

CORONERS COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	Inquest into the death of Bradyn Stuart Dillon
Citation:	[2021] ACTCD 3
Hearing Dates:	2-6, 10-13 September 2019, 17, 19-21, and 24-28 February 2020, 10-14 August 2020, 23-27, 30 November 2020, 1 December 2020 (30 days)
Decision Date:	29 April 2021
Before:	Coroner M.A. Hunter OAM
Findings:	See [3621] – [3625]
Catchwords:	CORONIAL LAW – manner and cause of death – death of a child known to child protection agencies – information sharing across jurisdictions - eyes of the community on the child – reports of bruising – domestic violence - filicide
Legislation Cited:	<i>Coroners Act 1997</i> (ACT) <i>Coroners Act 2003</i> (SA) <i>Coroners Act 1985</i> (Victoria)
Cases Cited:	<i>Alphacell Ltd v Woodward</i> [1972] AC 824 <i>Briginshaw v Briginshaw</i> (1938) 60 CLR 336 <i>Chief Commissioner of Police v Hallenstein</i> [1996] 2 VR 1 <i>E & M.H. March v Stramare Pty Ltd</i> (1991) 171 CLR 506 <i>Harmsworth v The State Coroner</i> [1989] VR 989 <i>Inquest into the Death of Luke Geoffrey Batty</i> (unreported) <i>Onuma v The Coroner's Court of South Australia</i> [2001] SASC 218 <i>R v Dillon</i> [2018] ACTSC 164 <i>The Queen v Coroner Maria Doogan; ex parte Peter Lucas-Smith & Ors; the Queen v Coroner Maria Doogan & Ors; ex parte Australian Capital Territory</i> [2005] ACTSC 74. <i>WRB Transport v Chivell</i> [1998] SASC 7002
Texts Cited:	Ian Freckelton and David Ranson, <i>Death Investigation and the Coroner's Inquest</i> (Oxford University Press, 1 st ed, 2006)
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File Number(s): CD 33 of 2016

¹ At the time of the Inquest, the Department was known as the Department of Health and Human Services. As of 1 February 2021 the Department of Health and Human Services was separated into two new departments: The Department of Health and the Department of Families, Fairness and Housing. To avoid confusion, I will refer to the Department of Families, Fairness and Housing as the Department of Health and Human Services (DHHS) throughout these findings and to the Department of Families, Fairness and Housing when making recommendations.

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CORONER HUNTER:

Opening Comments

1. Bradyn Dillon was murdered by his father Graham Dillon on 15 February 2016.
2. On 15 February 2016, Bradyn was beaten brutally by his father in the presence of his sister, JL. That beating ultimately, resulted in Bradyn's death.
3. Bradyn had been beaten by his father over a period spanning December 2014 through to his death in February 2016. Those beatings caused injuries to Bradyn over that period. Graham Dillon inflicted serious injuries including subdural haemorrhage, fractured rib, broken teeth, and significant bruises to all parts of his body, including his genitals, between late August 2015 and February 2016.²
4. Bradyn also suffered cigarette burns inflicted by his father to parts of his body. Graham Dillon inflicted these injuries by extinguishing lit cigarettes out on Bradyn's body. There was also evidence that Graham Dillon pushed Bradyn's head into a bath holding his head under the water whilst Bradyn struggled to get out (water boarding). There was evidence that Graham Dillon choked his son as well.³
5. Graham Dillon inflicted extensive injuries to his daughter JL using the same or similar methods which included extinguishing lit cigarettes out on her body, pushing her head under water for extensive periods whilst she struggled to get air, choking her, and beating her. There is no doubt that Graham Dillon cruelly tortured both of his children over a significant period of time.⁴
6. Examination of Bradyn's body at autopsy revealed previously healed fractures and resolved haemorrhages, The Autopsy Report concluded that further beatings around the time of his death caused a re-bleed of the subdural haemorrhage and a re-fracture of his rib, injuries already inflicted by Graham Dillon, some over period of time being December 2014 to February 2016, and in relation to the subdural haemorrhage over a period of at least 8 weeks.⁵
7. After yet another beating by Graham Dillon on the morning of 15 February 2016, Bradyn became rapidly unconscious. Graham Dillon did not seek any medical assistance for his son until many hours later when it was too late for any successful resuscitation.
8. Eventually, it was Bradyn's sister JL who called 000 at 19:47 hours for assistance. Bradyn was taken to hospital arriving and 20:25 hours. Bradyn was unable to be revived.
9. Not only had Bradyn suffered a further subdural haemorrhage, he also suffered a re-fracture of his 10th rib. Fractures to his teeth were also identified on autopsy. The teeth fractures resulted from significant force applied to his face. The evidence is clear that many of Bradyn's injuries were sustained from the cruel and repeated beating by his father Graham Dillon.

² R v Dillon [2018] ACTSC 164 per Burns J.

³ Recorded interview with JL

⁴ Ibid.

⁵ R v Dillon [2018] ACTSC 164

10. Forensic examination was conducted at the Jacka home where the children lived. The results showed numerous areas of blood spatter identified as coming from both children.
11. Having considered the forensic evidence, autopsy report, and the interview with JL, there is no doubt who caused the death of Bradyn Dillon. Graham Dillon viciously, violently, and cowardly beat his son to death.
12. It is important to note that Bradyn's sister, JL, had also been brutally beaten by her father.
13. JL also suffered horrendous injuries, including substantial bruising all over her body, cigarette burns to her body, fractured teeth, a severely fractured pelvis and five fractured ribs, all inflicted by Graham Dillon.

Purpose of Coronial Inquest

14. The purpose of a coronial inquest is to independently investigate a death which is referable pursuant to the legislation. The coroner must where possible ascertain the identity of the deceased person, the manner and cause of the death of the person. Included in that finding is the medical cause of the death and the circumstances surrounding the death. Circumstances may include the background and surrounding circumstances to give context to the death if possible.
15. Clearly the legislation confines those findings in respect to those circumstances, to be sufficiently proximate and causally relevant to the death and not merely all circumstances which might form part of a narrative accommodating any death.⁶
16. There is a broader purpose for coronial investigation and that relates to matters of Public Safety which is to

*'contribute to the reduction of the number of preventable deaths through the investigation findings and the making of recommendations by the coroners, generally referred to as the 'prevention role'.'*⁷
17. The evidence in this inquest comprised of 30 hearing days, taking oral evidence from 31 witnesses, 14 folders of material from the AFP investigation team, which included statements, records of interview and the autopsy report. There was also over 5000 pages of material which had been subpoenaed. That material was contained on a USB which was tendered in evidence. There were 149 exhibits tendered in the proceedings. The transcript of the proceedings comprised 2516 pages.
18. Given the enormity of the evidence before me, including oral evidence and materials tendered in evidence, I formed the view that it was important to summarise the statements and oral evidence given by each witness.
19. I also had the benefit of having three reports tendered in evidence before me. The 'K' Review⁸ was an internal review initiated by CYPS specifically in relation to Bradyn's death and conducted within 10 days of his death. The Muir report was conducted shortly after Bradyn's death. This was an external review to review the documents associated with Bradyn's death. Finally, the Glanfield Inquiry, which looked broadly at

⁶ *Harmsworth v The State Coroner* [1989] VR 989 (cited at [55] inquest into the death of Luke Batty 2015)

⁷ *Inquest into the Death of Luke Geoffrey Batty 2015*

⁸ Report Author name suppressed by order of the Coroner

the care and protection systems. Each of the reviews made recommendations, which I have considered very carefully. I have attached as an annexure to my findings, the Glanfield Inquiry.

Jurisdiction

20. I have set out the jurisdiction relevant to this inquest.

21. S3BA of the Coroners Act 1997 ('the Act') effective as at 16 February 2016 sets out the objectives of the Act.

22. S13 sets out the jurisdiction in relation to coronial powers.

Coroner's jurisdiction in relation to deaths

(1) A coroner must hold an inquest into the manner and cause of death of a person who—

- (a) dies violently, or unnaturally, in unknown circumstances; or all
- (b) dies under suspicious circumstances; or
- (c) dies and the death appears to be completely or partly attributable to an operation or procedure (other than an operation or procedure prescribed by regulation for this paragraph); or
- (d) dies after having undergone an operation or procedure and in circumstances that, in the opinion of the Chief Coroner, should be better ascertained; or
- (e) dies and a doctor has not given a certificate about the cause of death; or
- (f) dies not having been attended by a doctor at any time within the period commencing 6 months before the death; or
- (g) dies after an accident where the cause of death appears to be directly attributable to the accident; or
- (h) dies, or is suspected to have died, in circumstances that, in the opinion of the Attorney-General, should be better ascertained; or
- (i) dies in custody

23. The evidence before the inquest is clear that Bradyn suffered a violent death and therefore the jurisdiction of the Coroner's Court is enlivened.

24. The Coroner must find the manner and cause of Bradyn's death. The cause of Bradyn's death is not contentious. Graham Dillon murdered his son by brutally beating him over a period of time, causing catastrophic injury which ultimately led to his death.⁹

25. The scope of enquiry available to a Coroner is set out in the decision of *Onuma v The Coroner's Court of South Australia* [2001] SASC 218, a case in which the Court considered the scope of the Coroner's power under the Coroners Act 2003 (SA) and applied *WRB Transport v Chivell* [1998] SASC 7002.

26. The relevant phrase under consideration was "cause and circumstances"; this compares favourably to the phrase "manner and cause" in the ACT Coroners Act. In *Chivell Lander J* (with whom both Prior and Mullighan JJ agreed) said with regard to the meaning of the word "cause":

⁹ R v Dillon per Burns J

“Clearly enough the cause and the circumstances must be two different things if it was otherwise there would be no reason for Parliament to have included both words. ... The cause of a person’s death may be understood as the legal cause. In determining those events which may be said to give rise to the cause of the death, the coroner is not limited by concepts such as direct cause nor is the coroner limited to a cause which is reasonably foreseeable. The cause of a person’s death in respect of the coroner’s jurisdiction is a question of fact which, like causation in the common law must be determined by applying common sense to the facts of each particular case.”

