakamurro continued to display challenging and violent behaviour after he was restored to his parents. Territory Families acknowledge that insufficient work was undertaken to understand why Yakamurro was behaving this way and what was happening for him developmentally. Baseline assessments should have occurred so that appropriate strategies could have been developed.[68]

107. On 31 July 2012, Territory Families was notified that C was adamant that she did not want Yakamurro to return to the placement with G and H.[69] There appears to have been limited curiosity from caseworkers about this notification.

108. On 10 August 2012, Territory Families were made aware of reports that Yakamurro had said he did not feel safe with his parents and was expressing a desire to return to G and H.[70]

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[66] Vol 18, Tab 467, p. 48.
[67] Transcript 10/06/22, p. 24, l. 25-30.
[68] Vol 18, Tab 467, p. 52.
[69] Vol 20, Tab 476, p. 230.
[70] Vol 20, Tab 476, p. 233.

109. The evidence suggests that Yakamurro was exposed to [redacted] during the period in which he was restored to his parents.

110. Territory Families acknowledges that Yakamurro's placement with his grandmother and restoration to Amala and N occurred without appropriate consideration being given to the safety of those placements.[71] It accepts there was insufficient safety planning and reunification planning and it resulted in Yakamurro being exposed to further harm.[72]

111. During this period, it is evident that Territory Families made efforts to conduct home visits with Amala and N and to check in with support services, particularly Mission Australia and Good Beginnings, to determine whether they could assist with facilitating access to these services. There is also evidence of some liaison between the casework team and the Therapeutic Services team. It is not clear from the evidence before me whether the support offered by Mission Australia and the Good Beginnings program was culturally appropriate or sufficiently trauma informed.

112. In his expert report, Mr Ralph comments that the consideration of restoration in April 2012 was inappropriate in the absence of Territory Families having knowledge and an understanding of Yakamurro's past exposure to [redacted], and in the absence of the agency developing strategies to mitigate the risks involved.[73] Mr Ralph criticised the risk assessment made by Territory Families when considering restoration and considered it "*short-sighted and ill-informed*".[74] As well as the failure to consider the risk of [redacted], Mr Ralph notes that there also seems to have been no requirement for Amala and N to demonstrate sustainable change, nor any consideration given to their capacity to manage Yakamurro's behaviour or to ensure his safety.[75] While it is true that Mr Ralph has the benefit of hindsight, I accept his opinion that the re-unification at this time was not well informed.

113. Although Territory Families outlined the support they provided and the risk assessments they conducted prior to restoration, these were largely in relation to Amala and N. It appears that limited regard was given to the risk that other members of Yakamurro's family, such as his brother D, posed. There should have been greater curiosity into what day-to-day life would actually have been like once Yakamurro was placed back with family. This should have factored more heavily into decision making during the restoration efforts in 2012.

114. Ms Broadfoot agreed with the Internal Review report noting that "*there was a lack of suitable safety planning to mitigate the risk for Yakamurro*."[76] She also acknowledged that Territory

[71] Vol 18, Tab 467 at [652].
[72] Vol 19, Tab 467, p. 370.
[73] Vol 26, Tab 561, p. 5.
[74] Vol 26, Tab 561, p. 6.
[75] Vol 26, Tab 561, p. 6.
[76] Transcript 9/06/22, p. 40, l. 48-49.

Families' "*caseworkers did not manage to form lasting or meaningful relationships with Yakamurro*".[77]

115. The decision by Territory Families to restore Yakamurro to his parents in circumstances where D was still in the house and another baby was on the way is extremely difficult to understand. Although some clear progress had been made by Amala and N with respect to their domestic relationship and their ability to parent, it should have been apparent to Territory Families that the challenges Yakamurro presented by 2012, coupled with caring for baby A and Amala being pregnant with a further child B, placed an enormous amount of pressure on Amala and N. While Territories Families do not accept that in those circumstances the risk of the restoration failing was extremely high,[78] in my view it clearly was. The fact that Yakamurro was [redacted] during this period is of grave concern.

116. The court accepts that Territory Families should strive to place a child with a member of their own family, indeed if it is in the child's best interests it is required to do so. Nevertheless, in the circumstances of this case and at this time, restoration had little chance of success and presented substantial risk.

117. On 18 August 2012, a further child, B, was born. That child was subsequently also placed with G and H.

118. On 11 October 2012, Yakamurro was returned to the placement with G and H and by the end of October 2012, all of his siblings had joined the placement. G and H were now placed in an extremely difficult situation, particularly so given the evidence suggests that Yakamurro had been re-victimised and re-traumatised during the period in which he was restored to his parents.

119. G and H were first-time foster carers. Although well intentioned, they were presented with a particularly complex set of circumstances after accepting all four children. Yakamurro was by now nine and a half. C had previously voiced that she did not want Yakamurro to return to the placement and their relationship as siblings was in and of itself extremely complex and dangerously intertwined. There were now also two extremely young babies, who needed constant care to consider. Frankly, it was a recipe for disaster.

120. Although there were many missed opportunities regarding Yakamurro prior to this point, the decision by Territory Families to place all four children with G and H was a really significant error. It set in motion a sequence of events that led to the eventual move to NSW, the breakdown of Yakamurro's placement with G and H and his entry into what became permanent out-of-home care in NSW, thousands of kilometres from his family and country.

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[77] Transcript 9/06/22, p. 41, l. 40-41.
[78] TF written submissions at [88].

121. Territory Families should have done more. No kinship placements were explored for any of the children at this juncture, and G and H, although well intentioned, were evidently overwhelmed, having already made it clear to Territory Families that they were struggling to cope with Yakamurro's behaviours. Adding two small babies into this situation was irresponsible. Territory Families acknowledge that the placement of the two younger siblings with G and H was a poor decision.[79]

Return to placement with G and H

122. Despite his ongoing challenging behaviours, G and H continued to advocate for Yakamurro's care as best they could.

123. On 8 November 2012, a case was opened for Yakamurro with the Top End Mental Health and Child and Adolescent Services (Top End Mental Health Service).[80]

124. On 3 December 2012, Yakamurro made a further disclosure of [redacted]. This was reported to Territory Families and [redacted] on 5 December 2012.[81] G reported to Territory Families that Yakamurro continued to display [redacted] behaviours.

125. G advised Territory Families that she was arranging for Yakamurro to be seen by a psychiatrist at the Tamarind Centre to address his high needs behaviour.[82]

126. On 23 May 2013, a psychologist from the Top End Mental Health Service advised that they did not recommend any further therapeutic intervention for Yakamurro and C, who were assessed as developing well. The case with the Top End Mental Health Service was closed in June 2013. The Internal Practice Review notes that there is no supporting documentation in the Substitute Care Case about the intention of the therapeutic sessions, concerns or feedback arising from therapy, nor the outcomes achieved by the Mental Health Program.[83]

127. G explained that one of the biggest challenges regarding Yakamurro's care was the lack of consistency in treatment and support services. G explained that the children were frequently visited by "*different people and getting told different things by different people, it was really difficult*."[84] This is borne out by the evidence. For example, Ms Broadfoot acknowledged it was "*very difficult*" to find psychologists in the Northern Territory during that period, "*particularly ones that have the ability to and the skill to work with children*".[85] Reading the file

[79] Vol 18, Tab 467, p. 55.
[80] Vol 5, Tab 147, p. 19.
[81] Vol 20, Tab 475, p. 6.
[82] Vol 19, Tab 467, p. 360 at [301].
[83] Vol 19, Tab 467, p. 367 at [335].
[84] Transcript 10/06/22, p. 24, l. 5.
[85] Transcript 9/6/22; p.43, l. 18-29

material, it is clear that the lack of any continuity in the therapeutic services provided greatly diminished any positive benefit that may have flowed from engagement.

128. However, Ms Broadfoot outlined various changes which she says have subsequently occurred. She explained that the key learnings of the *Royal Commission into the Detention and Protection of Children in the Northern Territory* had greatly informed the recent policies and practices of Territory Families. This has included taking steps toward replacing fly-in-fly-out positions with positions with a requirement for practitioners to live in the community, as well as expanding the nature of those roles from purely family support to accommodate statutory roles.[86]

129. In August 2013, G wrote to Territory Families with a proposal for the family to move to Ballina in order to access better support services. It is evident that this was a well-intentioned proposal which G thought would be beneficial for the children. Mr Ralph states the rationale provided by G would have been "*compelling*".[87] Ms Broadfoot told the Court that "*one of the benefits that was agreed across the board [was] that New South Wales certainly offered easier access to more skilled professionals, in particular psychiatrists and psychologists*."[88] Whether these services would be culturally appropriate does not seem to have been given significant attention. Nor does balancing the benefit of greater access to professional services against the loss of cultural and family connection. It is clear that, from at least this point, G and H are effectively in control of therapeutic planning for the children.

130. It may be that as well as providing access to increased services, G and H saw NSW as offering their family more stability. H explained to the court their decision to move as also being related to the need for "*space and time*". He stated "*you know the kids would be backwards and forwards, backwards and forwards and backwards and forwards and it's – and it's disconcerting I think for anybody in that situation and I think really what we wanted to do was carve out space and time with specialist care, because we knew that that's what they needed, you know, and to give the children time to heal and develop, you know and to have moments in the sun like C's time in sport and those sorts of things, you know. To give them memories. Good memories, positive memories, happy memories, you know*."[89] There was a sense in which H was describing the need for them to have greater control over the way they cared for their family and an understanding that this would be easier away from the Northern Territory. I have concerns that Territory Families did not understand how the ongoing stress G and H had been subjected to factored into their decision to want to get away. It was not a firm basis on which to undertake such a significant move.

[86] Transcript 9/06/22, p.38. l. 10-20.
[87] Vol 26, Tab 561, p. 9.
[88] Transcript 9/6/22; p.43, l. 20-22.
[89] Transcript 10/6/22, p 83, l. 47 onwards.

131. G and H told the court that they consulted with First Nations elders, albeit not ones from Yakamurro's community. This consultation appeared to involve conversation with elders from the Kybrook Aboriginal Community, close to five hours from the communities of Ngukurr and Minyerri. I accept that, to Amala, this was consultation was with the "wrong mob."

132. G and H told the court that they wanted to go to New South Wales to engage Yakamurro with a number of different professionals to help with specific learning and behavioural difficulties.

133. On 5 September 2013, Amala attended the Katherine office of Territory Families and told staff that she felt the move to Ballina was too far away.

134. On 19 September 2013, the proposed move of Yakamurro and his siblings to Ballina was discussed in a single panel consultation.[90] It included the Senior Practice Leader, who in addition to a written statement, provided further oral evidence at the hearing. She was the Senior Practice Leader, also known as the Practice Advisor, for Territory Families during her involvement with Yakamurro. The panel consultation also included the Aboriginal Practice Advisor and the acting manager of the Katherine Office of Territory Families.

135. The evidence of the Senior Practice Leader in relation to the decision-making process for approving Yakamurro's move to Ballina demonstrated the unsatisfactory processes in place at that time. Moving a child from the Northern Territory to NSW was an enormously significant step. The implications for Yakamurro and his family were obvious - they would be separated by thousands of kilometres, in different states and in different surrounds. This should not have taken place by rubber stamping a decision G and H wanted made. It was Territory Families' responsibility to ensure the decision to move Yakamurro was given adequate consideration, and that ample weight was given to the views of the children and their family members. The evidence suggests this did not happen.

136. At the time of the panel consultation, the Senior Practice Leader had never engaged with Yakamurro or his siblings, and had only received a brief overview of the background of the children from Aboriginal Practice Advisor.[91] The Senior Practice Leader gave evidence that it was not the expectation that the Practice Advisor would communicate with the children prior to sitting on the panel, and that it was the role of the case manager to inform the panel of the nature and circumstances of the children.[92]

137. The Senior Practice Leader told the court that she had sat on "*several interstate panel discussions,*" and gave evidence that it would not be an unusual request for foster carers to submit requests to move Indigenous children interstate, because "*carers would form a relationship attachment*" with the children during their stay in the Northern Territory.[93] Despite

[90] Transcript 8/06/22, p. 32, l. 30-35.
[91] Transcript 8/06/22, p. 29, l. 35-40.
[92] Transcript 8/06/22, p. 32, l. 35-40.
[93] Transcript 8/06/22, p. 30, l. 25-30.

only receiving a brief overview of Yakamurro and his siblings, and having no interaction with them, she sat on the panel that provided advice to the Chief Executive Officer of Territory Families as to whether the interstate move should progress.

138. The Senior Practice Leader estimated that the panel consultation, which ultimately approved the move to Ballina, lasted for approximately 40 minutes. It is unclear whether the children's case worker was present at the panel consultation.

139. What is however clear is that at the panel consultation, the Aboriginal Practice Advisor raised concerns about how the move would affect the children's cultural needs.[94] The Senior Practice Leader told the court that the Aboriginal Practice Advisor had a clear view that Yakamurro and his siblings should remain in the Northern Territory, due to concerns about the distance between the siblings and their family, and the maintenance of their cultural connections. Notwithstanding her initial concerns, by the end of the meeting, the Senior Practice Leader had agreed to the move. Given that the Aboriginal Practice Advisor did not give evidence in these proceedings, it is impossible to know exactly what changed her view.

140. Arguably, the opinion of the Aboriginal Practice Advisor as to the cultural impact on Yakamurro and his family by moving to New South Wales should have outweighed all other opinions. The fact that her opinion had been changed by the end of the panel discussion is hard to understand in the context of the records now available, particularly as there does not appear to be a detailed plan which would address the concerns she had apparently raised at first instance. Nor are detailed reasons for her change of mind clearly recorded on the file.

141. Records indicate, and the Senior Practice Leader confirmed in oral evidence, that the only consultation with elders in the Aboriginal community in relation to the move was with Mohammed Douglas and Doug Kelly.[95] While G and H also brought this consultation to the attention of the Court, it was clearly misconceived. These men came from the Kybrook Community some five hours from the communities of Ngukurr and Minyerri. I accept counsel for Amala's submission that while this consultation may have been well intentioned, it was ultimately both misconceived and disrespectful.

142. The Senior Practice Leader stated that the cultural maintenance plan would be "led heavily" by the carers, who would be financially supported by the Department. [96] However, she indicated that as a Practice Advisor, she had no role in discussions regarding who would facilitate these meetings. She agreed that it was her expectation that the case manager would develop the details of a plan that would demonstrate how cultural connection and familial

[94] Vol 26, Tab 559A, p. 8 at [48].
[95] Transcript 9/6/22, p. 4, l. 33 onwards.
[96] Transcript 8/06/22, p. 31, l. 35-40.

relationships would be maintained, "*because the case management approvals sat with the decision in the care plans."*[97]

143. She stated that the cultural maintenance plan was largely centred on trips to and from Ballina: "*that the family would be able to go to Ballina and that the carers would support that, and the carers would bring [Yakamurro] and his siblings back to the Northern Territory*."[98] Territory Families submitted that this responsibility would have fallen to the Case Manager. It was also the Senior Practice Leader's expectation that Amala would visit Ballina twice a year, and that the children would travel to the NT twice a year.[99]

144. Yakamurro's parents and family members were not present during the panel consultation, and the Senior Practice Leader made no effort to communicate with them as she "*didn't at that time see it as [her] role*."[100] However, she told the Court that previously "*the family were of the strong view that the child should not move interstate*."[101] She clarified that by the time of the panel consultation, only Amala was informed of the possibility of the children moving to Lismore or Ballina, and that Amala was supportive of the children remaining in the care of G and H.[102]

145. However, a memorandum written to the CEO of Territory Families recorded that Amala is "*unlikely to formally consent to the children moving away given her natural distress and anxiety regarding reduced contact with the children*."[103] Yakamurro had kin, aside from his parents, in the NT and I have not been satisfied that all options were properly interrogated for placement suitability.