27. In *Lucas-Smith v Ors* SC 117 of 2007 Higgins CJ sitting in the full court in *The Queen v Coroner Maria Doogan; ex parte Peter Lucas-Smith & Ors* [2005] ACTSC 74; (2006) 158 ACTR 1 (*R v Doogan* (No. 2)) where the Court in relation to manner and cause concluded:

“that the range of matters falling within the scope of inquiry, whilst not open-ended, are those that could be considered relevant to determining the cause and origin of the fire causing the damage.”

28. His Honour then went on to say:

All intervening or contributing events may be considered (see R v Doogan (No. 2) [20]).

And at [18] The limiting factor is that of relevance to the issue of cause and origin of the fire process and progress.

29. His Honour then went on to give an example at [19- 20].

“An example of that limitation may be found in the evidence given by the plaintiffs of attempts to obtain government funding for the purposes of community education programs (plaintiffs’ submission [28]). Whilst the Coroner might well comment that lack of such programs contributed to the extent of fire damage, it would be inappropriate for the Coroner to enquire into the reasons for the Government or the Parliament declining funding for such programs.”

30. Those passages are apposite to the present case in respect to all intervening or contributing events with the limiting factor being relevance as to the manner and cause of the death.

31. In relation to standard of proof as to facts found in a Coroners finding, the Coroner is to have regard to the principle laid down in *Briginshaw v Briginshaw* (1938) 60 CLR 336 as stated by Dixon J at 361-2:

“The truth is that, when the law requires the proof of any fact, the tribunal must feel an actual persuasion of its occurrence or existence before it can be found. ... The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal.”

32. In relation to the nature of the Coroner’s Inquest, in *R v Doogan; Ex Parte Lucas Smith & Ors* [2005] ACTSC 74 (5 August 2005) the Full Court of the Supreme Court comprising Higgins CJ, Crispin and Bennett JJ stated at [12] in relation to the nature of the Coroner’s inquiry:

“The task of a coroner is not to determine whether anyone is entitled to some legal remedy, is liable to another or is guilty of an offence. The Coroner’s task is to inquire into the matters specified in the relevant section of the Coroners Act 1997 and make, if possible, the required findings and any comments that may be appropriate.”

33. In relation to the power to make comments, in *Harmsworth v The State Coroner* [1989] VR 989 at 997, Nathan J discussed the ambit of the Coroner's power to comment as follows:

"The power to comment arises as a consequence of the obligation to make findings ... It is not free ranging. It must be comment 'on any matter connected with the death.' The powers to comment and also to make recommendations ... are inextricably connected with, but not independent of the power to enquire into a death or fire for the purposes of making findings. They are not separate or distinct sources of power enabling a coroner to enquire for the sole or dominant reason of making comment or recommendation. It arises as a consequence of the exercise of a coroner's prime function that is to make 'findings.'"

34. In relation to the power to make recommendations, Section 3BA(c) of the Coroners Act sets out the functions given to a coroner.

(c) give the following functions to coroners:

(i) to hold inquests into particular kinds of deaths or suspected deaths, and to make findings about the deaths, including the identities of deceased people and causes of death;

(d) allow a coroner, based on the coroner's findings in an inquest or inquiry, to make recommendations and comments about the following:

(i) the prevention of deaths;

(ii) the promotion of general public health and safety including occupational health and safety;

(iii) the administration of justice;

(iv) the need for a matter to be investigated or reviewed by an entity.

Subsection (2) As far as practicable, the objects of this Act must be carried out in a way that—

for an inquest into a person's death—recognises the following:

(c) promotes the development of a systematic and comprehensive public record of findings made by a coroner and any associated recommendations made by the coroner; and

(d) increases public awareness of a coroner's findings about—

(i) violent or unusual deaths; and

(ii) serious risks to public health and safety; and

(iii) ways to protect public health and safety by reducing the risk of death, fire, or disaster; and

(e) promotes public understanding about the function of the Coroner's Court.

35. The coroner must make findings in respect to an inquest and where relevant must state if matters of public safety arise in connection with the inquest and may comment on the matter or make recommendations.

36. Section 52 of the act defines what is required or a coroner to find if possible the following;

(a) the identity of the deceased; and

(b) when and where the death happened; and

(c) the manner and cause of death; and

- (d) in the case of the suspected death of a person—that the person has died.
- (2) A coroner holding an inquiry must find, if possible—
 - (a) the cause and origin of the fire or disaster; and
 - (b) the circumstances in which the fire or disaster happened.
- (3) At the conclusion of an inquest or inquiry, the coroner must record the coroner's findings in writing.
- (4) The coroner, in the coroner's findings—
 - (a) must—
 - (i) state whether a matter of public safety is found to arise in connection with the inquest or inquiry; and
 - (ii) if a matter of public safety is found to arise—comment on the matter; and
 - (b) may comment on any matter about the administration of justice connected with the inquest or inquiry.

37. It may be that an issue arises as to what is meant by connection with the inquest or connected with the inquest.

38. A helpful statement can be found in relation to that issue in *R v Doogan; Ex parte Lucas-Smith* [2005] ACTSC 74 whether court said at [29];

“A line must be drawn at some point beyond which, even if relevant, factors which come to light will be considered too remote from the event to be regarded as causative. The point where such a line is to be drawn must be determined not by the application of some concrete rule, but by what is described as the “common sense” test of causation affirmed by the High Court of Australia in March v E & MH Stramare Pty Ltd (1991) 171 CLR 506. The application of that test will obviously depend upon the circumstances of the case and, in the context of a coronial inquiry, it may be influenced by the limited scope of the inquiry which, as we have mentioned, does not extend to the resolution of collateral issues relating to compensation or the attribution of blame.”¹⁰

39. Further at [31] the court stated in relation to causation.

“There will, of course, be many cases in which the issue of causation will necessarily involve an examination of a person's conduct. A coroner conducting an inquest into the death of a person may be obliged to consider whether the death was attributable to accident or homicide. If reasonable grounds emerge for a belief that a person has committed murder, manslaughter, or some other indictable offence the coroner will be required by s 58 of the Act to inform the Director of Public Prosecutions by written notice and the inquest will be adjourned. If that situation does not arise, the coroner will be obliged to make findings as to the nature of the acts and/or omissions that caused the death, even if they reflect adversely on the reputation of one or more people involved in the relevant incident. Hence, a coroner might well hear evidence suggesting that a cyclist's death had been caused not merely by a collision with a motor vehicle, but also by the antecedent conduct of the driver of that vehicle in failing to stop at a stop sign adjacent to an intersection. However, the limited jurisdiction conferred by s 18(1) would not authorise the coroner to inquire into any perceived failures in relation to general policy relating to the siting of stop signs or the enforcement of traffic regulations. The particular siting and design of the relevant intersection may be a different matter. The application of the common-sense test of causation will normally

¹⁰ *R v Doogan Ex Parte Lucas-Smith* [2005] ACTSC 74 at [29]

exclude a quest to apportion blame or a wide-ranging investigation into antecedent policies and practices.”

40. I have very carefully considered legislation and the authorities in respect to the matters which I have set out above.

History of Criminal Proceedings in Relation to Bradyn’s Death

41. On 15 February 2016, Graham Dillon was arrested and charged with the murder of Bradyn Dillon. He was also charged with 3 counts of inflicting actual bodily harm to JL.
42. On 1 September 2016 Graham Dillon pleaded not guilty in the Magistrates Court and was committed for trial to the Supreme Court.
43. On 29 August 2017 Graham Dillon pleaded guilty to 11 charges. Additional charges were also taken into account.
44. The first 6 counts on the indictment relate to charges of murder, threat to kill, choke render insensible, assault occasioning grievous bodily harm, and assault occasioning actual bodily harm in relation to Bradyn Dillon.
45. Graham Dillon also pleaded guilty to 3 counts of grievous bodily harm inflicted upon JL, as well as a charge of choke render insensible, and a charge of threat to kill, in relation to JL.
46. All of the charges relate to offences committed between dates of 7 December 2014 on 16 February 2016.¹¹
47. The agreed statement of facts exhibited before Burns J, for the purposes of the sentencing procedure, outlined the circumstances alleged against Graham Dillon in relation to the charges he pleaded guilty to. These included the circumstances in relation to the charges taken into account.
48. The facts were prepared by the Director of Public Prosecutions and agreed to by Defence. The facts tendered in the proceedings must establish evidence to prove beyond reasonable doubt the elements of the offences as charged. The findings by Burns J reflects that requirement.
49. The facts outlined those behaviours. Those behaviours included that Graham Dillon Inflicted punches, kicks, cigarette burns, as well as waterboarding (pushing the head of the child into the bath and refusing to let the child up to breathe). Graham Dillon also used a belt to hit the children with.
50. The statement of facts also included the facts and circumstances relating to the charges that were taken into account on the indictment.¹²
51. A history and chronology of those charges with the relevant factual circumstances in relation to them is annexed to these findings as annexure B.
52. Graham Dillon was sentenced to a total of 41 years and one month on 4 June 2018. That sentence included the murder of Bradyn together with other charges in relation to Bradyn, his sister JL, and his stepmother UN.

¹¹ R v Dillon [2018] ACTSC 164.

¹² See Annexure A.

Inquest Proceedings

53. The Inquest into the death of Bradyn Dillon commenced on 11 October 2018. 4 months after Graham Dillon was convicted and sentenced in respect to the death of Bradyn Dillon.
54. On 13 March 2019 and 28 June 2019 letters were sent to Graham Dillon advising him of directions hearings in relation to the Inquest. On 12 August 2019, a letter was sent to Graham Dillon, advising him of the commencement of the Inquest. Graham Dillon declined to engage with the proceedings.
55. Sections 58 and 58A of the Coroners Act do not apply to these proceedings. No referral was ever made to the Director of Public Prosecutions in regard to this inquest.
56. Section 55 will not apply in relation to Graham Dillon, given he has pleaded guilty to charges relating to the conduct the subject of this inquest. By his plea of guilt, he admits to the conduct.
57. This inquest has exposed much of what happened in relation to Bradyn and JL while they were in their father's care. Much of this information was unknown to his Honour Justice Burns, the Crown and even the Defence in Graham Dillon's sentencing proceedings.

Prohibition Order

58. On 27 August 2019 at a directions hearing, I ordered that all named identified in these proceedings (except for the names Graham Dillon and Bradyn Dillon) be the subject of a prohibition order.
59. That order remains in place and I ordered that the order continue indefinitely.
60. All witnesses who gave evidence in this inquest will have anonymized initials. I have annexed to these findings a schedule of the anonymised identities with an explanation of their role, relevant to this inquest.¹³

Issues for Consideration

61. There is no issue as to who caused Bradyn's death. That fact has been well established. Graham Dillon is the sole person responsible for the murder of his son Bradyn.¹⁴
62. The evidence clearly established that Bradyn Dillon and his sister JL were children at risk of harm.
63. Many reports from teachers were made in respect to both Bradyn Dillon and his sister about bruising being found on their bodies and absenteeism from school (which seemed to coincide with those reports of bruising)
64. Prior to my taking over this matter, I note that Chief Coroner Walker, with agreement of the parties identified the issues for determination in relation to manner and cause of Bradyn's death. Those were:

¹³ See Annexure A.

¹⁴ R v Dillon [2018] ACTSC 164 [14]

How was it that Bradyn had become isolated from the community? What was known by the various authorities, and how was that information communicated to those who could action it?

In 2014-2015, the following agencies had intervention with Bradyn:

- i. ACT Education
- ii. CanFaCS
- iii. CYPS
- iv. Vic DHHS – Children’s Court
- v. ACT Health
- vi. AFP – SACAT

How was it that intervention from these entities discontinued? The salient events that this would then permit analysis of 8 includes:

- a. Involvement of CYPS from late 2013 including upon the children’s return to ACT in November 2014
- b. Attempted intervention from Vic DHHS in November 2014
- c. The decision not to investigate by SACAT on return to the ACT
- d. Circumstances of CYPS interviewing the children in January 2015 and closing the file
- e. The communication of ongoing reports of harm by SK to DHHS from November 2014 to June 2015
- f. The failure to recognise and address cumulative harm
- g. Capacity for Bradyn to be unenrolled from school in the ACT and remain in the ACT unnoticed. The interagency and interstate communication and information sharing

Family History

- 65. In order to understand the family dynamics, I have set out a history of Graham Dillon’s family.
- 66. Graham Dillon met SK in Tasmania in 2002. At that time, SK had a daughter BK, born June 1999. Graham Dillon and SK had two children together, JL born on 3 November 2005 and Bradyn Dillon born on 25 October 2006.
- 67. Graham Dillon and SK separated because after years of enduring physical abuse SK could take no more and left Graham Dillon. Graham Dillon then moved to Queensland where he met UN in 2007.
- 68. Graham Dillon lived with, and then married UN and had 3 children with her, a boy born October 2010 and twin girls born 2012. They were living in Canberra.
- 69. Bradyn and JL came to reside with Graham Dillon and UN for an extended holiday in mid-2013. When SK asked for the children to be returned to her care, Graham Dillon refused to return the children to their mother as pre-arranged.
- 70. Graham Dillon took out a DVO against SK in 2013, preventing SK from access to Bradyn and JL.

71. There was some confusion in relation to the DVO as SK had applied for the children's names to be removed. On the Interim Order given to SK, the children's names had been removed.
72. UN separated from Graham Dillon in April 2014, and he, Bradyn and JL left the home. They were eventually housed by Canberra Fathers and Children Service (**CanFaCs**) in August 2014.
73. SK removed the children and took them back to Victoria in November 2014 as she held grave concerns as to the children's safety in the care of Graham Dillon. Graham Dillon sought a recovery order from Shepparton Children's Court and the children were returned to him by the Magistrate on 17 November 2014.
74. At the time the ACT Registry, under the slip rule added Bradyn and JL (as originally ordered by the Magistrate) onto the DVO. This change to the order was not served upon SK. At the time of her taking the children from the ACT there was no order in place (as far as she was aware) which included Bradyn and JL.
75. The amended order was not served upon SK until she was found in Victoria just prior to the Court case in November 2014. Technically SK was not prevented from taking the children from the ACT at the time she did, because according to the order she had been served with, the children were not named on it.
76. SK was not charged with a breach of the DVO.
77. On 17 November 2014 a Magistrate returned the children to the care of Graham Dillon, on the basis that SK should not be rewarded for breaching the DVO. Unfortunately, the Magistrate was not told of the error made by the ACT Magistrates Court Registry.
78. Bradyn and JL returned to the ACT and lived with Graham Dillon until Bradyn's death on 15 January 2016.

Summary of Statements and Evidence

Police Investigation

Detective Senior Constable NF – Part of the Homicide Investigation into Bradyn's Death

Statement¹⁵

79. Detective Senior Constable NF was part of the homicide investigation team investigating the death of Bradyn. He assisted in the interview with Graham Dillon and advised him that Bradyn had deceased.
80. Detective NF also interviewed Bradyn's mother (SK), Bradyn's step-mother (UN), and Bradyn's sister (JL). When speaking with JL he made observations of the numerous bruises, lacerations, and injuries which appeared all over her body.
81. Detective NF also assisted other teams in examining the crime scene at the Jacka house with the collection of evidence and information relating to Bradyn's death.
82. Detective NF recorded an interview with Graham Dillon. During the course of the interview, Graham Dillon admitted that he had struck his son and displayed an attitude of justifying his behaviour as parental discipline of the children.
83. Graham Dillon tended to blame everybody but himself for his actions. Graham Dillon lied about how long it was that he knew Bradyn was unconscious, he also lied about what he did to help his son after he became unconscious.
84. Graham Dillon also lied about the state of the children in respect to the significant bruising and lacerations found on both their bodies. Graham Dillon denied that the bruising was of any great significance. When confronted with photographs of his daughter JL, he initially denied causing most of the bruising but then admitted that probably he caused 90% of them.
85. Graham Dillon then explained that over the past eight weeks prior to Bradyn's death the children had played up badly and that was the reason why they got punished. Ultimately, he could provide no explanation as to why JL and Bradyn had so many terrible bruises all over their bodies other than that he was extremely violent towards his children.

In Evidence before the Inquest

86. Detective NF provided a statement he had made, together with other documents included in his investigation which were tendered in evidence. Detective NF summarised the information that he received from the Australian Federal Police (AFP) and Ambulance Service in respect to an unresponsive male child, Bradyn, being found at Bitterman Street Jacka.

¹⁵ (Evidence pp 25-32).

87. Detective NF outlined the arrest of Graham Dillon and the interview conducted with him. Detective NF also provided the material arising from his investigation which was ultimately tendered in evidence before me. That material was tendered as a single exhibit of 14 volumes of material.
88. Included in the bundle was a document compiled by an intelligence analyst of the timeline of events documenting the history of abuse involving Graham Dillon and his extended family.

Acting Sergeant MI – Property Officer during the Search of 7 Bitterman Street Jacka

Statement

89. Sergeant MI attended the scene at 7 Bitterman Street Jacka. Sergeant MI acted as property officer during a search of the premises.
90. Sergeant MI observed that the residence was a split-level house with two living areas, a kitchen laundry, bathroom, separate toilet and three bedrooms. Sergeant MI described the house as being in a general state of disarray. There were rotten food items throughout the kitchen and garbage which had not been taken out. It did not appear as though clothes had been washed in some time. Sergeant MI observed maggots in various parts of the living and kitchen area around the rubbish and uneaten food.
91. Sergeant MI took possession of drugs found at the home.
92. Sergeant MI also made enquiries at the Bonner shops and the petrol station in Amaroo in relation to potential purchases made by Graham Dillon on 15 February 2016.

Senior Constable ZL

Statement

93. Constable ZL attended Bitterman Street Jacka in relation to the search warrant executed at that address. He observed what appeared to be dark blood spatter on the walls near the bed of a girl's room. There was a bloodied towel on the floor and a bloodied white kids' shirt also on the floor.
94. In what appeared to be a boy's room, Constable ZL observed bloodied tissue on the bedside table. As he exited the hallway, he observed blood spatter on the wall closest to the front of the house.
95. There was a complete investigation into Bradyn's death by Police from ACT Criminal Investigation. This included forensic evidence being obtained particularly the blood spatter found in various rooms and the bathroom of the premises at 7 Bitterman Street in Jacka.
96. The result of that blood spatter found that the majority of the blood belonged to either Bradyn or JL and in two areas the blood belonged to Graham Dillon.