146. The Senior Practice Leader explained that "*enormous weight*" was given to the views of the children as to whether they wanted to move interstate, "*especially being Aboriginal children and that connection"*.[104] The Court was presented with evidence that C wanted to move to Ballina, but was sad about leaving her mum, and wanted her mum to visit her. Yakamurro also expressed that he was unsure about moving interstate but wanted to stay with his siblings and G and H. The Senior Practice Leader stated that the views of the children would "*inform the decision*" and "*… would be given weight by myself certainly*."[105]

147. It is important to remember that at the time this decision was being made, Yakamurro was only 10 years of age. While it was difficult to accurately determine his cognitive function, by the time he was assessed by Stephen Ralph in 2011, there was evidence of developmental

[97] Transcript 8/06/22, p. 32, l. 10-15.
[98] Transcript 8/06/22, p. 31, l. 45-50.
[99] Transcript 8/06/22, p. 33, l. 45-50.
[100] Transcript 8/06/22, p. 33, l. 30-35.
[101] Transcript 8/06/22, p. 32, l. 10-15.
[102] Transcript 8/06/22, p. 33, l. 20-25.
[103] Vol 7, Tab 224, p. 4.
[104] Transcript 8/06/22, p. 33, l. 5.
[105] Transcript 8/06/22, p. 33, l. 5.

delay and Yakamurro had little tolerance for issues which were intellectually challenging or frustrating[106].

148. The Senior Practice Leader did not recall the family genogram being discussed as a part of the panel's decision-making process.

149. The panel members did not discuss what the care arrangements of the children would be in the event the move to Ballina was refused. The Senior Practice Leader gave evidence that these discussions were only general practice in the event that a decision was not made. She explained that in panel meetings she consulted on, where a decision was not made, the panel would continue to meet several times to resolve the issue of where the children would remain.[107]

150. G told the Court in no uncertain terms that had the move to Ballina been denied, they would have stayed with the children in the Northern Territory. She stated that they were only going to Ballina for "*support for the children*" and that if the move had been refused they would have looked at other local options.[108] In these circumstances it is especially difficult to understand the speed with which the move was approved.

151. Ultimately, the panel submitted a recommendation to the CEO of Territory Families that endorsed the move of the children from the Northern Territory to Ballina. This recommendation was subsequently approved by Territory Families.

152. In order to facilitate the care of the children, it was understood that the Case Manager would maintain his role as caseworker, and that an interstate liaison officer ("ILO") would be appointed to discuss with the New South Wales caseworker. It was the ILO's responsibility to "*manage the relationship with the incoming State*."[109] The Senior Practice Leader gave evidence that the communication between the ILO and the receiving state could only occur after the case manager had commenced the paperwork process – however, she explained that ordinarily, the ILO "*should have been notified as soon as any child was being considered to move interstate*."[110] She explained it was the ILO's job to communicate what is "*required and putting that request to the incoming state. So, it's not only advising the state* [that] *a child from, on an NT order is coming into a different State, but it's also beginning those discussions of what may be required and seeking agreement of tasks*."[111]

153. It is clear that this panel consultation was entirely inadequate for deciding the future of Yakamurro's placement location. There were considerable deficiencies in the material used

[106] Vol 3, Tab 79, p 194.
[107] Transcript 8/06/22, p. 35. L. 30-35.
[108] Transcript 10/6/22, p 29 1 onwards.
[109] Transcript 8/06/22, p. 37, l. 20-25.
[110] Transcript 8/06/22, p. 38, l. 35-40.
[111] Transcript 8/06/22, p. 39, l. 15-20.

to inform the panel. The panel failed to consult the siblings' extended family and include them in the decision-making process. Alternative kinship care arrangements were not explored by the panel. The substantial concerns initially voiced by the Aboriginal Practice Advisor regarding the maintenance of cultural connectedness should have been a red flag that triggered further exploration, even though she is recorded as having changed her view by the end of the meeting. The panel apparently met on a single occasion to make a decision that would reverberate throughout Yakamurro's life. The difficulties that G and H were already experiencing with Yakamurro should have aroused greater curiosity about the health of the placement before allowing such a huge step to be taken.

154. The Senior Practice Leader agreed that the panel failed to consider the complexities and vulnerabilities of Yakamurro and his siblings. She conceded that "*if a family meeting had occurred it would have brought a different depth in informing the move*," and that if Amala had had support persons present during her interactions with Territory Families, she may have felt more comfortable and secure in voicing her concerns about the interstate transfer of the children.[112] She agreed that had there been a "*family meeting convened"* where *"people from Yakamurro's family and community had expressed strong concerns about the removal of a child from the Northern Territory to New South Wales*", extra weight would have been placed on the concerns addressed by her.[113]

155. Ms Broadfoot conceded that the decision-making of the panel was inadequate due to its failure to consider the complexities of the situation. Ms Broadfoot also acknowledged that the deficiencies in record keeping make it difficult to identify the precise interactions between Territory Families and Yakamurro and his siblings.

156. Ms Broadfoot told the Court: "*one of the difficulties I think is the record keeping. There were certainly as you can see there was the Aboriginal Practice Advisor involved and there were genograms done and there was a genogram with a table attached that showed quite an extensive number of family that had certainly been identified but what we can't see is any evidence that things were followed up effectively*."[114]

157. Ms Broadfoot gave evidence that there has now been a significant shift in policy which states that "*transfers interstate are only to occur in exceptional circumstances*."[115] Additionally, any transfer must be compliant with the Secretariat of National Aboriginal and Islander Child Care's "SNAICC" (the national non-governmental peak body for Aboriginal and Torres Strait Islander children) principles which require a demonstration of how the cultural connection will actually be maintained. Part of the SNAICC principles is participation, which Ms Broadfoot

[112] Transcript 9/07/22, p.8, l. 40-45.
[113] Transcript 9/07/22, p.9, l. 45-50.
[114] Transcript 9/06/22, p. 42, l. 20-25.
[115] Transcript 9/06/22, p. 42, l. 35-50.

explains "*goes directly to ensuring that the family, not just the parents or individual parents but extended family as well and in particular, the children, have a say in what's actually happening*."[116] Ms Broadfoot added:

"I think the existence now of an elder in residence and the Aboriginal cultural consultative committee that is onboard that now reviews all policy that actually occurs in the agency has been a fundamental improvement in the way in which we ensure that these sorts of things are embedded in the day to day practice."[117]

Physical discipline of Yakamurro

158. On 25 November 2013, Territory Families recorded a risk of harm report in relation to inappropriate physical discipline of Yakamurro by H. This occurred prior to the move to NSW and in my view should have been a further red flag.

159. Territory Families spoke with H who indicated he would continue to smack Yakamurro.[118] At the inquest, H re-iterated his belief that it was appropriate for him to physically discipline Yakamurro as it was his belief that it was culturally appropriate to do so. H explained that it was necessary to physically restrain and discipline Yakamurro because he, "*was dealing with a child who was trying to stab me with a knife. So, I'm dealing with a child who's throwing themselves at me, spitting at me, calling me a fucking white cunt daily on a daily basis, exceedingly abusive who was in a complete state of complete emotional meltdown and therefore not in charge of himself, and he would regularly hurt [G]. She has bruises and photos of bruises on her body and we can tell you that is what he did."* [119]

160. H elaborated on his decision to engage in physical discipline, citing "*fear based stories*" that are "*absolutely profound in their [Aboriginal] society and the law itself is fear based and the law is ferocious*."[120] He told the Court that he was "*not a physically violent person*" and that his use of physical discipline was based in his understanding of Aboriginal culture.

161. In later submissions to the Court, H wanted to stress that he had never "*flogged*" Yakamurro and that the *"beneficial behavioural modification effect was not from pain but gave him a "start" to assist him to de-escalate which worked well*."[121] He explained it was part of the family attempting to set boundaries. G and H further explained that "*to initiate success, H sat with Yakamurro and explained to him that in our culture (British/Australian) men did not hit women and they did not try to stab and hurt them because they do not get their own way*." Leaving aside the extraordinarily positive summary of British/Australian culture – clearly a

[116] Transcript 9/06/22, p. 54, l. 10-20.
[117] Transcript 9/06/22, p.42, l. 35-50.
[118] Vol 20, Tab 476, p. 284.
[119] Transcript 10/06/22, p. 98, l. 45-50.
[120] Transcript 10/06/22, p. 99, l. 15.
[121] Submissions of G and H at [2].

culture still grappling with domestic violence - I am very concerned that H's analysis tends to characterise Yakamurro's trauma-influenced behaviour as a fault of his culture. I do not accept H's analysis.

162. H's anger was palpable in the courtroom when he discussed these issues. He made it very clear to the Court that he did not resile from the use of physical punishment on Yakamurro. He explained his approach was based in a positive requirement for creating or establishing his authority. He stated that he "*needed to…create authority because he didn't see me in any authoritative manner. And you have to have authority with Indigenous kids because if you don't have authority and you don't stand towards the law, they will fuck you over, they will do things to you and even in a classroom basis*."[122]

163. I was very concerned about H's rationale for physical discipline. I think it likely his use of physical punishment grew out of extreme frustration and anger. His rage and trauma were clearly demonstrated by the explosive way he spoke in Court. I do not accept his rationale for using physical punishment. In my view Psychologist Stephen Ralph is correct when he states that this is "*using culture as an excuse*"[123]. Mr Ralph told the Court:

"I think it's just taken out of context and using culture as an excuse in this situation. It's not common - from a cultural perspective it's not common for Aboriginal children to be raised by non-Aboriginal carers in that situation. I just think it's - I don't accept it."

164. I do not accept that there is a role for hitting children and young people. In my view it would be useful for Territory Families to review this issue and accept that carers who continue to use physical punishment need to have their authorisation removed.

165. It is clear that the huge challenges G and H were having with Yakamurro and his siblings needed to be given greater weight when considering the appropriateness of the placement continuing.

166. While H clearly had a belief in the appropriateness of physical punishment of Aboriginal male children, his disciplining of Yakamurro in this manner was also symptomatic of the strain G and H were under. Territory Families should have understood this strain better and this should have factored heavily in the decision-making process around the intended move to Ballina, where there would be limited day-to-day oversight available to the Chief Executive Office. Ms Broadfoot agreed that the notification of physical discipline should have prompted reconsideration of the approval for the move.[124] Territory Families characterised the approval as having failed Yakamurro and his siblings. The decision did not pay sufficient attention to the multiple occasions on which the carers had stated that they did not want to care for the

[122] Transcript 10/06/22 p. 99, l. 23 onwards.
[123] Transcript 16/6/22 p. 45, l. 15 onwards.
[124] Vol 18, Tab 467, p. 66.

children anymore, and the male carer's own disclosure of physical disciple and his unwillingness to cease the use of that form of discipline. The Agency Panel lacked independence and objectivity to critically appraise the proposal to relocate interstate.[125]

167. The physical discipline of Yakamurro escalated after the family moved to Ballina, and it is an issue to which I will return. However, it is clear that the issue had been raised before the family left the Northern Territory and was not adequately dealt with.

Cultural Planning for the move to Ballina

168. Mr Ralph drew the court's attention to the fact that there appears to have been an absence of planning in relation to meeting the children's cultural needs in Ballina and that Yakamurro's views on the move do not seem to have been meaningfully considered.[126] Territory Families acknowledges the approval process for the move was "*demonstrably flawed*" and lacking in independence and objectivity.[127] As the placement was threatening to break down prior to the family relocating to Ballina, a more considered assessment of the family's suitability and ability to manage the care of the children interstate was warranted.[128]

169. Ms Broadfoot acknowledged that Territory Families failed to maintain Yakamurro's connections to his family, culture and country once he left the jurisdiction, and agreed that this lack of connectedness caused significant pain to Amala.[129] However, she also pointed to some encouraging reforms which might prevent a situation like this occurring for other families.

170. In 2019, Territory Families developed an Aboriginal Cultural Security Framework which promotes the responsiveness and safety of Aboriginal people where cultural values, strength and difference are integrated into service delivery. Ms Broadfoot explained that, in practice, it means "*ensuring or working towards having a far more culturally appropriate workplace … Part of it also goes to individual learning and an acknowledgement that the majority of staff that we have are non-Aboriginal, so we have about 295 Aboriginal staff in the agency but the large proportion aren't. So it's about how we have the systemic safety with those policy settings that are appropriate but that people are actually taking responsibility for their own learning around how to deliver culturally appropriate services."*[130]

[125] Vol 19, Tab 467, p. 424.
[126] Vol 26, Tab 561, p. 10.
[127] Vol 19, Tab 467, p. 424.
[128] Vol 19, Tab 467, p. 424.
[129] Transcript 9/06/22, p. 48, l. 15.
[130] Transcript 9/06/22, p. 49, l. 5-10.

171. Ms Broadfoot further elaborated that "*it is considered a priority by our agency to increase the number of Aboriginal people we have on staff, it's absolutely critical given the, the clients that we have"*.[131]

172. Counsel for Amala also questioned Ms Broadfoot on the development of an intensive therapeutic care system, which was a significant factor that led Yakamurro to remain in New South Wales rather than be relocated to a place closer to his family. Ms Broadfoot stated that there are placements in Darwin and Alice Springs as they are key areas, and indicated that *"there have been discussions around whether that expands out any further but that's where they are at the moment."*[1] Ms Broadfoot stated that the expansion of these services would be "*really positive*" but "*the part of the reality of delivering that is actually being able to source the expertise and the workforce out in more remote areas*."

Yakamurro arrives in Ballina in 2014

173. Upon arriving in NSW, G and H undertook significant efforts to link Yakamurro with key service providers in NSW. Less than a month after the move, G contacted Territory Families to provide a list of paediatricians and child psychiatrists Yakamurro and C were seeing.[132] G ensured Yakamurro saw psychiatrist Dr Wendy Jackson who prescribed medication for Yakamurro and recommended ongoing learning support for him. Dr Jackson assessed Yakamurro as having "*complex Post-Traumatic Stress Disorder ("PTSD") and Chronic Adjustment Disorder with disturbance of conduct, characterised by extreme emotional dysregulation and aggression*". She conducted assessments for Yakamurro which revealed that he had "*mild intellectual impairment and severe receptive-expressive language disorder".*[133] Dr Jackson also reported that a diagnosis of foetal alcohol spectrum disorder ("FASD") was likely and recommended that Yakamurro would benefit from ongoing learning support and allocation to a local DCJ Community Services Centre ("CSC") for more intensive local support.[134] G also arranged for Yakamurro to have orthodontic surgery and reached out to DCJ with options for support groups for Yakamurro. Yakamurro also settled into school at Ballina.