Sergeant JR – CYPS Liaison Officer

Statement¹⁶

97. Sergeant JR was attached to the Sexual Assault and Child Abuse Team (**SACAT**) and then to the Child and Youth Protection Services (**CYPS**) as a liaison officer within SACAT. That role allowed referrals from CYPS to the Police. The liaison officer conducts an assessment to determine whether Police will accept the matter for further investigation.
98. The role of a liaison officer was to assess referrals which were then either accepted, rejected, or referred back to CYPS for their action, or allocated to Police for investigation.
99. Bradyn Dillon was first referred to Sergeant JR on 28 July 2014. Sergeant JR indicated that her usual practice was to review the real-time Police indices for entries for the family. There were two entries, one in relation to a threatened kidnap of the children by the mother. The second was an alleged domestic violence incident involving Graham Dillon and his then partner. Bradyn's sister also had the same entries linked to her name, as well as one in relation to a threatened kidnap by her mother. There was also a breach of a Domestic Violence Order ('**DVO**') from Victoria against Graham Dillon.
100. Graham Dillon had the same entries with three additional matters relating to domestic violence incidents with his partner UN. The three domestic incidents with UN were not progressed and no action was taken. Sergeant JR indicated that at no time was it stated that Graham Dillon had assaulted either Bradyn or JL or any of the other children.
101. Sergeant JR assessed the referral and considered that there was only a suspicion from the teachers because of absenteeism and some unexplained bruising without disclosure. There were no reports in relation to any violence committed by Graham Dillon against the children nor were there any reports he suffered from mental illnesses.
102. Interestingly, Sergeant JR indicated that in her experience it is uncommon for children who are abused to suffer facial injuries because perpetrators usually target nonvisible areas to prevent detection. Sergeant JR opined that children could sustain injuries through accident or misadventure and the explanations provided by the children were plausible.
103. In her view, given the lack of initial information, police involvement would be heavy-handed particularly in a complex family situation where parents need support rather than Police involvement.
104. Sergeant JR opined

"whether there has been a disclosure of abuse or not is only a single factor to consider when deciding whether to accept or reject a referral. It was the combination of the above considerations that support my decision to reject this referral, noting there has been no

¹⁶ Transcript of Proceedings, p 422 – 510

disclosure of a criminal offence to warrant further Police investigation or involvement at this time.”¹⁷

105. Sergeant JR advised CYPS that she was rejecting the referral stating

“as you are unable to identify a specific disclosure this matter is currently rejected. If you receive any further information to indicate otherwise please let me know.”¹⁸

106. The second referral came on 4 December 2014. Sergeant JR opined that the report was non-urgent given CYPS had taken 14 days to make the report and it was listed as a non-urgent seven days rating.

107. Sergeant JR noted that it was alleged that the mother had drugged Graham Dillon and taken the children to Victoria, they had been recovered from Victoria and Graham Dillon was given care of them. Sergeant JR also noted that it was the Victorian Department of Health and Human Services (**‘DHHS’**) who had returned the children to his care. Sergeant JR said she thought if there were serious concerns DHHS would take the children into care.

108. Sergeant JR said that she had experience with parents engaged in custody disputes providing differing versions of events that are averse to the other partner to favour obtaining custody. She said that given the complex family dynamics she had turned her mind to the fact that this could be possible in this case.

109. Sergeant JR also reviewed the report of the Child at Risk Health Unit, which assessed the children with no significant concerns noted. Whilst there was a report that Graham Dillon was using ice, it was not recorded in Police Real-time Online Management System (PROMIS). However, PROMIS did record that SK had a history with ice.

110. Sergeant JR considered that given CYPS were involved in the case Police involvement would be traumatic for the children. Therefore, she rejected the referral and stated to CYPS that she was happy for them to take the lead in the case.

111. Sergeant JR said that she did not receive any further referrals from CYPS.

112. I note the report attached to the statement from CYPS notes that there had been three reports of facial bruising since 17 June 2014 and there had been absences from school which were suspicious. It is also noted that the teachers were very concerned about the bruising and the absences.¹⁹

In Evidence before the Inquest

113. Sergeant JR was and still is the community policing liaison officer. In 2014 Sergeant JR was transferred to the CYPS liaison officer role

114. Sergeant JR described the role as a conduit between the SACAT and CYPS. This was done in order to build a relationship between the organisations so that there was a whole of government approach to matters.

¹⁷ statement – paragraph 29

¹⁸ statement – paragraph 30

¹⁹ my comment

115. The system consists of referrals from CYPS or others in relation to non-accidental injuries to children. There is also an element of training for CYPS staff and also policing. Sergeant JR described it as an interlinking relationship.
116. Generally, CYPS would refer the matter to the liaison officer via a generic inbox. This was monitored by the CYPS liaison officer or another Team Leader from the SACAT . The CYPS Interstate Liaison Officer (**ILO**) would receive between 10 and 30 referrals per week depending on whether it was a peak time such as after school holidays.
117. Following receipt of a referral an assessment was conducted in respect to it. The result was either accepting or rejecting the referral. If the referral was accepted, it would be investigated within the SACAT and either allocated to a general duties person or a SACAT member. The referral would receive a PROMIS number (Police Real-time Online Management System) and then be allocated to a member for investigation.
118. If the referral was rejected CYPS are notified that their referral has been rejected. Once the email is sent to CYPS, Police would upload the report and request received from CYPS to PROMIS within a fortnight.
119. Sergeant JR was asked to think about the factors which are to be considered when analysing whether a referral should be accepted. Sergeant JR was referred to a non-exhaustive checklist provided by Sgt Crocker listing matters to be taken into consideration as to whether a referral is accepted. Sergeant JR agreed that these are the types of considerations used when making that decision.²⁰
120. Sergeant JR was taken to the first referral she received on 28 July 2014. Sergeant JR said that while she could not recall exactly, her usual practice was to read the contents and any supplementary notes attached, taking into account the checklist referred to in Sgt Crocker's statement paragraphs A to M. She would examine who the parties involved in the case were and look up PROMIS and other systems for any records relating to the parents or children.
121. Sergeant JR was taken to the PROMIS note 5458748, July 2014, in relation to a report from Graham Dillon alleging that the children's mother had threatened to drive to the ACT and take the children. Graham Dillon also advised that child protection Victoria and CYPS were involved and have advised that the children are to stay with Graham Dillon. The note also advised that children's mother had allegedly been smoking ice and was in a drug induced rage.
122. Sergeant JR was also taken to the PROMIS entry 5511506, in relation to an allegation of domestic violence perpetrated by Graham Dillon to UN. Sergeant JR agreed that it was the information she had at the time of that first referral.
123. Sergeant JR agreed that she also had information about Bradyn's sister, with two additional entries recorded about an attempted kidnap at the Tuggeranong Hyperdome and a potential breach of a DVO.
124. Sergeant JR also agreed that at the time she had information in respect to a DVO where Bradyn's mother was the respondent and three domestic violence incidences involving

²⁰ Sgt Crocker Statement para-A – M.

his wife UN. Sergeant JR noted that there was no evidence that Graham Dillon had assaulted any of the children in that history.

125. Sergeant JR outlined the process she undertakes *"including reading the information in conjunction with the checks that are conducted and then make an assessment"*, these included no specific disclosures made by the children, no specific alerts in respect to violence towards the children, no mental health impairment or illness which would make the perpetrator erratic. In her opinion, children of that age would commonly have bruises sustained through misadventure or accident. They are the types of things that she would consider.
126. Sergeant JR opined that she has experience in bruises that are more likely to be accidental or not. Sergeant JR stated she had worked in the SACAT for 6 and a half years and that there is a commonality between injuries that present and turn out to be abuse and injuries that turn to be accidental. Sergeant JR also utilised her experience as a mother to assist her consideration as to whether the abuse was accidental or not.
127. Sergeant JR opined that an abuser would generally not hit a child in the face in her experience. They would normally be in areas not obvious. Sergeant JR also considered that given the complexity of the case CYPS would be in the best place to investigate the matter before police became involved.
128. Sergeant JR also agreed that she had details of the mandatory reporter as well as a telephone number. Sergeant JR also agreed that the report identified that two children, who were siblings, had bruising to their facial region. Sergeant JR also was aware that when Bradyn was asked about how he got the bruise he could not account for it saying he did not know. There was also the fact that he had been away from school for a week.
129. Sergeant JR stated that this information would ordinarily be something that CYPS would consider because they contact with the schools. It is not something police would get involved in. It was suggested to Sergeant JR that further information on that form indicated that there had been nine such reports in respect to both siblings. All reports were in relation to domestic violence.
130. Sergeant JR believed that the nine reports were in relation to them being present while domestic violence incidents were going on and the domestic violence was not against the children. That distinction made a difference to her.
131. When asked about whether witnessing domestic violence was something to have caused her concern, Sergeant JR considered that it was a child welfare concern rather than a police concern. Sergeant JR confirmed that she rejected the referral but stated that if any further information came forward then CYPS could re-engage with the CYPS Liaison Officer. It was her view that it was more of a welfare concern than a policing concern.
132. Sergeant JR agreed that her reasoning was that because there was no specific disclosure the matter was rejected and therefore it was a matter for CYPS to follow up.
133. In relation to the second referral of 4 December 2014 Sergeant JR understood that CYPS were taking the lead in the matter but sought input from ACT policing. It was her view that they wished to take the lead on that particular matter.