174. Despite this, there were early signs of strain. G was reaching out for respite care within a month of arriving in Ballina and indicated to Territory Families that she was "*at the end of her tether*". By the end of January 2014, G and H had requested six weekends of respite care from Territory Families.

[131] Transcript 9/06/22, p. 49, l. 25-35.
[132] Vol 18, Tab 467, p. 67.
[133] Vol 7, Tab 223.
[134] Vol 4, Tab 110.

175. In February 2014, two months after moving to Ballina, Yakamurro's Case Manager visited the family. G and H discussed their need for respite care with him and put forward a proposed respite carer, Amanda Reid. The Case Manager directed G and H to seek approval for Ms Reid with a respite care organisation. Territory Families subsequently arranged six weekends of respite care for Yakamurro with Ms Reid. This commenced on 28 March 2014. Respite weekends were also arranged for Yakamurro's siblings from 4 April 2014.

176. The Territory Families Care Plan in place from 4 March 2014 identified Yakamurro's high needs and challenging behaviours, including his [redacted] behaviours and identified a need for Yakamurro to have a professional assessment of his trauma.

177. Territory Families have acknowledged that there was an inappropriate level of planning to instigate a placement support plan *prior* to G and H relocating interstate and that once Yakamurro moved, it notionally delegated its casework responsibilities to G and H and later CASPA. In accordance with the Interstate Protocol, requests by Territory Families for casework assistance were also made of DCJ, however that Protocol also provided that full case management responsibility remained with the requester (i.e. Territory Families). [135] The March Territory Families Care Plan did not require Territory Families to have proactive communication with Yakamurro's care team, despite having statutory responsibility for Yakamurro's care.

178. Although there were some efforts by Territory Families to undertake casework with the family following their move to NSW, they were insufficient for the demonstrated level of need. Territory Families acknowledges that the limited amount of contact from Territory Families meant emerging issues in the placement were not identified promptly.

179. Territory Families drew the Court's attention to a potentially relevant document from its file dated and signed 9 January 2014. However, it is not at all clear that the document, "An interstate Transfer of Casework Request" was ever sent. In any event, if sent it was not followed up.

180. It was not until 11 June 2014, six months after the family had moved to Ballina, that DCJ clearly became aware of the family's presence in NSW after G and H reached out to DCJ with a request for respite care.[136]

181. Notification to DCJ for the relocation should have been made by the ILO well before six months had passed. In her statement, the ILO detailed that since she took various periods of leave in 2013, a number of people acted in her role, so she was not made aware of Yakamurro's interstate transfer until the Senior Practice Leader informed her that she would be visiting Yakamurro in August 2014. On 12 August 2014, an email from the ILO was sent

[135] Vol 18, Tab 466A, at [67].
[136] Vol 7, Tab 245, pp. 4, 17.

to the Territory Families casework team which raised concern about the fact that the ILO had still not received a request for interstate casework.[137]

182. This is a systemic failing stemming from a lack of timely cross-jurisdictional inter-agency communication. It highlights the limited oversight Territory Families had during these six months as they were reliant on information and requests made to them by G and H. In circumstances where an Aboriginal child under the care of the Chief Executive Officer was allowed to leave the Northern Territory, and approval was given for that child to live in NSW, notification of that child's arrival in NSW should have been promptly made to DCJ. This is particularly so in the case of Yakamurro, who was incredibly vulnerable and had particularly complex needs. It is not surprising that the strain the foster care placement was under prior to the move was compounded by the move to Ballina. In order for Territory Families to continue to have adequate oversight over Yakamurro and his siblings, it was necessary that Territory Families notified its NSW counterpart to ensure continuity of oversight. The failure to do so was a significant error.

183. Territory Families properly recognised that the management of the interstate transfer of casework and care orders was deficient.[138] In her statement, Ms Broadfoot, noted that multiple attempts were made to initiate the paperwork to transfer casework and/or the order, many of which did not transpire. She listed some of the contributing variables as:

- *"Transfer protocol demands that a placement is stable for a period of six months before transfer of a Court authority will be accepted.*
- *[Yakamurro's] placement was in crisis that resulted in placement breakdown.*
- *The case was unallocated for periods of time.*
- *The lack of internal quality assurance to monitor the status of children in care living across the border.*
- *Parties oscillating in their views on whether they supported the transfer or not*[139]*"*

184. Territory Families acknowledged that the ILO did not appear to assume the level of internal professional quality assurance required[140], and that they contributed to the vulnerability of the placement, and its subsequent breakdown, by not transmitting timely interstate casework documentation to DCJ.[141] They acknowledged that their delay in progressing interstate transfer documentation meant that DCJ could not provide proactive assistance with the aim

[137] Vol 20, Tab 476, p. 302.
[138] Vol 19, Tab 467, p. 452.
[139] Vol 29, Tab 467, p. 453.
[140] Vol 19, Tab 467, p. 453.
[141] Vol 19, Tab 467, p. 425.

of preventing placement breakdown.[142] Had the documentation been transferred to NSW earlier, it is likely that DCJ would have commenced conducting home visits and making assessments of the placement earlier in 2014. Mr Ralph agreed that the failure of Territory Families to notify DCJ of the presence of Yakamurro in NSW can be viewed as a contributing factor to the breakdown of the placement.[143] Similarly, Mr Ralph is of the view that the delay in transferring case management from Territory Families to DCJ contributed significantly to the substandard casework provided to Yakamurro and G and H.[144] I accept his view on this matter.

185. In July 2014, Amala visited the children in Ballina for two weeks. Amala stayed with G and H during this time. In circumstances where no appropriate cultural plan had been put into place prior to Yakamurro's move to Ballina and in circumstances where, by July 2014, the placement was under considerable strain, it is not surprising that the visit did not go smoothly. By this stage, Yakamurro's violent behaviours were escalating and the likelihood that the placement would break down was growing. As observed by Mr Ralph, there is little in the evidence to suggest that there was any coordination between Territory Families and DCJ in relation to Amala's visit. Mr Ralph notes that there does not appear to have been any risk analysis or casework undertaken with Yakamurro or Amala to prepare either of them for the visit and to ensure Yakamurro's emotional safety and the success of the visit.[145] Family visits had been a central platform of the cultural plan and yet aside from organising a ticket for Amala, little further thought appears to have been given to the visit.

186. On 12 July 2014, H called DCJ to report that Yakamurro's behaviour had escalated, that he was demonstrating [redacted] behaviours and that he was threatening to hurt G and his siblings. H asked DCJ to contact Territory Families about the possibility of transferring Yakamurro back to the Northern Territory.[146]

187. On 30 and 31 July 2014, G and H contacted DCJ for urgent respite care and indicated that Yakamurro's behaviour at home was rapidly escalating.

188. On 31 July 2014, a formal request for respite care was sent to DCJ from Territory Families.[147] Mr Ralph notes that the response to G and H's requests for support were hampered by the failure of Territory Families to formally request casework assistance from DCJ. This meant that DCJ was required to respond to a critical family crisis after it had been escalating for some time without any meaningful opportunity to build relationships with the Yakamurro and

[142] Vol 19, Tab 467, p. 425.
[143] Vol 26, Tab 561, p. 12.
[144] Vol 26, Tab 561, p. 19.
[145] Vol 26, Tab 561, p. 13.
[146] Vol 7, Tab 240; Vol 20, Tab 476, p. 295.
[147] Vol 6, Tab 210.

the family.[148] G made it clear in her correspondence with Territory Families around this time that the care orders of Yakamurro and his siblings should be transferred to NSW as a matter of urgency.[149]

189. On 7 August 2014, DCJ completed a Child Assessment Tool (CAT) for Yakamurro for the purpose of organising respite care.

190. On 22 August 2014, DCJ referred Yakamurro to CASPA for respite care for a period of six consecutive weekends. He was referred as a "care plus 1", a low needs child. That same day, CASPA confirmed the availability of a placement for Yakamurro with CASPA foster carer, J, and her then husband.[150] J also had young children of her own at that time. The CEO of CASPA, Naarah Rodwell, contacted Territory Families to seek further information about Yakamurro's needs, as the DCJ referral indicated that Yakamurro had displayed "*assaultive behaviours*" and given that Yakamurro would be placed with other children during his respite stay with J.[151] A Territory Families caseworker contacted G and provided an update to DCJ that Yakamurro had been physically aggressive to her. It does not appear that Yakamurro's [redacted] behaviours were adequately communicated to Ms Rodwell at this time, which, given J's young children, is a very significant oversight that exposed J and her children to unnecessary risk. Ms Rodwell gave evidence that CASPA would have still supported the placement but would have ensured that J and her husband were informed of the need to be vigilant in caring for Yakamurro to reduce the level of risk.

191. Ms Rodwell stated that CASPA had difficulties in progressing Yakamurro's casework due to the lack of information received from Territory Families and DCJ.[152]

192. On 26 August 2014, Ballina CSC allocated a DCJ caseworker to assist G and H.[153]

193. From 25 to 27 August 2014, the Senior Practice Leader of Territory Families conducted an interstate visit to G and H. She came to NSW on two separate occasions, once in August and once in September 2014 to try and assist the family.[154]

194. She identified that G and H were exhausted by Yakamurro's behaviours. She gave evidence that it was only when she visited the children that she became aware of how complex their needs really were and that this was not conveyed at the panel meeting discussing the move. During this visit, she became aware of an incident with a camper van. While details about what actually occurred are still difficult to ascertain, it appears that G, H and the children had attended a camping trip and that during the trip, Yakamurro had made a fire which

[148] Vol 26, Tab 561, p. 13.
[149] Vol 18, Tab 467, p. 72 at [400].
[150] Vol 18, Tab 467, p. 72 at [404].
[151] Tab 513B.
[152] Vol 18, Tab 464, p. 2 at [10].
[153] Vol 7, Tab 245, pp. 17-18.
[154] Transcript 14/06/2, p.14, l. 30.

accidentally (or on some accounts intentionally) destroyed a camper van that had the family dog inside.

195. The Senior Practice Leader became aware of the CAT prepared for Yakamurro within the context of respite care. Given that she had just learnt that Yakamurro had engaged with fire, she agreed that the CAT was not an accurate reflection of Yakamurro's complexities.[155]

196. She told the Court that G and H should have been offered more comprehensive support instead of the minimal amount offered. This visit should have raised various red flags for Territory Families and should have prompted greater action.

197. It is evident that the Senior Practice Leader tried her best to assist with a rapidly deteriorating and challenging situation. However, her intervention was just too late for the family. In their evidence, G and H made it clear that they appreciated the Senior Practice Leader's efforts and that they felt heard and understood by her. Their evidence is that she made extra efforts to assist them and tried to observe the family dynamic for a longer period of time, so that she could truly be aware of the family's difficult circumstances. However, following her visits, despite the extent of the crisis she witnessed, no urgent intervention was triggered.

198. On 29 August 2014, Ms Rodwell followed up with Territory Families about obtaining relevant paperwork, including Yakamurro's Essential Information Record, so that respite could commence. A Case Worker called Ms Rodwell that day to advise that he would send this paperwork through, which he did later that afternoon. The Essential Information Record identified that Yakamurro had displayed [redacted] towards young children.[156] This was the first time CASPA was informed of Yakamurro displaying [redacted] behaviours. Due to the timing of the correspondence, Ms Rodwell was not made aware of this information until 1 September 2014, the Monday after the first weekend of respite with J.

199. On 30 August 2014, Yakamurro moved to a weekend respite care arrangement organised with J in Lismore. J's young children were also in that placement. It is evident that CASPA were not informed of Yakamurro's [redacted] behaviour until it was too late, as Yakamurro was already in a placement with J. CASPA should have been informed of Yakamurro's [redacted] behaviour when they were first requested to provide respite assistance, prior to making arrangements for Yakamurro's respite care. The risk this exposed J's children to was entirely unnecessary and avoidable.

200. After the initial weekend of respite, when Yakamurro returned to G and H's home, there was a significant incident around 5 September 2014 where Yakamurro apparently threatened G with a meat cleaver in the family home. DCJ were informed of the significant incident. H told

[155] Transcript 9/06/22, p. 27, l. 35-45.
[156] Tab 513A.

DCJ that he had held Yakamurro down to protect G when Yakamurro had threatened her.[157] Understandably, this event had a significant impact on G and H's views on the sustainability of the placement and they expressed this to DCJ. Mr Ralph describes the family as being in a state of crisis at this time.[158] I accept his opinion on this issue.

201. In submissions to the Court, H explained "*the breakdown of our family balance in Ballina was because I became employed full-time and was not at home as the main caregiver as I had been up to that time. This meant that Yakamurro diverted to his broken cultural and learnt norms as the man in the house, trying to take over and be derisive and control Mum*." G and H explained the issue as a failure to respect G's authority. They stated "*We believed and tried tirelessly to convey to CASPA that Yakamurro's heritage and belief in himself as a man meant that he should not have been left with women, as it was completely inappropriate and undermined his growth as a man culturally.*" As previously stated, I do not accept the characterisation of Yakamurro's complex issues at this time as primarily grounded in his "heritage" or culture. With respect to G and H, what appears to have been called for was further trauma-informed care. Clearly at this point Yakamurro needed to leave his placement with G and H but as it played out, the experience is likely to have felt like further abandonment.

202. The Court heard evidence about a letter that Yakamurro found in a bag of his property on 2 October 2014, that his respite carer, J had earlier collected from G and H. J was not forewarned that a letter from G had been placed in the bag. When she found Yakamurro in his room, he had clearly read it and was quite upset. He held a photo of himself, his sister, and G and H and was crying and wanting to go home. She tried to offer him support and told him that they would have a meeting soon with G and H and CASPA to work out what is happening next and to make sure he saw his siblings soon and often.[159] The letter, which was dated 13 August 2014, expressed G's love for Yakamurro but was essentially a goodbye letter. She wrote "*My heart is breaking knowing you are going to leave us today. I need you to know today and every day that I love you more than anything in the world and always will….one day when you are grown up and are an adult, you will understand that I must protect all the children in the family."*[160] CASPA notes record that Yakamurro was crying and wanting to go home when he read it. He wanted to call G, but the call went to voice mail. In my view, this would have been extremely distressing for Yakamurro.

203. On 6 September 2014, Yakamurro moved to J's home in Lismore on a permanent basis. This move meant that Yakamurro changed schools and his casework was transferred from Ballina

[157] Vol 20, Tab 476, p. 313.
[158] Vol 26, Tab 561, p. 15.
[159] Vol 12, Tab 365, p. 289.
[160] Vol 12, Tab 365, p. 286

CSC to Lismore CSC.[161] On 8 September 2014, Yakamurro's placement with G and H formally ended.[162]

204. That same day, DCJ conducted a home visit to G and H and was informed that Yakamurro had been saying that he wished to live in the Northern Territory.[163] The Territory Families Internal Practice Review found that the breakdown of this placement should have prompted Territory Families to assess a return of Yakamurro to the Northern Territory.

205. Between 15 to 19 September 2014, the Senior Practice Leader attended Ballina for a second time to visit Yakamurro. During meetings with Yakamurro, he initially expressed a desire to return to the Northern Territory but then also expressed a desire to remain living in NSW.[164]

206. In October 2014, correspondence between Territory Families and DCJ indicates that there was consideration of Yakamurro returning to the Northern Territory if a long-term placement could not be arranged in NSW. Options for Yakamurro's return to the Northern Territory were proposed. However, Territory Families indicated that they planned to transfer the care orders for Yakamurro and his siblings to NSW if a long-term placement could be found for Yakamurro.[165] This conditional approach meant that the transfer of care orders was contingent on a long-term placement, which in turn was difficult to find due to Yakamurro's challenging and complex behaviours. The lack of stability and removal from his siblings undoubtedly created greater uncertainty for Yakamurro. Territory Families should have done more at this juncture to ensure Yakamurro's future placement was stabilised.

207. At this time, CASPA had arranged (and Territory Families paid) for Yakamurro to attend therapy sessions with John de Laurence, a specialist therapist for children who had experienced [redacted] and were displaying [redacted].

208. In late October 2014, Yakamurro was removed from the placement with J after he [redacted]. Notwithstanding the breakdown of the placement, J and her family maintained their relationship with Yakamurro. J gave oral evidence before this Court. She clearly demonstrated her very deep affection for Yakamurro. Her ongoing commitment to Yakamurro was remarkable under the circumstances.

209. On 3 November 2014, Yakamurro was placed with experienced CASPA foster carers AB and SB in Yorklea.

210. During this time, CASPA went to great efforts to arrange for Yakamurro to see his siblings and have access visits with G and H. However, it appears that there were fractures in the

[161] Vol 9, Tab 257, p. 2 [11].
[162] Vol 7, Tab 221, p. 8.
[163] Vol 4, Tab 103; Vol 20, Tab 476, p. 320.
[164] Vol 7, Tab 222; Tab 245, pp. 20-21.
[165] Vol 7, Tab 221, Tab 229.

relationship between CASPA and G and H and there was confusion about access arrangements for Yakamurro.

211. On 2 December 2014, almost one year after Yakamurro moved to NSW, the first multi-agency case conference was held in relation to him. During this case conference, Lismore CSC expressed the view that Yakamurro should be relocated to the Northern Territory, however Territory Families indicated that his community was very small and that there were no appropriate or safe kinship placements.[166] The lack of renewed consultation with Yakamurro's family regarding a possible kinship placement was another significant missed opportunity.

212. On 4 December 2014, CASPA conducted a case review meeting for Yakamurro. Among other things, the minutes of that meeting indicate that a Cultural Plan had not yet been developed for Yakamurro, almost 12 months after Yakamurro left the Northern Territory.[167]

213. Ms Rodwell stated that CASPA had no case management delegation powers in that respect. She stated that had CASPA had case management at that stage they could have involved Amala directly and consulted with family to have them attend the meeting. At this stage, the aim was for Yakamurro to maintain contact with his siblings and go back to the Northern Territory to visit family.[168]

214. On 16 December 2014, a second multi-agency meeting was held. The minutes from this meeting indicate that interstate transfer of care orders were still being pursued.[169]

215. Around this time, Yakamurro's ability to maintain contact with his siblings and G and H was impacted by the recommendation of the [redacted] that he have no contact with his siblings for a period of three months.

216. On 29 December 2014, Yakamurro moved into a residential care home in Casino, NSW. There were no other children in this home, and he had one-on-one supervision. He remained in this placement for a one-year period. Despite the care that Yakamurro received from CASPA, it is difficult to understand why Territory Families preferred an isolated placement of Yakamurro over exploring kinship (or other) placement options back in the Northern Territory, which would have given him access to his family.

217. Whilst in the placement in Casino, there was a care team dedicated solely to him, with some Aboriginal men in the team. G and H were able to visit the home regularly. CASPA also

[166] Vol 7, Tab 213.
[167] Vol 9, Tab 277.
[168] Transcript 14/06/22, p. 31-32, l. 5-45.
[169] Vol 9, Tab 280.

facilitated visits for Yakamurro out of the house to visit his siblings.[170] J and her family continued to take Yakamurro on outings.

218. CASPA continued to make great efforts to support Yakamurro's medical and emotional needs. CASPA consulted with Yakamurro's practitioners about his support needs. On 25 February 2015, CASPA received a report from Dr Jackson in support of his placement option at the residential care home in Casino due to his emotional and behavioural difficulties.[171] CASPA also consulted with Mr de Laurence in relation to Yakamurro's therapeutic needs. Mr de Laurence observed that Yakamurro would be less likely to develop strong attachments in a situation where he had multiple caregivers.[172]

219. Around March 2015, H contacted Territory Families and CASPA to alert them to concerns about the negative behaviour of Yakamurro's siblings following contact visits between the siblings.

220. CASPA continued to support Yakamurro's medical needs, arranging his attendance with numerous paediatricians, general practitioners, psychiatrists and psychologists. His medication was regularly reviewed and the earlier diagnoses of FASD, complex PTSD and severe learning difficulties were supported.[173] Territory Families paid for this treatment.

221. CASPA also arranged for equine therapy, participation in a violence management program, participation in the BackTrack program to gain practical skills, guitar lessons and numerous sporting opportunities for Yakamurro.

222. Prior to Yakamurro's placement in CASPA, Territory Families did not monitor the delivery of services to Yakamurro to meet these needs.[174]

223. Territory Families credit CASPA, and to an extent G and H, for the leadership they showed in undertaking casework for Yakamurro and recognise that without this, Yakamurro would not have received as many services as he did.[175] Territory Families praised CASPA for the casework they undertook in championing Yakamurro's needs in the absence of strong case management leadership from Territory Families.

224. Territory Families have acknowledged that there were multiple missed opportunities to review Yakamurro's interstate placement.[176] Territory Families recognised it failed to uphold Interstate Child Protection Protocols.

[170] Transcript 14/06/22: p25. l. 20-45.
[171] Vol 4, Tab 111.
[172] Vol 13, Tab 368.
[173] Vol 4, Tab 122; Vol 13, Tab 379.
[174] Vol 20, Tab 475, p. 25.
[175] Vol 19, Tab 467, p. 452.
[176] Vol 20, Tab 465, p. 26.

225. Once the placement with G and H broke down, there were continual discussions about whether Yakamurro should return to the Northern Territory. As acknowledged by Territory Families, this position "*frequently oscillated*" and there was a lack of leadership to follow through with the decision.[177]

226. Territory Families acknowledged that they failed to justify what alternate placement options had been exhausted for Yakamurro to return to the Northern Territory.[178]

227. Although DCJ had more limited involvement in Yakamurro's care, the contact they did have does not show any significant effort to support Yakamurro in New South Wales.

228. DCJ also recognised that their policy and practice procedures relating to the transfer of interstate care orders for children living in NSW were not child centred and did not enable a timely handover that promoted Yakamurro's best interests or need for permanency.[179]

229. In its internal review, DCJ found that there was a systemic failure for Yakamurro because he received substandard care while living in NSW. DCJ recognise that the casework response was inadequate due to a lack of understanding of Yakamurro's culture.[180]

230. DCJ acknowledged that their response to the Risk of Significant Harm ("ROSH") reports describing concerns about Yakamurro's care as well as his violent and [redacted] behaviours towards other [redacted] and carers, was inadequate.[181]

231. DCJ acknowledged that the decision-making process around finding Yakamurro respite care in September 2014 was inadequate and it placed other children at an unacceptable level of risk.[182] In its "Serious Case Review from the Office of the Senior Practitioner – Internal Child Death review", it was noted that[183]:

> *"DCJ has a non-delegable responsibility to respond to ROSH reports. What was needed was a joint response to assess Yakamurro's living arrangements and what was in place to address his [redacted] behaviours, in light of the ongoing reports by numerous children. DCJ also had an important role to play given the numerous disclosures by other children under the parental responsibility of the minister who lived with him and [redacted] DCJ knew Yakamurro's behaviour placed other children at risk, and [redacted] The response needed to be intensive and comprehensive. It was also clear that his placement and carers were not providing*

[177] Vol 19, Tab 467, p. 451.
[178] Vol 19, Tab 467, p. 451.
[179] Vol 7, Tab 245.
[180] Vol 7, Tab 245.
[181] Vol 7, Tab 245, see in particular p. 531.
[182] Vol 7, Tab 245.
[183] Vol 7, Tab 245, p 531.

adequate care, supervision or control. DCJ needed to be more active in its response to make sure Yakamurro and other children who came into contact with him, were safe".

232. In a review of DCJ processes for children on interstate orders living in NSW, the Statewide Services Information Access and Exchange, which oversees the Interstate Liaison team, identified gaps in DCJ processes. It was recognised that there was no system in place for identifying and monitoring children living in NSW under care orders of other jurisdictions. Additionally, children under interstate care orders are not routinely flagged with the DCJ Interstate Liaison Team, making it uncertain whether the interstate statutory agency is aware of the reported concerns for the children in their care.[184]

233. Mr Ralph considered it "*deeply concerning*" that case responsibility for Yakamurro was never transferred to NSW in the five years that Yakamurro resided there. He considers that best practice was not followed in making care arrangements for Yakamurro in the Northern Territory and in NSW.[185] I accept his view.

2015 to 2018

234. CASPA began working with Trent Savill from Complex Care to provide more intensive support for Yakamurro. At the time he provided trauma and attachment workshops to carers, specifically [redacted] workshops. Territory Families wanted Trent Savill to conduct training with G and H, with the possible goal of reunification. However, G and H did not participate in the training. G gave evidence that she and H would have benefitted from trauma training even before they got the children[186]. However, she also acknowledged that they did eventually get some trauma support. They were offered counselling through CASPA in 2015, but G said she didn't need it because she had her own counsellor[187]. In response to questions from counsel for Territory families, G seemed to reject the idea that they needed more training, and said[188]:

> *"But it wasn't about what we needed or what we wanted or what we, we - it was - and, and again it was difficult to be able to manage that when you've got four kids and, and we're working full-time and all that sort of stuff so I won't labour it again but I don't know that, that you know like training is what we needed. We needed - we needed an [name of Senior Practice Leader]."*

[184] Vol 7, Tab 246A.
[185] Vol 26, Tab 561, p. 19.
[186] Transcript 10/06/22 at pp. 16-17.
[187] Transcript 10/06/22 at p. 66, l. 35.
[188] Transcript 10/06/22 at p. 67, l. 4.

235. The attitude of G is epitomised in the following exchange with Mr Hutton, who appeared for Territory Families[189]:

> *Q: What I want to suggest to you is, the department appreciated that these were complex children, particularly given the notifications that arose during the time they were in your care and they identified training, that would have assisted you to respond to that complex behaviour, including in relation to* [redacted] *and they suggested that you undertake that training?*
>
> *A: Absolutely and what I would say in response to that as well is, is no disrespect to doing that training but I, I had been - I have been working with* [redacted] *in children since I was probably 20 …*
>
> *I know it with - without any you know disrespect to any, anybody but you know like it's, it's a little bit about sucking eggs. Sorry for that coarse way, but I, I really believe that there was not a lot that I would gain from going to a course by people who perhaps were - were - and that had happened to me in times when I've gone to courses and that the people were not really as knowledgeable as they could be*

236. H said that he had done training in trauma-informed care because of his work in education[190]. In the period after Yakamurro came into his care, he did some training with DCJ because of work he had with Challenge Children's Services[191].

237. On 2 June 2015, a meeting occurred between DCJ and G and H to discuss the care orders of Yakamurro and his siblings. During this meeting, among other things, DCJ indicated to G and H that when the children's care orders were transferred to NSW, DCJ would seek to find Aboriginal carers for the children as a matter of priority, in accordance with the NSW Aboriginal Child and Young Person Placement Principles ("Aboriginal Placement Principles"). The possibility of the children being separated in these placements was also apparently conveyed.

238. G told the court that the meeting with DCJ was "*the most horrific day of our life*"[192]. They were notified at short notice and treated "*like criminals.*" G explained that they were told "*the children in your care are now being taken over from – they won't be under Territory Families anymore, they are going to be under New South Wales DOCS and what that means is number 1, we are going to immediately look for Aboriginal families for these children to be with….number 2, we will not finance any going or coming back of the children or the family….it will have to be financed by you or them….*"[193] Whatever the exact content of the meeting, it is clear the situation was poorly handled and provoked an immediate flight response in G and H who feared losing the remaining children. G told the court they were distressed and heartbroken and it was immediately clear to them that they must move back

[189] Transcript 10/06/22 at pp. 67.
[190] Transcript 10/6/22 at p.75, l. 42.
[191] Transcript 10/6/22 at p.77, l. 66.
[192] Transcript 10/6/22 p.37, l. 23.
[193] Transcript 10/6/22 p.37, l. 35-47.

to the NT to avoid the interference of DCJ on their family. G told the court she applied for jobs the following day.

239. As a result of this meeting with DCJ, G and H also told Ms Rodwell that they were moving back to the Northern Territory with Yakamurro's brother and sisters. Ms Rodwell told the court that she consulted Mr Savill about how to inform Yakamurro of this, and a highly facilitated trauma session was organised.[194]

240. Unfortunately, prior to taking up that session, Yakamurro had already been told about the move by G. It was a terrible blow to Yakamurro when he found out. He was assured he could still contact his siblings and have direct contact with Territory Families.[195]

241. G and H moved back to the Northern Territory within six weeks. From their evidence and statements to the Court, it is clear that the most significant reason they moved back to the Northern Territory related to their deep concern that Yakamurro's siblings would be removed from their care.

242. There is little doubt that DCJ caseworkers sought to emphasise the Aboriginal Placement Principles which operated in NSW. The possibility of losing care of Yakamurro's three siblings, who by now had all been together for three years, would have been distressing. G and H saw the meeting, understandably, as a "*veiled threat*" to their family and they acted quickly to remove themselves from the jurisdiction.

243. In hindsight, the actions of DCJ in their dealings with G and H, when such little support had been offered to the family, were clumsy and a major cause for G and H deciding to move back to the Northern Territory with unnecessary stress and urgency. Counsel for DCJ reminded the Court that G and H had previously expressed a long term wish to return to the NT. Further, it was submitted that there were likely to have been numerous and complex contributing factors to the decision. The court's attention was drawn to G and H's stated views about CASPA's "*lack of understanding*" and what they understood to be Yakamurro's belief that he would never be allowed to return to them in NSW. While these factors may well have been present, the proximity of the decision to the meeting suggests it was the major factor in the decision.

244. The departure of G and H from NSW in such a way had significant implications for Yakamurro. Although his siblings returned to the Northern Territory, he remained in NSW, where he did not have any family left at all. Although Yakamurro had formed bonds with CASPA carers, he did not have the opportunity to visit the Northern Territory until April 2016, almost two and a half years since he had left. Yakamurro's case plans from this time indicate

[194] Transcript 14/06/22, p. 27, l. 25.
[195] Transcript 14/06/22, p. 27, l. 30-50.

that he had phone contact with his siblings but Mr Ralph notes that this contact was not consistent or regular.[196]

245. Ms Rodwell noted that G and H appeared to have "*a lot of decision-making delegation, which is unusual*". Most notably, the carers stopped Yakamurro having contact with his siblings at one point. She suggested that there should be an emphasis on foster carers getting trauma informed training before being responsible for children in high needs situations.[197] I accept her assessment of the situation.