134. Sergeant JR agreed that they were questioning whether police wished to take the lead given there had been previous reports of bruising which she was aware of. It was also reported by CYPS that the children had attended CARHU and there were no significant concerns noted.
135. Sergeant JR stated that she would have access to the CARHU report if she was involved in the matter as it was able to be requested. In this instance she did not see the report from CARHU. Sergeant JR agreed that if they had investigated, they would have seen the CARHU report and the outcomes. Even if the report had indicated that there were unexplained bruises where the children did not make disclosures it would depend on the outcome as to whether police investigated or not.
136. In relation to the 4 December 2014 referral, Sergeant JR was also aware that CYPS was closing the file because the children had been removed from the father's care by their mother who took them to Victoria. Sergeant JR was also aware that the children were returned to their father and that the children had been interviewed by DHHS Victoria where they had made disclosures of physical abuse. Sergeant JR agreed that that was the first time she had been advised that the children had disclosed physical abuse and agreed that it was significant.
137. Sergeant JR was asked if that information was important, and she said yes however noted that the referral was made two weeks after the children were returned. The concern was that the children were making disclosures of physical abuse by Graham Dillon. Sergeant JR agreed that much of the information of concern came from the Victorian Child Protection workers BN. Sergeant JR had access to contact details for BN, yet she did not contact her.
138. Sergeant JR also took into consideration other factors including that SK had drugged Graham Dillon and had taken the children. Sergeant JR said she turned her mind to the fact that in complex situations parents say things which are not true, particularly where there are custody disputes resulting in parents coaching children to say certain things for that purpose. That was a factor which she had turned her mind to in assessing the information.
139. Sergeant JR agreed that she had been aware that SK had undertaken a urinalysis in Victoria which only detected small amount of cannabis. It was also suggested to Sergeant JR that there had been a toxicology report in relation to Graham Dillon which indicated that he had methamphetamine in his system. Sergeant JR said she had not seen that report. Sergeant JR said that it would not have been on the PROMIS system, however there was a PROMIS reference number for that toxicology results. Sergeant JR advised that the report was something that she would not have seen as it was not part of her investigation.
140. Sergeant JR explained how the PROMIS system works and that all reports are not on the immediate front page and only the front pages would be something that they would look at. Sergeant JR also indicated that she knew about his past criminal history in Tasmania although she did not seek that criminal history.
141. Sergeant JR also agreed that she knew that he had been incarcerated for six months for assault and that his former partner and former wife both had alleged that Graham Dillon was still using ice. Sergeant JR also agreed that it would be a red flag to her. Sergeant JR also agreed that the fact that the urinalysis from SK revealed that she

was not taking ice would be significant, particular given the disclosures made by the children.

142. Sergeant JR said the disclosures made to BN was a significant factor. Given the children had been removed from their mother's care even after disclosures, they would not have had a great deal of trust in police. Sergeant JR said that she was concerned about police being brought into the situation because it would be harmful for the children, and the priority was the children's welfare.
143. Sergeant JR considered that the best outcome would be for CYPS, who had relationships with the children, could conversed with them and see whether it could obtain disclosures. If it did obtain disclosures, CYPS could take action including removing the children from the care of a predator. In contrast, if police became involved, the children would be scared.
144. I asked whether Sergeant JR had told CYPS of her views and she said she did not believe she had. I asked her how they would know what she was thinking, and she said:

"Because I think that by saying that they would take the lead, that is a known entity without us speaking about it when there's a clear disclosure. It's - I guess because we engage so much that that would be clear to them and clear to us that that is the reason" When you say engage do you mean orally? You talk to them? ---Yes, when we do talk to them. But meaning because we're constantly talking about these things, we're constantly training together, we're constantly having referrals go back and forth, if there is a disclosure that would - to me would be obvious that that would be the reason why we wouldn't be doing it when there is a clear disclosure that the children are being harmed by someone, that would be the case. ²¹

145. Sergeant JR said that with the existence of those disclosures it was her expectation that action would be taken. Sergeant JR emailed BU advising that she was happy for them to take the lead confirming that they would speak to the family. Sergeant JR also advised CYPS that it was to keep the SACAT in the loop if further information about criminal prosecution comes to light.
146. It was suggested to Sergeant JR that brief analysis on the intake form from care and protection indicated there had been 12 reports in respect of Bradyn and JL, seven received in relation to family violence and the mother's substance misuse. That since June 2014 there had been five reports of allegations of physical abuse whilst in the care of their father. Sergeant JR agreed that they would be flags for potential intervention considering her checklist.
147. Sergeant JR also considered that the children's safety was first and foremost in her mind and that referring back to CYPS was the best way to address that.
148. Sergeant JR indicated that while CYPS have undertaken an appraisal and if the children did disclose matters then the police would intervene and interview them. However, if no disclosures were made, the police could not pursue the criminal side of things.²²

²¹ Transcript p 440

²² Transcript p 441

149. Sergeant JR was shown that a concern identified in page 5 of the report that read as follows:

"The father presents as volatile and aggressive and has made physical threats to caseworkers and school staff when he finds himself in threatening situations. As a result of threats made against caseworker [NL], the case has been reallocated to another worker."²³

150. Sergeant JR was asked whether this would have been a red flag and of concern. Sgt JR agreed with that but stated that further in the report CYPS advised that the father is engaging with and working well with CYPS. Further if CYPS had concerns they could ask police to attend with them."

151. Sergeant JR stated that there was no follow-up with the refusal to accept the referral because CYPS would contact the SACAT if there was any concern. Sergeant JR's expectation was that if the children did make disclosures then CYPS would contact them, and the police could look at the criminal side of the matter.

152. Sergeant JR stated that if Victorian Child Protection services had serious concerns in respect to the children, they would have made an application to have the children taken into care. Sergeant JR was not aware that an application by them had been made in that regard.

153. Sergeant JR said that she did turn her mind to the fact that the children only made disclosures when they were out of Graham Dillon's reach and that the children may not disclose because they were now back in his care. She thought CYPS would have a better chance than police of getting disclosures from them.

154. Sergeant JR assumed that Victorian police had acted on the application and had taken the children from their mother in Victoria and was not aware that an application to return to the children had been made by the Victorian care and protection service.

155. In respect to whether the rejection of the referral was a clear rejection, Sergeant JR said that her main concern was the welfare of the children and what would be the best way of receiving a truthful account of what had occurred. That would be through a process of CYPS building up a relationship with the children and ensuring their safety rather than through police action, saying:

"I felt that that was the best way to receive that information to try and make sure that the children were safe, to try and get them out of the custody of a person who was harming them versus police interaction, them being more scared, not wanting to talk to us and then them being handed back because not only would CYPS not have the information, they'd have a - from what we've spoken about before, but then what action could they then take and then he would be aware that the children had spoken to police and that might have put them at more risk"²⁴.

156. Sergeant JR said that it was the usual practice to have CYPS take the lead. Sergeant JR said she did not discuss her reasoning in relation to the refusal of the referral with CYPS.

157. In respect to whether Sergeant JR would have made the same decision, she said that she would have because she believes that police intervention can often spark

²³ Transcript p 442

²⁴ Transcript of Proceedings, p 446

something like what happened Bradyn and that CYPS were in a better position to keep the children safe.

158. Sergeant JR explained that the way they work has changed and that there is a family violence unit now embedded in ACT policing and that referrals have oversight by the senior member or Team Leader. And if a similar matter was rejected it would be reviewed by the family violence coordination unit as well as oversight by the Sergeant. This process now involves three sets of eyes as opposed to one to assess the situation.
159. Sergeant JR agreed that she had not spoken personally to SK to confirm that she had self-reported use of methamphetamine. Sergeant JR cited that in the second referral there was a reference to the mother using ice in the past but is no longer using and that was the basis of her knowledge.
160. Sergeant JR reflected that even though things at an institutional level may be different it was her view that based on the same criteria and her concern for the welfare of the children she would make the same decision. That is because from a policing perspective, she wanted the children to be safe and that CYPS would continue to monitor them. Added to that was the feeling of distrust between the children and police because of their experience in Victoria.
161. Sergeant JR said that it was because the information she had, was that the children were quite distressed after being taken away from their mother and she believed that was because police were the ones who were there. It was Sergeant JR's view that that was after they had made disclosures.
162. Sergeant JR also stated that not only was the CYPS worker saying the children did not disclose, but that the teachers also said the children did not disclose abuse. However, they gave examples of how the children were injured. It was her view that CYPS had a good rapport with the children and the likelihood of them disclosing to it was greater than it would be for police.
163. Sergeant JR said she was aware that a child suffering from violence at the hands of a perpetrator who they live with would be reluctant to disclose that abuse whilst they remain living with that person. It was pointed out to her that this reluctance would extend to talking to CYPS and the teachers in Canberra.
164. Sergeant JR did consider there may be means by which the perceived issue could be overcome and that would have been if CYPS spoke to the children and those criminal elements were identified. Sergeant JR agreed that the children were in Victoria separated from their father in Canberra in a different environment and that is where they made disclosures against their father. It was suggested by Sergeant JR that it will also be a new event to give them confidence to speak with police. Sergeant JR disagreed with that proposition because she felt the children would have a negative view of police given that they had been taken from their mother by police and they were distressed by this.
165. It was suggested to Sergeant JR that there was another approach in that the police could investigate by speaking to the children without their father present. Sergeant JR said that was the approach CYPS were to use. However, it was pointed out that was not the case, as the father would be spoken to first and then the children. With all being

spoken to on the same day, at the same place. Sergeant JR said that this would not be the case because the children would be spoken to without the father present and in her view the email did not disclose the order of interview, just that it would be on the same day. It was her view that it would be a “fools plan” to speak with the father first and that is not how she would have done things.²⁵

166. It was suggested to Sergeant JR that police would be in a far better position forensically to interview children however Sergeant JR replied that whilst they are expert in interviewing CYPS also has skill sets including appraising the situation.

167. Sergeant JR was asked questions in respect to the certificate of analysis of 20 November 2014 showing the presence of methamphetamine, amphetamine, and Ibuprofen. She was asked whether it should have been on the PROMIS notes. Sergeant JR opined that the information should not have necessarily been on the front screen because you can click to where there are documents uploaded. It was her practice to review the front screen when reviewing a job.²⁶

168. Sergeant JR said that she was looking to see whether there was a stupefying drug to determine whether he was a victim and said:

“And I guess that obviously why I wouldn't have looked deeper is because what the job pertained to was looking for that - those stupefying drugs, whatever the actual term was, whether he'd been drugged, so it related to him claiming to be a victim of something. So yes, again, I don't know that that would change things if I had have seen that either”²⁷

169. It was suggested to Sergeant JR that it was only the AFP who knew and could prove that Graham Dillon was using methamphetamine in November 2014. Sergeant JR could not comment on that fact, although Sergeant JR accepted that there was information that Graham Dillon was using methamphetamine at the time. The allegation that he was using, she agreed was something that she would accept would require confirmation.