246. Despite the trauma of his sudden separation from family, Yakamurro's behaviour improved, which led to some achievements. Following a period of transition managed by CASPA, Yakamurro was able to move from his one-on-one residential care home in Casino to a CASPA residential care home in Jiggi NSW, "Jiggi House", where other young people were living on 17 December 2015. Yakamurro appeared to be doing well in the placement at Jiggi House. He had a girlfriend, was receiving extra tutoring support and appears to have had a good nucleus of friends at school. The brief of evidence contains statements from a number of these young people who were close friends with Yakamurro.

247. By February 2016 Yakamurro was living with two other young people in Jiggi house, with whom he apparently got along well with. Yakamurro had identified to CASPA that his goal was to be living with other young people. Ms Rodwell noted that he had made positive progress, despite G and H moving back to the NT in August 2015. According to her notes he "*reduced his temper outbursts*", he became "*agreeable to re-engaging with a counsellor*" and he played basketball which was "*further enhancing his social skills*".[198]

248. From March 2016, Yakamurro's behaviour continued to improve. Around this time, Territory Families indicated that there was no suitable placement for Yakamurro in the Northern Territory and it was agreed between Territory Families and CASPA that Yakamurro should stay at Jiggi House, with a view to him returning to the Northern Territory if his behaviours stabilised and he wanted to do so.[199] In September 2016, Yakamurro visited the Northern Territory again.

249. Yakamurro's medical practitioners made observations about the impact of multiple placements on him. His paediatrician, Dr Jackie Andrews, observed that his significant attachment issues were likely to be made worse by living in a residential placement with multiple carers.

250. On 10 October 2016, Dr Andrews wrote to CASPA to report that Yakamurro needed a long term stable placement and the ability to attach to a carer in the longer term. Dr Andrews

[196] Vol 26, Tab 561, p. 23.
[197] Transcript 14/06/22, p. 34, l.5.
[198] Vol 21, Tab 476, p. 160.
[199] Vol 7, Tab 216.

observed that it was imperative that "*his ultimate guardian who is the case worker in the NT make a decision about [his] longer term placement as soon as possible*."[200]

251. On 9 December 2016, Territory Families made a request to DCJ seeking a transfer of Yakamurro's casework to NSW. Lismore CSC advised Territory Families that Yakamurro would not be allocated a DCJ caseworker and that case management may be transferred to CASPA if his care orders were transferred to NSW.[201] At this time, Territory Families also contacted DCJ to indicate that Yakamurro's care orders would be transferred to NSW once he had been in a stable placement for three months. This transfer did not occur. Despite Yakamurro remaining at Jiggi House (by December 2016 he had been at Jiggi house for almost 8 months), the Court accepts that ongoing behavioural instability continued to be identified.

252. On 12 December 2016, a teleconference was held between Territory Families and CASPA (and other staff) which included Naarah Rodwell (CASPA Manager), Jacob Walsh (CASPA case manager), Andrew Wolfe (Secondary School), June Wilkie (Education Co-ordinator) as well as the following officers from Territory Families: Placement Manager, Team Leader, Case Manager, a member of the Territory Families Placement Unit, the Practice Manager, ILO and Aboriginal Advisory Manager. Among other things the following was recorded:

"It was discussed where would [Yakamurro] go if he were to return to the NT, Darwin or Katherine, is there anybody in the family who could take on [Yakamurro's] care? What has the NT TF got to offer for [Yakamurro] to replicate what he is now receiving? The obvious theme that came through is that [Yakamurro] has been in NSW for over 2 years and TF have not formalised that process, consequently there have been some gaps and concerns with the ongoing placement process."

[The Placement Manager] stated that the current placement finishes on 13 January 2017 and that she would have to put together a Memo to the CEO to have his placement extended, which will not go down very well. Request Interstate Case Work Management with NSW CFC to be completed asap and sent to ILO. A Cultural Consult with ILO specific to take place. Genogram to be updated by ACW urgently.

The consensus of the meeting is that [Yakamurro] will be supported to remain in his current placement for another 6 months at least."

253. On the same day, the Territory Families Intestate Liaison Officer emailed the Case Manager to inform him that she had just submitted the casework assistance request to NSW, further noting that NSW had six weeks to accept the request.[202]

[200] Vol 4, Tab 127.
[201] Vol 7, Tab 245, p. 33.
[202] Vol 21, Tab 476, pp. 11096-11097.

254. On 14 December 2016, DCJ accepted the request for casework assistance, on the understanding that CASPA would undertake the casework tasks.[203]

255. Over the Christmas and New Year period in December 2016 to January 2017, CASPA supported Amala and Yakamurro's siblings to stay at Jiggi House with him.[204] These visits were not without difficulty. Amala expressed happiness in seeing that Yakamurro had a nice place to live with nice people.

256. A trip was planned for over the Easter period 2017. This trip was cancelled several times due to issues with getting approvals to travel to the Northern Territory. However, in May 2017 Yakamurro eventually did travel to Katherine with Ms Rodwell, whom he requested go with him. He had the chance to visit Amala and his siblings, which he apparently enjoyed .[205] It does not appear that any Territory Families staff met him during this visit.

257. In August 2017, Yakamurro's behaviour at school was deteriorating and he was observed to be impulsive and have difficulty controlling his anger. During this time, CASPA arranged for his attendance with psychiatrist Dr Chris Wever and General Practitioner, Dr Cristina Penanueva, to monitor his medication.[206]

258. In September 2017, Yakamurro was observed to have been frequently asking to return to the Northern Territory. CASPA indicated that they were exploring schools for him to attend in the Northern Territory and NSW.

259. In November 2017, Yakamurro attended the Northern Territory for a men's business cultural circumcision ceremony.

260. In January 2018, Amala and C visited Yakamurro in NSW.

261. On 28 January 2018, Yakamurro became dysregulated and was picked up by NSW Ambulance for behavioural disturbance after threatening a CASPA worker, lying in the middle of the highway and running into traffic.[207] He spent the night in the Emergency Department and his medication was reviewed. Follow-up was arranged with Dr Wever.

262. On 28 April 2018, Yakamurro attended the funeral of his maternal grandfather in the Northern Territory.

263. I was impressed by the care CASPA provided to Yakamurro in extremely difficult circumstances during this period. It is clear that the agency staff did their best to manage Yakamurro's complex needs. Their efforts are demonstrated by the bonds that he was able to form with many CASPA employees, including Ms Rodwell herself. Yakamurro formed a

[203] Vol 18, Tab 446A at [161].
[204] Vol 18, Tab 467 at [579].
[205] Transcript 9/06/22, p.41- 43, l. 45-4.
[206] Vol 13, Tab 379, p. 60.
[207] Vol 13, Tab 392.

particularly close bond with Maxine Fromm, whom he referred to as "Mumma Max". Ms Rodwell told the court that he also had strong bonds with a number of CASPA employees, one of whom gave evidence before me.

264. I note that H made sustained criticisms of the care CASPA offered, particularly regarding the use of female carers. He stated Yakamurro "*brutalised those women in the houses and he was allowed to do that because he did not have men around him to hold him where he needed to have men to hold him."*[208] I have seen no evidence that female staff were systematically "*brutalised*" as was suggested. I accept Ms Rodwell's evidence that both male and female staff worked with Yakamurro and that efforts were made to find him mentors in the local Aboriginal community.

265. Further, I accept Ms Rodwell's evidence that it was therapeutically appropriate that Yakamurro also worked with female staff and that he was at times fearful of males.[209]

266. CASPA maintained their commitment to Yakamurro's physical and emotional development despite his challenging behaviours and difficulties when engaging with professional services. Records from CASPA caseworkers refer to Yakamurro's refusal to attend appointments and speak with professionals.

267. I accept that a number of CASPA staff formed meaningful bonds with Yakamurro and his family in a way no other agency was able to.

268. By at times declining to take on casework for Yakamurro, DCJ largely left opportunities for on-the-ground casework entirely up to CASPA. DCJ acknowledged that as Yakamurro continued to move between placements, and when G and H returned to the Northern Territory with his siblings, DCJ caseworkers did not seek to build a relationship with Yakamurro and did not take steps to connect him to his culture.[210] Susan Mattick, the Executive District Director for the Mid North Coast, Northern New South Wales and New England Districts at DCJ conceded DCJ played a very passive role in Yakamurro's care, with limited casework assistance and limited responsibility being taken to understand Yakamurro's needs.[211]

269. Ms Rodwell told that court that it would have been helpful to have a dedicated DCJ caseworker with whom CASPA employees could liaise. In addition, DCJ did not share some very crucial file information with CASPA, for example the risk of serious harm reports, which is typically common practice. [212]

[208] Transcript 10/6/22 Page 99, l. 5-8
[209] Transcript 14/6/22 page 38, l. 40 to page 39, l. 20.
[210] Vol 7, Tab 245.
[211] Vol 18, Tab 466 [13].
[212] Transcript 14/06/22, p.23, l. 15-25.

270. Territory Families have accepted that they too readily allowed the decision-making role for Yakamurro to be performed by external parties despite Territory Families having statutory responsibility for Yakamurro.[213]

271. Territory Families recognise that once Yakamurro moved to NSW, the services he was offered were substantially devoid of the statutory leadership expected of Territory Families and DCJ, particularly given their role as statutory bodies charged with responsibility for the care and protection of children.[214] DCJ had a non-delegable responsibility to respond to ROSH reports which was not fully discharged.[215] Further, Territory Families at all times retained parental responsibility for Yakamurro, as well as full case management responsibility, notwithstanding that DCJ had at times accepted requests for casework assistance, and CASPA for its part had accepted requests to provide casework services.[216]

272. Territory Families failed to visit Yakamurro following the breakdowns of his placement in NSW and did not visit him for the entire period in which he was in residential care in NSW.[217]

273. Territory Families relied on CASPA to lead the engagement of services and care planning for Yakamurro in NSW. As a result, Territory Families, who ultimately had parental responsibility for Yakamurro, had a limited understanding of his ongoing wellbeing.[218]

274. Territory Families have accepted that there is little evidence that it communicated directly with medical and other professionals in relation to its assessment or intervention planning for Yakamurro. There are limited records to confirm the extent to which Territory Families acted upon the recommendations of key service providers.[219]

275. Both Territory Families and DCJ recognise the deficiencies in information sharing between the agencies and a lack of clarity around case management responsibility for Yakamurro. Mr Ralph is of the view that the poor communication between the agencies and confusion around Yakamurro's casework and case management responsibility are factors which contributed to the substandard casework undertaken.[220]

276. Yakamurro had regular consultations with medical and therapeutic practitioners during this time. Neither suicidal ideation nor self-harm were raised as concerns during this time, although it was clear that Yakamurro was experiencing significant life stressors and was sometimes emotionally dysregulated.

[213] Vol 18, Tab 467 at [660].
[214] Vol 19, Tab 467 at [24].
[215] Vol 7, Tab 245, p. 2921
[216] Per Protocol: Vol 18, Tab 466A at [67].
[217] Vol 20, Tab 475 at [233].
[218] Vol 20, Tab 475 at [226].
[219] Vol 20, Tab 475, p. 26.
[220] Vol 26, Tab 561, p. 17.

277. Territory Families acknowledge their failure in maintaining Yakamurro's connections to family, culture and country once he left the Northern Territory.[221] They also acknowledge their failure to deliver culturally appropriate services to Yakamurro.

August to December 2018

278. This was a key period in Yakamurro's life. He was well into his adolescence at the age of 15 and had recently been circumcised in a manhood ceremony.

279. One of the most significant events occurred on 26 August 2018, when "Mumma Max" was tragically killed in a car accident. This event touched Yakamurro and the staff at CASPA deeply. It particularly affected Yakamurro as the accident occurred when he had been waiting for Ms Fromm to pick him up. Yakamurro was distraught and Ms Fromm's family involved him in the funeral preparations and planning. Yakamurro sat with her family at the funeral.[222]

280. After her death, Ms Fromm's partner accompanied Yakamurro on a visit to the Northern Territory. There was clearly a strong bond between Yakamurro, Ms Fromm's family and many of the CASPA staff.

281. In the wake of this turbulent time, Yakamurro appears to have experimented with drugs and had interactions with the law in relation to joy riding and property damage offences.

282. As a result, he appeared before the courts for these charges. CASPA supported him in his court appearances and arranged for Yakamurro's medical practitioners to provide evidence to the courts in support of him.

283. Yakamurro attended consultations with his psychiatrist Dr Wever, whom he had seen for over two years at the initial request of CASPA. Around this time, Dr Wever considered that Yakamurro may have a form of inattentive attention deficit hyperactivity disorder ("ADHD") and poor impulse control. Dr Wever recommended a trial of Vyvanse to manage possible ADHD.[223]

Incident of [redacted]

284. During December 2018, Yakamurro had spent some days with his sister, C and family members in the Northern Territory. He returned home on 8 December 2018.

285. On 11 December 2018 Territories Families received a report that there had been a [redacted] the previous day. Territory Families was notified that [redacted]

[221] Vol 19, Tab 467, p. 456.
[222] Vol 18, Tab 464, p. 14.
[223] Vol 13, Tab 379, p. 63.

[redacted]."[224] It was recorded that [redacted]. There was also reference to a disagreement with another child in care which resulted in a [redacted]

286. It appears that Territory Families took some action. It was confirmed that the [redacted]. An Aboriginal Community Worker was engaged to provide additional support and a referral was sent to the Adolescent Mental Health Team in Darwin.

287. The information was shared with G and H, who were the carers for C and Yakamurro's siblings, A and B. However, the information was not shared with CASPA. In oral evidence Ms Broadfoot stated that she "*appreciated CASPA's view that [having the information] would have assisted them…*"[225] However she was not critical of the decision in the context of what was already known about [redacted]. She stated " *I am certainly not attempting to minimise anything at all in the presentation of that* [redacted][226]

288. There is no direct evidence before me that Yakamurro was informed about the incident by a family member or carer. However, I accept Ms Rodwell's evidence that Yakamurro and [redacted] were very close and given their ability to communicate freely with each other by telephone or social media, it is certainly *possible*, even *likely* that it came to his attention. I cannot put it any higher on the material before me. However, it is worth noting that there is no evidence before me that Yakamurro had ever attempted self-harm by ligature prior to his death 12 days later.

289. There is no doubt that this was important information for those caring for Yakamurro. He was just back from a visit with family and it was well known that such visits, while extremely important, could also be emotional and at times cause temporary emotional destabilisation. Dr Ralph told the Court that the information "*should have been passed on to CASPA…I think it is information they need to be aware of…it would be a red flag*".[227]

290. Naarah Rodwell gave evidence that had CASPA been informed of [redacted] she would have implemented a specific safety plan providing additional

[224] Vol 20,Tab 467, 145-146.
[225] Transcript 10/6/22, p. 2, l. 37.
[226] Transcript 10/6/22, p. 2, l. 30.
[227] Transcript 16/6/22, p. 43, l. 20-30.

services and supports.[228] I accept her evidence that short term protective measures had been put in place before. I have no doubt whatsoever, that had CASPA been apprised of the information indicating [redacted] that CASPA would have taken protective action. In my view it is clear that more transparent communication by Territory Families to CASPA would have provided further support opportunities to Yakamurro during this period. CASPA staff were extremely committed to keeping Yakamurro safe. By keeping them in the dark about this important event, Territory Families prevented them from having the opportunity to provide additional assistance at what *may* have been a very challenging time for Yakamurro given the information he *may* well have known.

291. Submissions provided by Territory Families record its acceptance of the importance of information sharing between agencies and persons caring for children and state that "*open channels of communication should be fostered and encouraged*". Further it identifies that information sharing is at the core of the Multi-Agency Community and Child Safety Framework. I will return to that particular reform shortly.

Events of 19 to 20 December 2018

292. On the evening of 19 December 2018, Yakamurro stayed at J's house. She observed that he was quiet, but not in a way that alarmed her.[229]

293. On 20 December 2018, Yakamurro attended a Christmas party run by CASPA at Iluka, NSW. Ms Rodwell told the court she only saw him briefly at that function as she was called elsewhere. She recalled that he appeared to be "*in great spirits*"[230] at the time she saw him early in the evening.

294. J reported that Yakamurro seemed upset at the party and wanted to tell her something, but they were interrupted and Yakamurro said that he wanted to go home.

295. Yakamurro's friends observed him to be upset about the fact that Ms Fromm was not at the party and that he had recently broken up with his girlfriend.[231]

296. Yakamurro attended the CASPA office after the Christmas party and returned to Jiggi House at around 17:00, with one of his carers. Present at the residence at that time was another child in care, and another CASPA carer, "I".

297. A shift handover was conducted between the two CASPA carers and the day shift carer left.

[228] Transcript 14/6/22, p. 81, l. 20.
[229] Vol 1, Tab 29, p. 3 [14].
[230] Transcript 14/06/22, page 56, l. 13.
[231] Vol 1, Tab 29, pp. 3-4 [14]-[16].

298. Sometime between 17:30 and 18:30, the remaining CASPA carer and the other resident went swimming at a nearby dam. Yakamurro stayed in the home and was reported to have been watching television in the lounge room when they returned.

299. Whilst at the dam, the carer was told that Yakamurro was upset about having broken up with his girlfriend.

300. At around 20:00, the carer observed Yakamurro enter his bedroom and shut the door. Sometime before 20:30pm she called out to him that his dinner was ready and he said he would be out soon. The carer heard Yakamurro open his bedroom door before closing it again 10 minutes later.[232]

301. At 20:42, a close friend of Yakamurro started receiving text messages from Yakamurro indicating that he was about to stab himself. She replied to him trying to comfort him. She told her parents about her concerns and they tried to contact CASPA, however their calls went through to an answering machine. She then contacted the other resident about her concerns.[233]

302. At around 21:00, the carer went into the CASPA office to read over Yakamurro's Therapeutic Support Plan. She heard Yakamurro open his bedroom door and close it again 10 minutes later.

303. At 21:32, another friend of Yakamurro also became aware that Yakamurro had been talking about killing himself.[234]

304. At around 22:20, the other resident at Jiggi House started to receive text messages informing him that Yakamurro was making threats of suicide. The carer could hear his phone receiving these text messages.

305. At around 22:30, the carer was preparing medication. She then saw the other resident knock on Yakamurro's bedroom door and noticed that Yakamurro had eaten some of his dinner.[235] The other resident went back to his room and the carer returned to the office.

306. At around 22:35, the resident came into the office again to ask the carer if she could check on Yakamurro. Yakamurro's door was locked and upon opening his door, the carer discovered Yakamurro deceased.[236] He had hung himself with an electrical cord from a shelving unit in his room.

[232] Vol 1, Tab 21, p. 2.
[233] Vol 1, Tab 27, p. 3.
[234] Vol 1, Tab 27, p. 4.
[235] Vol 1, Tab 21, p. 2.
[236] Vol 1, Tab 21, p. 2.

Emergency Response

307. Once Yakamurro was discovered, Triple O was called by the resident and "I" started CPR. Ambulance documents show that the Triple 0 call was made at 22.37, the ambulance was dispatched at 22.40 and on scene at 23.02[237]. Police were the first on the scene and took over CPR, and ambulance officers arrived soon after. Sadly, ambulance officers could not find a pulse and Yakamurro was declared deceased at 11.08pm[238].

Autopsy and cause of death

308. A limited post mortem examination was conducted by Dr Leah Clifton, Staff Specialist in Forensic Pathology on 24 December 2018. Dr Clifton noted that there was an asymmetrical circumferential unpatterned ligature abrasion around the neck rising to a point of suspension on the left posterior neck. This kind of mark is in keeping with hanging. There were no other marks or any suspicious findings.[239]

309. Toxicological testing indicated a low level of amphetamine and fluvoxamine. These findings were in keeping with his prescribed medications at the time of his death.

Was Yakamurro's death intentionally self-inflicted and if so, was it foreseeable ?

310. Yakamurro did not have a sustained history of self-harm or suicidal ideation. There are limited references to self-harm or suicidal ideation in the extensive brief of evidence.

311. On 7 August 2014, the DCJ CAT identified that Yakamurro may have some self-harm and/or suicidal ideation but had no history of any suicide attempt or plans toward suicide.[240]

312. A Territory Families Out of Home Care Plan dated 25 July 2017 identified that Yakamurro's challenging behaviours included "*at times suicidal ideation*".[241]

313. A CASPA Therapeutic Support Plan dated 31 August 2017 identified that "*following prolonged triggers in his environment, family contact and key relationships [Yakamurro] has remained in a state highly sensitive to stress for hours to days. During peak states of dysregulation at these times [Yakamurro] has expressed suicide ideation"*.[242]

314. In her statement, Yakamurro's friend noted that Yakamurro had made frequent jokes about committing suicide but that she thought they were "*throw away comments*"[243].

[237] Vol 2, Tab 24.
[238] Vol 1, Tab 22 at [7].
[239] Vol 1, Tab 6.
[240] Vol 7, Tab 244, p. 495.
[241] Vol 5, Tab 168, p. 237.
[242] Vol 15, Tab 457, p. 404.
[243] Vol 1, Tab 29 at [22].

315. CASPA had a safety plan in place for Yakamurro.[244] This safety plan set out that if staff were concerned about Yakamurro's mental health, they were to ask him to keep his bedroom door ajar in order to monitor him more closely. These measures were to be used where a CASPA worker perceived an acute risk of self-harm or suicide. On the evening of 20 December 2018, there was no indication that Yakamurro was at such a risk.

316. The two CASPA carers on shift that day cannot be blamed in any way for what occurred. It is clear that if they had thought there was a risk of self-harm, they would have intervened. Although there were some sporadic indications of emotional distress and limited suicidal ideation throughout Yakamurro's life, there was nothing to indicate an elevated level of distress before the evening of 20 December 2018. By the time the carer had been informed that there was an imminent risk she took steps to open Yakamurro's door. Suicide is extremely difficult to predict and I accept that Yakamurro's death was unexpected and deeply shocking to those who knew him. While it is regrettable that Yakamurro could not be placed with a family, CASPA did what it could and I am of the view it provided high-quality care whilst Yakamurro lived at Jiggi house. I have no doubt his death caused profound pain for all those who had worked with him and I extend my condolences to them.

317. A finding that a death is intentionally self-inflicted must never been made lightly. There must be clear evidence of intention. I have taken into account the messages Yakamurro sent to friends just prior to his death. I conclude that when Yakamurro shut his door and placed a ligature around his neck, he did so with the intention of ending his life. I think it is likely to have been an impulsive decision. The despair he must have felt in those moments is profoundly tragic.

Important reforms

318. It was evident during the inquest process, both throughout the documentary material collected and during oral evidence provided by agency representatives, that following Yakamurro's death significant changes have been implemented in key areas. Many of those reforms have already been referred to. However, it is necessary to make clear that Territories Families, DCJ and CASPA each went through extensive internal processes after Yakamurro's death aimed at learning from the tragedy.

Reforms implemented by Territory Families

319. The court received comprehensive evidence and submissions outlining significant changes made in relation to Aboriginal children in care since Yakamurro's death. It is well beyond the scope of these findings to record them all. Significantly, given the subject matter of this

[244] Vol 1, Tab 10, p. 118.

inquest, the court heard that reforms have now reduced the number of Aboriginal children in the care of the CEO residing interstate.[245]

320. The reforms include policy that a proposal to relocate a child interstate with a carer should only be approved in exceptional circumstances, that the transfer decision must demonstrate the Department's commitment to the five elements of the Secretariat of National Aboriginal and Islander Child Care's (SNAICC) Aboriginal Child Placement Principles, that contact should be made with local cultural authorities or Aboriginal Community Controlled Organisations when preparing for an Interstate Panel meeting to ascertain if they can assist with enabling the child to remain connected to culture, community and participation in cultural events, and that the Interstate Transfer Panel must include members who are independent from the care and Protection Office responsible for case management of the child among others.[246]

321. The Court was also informed about the particular reforms implemented by Territory Families regarding family support and child protection services and regarding the out-of-home care sector. These reforms are briefly summarised below. I cannot do them all justice here, but I commend Territory families in a number of significant respects. First, the level of cooperation with this inquest was obvious. Territory Families went out of its way to provide comprehensive material, admitting shortcomings and explaining the complexity of their important work. Further, it appears that they have been proactive in efforts to make systemic changes that will benefit children like Yakamurro and their families. I commend their report and the statement of Ms Karen Broadfoot, General Manager for the Greater Darwin region of Territory Families. That is not to suggest that there is now a system offering perfect protection, but rather there appears to have been genuine reflection following the tragedy of Yakamurro's death, and a willingness to examine the need for change.

Reforms implemented by Territory Families regarding family support and child protection services

322. In July 2018, Territory Families formed the Clinical and Professional Practice Leadership Directorate ("CPPLD"), which is dedicated to policy uplift, policy implementation and training.[247] The CPPLD are responsible for a number of areas of reform relevant to the delivery of child protection services, including the introduction of the Signs of Safety Practice Framework ("Signs of Safety"); reforms to policy, procedure and training with respect to responses to domestic violence and sexual harm; the rollout of other specialised training for

[245] Vol 26, Tab 559C, pp. 7-8; Transcript 9/06/22, p. 53, l. 47 onwards.
[246] Note this summary is taken from written submissions produced by counsel for Territory Families.
[247] Vol 18, Tab 467, p. 150-151.

Territory Families Staff; and the development of Practice Guidance related to delivery of services to young people.[248]

323. In November 2019, Territory Families began implementing the Signs of Safety program. Signs of Safety includes a safety assessment and safety planning process during which risks and safety for a young person are assessed and where a Safety Plan is developed and implemented if necessary.[249] New staff to Territory Families are provided with training in the use of Signs of Safety and all levels of staff are being upskilled on an ongoing basis.[250]

324. In 2018/19, Territory Families launched its Aboriginal Cultural Security Framework ("the Framework"), which aims to promote responsiveness and safety for Aboriginal people and to ensure cultural values are integrated into the governance, management, design and delivery of services.[251] Territory Families' Aboriginal Cultural Security Advisory Committee oversees the implementation of the Framework. Territory Families has also introduced an Elder in Residence role, which provides expert cultural advice and guidance across policies and programs to the executive.[252]

325. Territory Families has implemented a number of reforms in order to improve its staff's capacity to identify and respond to concerns related to domestic violence, including the following:[253]

    a. Introducing a training series in relation to identifying and responding to domestic and family violence.

    b. Contacting an NGO to provide formal training on the Safe and Together Model.

326. Territory Families has implemented a number of reforms in order to improve its staff's capacity to identify and respond to concerns related to sexual harm, including the following:[254]

    a. Revising the Investigation and Safety Assessment Guidance to provide flexibility to assess harm regardless of whether or not the alleged perpetrator was intra or extra-familial.

    b. Developing a Sexual Harm and Exploitation Project Plan ("the Project Plan"), which focuses on improving the training provided to staff with respect to responding to child sexual harm and updating policy and procedures to ensure there are effective responses to sexual harm and exploitation.

[248] Vol 18, Tab 467, p. 151.
[249] Vol 18, Tab 467, p. 152.
[250] Vol 18, Tab 467, p. 152.
[251] Vol 18, Tab 467, p. 153.
[252] Vol 18, Tab 467, p. 154.
[253] Vol 18, Tab 467, p. 154-155.
[254] Vol 18, Tab 467, p. 155-156.

c. Working with NT Police and the Departments of Health and Education to revise the MOU into a Multi-Agency Child Abuse Taskforce Protocol relevant to the screening and investigation of allegations of child sexual abuse and exploitation.

327. In 2020, the CPPLD introduced Best Interests Mappings. These occur at meetings to analyse the situation for a particular child to ensure information gaps are identified and appropriate next steps are planned during important decision-making points throughout the child protection continuum.[255]

328. In addition to the various programs identified in the preceding paragraphs, the court was informed that Territory Families have also implemented continuous recruitment to increase staff numbers and improve its case manager to client ratio.[256]

Reforms implemented by Territory Families regarding out-of-home care

329. The Court was informed that in August 2018, Territory Families released the first round of Aboriginal Carers Growing Up Aboriginal Children grants. The grants are available to Aboriginal-led organisations to assist with finding, recruiting, training and supporting Aboriginal kinship and foster carers for Aboriginal children in out-of-home care.[257] In early 2021, Territory Families released Practice Guidance in relation to sourcing and assessing kinship carers in order to increase the number of Aboriginal kinship and foster carers.

330. In May 2021, Territory Families updated its Reunification Policy to implement the requirement that Central Intake be notified if concerns for the safety and wellbeing of a child are identified during the reunification process.[258]

331. In 2018, Territory Families introduced a "Welcome to Our Home" booklet and developed procedures to provide children transitioning to a new care placement with an informative and welcoming introduction.[259] Territory Families also entered into a five-year contract with the CREATE Foundation to organise the collection of views of children with a care experience.

332. Territory Families implemented the Housing for Young People Program which is a supported accommodation model for those leaving out-of-home care.[260] Additionally, the Family and Children Enquiry Service ("FACES") has been established as a telephone hotline offering information and referrals to support services throughout the Northern Territory.[261]

[255] Vol 18, Tab 467, p. 156.
[256] Vol 18, Tab 467, p. 157-158.
[257] Vol 18, Tab 467, p. 158.
[258] Vol 18, Tab 467, p. 158.
[259] Vol 18, Tab 467, p. 160.
[260] Vol 18, Tab 467, p. 160.
[261] Vol 18, Tab 467, p. 161.