170. Sergeant JR agreed that the certificate on the system confirmed he was taking drugs and contradicted the veracity of Graham Dillon's narrative about his drug taking. Sergeant JR did not tell the social workers about this information because she believed they had the same information that she did in that regard. However, at the time she was unaware that there was confirmation that Graham Dillon was taking ice.

171. Sergeant JR would not comment on the fact that independent certification that Graham Dillon was using ice was any better information than information from his ex-partners that he was using ice. This information was reflected on the front sheet of PROMIS. In her view it was sufficient evidence to make a call regarding whether care and protection take the matter on versus the police.

172. Sergeant JR clarified that the front sheet did have something in respect to the analysis of the blood and urine to indicate that there wasn't a stupefying drug in his system however it did not mention that he in fact had other drugs such as methamphetamine

²⁵ Transcript of Proceedings, p 454

²⁶ Transcript of Proceedings, p 457

²⁷ Ibid 457

in his system. Police were considering it was a prosecutorial factor in relation to Bradyn's mother rather than Graham Dillon consuming methamphetamine.²⁸

173. Sergeant JR agreed that it may have been better to have added that whilst Graham Dillon did not have any stupefying drug in his system, he did have methamphetamine, however it was still her view that it would not have changed the outcome of her assessment.
174. Sergeant JR identified that she had been the supervisor to a complaint in respect to an alleged kidnapping attempt by the mother at the Tuggeranong shopping centre. She was aware that there were two versions as to what happened that day, that is, abduction versus breach of DVO.
175. Sergeant JR was taken to an interim DVO where allegations were made against Graham Dillon as to his physical and emotional abuse throughout the relationship with SK. These allegations included the fact that he refused to return the children to her and has threatened to kill her if she tries to remove them. It was also alleged that the children were witness to serious physical abuse toward Graham Dillon's wife. One of the children witnessed Graham Dillon losing control and throwing knives at his wife while she was holding an infant child. SK was concerned in respect to the children's safety while they were in the care of Graham Dillon.
176. Sergeant JR was unable to recall whether she specifically knew about this application and the account therein. However, she agreed they were very serious allegations. Sergeant JR recalls that she did see an order but was not sure whether it had been withdrawn or that the order only applied to the mother because the children had been placed back into his care.
177. Sergeant JR thought she may have seen the order and was investigating whether it was a conflicting order but does not recall exactly. Sergeant JR was aware that there were issues in respect to his behaviour toward his partners however she did not believe there was any information that he had been violent towards the children.
178. It was suggested to Sergeant JR that the concerns of the mother for the children's safety would be a relevant consideration. She agreed and said that was even more reason why it was CYPS who should have dealt with the matter as it was a welfare issue rather than a criminal issue.
179. Sergeant JR agreed that Graham Dillon refusing to allow the children to return and threatening to kill anyone who tries to remove them is a relevant consideration, but it was a welfare priority in her view.
180. Sergeant JR agreed that when she was considering whether she would accept the referral, she recalled prominently in her mind that Graham Dillon did not suffer from any mental health issues and that the report from the teachers were only suspicions. However, she did not recall considering the fears that the mother stated she had for the children's safety if they lived with their father.²⁹

²⁸ Ibid 470

²⁹ Transcript of Proceedings, p 477

181. Sergeant JR did not agree that it was a more prominent feature when bouncing the considerations, but it is one of the considerations and it still would not change her view about how she would have dealt with the referral.³⁰
182. Sergeant JR was taken to the reports where there had been bruising noted to both siblings faces which were unexplained. It was suggested that the overall effect of the content of report 70027 was that the children had bruises and they were not talking about them and therefore it was a concern as to whether the bruising was non-accidental. Sergeant JR agreed that was the effect of the report.
183. Despite several matters being reported in relation to the children about suspicions of non-accidental injury, Sergeant JR considered that it was more appropriate to deal with this matter as a care and protection matter in relation to the welfare of the children prior to or rather than police involvement. Once that has been investigated by care and protection and they provide information back to police that is when the Police can act in respect of any criminal matters which are secondary to the welfare matters.
184. It was suggested to Sergeant JR that if a disclosure had been made by a child stating that their father had hit them that referral would not be rejected. Sergeant JR said that it depends on what was said and in what context it was said in, but if there were bruises and there was a disclosure that arose from an assault by a parent then a referral would be accepted.³¹
185. In relation to Sergeant JR's understanding of police involvement in Victoria the only information was that police found them at the caravan park. There was no information that police had taken them although Sergeant JR believe that the police were there and in fact assisted in taking the children. Sergeant JR accepted that she made no enquiry as to the circumstances of their removal. It was an assumption she had made based on what she had read. Sergeant JR was unaware of any negative sentiment being expressed by either child.
186. Sergeant JR was asked to assume that there was no evidence of police involvement in any traumatic separation of the children from their mother in Victoria. When asked whether that would have changed her decision in relation to the rejection of the second referral, Sergeant JR said it was tricky, but she still does not believe she would have changed her view on the matter given that interaction with police would have been negative.
187. If the children had been comfortable with police and they had disclosed to them then she may have considered not rejecting the second referral. However, she also said
- "it's too difficult to answer that because 'comfortable' to me would be that they feel able to discuss the things that they discuss with the DOCS workers that's comfortable".*³²
188. Sergeant JR was asked to assume that the police located the children but left the children with their mother and it was later that the Child Protection workers from Victoria who separated the children from their mother. She was asked whether that would have weighed against rejecting the second referral. Sergeant JR said that possibly she would have had looked at that however she maintained her view that

³⁰ Ibid.

³¹ Transcript of Proceedings, p 483

³² Ibid 488

interactions with police have negative connotations particularly if there is domestic violence incidences at home.³³

189. Sergeant JR was aware of the provisions of the *Children and Young Persons Act 2008* where consent is required by a parent to assess or appraise or investigate matters. However, she was also aware that there is a provision that states agreement is not required in certain circumstances, if there is a suspicion that it is not in the best interests of the children to get that consent.
190. In respect to recommendation nine of the Glanfield Inquiry which recommends removing a requirement for agreement to appraise or investigate, Sergeant JR was asked what her view was in relation to that recommendation. She considered that it would make care and protection's job a lot easier if they were able to access the children in a manner to be able to protect them and thought it was a positive recommendation.
191. Sergeant JR said she was aware of the prior history of significant family violence which included Graham Dillon spending time in a Tasmanian jail. Sergeant JR agreed that any threats such as those alleged to have been made by Graham Dillon in Facebook posts could be regarded as violence against a child. However, she considered that if the children are not direct victims then the issue raised is one of being a welfare issue.
192. Sergeant JR did not appreciate that the AFP held additional information that CYPS did not have and assumed in fact that it was the other way around. Sergeant JR agreed that whilst the AFP have a role in relation to investigating criminal offences, they also have a role in relation to welfare.
193. Sergeant JR agreed that there is room within the system for the AFP to share information with Child Protection and that any opportunity to prevent this from happening again is an important positive step.
194. Sergeant JR was asked whether there was any reason why a SACAT referral should not trigger the kind of proactive information sharing response she described, and she was asked if

"CYPS refers a matter to you, do you agree that that is probably quite a useful time to have a trigger where AFP not only responds to the request to interview, but actually looks at the matter in greater detail and goes through their records and also more proactively shares information back to CYPS so that they can perform their welfare role" ³⁴
195. Rather than a mandatory requirement it would be a policy process involving a Memorandum of Understanding (MOU). In respect to the CARHU report Sergeant JR agreed that it would be useful for them to have that report in making decisions in respect to referrals.
196. Sergeant JR identified that there is a system on PROMIS which identifies whether there is a DVO in place and has a process where it's possible to check the details and to determine whether it is active. In respect to emails sent from a Victorian police officer to an AFP officer concerning toxicology report for Graham Dillon given there was one for SK, Sergeant JR could not identify any reason why that could not have been given

³³ Ibid 489

³⁴ Transcript of Proceedings, p 496

to Victorian police and nothing which would prohibit her from giving that domestic violence issues and other safety issues for police.

197. Sergeant JR agreed that it would have been good practice for the AFP to inform Victorian police of the results of the toxicology report in relation to Graham Dillon.
198. Sergeant JR agreed that it would be good practice for alerts placed on PROMIS to include things such as confirmed drug use, and when it was confirmed, as well as other useful information such as whether the person is violent or not.
199. Sergeant JR agreed also that could be an alert on the system that there are concerns for children or family's welfare, but it would have to be at the very high-end of the scale.
200. Sergeant JR agreed in respect to the toxicology report, known to the AFP on 14 November 2014, that would be information CYPS would not have, and it would have been important to confirm the allegations made by SK and UN about Graham Dillon taking ice. Sergeant JR stated that Police would have been able to share that information with CYPS and that it was normal practice at the time to share information of that kind.³⁵ Sergeant JR agreed that on upon reflection that information should have been conveyed to CYPS.
201. The time for consideration of a referral appears to be about one and a half hours, which did not include other matters which she may have been dealing with. Sergeant JR agreed and said looking at it today in the detail of the material that was available on PROMIS she could have looked into the matter more deeply.
202. Sergeant JR agreed that given the amount of material, one and a half hours would not have given her sufficient time to look at the matter more deeply. Sergeant JR agreed that if the matter had been conducted more thoroughly further material would have been uncovered which may have been relevant to the CYPS assessment. Sergeant JR also agreed that had CYPS known that information on 14 December or thereabouts they could have shared that information with Care and Protection in Victoria for a court proceeding on 17 November which may have been relevant to those proceedings.³⁶
203. Sergeant JR made assumptions in respect to the information that CYPS did hold and was of the view they would have the same information that the AFP had. Sergeant JR agreed that the information in respect to the Victorian DVO would not be something that CYPS would have access to but agreed that it was relevant in this case. Sergeant JR was unsure as to the jurisdictional complexities of whether they were entitled to give that information to CYPS.
204. Sergeant JR agreed that as at 2014, part of the role was to proactively share information through a MOU. Sergeant JR agreed that in this case the toxicology information was not shared, and neither was the Ringwood Magistrates Court DVO allegations shared. She accepted that this information would have been beneficial to CYPS.
205. Sergeant JR identified that an interstate DVO should also come up on the PROMIS system as well as one from the ACT and if Sergeant JR had checked the system for

³⁵ Ibid 503

³⁶ Transcript of Proceedings, p 504

an alert such as a DVO the Victorian order would have come up in the same way that the ACT order would come up. Sergeant JR recalled that she did see the orders.³⁷

206. Sergeant JR said that she does rely on taking the information at face value and relying on its accuracy. However, she does not always believe the truth of each assertion as that would be *“the police officer’s curse”*. Rather, she seeks to confirm and clarify the point as best she can. However, she has a level of trusting people reporting accurately. Sergeant JR said she would be more inclined to believe the information at face value from Care and Protection workers as opposed to someone who is in a custody dispute. Sergeant JR identified that if a reporter does not have anything to gain, and is a professional, it is more likely that their reporting is accurate.