333. In 2018, Territory Families partnered with the Foster and Kinship Carers Association for five years to conduct regular forms for carers and to deliver training and support services.[262]

334. Territory Families is also working to provide therapeutic services designed to achieve positive outcomes for children and young people in care. In May 2020, Life Without Barriers and CASPA were awarded a $200 million, five-year contract to deliver intensive therapeutic care and support for up to 100 young people.[263]

Reforms implemented by Department of Communities and Justice NSW (DCJ)

335. In April 2020, the Serious Case Review Unit prepared an Internal Child Death Review ("ICDR") in relation to Yakamurro's death. The Court had an opportunity to assess the review. The ICDR outlined eight recommendations for areas of improvement, including:[264]

    a. That the ICDR be shared with the Director of Information Access and Exchange for consideration of what measures could be taken within DCJ to identify and support children and young people who are living in NSW under interstate child protection orders.[265]

    b. That Information Access and Exchange provide a draft paper regarding solutions. The Interstate Practice Report ("IPR") has been finalised and explores potential measures that can be taken by DCJ to better identify and support children or young people residing in NSW under interstate care orders.[266]

    c. That Lismore CSC and Ballina CSC practitioners participate in the "Connecting with Aboriginal Communities" training. This recommendation has apparently been successfully implemented.[267]

    d. That a group session facilitated by Practice Support to allow practitioners in the Lismore and Ballina CSC to reflect on the learning arising from the ICDR. This recommendation was also apparently implemented.[268]

    e. That the Serious Case Review facilitate a group supervision with leaders from Northern NSW, JCPR and the Interstate Liaison Team and CASPA to reflect on the learning the ICDR offers and to consider additional changes to enhance practices. Some contact between the organisations has taken place, however the court was

[262] Vol 18, Tab 467, p. 161.
[263] Vol 18, Tab 467, p. 162.
[264] Submissions on behalf of DCJ dated 5 October 2022.
[265] Submissions on behalf of DCJ dated 5 October 2022 at [17.a].
[266] Submissions on behalf of DCJ dated 5 October 2022, [17.b] and Vol 7, Tab 246A.
[267] Submissions on behalf of DCJ dated 5 October 2022, [17.c].
[268] Submissions on behalf of DCJ dated 5 October 2022, [17.c].

informed that the recommendation has not been implemented as there will be a formal debrief following the finalisation of the inquest. [269]

f. That the critique and learning from the ICDR is shared with Territory Families in order to enhance the work around interstate orders and supporting children who live interstate under care orders. The court was informed that this recommendation has not been implemented as engagement between DCJ and Territory Families will take place following the finalisation of the inquest.[270]

g. That the ICDR is provided to the Deputy Secretary, Strategy, Policy & Commissioning and Executive Director, Child & Family, Commission to inform their role in leading discussion of practice issues.[271]

336. In her statement, Ms Susan Mattick, Executive District Director of the Northern District, acknowledged the findings of the ICDR and outlined the implementation of the recommendations and some other remedial actions subsequently taken to support children in circumstances similar to Yakamurro. A statement from Lisa Gava, former Manager Client Services at Lismore CSC from 2008-2018 was also before the Court[272]. Both statements indicated that DCJ had seriously reflected upon deficiencies in relation to the issues raised in this inquest.

337. Ms Mattick assured the Court that DCJ is committed to engaging with CASPA and Territory Families following this Inquest in relation to learnings and in relation to planning and collaboration in the future[273].

338. The statement of Ms Mattick sets out some of the lessons learnt since Yakamurro's death, including[274]:

- Whilst awaiting the development and implementation of ChildStory enhancements which will enable DCJ to enter interstate child protection orders into the system, Interstate Liaison continues to add 'Alerts' into ChildStory when a child or young person is on interstate orders. This interim solution increases visibility for ChildStory users as to the status of the child or young person as being on interstate orders.
- Information Access and Exchange Unit continues to work alongside ChildStory and DCJ's Corporate Information Warehouse to increase visibility of information to Districts which will be fully realised once the ChildStory enhancements are implemented.
- The Interstate Liaison team continues to build its practice in advocating and working

[269] Submissions on behalf of DCJ dated 5 October 2022, [17.d].
[270] Submissions on behalf of DCJ dated 5 October 2022, [17.e].
[271] Submissions on behalf of DCJ dated 5 October 2022, [17.f].
[272] Vol 19, Tab 467A.
[273] Vol 18, Tab 466A at [79].
[274] Vol 18, Tab 466A at [82]-[84].

collaboratively with jurisdictions to support decision making in a child's best interest, including through:

i. monitoring and being responsive to incoming requests

ii. advocating for and facilitating case conferences for complex matters or transfers that have not progressed in a timely way

iii. championing the Protocol principles, with particular regard to prioritising the best interests of the child and participation of children in decisions that affect them

339. The Court is concerned that interstate care transfers remain an area of potential risk and hopes the issue remains on the agenda for DCJ and Territory Families at the conclusion of these proceedings.

Reforms implemented by CASPA

340. In the weeks following Yakamurro's death, CASPA implemented additional training measures relating to suicide prevention, awareness and intervention skills in order to upskill staff to be able to identify and intervene with confidence.[275] The Applied Suicide Intervention Skills Training (ASIST) is a two-day workshop in suicide first aid that is now mandatory for all frontline staff.

341. Additionally, CASPA have increased the size of its clinical team in order to ensure greater clinical oversight in relation to the care and day-to-day functioning of young people.[276]

342. I am confident after hearing from Ms Rodwell that CASPA remains committed to continual service improvement. Her participation in the inquest demonstrated her leadership capacity, skill and great compassion.

The need for recommendations

343. The changes I have already referred to have reduced the number of recommendations that need to be considered. Tragically, some of the changes outlined may have had a significant impact on the trajectory of Yakamurro's life had they been implemented earlier.

Recommendations proposed by Counsel Assisting

344. Counsel assisting put forward a single recommendation. It mirrored a recommendation made by NT Coroner Greg Cavanagh in an earlier inquest[277] and was directed towards progressing

[275] Submissions on behalf of CASPA dated 5 October 2022, [22]-[23].
[276] Submissions on behalf of CASPA dated 5 October 2022, [25].
[277] Inquest into the death of Fionica Yarranganlagi James, Keturah Cheralyn Mamarika and Layla Leering [2020] NTLC 022

legislative reform in relation to the Multi-Agency Community and Child Safety Framework ("the Framework").

Multi-Agency Community and Child Safety Framework

345. The Court received evidence about the Framework.

346. I am advised there are two mechanisms in place now to improve communication with CASPA beyond that which occurred prior to 2018. The first is the shift in practice at Territory Families to incorporate the Signs of Safety practice framework. The second is the contractual arrangement now in place with CASPA.

347. The Signs of Safety practice framework is described in the affidavit of Karen Broadfoot.[278] It has at its core the establishment of Care Teams. The role of Care Teams in monitoring the wellbeing of children in care and the associated decision making is incorporated into training. The Care Team is intended to create stability and reduce the disruptions when a child enters out-of-home care. It maintains the naturally occurring networks the child belongs to before coming into care and should strengthen them.

348. The carers of young people, be they kinship, foster or residential care providers, such as CASPA, have a role in the Care Team and in cooperatively making decisions about the day-to-day care of a child. Care Teams include CASPA staff when children are placed in ITRC with that provider.

349. This practice differs from what was occurring between 2014-18, when case management deferred to the day-to-day care provider rather than asserting decision-making while listening to and, as appropriate, incorporating the views of key people including CASPA and the family through a Care Team arrangement.

350. Further, the contractual arrangements now in place with CASPA explicitly provide for cooperation and communication, and regular reporting and meetings

351. I was advised that Territory Families is currently progressing legislative reform in relation to the Framework. Territory Families has also advised that while was it was initially proposed that the legislative framework would be included in the *Territory Families Legislation Amendment Bill 2021,* this was postponed to ensure that there was comprehensive engagement with Aboriginal peak bodies and the community on the design of the Framework and to ensure the legislation properly reflected the findings of a review of the Framework conducted from late 2021 and in 2022.

352. Counsel for Territory Families advised the court that since Coroner Cavanagh made the recommendation the Framework has been comprehensively reviewed and has also been the

[278] Vol 18, Tab 467, at [807] and following.

subject of extensive consultations, especially with Aboriginal Controlled Community Organisations (ACCOs). The provisions now proposed will prescribe the governance and management of the Framework, whilst the Framework itself will be enshrined in a policy document – making it more flexible and potentially responsive to the needs of children and their families. I accept Territory Families' submission that given the changed environment, there is no need to make the proposed recommendation.

Recommendations proposed by CASPA

353. The legal representatives for CASPA put forward two recommendations for consideration arising from the evidence.

Notification of Significant incidents relating to family member

354. The first was aimed at ensuring Territory Families include in their relevant policies a requirement that where a significant incident relating to a family member of a child or young person in care occurs, that Territory Families must notify the Agency with responsibility for the day-day care of that child or young person. The proposal grew out of CASPA's concern that it had been prevented from putting into place protective measures for Yakamurro because it had not been given relevant and important information.

355. As I have said, I am unable to make a positive finding that Yakamurro *knew* of [redacted] in the days prior to his death. However, I accept Ms Rodwell's evidence that given how close they were it is certainly possible that he did. I also accept that whether or not Yakamurro already knew, there was always a risk that he would find out in an informal or unsupervised way. The information should have been provided to Yakamurro's carers so that they were prepared for this possibility and so that they could have assessed the potential risk and provided additional support, if necessary.

356. I note that Territory Families embraced the spirit of the recommendation put forward and, in effect, go further by suggesting an alternative that makes it abundantly clear that Territories Families should not only notify the Agency of a significant incident but also be involved in formulating a response.

357. I intend to make a recommendation in this regard.

Transfer of Case Management to agencies where medium to long term placement

358. CASPA's second proposed recommendation was directed towards policy relating to case management control. CASPA asked the court to consider recommending that Territory Families give consideration to the transfer of case management responsibility where children are placed with an agency for the medium to long term.

359. There was extensive evidence before this Court about the difficulties facing CASPA in trying to adequately plan care for Yakamurro when it did not hold case management authority, especially given the distance and lack of oversight provided by Territory Families. I accept there were times when this may have impeded CASPA's ability to plan and provide necessary support in a timely manner.

360. The Court was informed that Territory Families did not and still does not transfer case management to external agencies which hold placement responsibilities whether the child resides interstate or within the Northern Territory. This differs from the approach taken in NSW where case management responsibilities would be transferred to the agency providing care in similar circumstances.

361. Ms Rodwell gave compelling evidence that in situations where placement becomes long term, as it did for Yakamurro, the agency actually providing care is better placed to drive appropriate case management. As a result of this evidence counsel for CASPA suggested consideration of a recommendation in this regard.

362. The proposal was opposed by Territory Families for four reasons. Firstly, Territory Families remain of the view that the statutory powers, functions and responsibilities relating to children in care should not be delegated to external agencies. Further, it was submitted that specifically when Aboriginal children are placed with agencies interstate, as Yakamurro was, that the office of Territory Families which is located closest to the family is "generally best placed to ensure continuing connection with family, culture and language, all of which are critical components of case management."[279] It was also submitted that many agencies who provide placements for children in care would not have the capacity or desire to take over case management and that there can be a benefit in separating case management and day-to-day care, particularly when the agency responsible for the latter is not performing to an appropriate standard.

363. I have considered the matters put to me very carefully. During the inquest, Territory Families candidly conceded many of the inadequacies in the case management they provided for Yakamurro. On the other hand, CASPA provided care which appears to have been responsive and trauma informed. CASPA workers worked closely with Yakamurro's birth family and were actively engaged in future planning. I have little doubt they were well equipped to provide case management in these circumstances. Nevertheless I am wary of making such a significant recommendation on the evidence from a single case.

364. While there may be merit to the proposal, the recommendation calls for a fundamental change to the NT care model. I do not have sufficient evidence to make it.

[279] Supplementary submission of Territory Families.

Recommendations proposed by Amala

365. Counsel for Amala put forward a number of recommendations for the court's consideration.

Mandate Family meeting prior to interstate transfer

366. There is no doubt that Yakamurro's life changed irrevocably once he was taken, in a placement that was already somewhat unstable, to NSW. Territory Families accepts that the process to approve this interstate movement was flawed. I have already referred to some of the reforms to policies around interstate transfers that have quite properly been progressed by Territory Families since Yakamurro's death.

367. The current policy titled "*Interstate Case Transfers from the Northern Territory to other jurisdictions (including New Zealand*)"[280] does not mandate the exact kind of family participation that is required in the decision-making process prior to a transfer taking place. It states "*Practitioners, with the support of Aboriginal Community Workers or Aboriginal Practice Advisors will seek opportunity to consult with parents, families and their naturally connected network about the child's cultural needs."*[281] Counsel for Amala brought the court's attention to the fact that the precise form of any consultation is left to the discretion of an individual practitioner.

368. While it could be said that Amala was "*consulted*", there was no proper attempt to have her *participate* in the decision-making process. Records indicate that Amala expressed to Territory Families' staff that "*she felt it was too far away*" and that she wanted to have a meeting with workers and G and H to discuss the proposal[282]. When a meeting was held a few days later, Amala was the only family member present and she "*appeared quiet*". Later, as we have seen, Departmental records indicate that she was "*unlikely to formally consent*" to her children moving away.[283]

369. I accept Amala's counsel's submission that these interactions must be viewed through the lens of the very significant power imbalance that exists between Aboriginal mothers like Amala and Territory Families. They exist against the historic backdrop of institutional racism that supported policies that resulted in the stolen generation and assimilation. It would not be surprising to hear Amala felt powerless and it is clear her reluctance was not adequately addressed.

370. The Senior Practice Leader accepted that a family meeting should have been an essential pre-requisite to considering the matter at an interstate panel meeting.[284] I accept that

[280] Vol 26 Tab 559C, p. 82.
[281] Vol 26 Tab 559C, p. 86.
[282] Vol 20, Tab 476, p. 276.
[283] Vol 3, Tab 91, p 110.
[284] Transcript 9/06/2022, p. 10, l. 10-16.

consultation with Yakamurro's extended family would have added depth to any discussion about the move, and reinforced real concerns about how the children's connection to culture could be maintained at that distance. It may also have resulted in the initial views of the Aboriginal Practice Advisor being given more weight and even empowered Amala to express her very real reservations more forcefully. Importantly, it could have re-focussed Territory Families on the importance of family mapping and given more attention to the possibility of finding a kinship placement.

371. Counsel for Amala suggested a recommendation in the following terms – "*that Territory Families revise their interstate Case Transfer Policy to provide that a family meeting should be held before an interstate panel is convened to formally discuss a proposal for an interstate move. This should be accompanied by updated family mapping to identify key kinship connections who should be included in the conference.*"

372. Counsel for Amala noted that although there was a relatively comprehensive genogram of Yakamurro's family created in 2012, there is little to indicate that it was ever used by Territory Families to follow up opportunities for connection or kinship placements. Later information recorded on file about his family was partial or incomplete.[285]As a consequence, it fell to workers at CASPA to attempt to build a family tree and establish contact.

373. Counsel for Territory Families, while generally supportive of the recommendation submitted that imposing a uniform mandatory policy requirement for family meetings prior to all Interstate Transfer Panel Meetings would be impracticable or undesirable in some circumstances such as where family do not want to participate, are difficult to find or where the circumstances suggest that participation of particular family members may actually be detrimental to the child. I accept that there may be cases in these categories. I also accept that in a limited number of circumstances creating a comprehensively updated genogram may cause undue delay.

374. Territory Families was supportive of recognising the importance of understanding a child's family and encouraging genuine family participation. However, it suggested that rather than mandating an updated genogram before the family meeting which could cause delay, Best Interests Mapping should be conducted prior to an Interstate Transfer Panel taking place. Ms Broadfoot had told the Court that Best Interests Mapping provides a structured decision-making forum in which practitioners seek guidance and input from a team of senior, experienced practitioners and where the child is Aboriginal an Aboriginal Community Worker.[286] Counsel for Territory Families submitted that introducing a requirement for Best

[285] Submissions on behalf of Amala page 6, referring to examples on file.
[286] Vol 18, Tab 467, page 719.

Interests Mapping to take place immediately prior to an Interstate Transfer Panel would assist in ensuring a rigorous decision-making process took place.