207. Sergeant JR agreed that she looks at the overall picture on the front screen of the PROMIS system rather than a thorough interrogation the whole of the record.³⁸

Acting Commander KD – Officer in Charge of the Family Violence Coordination Unit

Statement

208. Acting Commander KD provided a statement exhibited as C 85. Commander KD was appointed OIC of the Family Violence Coordination Unit in October 2015. The unit was created for the purpose of there being an increased focus on family violence within ACT Policing. It was aimed at improving the strategic coordination of operational responses to family violence incidents.

209. Commander KD identified that Bradyn’s death highlighted significant need to review the processes associated with reporting children at risk to CYPS and the operational engagement between CYPS and the AFP.

210. Policies and strategies have since been developed in respect to family violence, with a focus on safety, well-being, and security of victims of family violence. Greater attention has been placed on offender accountability strategies.

QS – Intelligence Officer, ACT Corrective Services

Statement

211. QS provided a report of a urinalysis test provided by Graham Dillon and conducted upon admissions to the Andrew McConachie Centre. The test results confirmed that Graham Dillon had tested positive for amphetamine and methamphetamine as well as cannabis on 15 February 2016.

Ambulance Paramedics

Summary of Statements

212. An Ambulance and two paramedics were sent to the Jacka house after the 000 call was made. They were the first to arrive at the scene. Given the briefing by operations, both

³⁷ Ibid 508

³⁸ Transcript p 511

officers had considered what their treatment plan should be upon arrival. They gathered up their equipment and went into the home.

213. The officers described coming into the home and said they saw a female child who told them where to go in the house. They walked through the house which was extremely cluttered, and it was difficult to get through the passage. Once going all the way down through the home, a male came charging out of the room, ran past both Ambulance Officers pushing one into the wall and yelled that he hadn't done anything wrong.
214. The two paramedics entered the room and observed Bradyn to be unresponsive. It was determined the best course was to pick him up and convey him out to the Ambulance (scoop and run). They did so as Bradyn was in an even worse condition than what they had been advised.
215. Upon entry into the Ambulance both paramedics observed that Bradyn had bruises from head to toe. He also had significant bilateral orbital bruising which in their view was significant because it suggested that Bradyn was suffering a head injury.
216. Bradyn was in ventricular fibrillation and the paramedics had to defibrillate him which revived his heart. However, Bradyn was not breathing and needed to be artificially ventilated. Soon thereafter, Bradyn began to deteriorate, and it was decided to take him to Calvary hospital. Bradyn was taken to Calvary and into the resuscitating unit.
217. Both paramedics said they observed that the little girl who had shown them into the house had significant injuries to her body and appeared unkempt, and small for her age.

Autopsy Report for Bradyn Dillion

218. An autopsy was performed on Bradyn by Dr Beng Beng Ong, and Dr Lavinia Hallam on 19 February 2016.
219. Upon external examination there were 78 separate signs of recent injury, including bruising, scabbing and abrasions on Bradyn's head, neck, front and back torso, genitalia, right upper limb, left upper limb, right lower limb and left lower limb and his mouth and nose. I have listed the injuries as described by Doctors Ong and Hallam at Annexure C.
220. An internal examination revealed a thin layer of subdural haemorrhage over the right cerebral cortex extending to the inferior aspect. There were focal contusions on the outer aspect of the left frontal and left temporal lobes. There was flattening of the Gyri and narrowing of sulci in keeping with cerebral oedema.
221. There was a recent incomplete fracture of the lateral aspect of the left 10th rib. A healed fracture with callous formation was present on the posterior aspect of the left 10th rib.
222. The right and left thoracic cavity contained straw coloured fluid. There were scattered areas of haemorrhage on the plural surface of the lungs.
223. There was soft tissue haemorrhage involving the para-testicular tissue around the region of the left spermatic cord.
224. On his body there were injuries to the posterior scalp, left posterior torso, left posterior buttock, right posterior buttock, right leg lesions, left leg skin lesions, right scalp area,

left temporalis muscle, central chest bruise, right flank bruise, left upper chest bruise, right upper arm bruise, right elbow bruise, back of right-hand bruise and left elbow bruise.

225. The CT of the brain and neck showed diffuse cerebral swelling more severe on the right than the left. What appears to be subarachnoid blood suggesting traumatic subarachnoid haemorrhage complicated by diffuse cerebral swelling with midline shift. Doctors Ong and Hallam opined that the swelling seen was sufficient to be regarded as the cause of death.
226. Upon dental examination it was confirmed that Bradyn had significant fractures of the two front teeth. Those injuries had been inflicted recently. It was concluded that the degree of force required to fracture the teeth was significant. The traumatic injury was consistent with being struck in the face with significant force and within 48 hours of death.
227. Neuropathology was performed on the brain by Dr Michael Rodriguez. This examination concluded that blunt force trauma head injury caused the acute subdural haemorrhage which showed moderate cerebral swelling and oedema. It was opined that the lesions identified were as a result of blunt force head injury. The injuries and their consequences were of different ages. There was evidence of previous subdural haemorrhage over the right cerebral convexity which could have occurred up to several weeks prior to his death. The more recent components identified reflected additional blunt force injury or episodes of re-bleeding during the assault.
228. Doctors Ong and Hallam concluded that the injuries sustained over the body were widespread and extensive. The injuries were found in all regions of his body including his genitalia. These injuries consisted mainly of bruises and abrasions, with a few non-specific in appearance as they were modified by healing. Although determining the age of the bruising is notoriously difficult, it can be interpreted that the injuries were of various ages.
229. It was concluded that
- “the extensiveness of injuries indicated that most of the injuries if not all were nonaccidental in nature. These injuries were sustained repeatedly over a period of time. The circumstances indicated that his sibling had similar extensive superficial injuries further corroborating the injuries were nonaccidental. Furthermore, some of the injuries occurred in areas not seen frequently in accidental injuries for example, injuries on genitalia and buttocks.”³⁹*
- Most of the injuries occurred with minimal force although some were compatible with more severe force. These injuries were the ones that caused fractures to the teeth left 10th rib and head injuries.*
- The brain showed features of old and new injuries particularly subdural haemorrhage, subdural haemorrhage would be traumatic in origin”⁴⁰.*
230. Moderate force would be required to cause these injuries. The subdural haemorrhage appeared to be chronic and at least a few weeks old. It would only require minimal force to further cause haemorrhage to the area. There was also organising contusions within the brain which would result in further bleeding as a result of additional injuries.

³⁹ Autopsy report p 34

⁴⁰ Ibid

The brain eventually became swollen and herniated resulting in ischaemic injuries and ultimately was responsible for Bradyn's death.

"In summary the deceased had sustained repeated blunt impact injuries over a period of time which were nonaccidental in nature. The cause of death was due to head injury secondary to these repeated impacts."⁴¹

Family Members

SK – Bradyn's Mother

Statement

231. SK and Graham Dillon first met in 2002 in Tasmania. They commenced a relationship soon after. Graham Dillon described himself as a "bad boy". Very soon after they commenced the relationship, he became controlling and dominating. Graham Dillon displayed conduct designed to show that he was capable of behaving in the way that he described himself. SK gave an example that when she was out Graham Dillon rang her to say that he knew that she was having a sandwich and where she was. This was done to intimidate her and control her and place her in fear.
232. SK eventually moved to Queensland to get away from him. SK tried to establish a life there. Unfortunately, Graham Dillon followed her to Queensland and ultimately moved in with her. The violence commenced almost immediately after he arrived. SK was trying to make a life for herself and had a job at a caravan park, which included a house as part of the package. Graham Dillon lived with her and stole money from the caravan park, telling SK to tell the owners that they'd been robbed.
233. This happened on a number of occasions with Graham Dillon stealing the takings because he was taking drugs and being violent. At one-point bikies on motorbikes came to the park dragging chains behind them. They had done so to intimidate SK on the behest of Graham Dillon. Graham Dillon appears to have advised them that SK was 'off her face'. When she confronted the bikies, they realised she was not drugged, and they then confronted Graham Dillon.
234. During the course of their relationship, Graham Dillon introduced SK to speed and other drugs. He became exceedingly violent and controlling. He was careful to leave bruises where they were not seen or could be covered up.
235. The Caravan park closed in part because of Graham Dillon's dishonest behaviour and SK left Queensland and returned to Tasmania. SK did so to get away from Graham Dillon. Unfortunately, he followed her again, and they eventually got back together. At first, Graham Dillon was nice to her, but it didn't last long, and he continued on with his violent behaviour against her. This violence increased and he became extremely violent and was violent to SK even when she was pregnant.
236. After she had had their first child, JL, there was an occasion when SK had JL in her arms, and Graham Dillon attacked her, and the baby got caught in the crossfire and both SK and infant JL were thrown against a wall. SK picked the baby up and ran

⁴¹ Ibid p 35

outside. Graham Dillon was more concerned about his reputation than concern for either SK or the baby.