375. I have carefully considered all the submissions on this issue and intend to make a recommendation in line with that suggested by Territory Families, however given that I think the situations where a family meeting cannot take place should be few and far between, I intend to add a proviso that reasons should be recorded where a meeting is not held. It is commendable that Territory Families remains committed to exploring methods of making Interstate Transfer decisions more robust.

Consultation with parents when significant change

376. Counsel for Amala informed the court that one of Amala's great heartbreaks was that she only learned of many of the difficulties Yakamurro had faced during the inquest process. Amala told the court that she did not get regular updates from Territory Families about her children, even when there were "*big changes*" and that she was the one having to chase up reports.[287]Ms Broadfoot agreed with the finding in the Practice Review that Territory Families were not pro-active enough in contacting Yakamurro's parents and that it was often them that initiated contact.[288]

377. Counsel for Amala drew the court's attention to the fact that the records indicate that an incident which was critical in the breakdown of the placement - where Yakamurro is reported to have threatened G with a meat cleaver - was not reported to Amala. In fact, it appears Amala was not contacted until critical decisions flowing from the breakdown of the placement had already been made.

378. Ms Broadfoot gave evidence that there are no *express* policies that would guide the level of communication that should be expected by a parent from Territory Families, nor guidance about what events might trigger contact. However, she told the court that within the Signs of Safety practice framework there is a general expectation that family will be involved in planning for their children and advised of critical events in relation to their children.[289]

379. In submissions, counsel for Territory Families submitted that there are now extensive legislative, policy and procedural safeguards to ensure reasonable efforts are made to update and consult parents and family members in relation to significant events in a child's life, having due regard to a child's wishes and best interests.

380. Counsel for Territory Families urged the court not to make the recommendation. He drew the court's attention to situations where a young person may not wish for information about

[287] Vol 1, Tab 8A at [59].
[288] Transcript 9/06/22, p. 48, l. 7-22; p. 70, l. 8-12; Vol 19, Tab 467, pp. 456-457.
[289] Transcript 9/06/22, p. 70.

their lives to be shared, noting that records indicate Yakamurro expressed this view from time to time. It was also submitted that at times the requirement may be impractical or undesirable or cause undue delay in the decision-making process. Rather than introduce a mandatory policy, it was suggested that relevant out-of-home care policies and procedures could include a direction that decisions in relation to Aboriginal children must demonstrate the Department's commitment to the SNAICC Aboriginal Child Placement Principles.

381. While I understand the approach taken by Territory Families on this issue, I think a clearer and more direct direction may be called for. The SNAICC principles are already in place, they should already be informing all placement decisions. Amala's recommendation goes to a particular concern that arises from the evidence before me. It will be useful to remind officers that parents must be notified or consulted where significant changes occur.

382. I intend to make a specific recommendation taking into account matters raised by Territories Families.

Agreements in relation to frequency of family contact

383. Counsel for Amala proposed a recommendation aimed at introducing a requirement that at each care team meeting, Territory Families should facilitate discussion around the frequency with which it will contact families and update them on the progress of their children. Further, it was suggested that any agreement reached should be reflected in a child's care plan.

384. The issue of communication was a significant one for Amala. Families need to understand when they will be contacted and what they can expect. There should be clearly articulated agreements and transparency around what families will be told.

385. The substantive recommendation was supported by Territory Families, although an alternative was suggested.

Recommendations in relation to the Tangentyere Model

386. The court was provided with written and oral evidence about a policy entitled "*Children Safe, Family Together*" prepared by Tangentyere Aboriginal Council and commissioned by Territory Families ("the Tangentyere Model").[290]The model was described as the "*new family and kin care model*" aimed at transforming out-of-home care in the Northern Territory. The executive summary states that the model:

"Aims to transition family and kin care services delivery to Aboriginal community controlled organisations and increases the decision making power of Aboriginal children, families, communities and organisations in relation to the care and protection of Aboriginal children.

[290] Vol 26 Tab 559C, p.127.

This is a fundamental step towards increasing community controlled and self-determination for Aboriginal people and communities."[291]

387. The model resembles a model operating in Victoria, where legislation can allow Aboriginal agencies to perform functions on behalf of the child protection authority, including where appropriate case management and planning functions. I accept that implementation of the model could be transformative.[292]

388. Counsel for Amala submitted that "*Amala embraces the commitment of Territory Families to the Tangentyere Model and commends Territory Families on their commitment to transforming out -of-home care in partnership with Aboriginal communities*." [293] One wonders what could have been achieved in Yakamurro's early life had greater support been available from ACCOs and had Yakamurro's family been supported and mentored within their own community.

389. The great potential of implementing a Tangentyere type model is obvious, but it will require significant funding and support from Government. In my view, it has the capacity to deliver a practical approach to reframing an out of date and frequently harmful care system.

390. Counsel for Territory Families urged against making recommendations in relation to the Tangentyere model, stressing that neither the model nor the time frame proposed has been formally endorsed by the Department or by the Aboriginal Community Controlled Organisations and Aboriginal Carer Services likely to be involved in the provision of services envisaged by the Model. Counsel submitted that it was premature and "*potentially counterproductive, for the Department to commit to the Tangentyere Model, consider and advocate for legislative amendments necessary to implement it, and publish a transition plan for the transition of services under it, in circumstances where the relevant service providers have not endorsed the Model, and in many cases, may not yet have the capacity to begin or accelerate the transition of services."*[294]

391. I understand that it may be early days and that as developments occur the model may be further adapted to suit the particular challenges of the NT environment, but in my view it is essential that a significant transformation occurs urgently. The Tangentyre or *like model* that increases community control and self-determination for Aboriginal families in the out-of-home care sector must be prioritised. Given the limited information I have available, the submissions of Counsel for Territory Families, the willingness of Territory Families to concede its mistakes and commit to reform, I will not make a formal recommendation in this regard. However, Territory Families are on the record offering to commit to continued work in favour

[291] Vol 26, Tab 559C, p. 130.
[292] Transcript 9/6/22, p. 66.
[293] Submissions on behalf of Amala, p. 11.
[294] Submissions on behalf of Territory Families, [51]

of a model that embraces, where possible, a *transition of family and kin care service delivery to Aboriginal community controlled organisations and increases the decision making power of Aboriginal children, families, communities and organisations in relation to the care and protection of Aboriginal children.* If there is no progress towards such a model, future governments will continue to fail Aboriginal children and their families.

Intensive therapeutic care on country

392. Counsel for Amala submitted that one of the key tensions that existed throughout Yakamurro's period in care was that his family and culture were in the Northern Territory, but the intensive therapeutic care that was required appeared to be only available in NSW. I accept that this was a big factor in G and H's decision to re-locate and remained an important factor when the placement broke down and he was cared for by CASPA. I accept that the inability to simultaneously meet both his therapeutic and cultural needs is a significant failing of the care system. It cannot be forgotten that for Aboriginal children, their cultural connection and identity are integral to their health and wellbeing.[295]

393. One hopes that such an impossible choice between culture and intensive therapy should never have to be made, however I fear there will be other cases like this. The Court heard evidence from Ms Broadfoot that there are now placements in Darwin and Alice Springs[296]. She said:

"I think our NGO partners do as well about bringing in the expertise that we need to run specialist services even in Darwin and Alice Springs, that's a challenge for us to go out beyond that at the moment I think would be very, very difficult for us to run a, a reliable and skilled service."[297]

394. Ms Rodwell also told the Court that CASPA was now providing therapeutic care in homes in Katherine.[298]Further information about the growth of trauma informed placements was provided by Ms Broadfoot for Territory Families[299], who explained that *"[f]ollowing the Royal Commission into the Protection and Detention of Children in the Northern Territory (the Royal Commission), the Department undertook to transform its out-of-home care service delivery model to one which would be underpinned by trauma informed practices and therapeutic care, in its response to harm experienced by children and young people as a result of abuse and neglect"*[300].

[295] For discussion of this and like issues see Vol 26, Tab 562.
[296] Transcript 9/6/22, p. 57, l. 7-10.
[297] Transcript 9/6/22, page 57, l. 20.
[298] Transcript 14/6/22, pp. 60-62, l. 40-49, l. 1-50.
[299] Vol 26, Tab 559C.
[300] Vol 26, Tab 559C at [9].

395. The importance of exploring and supporting intensive therapeutic options for children with complex needs in the NT cannot be underestimated and I note that Territory Families supports a recommendation in principle. Those initiatives are to be applauded and I accept that Territory Families are committed to building long-term capacity in this area. Nevertheless, the work is urgent and must be prioritised. I intend to make the recommendation suggested by Amala in this regard.

Findings

396. The findings I make under section 81(1) of the *Coroners Act 2009* (NSW) are:

Identity

The person who died was [redacted], also known as [redacted] (Yakamurro). He is referred to in these findings by Yakamurro, out of respect and in recognition of his culture

Date of death

He died on 20 December 2018.

Place of death

He died at a CASPA care residential home at 821 Jiggi Road, Jiggi NSW.

Cause of death

He died from neck compression due to hanging.

Manner of death

Yakamurro's death was intentionally self inflicted. At the time of his death he was under the parental responsibility of Chief Executive Officer (CEO) of Territory Families, Housing and Communities, the child protection agency of the Northern Territory.

Recommendations pursuant to section 82 *Coroners Act 2009*

397. For the reasons stated above, I recommend:

To Territory Families

1. Where Territory Families, Housing and Communities becomes aware of a significant incident relating to a family member of a child or young person who is in care and placed with an Agency, and it is considered that incident is likely to significantly affect

that child or young person, Territory Families, Housing and Communities must notify the Agency with responsibility for the day-to-day care of that child or young person and collaborate with the Agency to develop a plan to support the child or young person.

2. That Territory Families, Housing and Communities further revise its Interstate Case Transfers from the Northern Territory to Other Jurisdictions (including New Zealand) Procedure to provide that, before the Interstate Transfer Panel is convened to formally discuss a proposed interstate relocation:

    a) Practitioners must hold a family meeting, wherever practicable and in the best interests of a child

    b) Where a meeting is not held, reasons for this decision must be recorded and signed off by a senior officer

    c) Where a meeting is not held, reasonable efforts must be made to consult with individual family members including parents and others who have ongoing involvement in the child's life

    d) Practitioners should update a child's genogram prior to the family conference where practicable or otherwise before the decision is considered by the Interstate Transfer Panel

    e) Best Interests Mapping should be conducted no more than three months prior to an interstate panel meeting and the documented outcomes from the Best Interests Mapping be included in the information considered by the Panel

3. That Territory Families, Housing and Communities introduce a policy that when there are significant changes to a child's placement, health or wellbeing, or a significant event occurs in the child's life, parents must be notified and consulted on future planning for the child. Where for some reason a decision is taken not to notify parents the reason for that decision must be recorded.

4. That Territory Families, Housing and Communities amend relevant out-of-home care policies and procedures to include a direction that practitioners are required to consider expectations around the frequency with which Territory Families will contact families and update them on the progress of their children at the initial care meeting, and as reasonably necessary and agreed thereafter.

5. That Territory Families, Housing and Communities continue to explore options for Intensive Therapeutic Care to be provided on or close to country for Aboriginal children who have complex or extreme needs and are unable to be placed in family-

based care.

Conclusion

398. This inquest concerned the life and tragic death of a single boy, Yakamurro. Nevertheless, his story raises some very significant issues and I am grateful that those participating in these proceedings have provided some suggestions for achievable change. Examination of Yakamurro's life and death demonstrated the very real challenges that result from inter-generational trauma in Aboriginal families caused by colonisation, the removal from traditional country and the disruption of safe family structures. In spite of how loved Yakamurro was, that love was not enough to protect him.

399. Efforts to support children must include ways to support the whole family and community, so that the ongoing systemic disadvantage experienced by Aboriginal Australians in health, housing, education and opportunity is addressed. The road to progress in those areas is a long and slow one, but I hope it is moving in the right direction. Certainly, there are good people in both Government and non-Government agencies, who are committed to walking alongside Aboriginal Australians and some of those people were present in this court.

400. I offer my sincere thanks to counsel assisting, Dr Peggy Dwyer and her instructing solicitors Lena Nash and James Herrington for their hard work and enormous commitment in the preparation of this matter and in drafting these findings. I thank Brittannie Miles and Nicolle Lowe, Aboriginal Coronial and Information Support Officers who assisted the Court during these proceedings. I thank others at the bar table for the sensitive way they approached these painful proceedings.

401. Finally, once again I offer my sincere condolences to Yakamurro's family, especially to Amala. I greatly respect her decision to participate in these proceedings.

402. I close this inquest.

Magistrate Harriet Grahame
Deputy State Coroner, NSW State Coroner's Court, Lidcombe
15 December 2022

Annexure A: Issues List

With respect to the case management of Yakamurro by the NT Department of Children and Families (now Territory Families):

1. Whether Yakamurro received adequate case management by Territory Families;
2. Whether the Chief Executive Officer of Territory Families adequately exercised parental responsibility over Yakamurro.

With respect to Yakamurro's placement (and later, return) to his foster parents G and H:

3. Whether Yakamurro received adequate support and access to services;
4. Whether Yakamurro's foster parents received adequate support and access to services to manage Yakamurro's behaviour.

With respect to Yakamurro's relocation to NSW with his foster parents:

5. Whether there was adequate consideration by Territory Families of the impact the relocation to NSW would have on Yakamurro's cultural connection;
6. Whether there was appropriate consultation, communication and handover between Territory Families and the Department of Family and Community Services ("FACS") (now Department of Communities and Justice ("DCJ")) prior to Yakamurro's relocation to NSW;
7. Whether parental responsibility for Yakamurro should have been transferred from the Chief Executive Officer of the NT Department of Children and Families to the Minister for Families and Communities upon Yakamurro moving to NSW;
8. Whether there was adequate consultation and communication with Yakamurro's birth parents about the relocation to NSW.

With respect to the case management of Yakamurro by DCJ:

9. Whether there was adequate liaison between DCJ and Territory Families as to the case management of Yakamurro;
10. Whether there was adequate case management and oversight of Yakamurro by DCJ;
11. Whether it was appropriate to end Yakamurro's placement with his foster parents;
12. Whether there was adequate liaison between DCJ and CASPA as to the case management of Yakamurro;
13. Whether Yakamurro should have been relocated to the Northern Territory after his siblings and foster parents returned to the Northern Territory in August 2015.

With respect to the case management of Yakamurro by CASPA Services Ltd ("CASPA"):

14. Whether Yakamurro received adequate case management by CASPA;
15. Whether Yakamurro's mental health was appropriately monitored and managed by staff at CASPA, and in particular whether a suicide risk assessment should have been undertaken;
16. Whether there were appropriate attempts by CASPA carers to engage Yakamurro in programs to foster cultural connection;

17. Whether the placements of Yakamurro in the residential care home in Casino NSW, and then in Jiggi NSW were appropriate.

With respect to contact with Yakamurro's birth family

18. Whether Yakamurro and Yakamurro's birth family were adequately supported so as to maintain contact and connection with each other.

With respect to the function under s82 of the Coroners Act 2009

19. The Coroner may make recommendations that are "necessary or desirable" in relation to any matter connected with Yakamurro's death. What, if any, recommendations should be made?