237. Not long after Graham Dillon assaulted SK, BK called Police in relation to this assault. Ultimately, he was convicted of the assault on SK and spent time in jail.
238. When Graham Dillon was released from custody he moved to Queensland and he requested that SK follow him, which she did. Graham Dillon and SK were involved in a church group who were apparently helping him. The church group soon realised that Graham Dillon was dangerous and advised SK to go back to Tasmania as they thought he would kill her if she did not do so.
239. SK then moved back to Tasmania and got her own place. Unfortunately, Graham Dillon came back to Tasmania and visited her. Graham Dillon wanted to make up with SK and she allowed him back in her life, but within one week the violence commenced again. JL was born in November 2005 and Bradyn was born in October 2006.
240. SK stated that Graham Dillon first hit Bradyn in the stomach at the Ravenswood address in Tasmania. He was only a toddler at the time. When young Bradyn cried, Graham Dillon told him to man up and not to cry.
241. Eventually Graham Dillon moved away because he was advised that Police would be called about his violent conduct. His conduct had been witnessed by SK's friends.
242. Not long after that he took up with a 14-year-old girl, UN, who was also from the church group that he had contact with, in Queensland.
243. Graham Dillon and UN went on to have three children together, including twins.
244. Graham Dillon started abusing UN and did so even when children were present. SK's oldest child BK had seen Graham Dillon hit one of the twin children in front of the other children.
245. SK indicated that at some point as BK became a teenager, she became a handful. SK asked Graham Dillon if he would look after JL and Bradyn for a short while so that she could have some one-on-one time with BK to try and sort out the issues.
246. A few weeks later, when she wanted to have the children returned to her, Graham Dillon refused. He then told lies about SK and applied to the Court and obtained a DVO against her. SK came to Canberra to fight the DVO. However, there were some issues in respect to his violence toward her, including at the court where he threatened her. SK was placed in a room in which she did not have any ability to tell that the court proceeding was on and because she was not in Court, the order was made against her.
247. SK tried on a number of occasions to advise those in authority that Graham Dillon was dangerous and violent however no one listened to her.
248. When she was in Canberra at the Tuggeranong shopping area, she saw her daughter JL. Another man was with JL. She went up to say hello to JL, but the man grabbed SK violently and held her down whilst he spoke with Graham Dillon on the phone. Security had held her, and she asked for Police to be called but they refused to call Police.

249. Later, SK had spoken to UN, who was now married to Graham Dillon. UN said that Graham Dillon had been violent toward her. SK was concerned that he was also violent to the children because he controlled all of them as well as her contact with them.
250. SK said that when she did eventually see the children, they had bruises on them and that they seemed scared. This was after she had been forced to give Graham Dillon \$2000 in order to see the children. It was her view that they looked like they were starving. Given they also had bruises all over them, she said was very concerned about the children and decided that she needed to rescue them from him.
251. SK came up to Canberra and placed sleeping tablets in Graham Dillon's coffee. Whilst he was asleep, she took the children back to Victoria with her in November 2014.
252. Graham Dillon went to Police and told them that he was the one that had full custody of the children, which I note was not true, Police issued alerts to look for the children in Victoria.

In Evidence before the Inquest⁴²

253. SK gave a history of how she met Graham Dillon. SK said that they met in 2002 and commenced a relationship shortly thereafter. SK described not long into the relationship Graham Dillon became controlling, dominating, and rough with her.
254. SK said that they broke up on a number of occasions, the first being when she moved to Queensland, because of his behaviour. At the time she had her first child, BK, with her and took her to Queensland. There, they lived in a caravan park where she eventually became the manager.
255. Not that long after she became settled, Graham Dillon visited her, and they recommenced a relationship. Soon after, the violence commenced as she outlined in her statement. SK's long-lasting memory was one of constantly living in fear.
256. Graham Dillon made threats that he would kill SK and her family and make her life unbearable. SK only had a small family comprised of her grandparents, a cousin, and a sister. Her grandparents raise them as her mother died when she was very young. As outlined in her statement, Graham Dillon made terrible threats about what he would do to them. Graham Dillon threatened her to keep her in line and said that he would have bikie to do his bidding.
257. At the time, Graham Dillon was also consuming speed and injected SK with it. When they left the caravan house they moved into a property in Wynnum West and the violence continued. SK said that once they were no longer under the watchful eye of the residents or the employer at the caravan park, the violence increased. As a result of that violence she was often injured. Graham Dillon did not allow her to go to a doctor or hospital and she was required to cover up the injuries.
258. SK stated that she went back to Tasmania to live with her grandparents and not long after, Graham Dillon returned. As she thought it was appropriate for him to see his children, she resumed a relationship with him.

⁴² Transcript of Proceedings, p 42 – 182

259. When SK was pregnant with Bradyn, Graham Dillon grabbed her from behind while she had the child she had in her arms and threw them both up against the wall. SK picked the baby up and ran outside. SK also gave a history of the violence she suffered through her pregnancies with both JL and Bradyn, including Graham Dillon choking her, putting her face down on the floor, putting his foot on lower back and grabbing her arms and pulling them backwards. Graham Dillon would also smash her head against walls. This was a constant throughout the relationship.
260. SK was referred to material,⁴³ which outlined the assaults that she suffered in 2006. These had been reported to the Police. There was another incident where Graham Dillon attacked her, hitting her in the head, strangling her and physically abusing her. That was when she was staying with her aunt. Police were called and Graham Dillon was taken by Police and ultimately sentenced to a term of imprisonment.
261. SK then moved back to Queensland where she gave birth to Bradyn. Ultimately Graham Dillon came back to Queensland and they resumed their relationship. During that time Graham Dillon was involved in a church group called the 'Tribe of Judah'. These groups help reformed criminals and provide assistance to them.
262. SK described a time when some of the people from the church group pulled up beside her and grabbed her and pulled her into the van. They apologised and said this was the only way they could save her from Graham Dillon killing her. The people from the church also described their view of Graham Dillon as violent and controlling and said they were aware of the injuries he inflicted upon SK.
263. SK then went to stay at her aunt's place in Chermside, but Graham Dillon tracked her down. Her family insisted on her returning to Tasmania to live with her grandparents. Prior to the separation at that time, SK told the court that there had been incidents of violence towards the children as well.
264. SK gave a history of when she returned to Tasmania and neighbours saw Graham Dillon punch Bradyn in the stomach. Graham Dillon had told Bradyn to man up. Not long after that there was a confrontation between Graham Dillon and the neighbour where he threatened to hurt them and the children. He kicked their toys and smashed things up. They all then confronted him and told him that they were going to the Police. They told him that he had two options either leave Tasmania or they would go to Police. Graham Dillon took the first option and left. That incident was never reported to Police.
265. SK said that Graham Dillon then went to live in Queensland and the children lived with her. SK told the court that Graham Dillon then commenced a relationship with UN. During that time SK was in touch with Graham Dillon but he did not see the children.
266. SK told the court that her relationship with UN was terrible to begin with because Graham Dillon had been cheating on her with UN. There was some jealousy and there were truths and lies told. Ultimately, the relationship became one of friendship because UN was also suffering from violence at the hands of Graham Dillon and SK felt like she wanted to protect her.
267. When UN met Graham Dillon she was only 14 years of age, and he was in a sexual relationship with her at that time.

⁴³ Exhibit C5, p 4662

268. SK eventually moved to Melbourne with the children and her new partner. The eldest child BK was then a teenager and was causing some trouble at home. SK said that unbeknown to her Graham Dillon was contacting BK by telephone and was giving her very poor advice in relation to a sexual relationship. Graham Dillon came down to Melbourne to visit and took BK to Care and Protection in Melbourne. SK was not aware of this until it was revealed in court.
269. At this point in time, SK asked Graham Dillon and UN to take Bradyn and JL to stay with them. So SK could help BK get some assistance. SK advised that she did this because she had seen the house where Graham Dillon and UN lived, and it was a comfortable house. SK thought that the children would settle until she could sort out BK.
270. Graham Dillon offered to help SK by having the children for a couple of months. However, after two weeks SK called Graham Dillon asking if he could bring the children home earlier. That was about July 2013. Graham Dillon point blank refused to give her the children back.
271. SK said that she contacted the CYPS on 30 July 2013 to tell them about wanting her children back. There was a note in respect to the phone call. SK advised that Graham Dillon had been extremely violent and that's why she left the relationship. SK also advised CYPS that Graham Dillon had threatened her new partner that if he was to interfere he would kill him.
272. SK said that she came to Canberra because she was concerned about the children.
273. Whilst she was there, she had been confused by all the roundabouts and she got lost. Police found her, took her to the Police station and gave her a piece of paper. Prior to that she had found the house where the children were living but did not see the children or speak to anyone there.
274. SK was not aware that Graham Dillon had obtained a DVO until Police served it upon her. SK saw that Bradyn and JL were listed on the order. After she was served with that order she returned to Melbourne.
275. SK advised that when she returned to Melbourne she spoke with Ringwood Courthouse and made an application for DVO. That order was granted which included her three children. At that time there was a similar order in Canberra with SK as the respondent.
276. Regarding the Victorian order, Graham Dillon told SK that if she dropped the Victorian order he would allow the children to come home, because the children were missing her. SK dropped the Victorian order. However, Graham Dillon did not drop the ACT order as he advised he would.
277. SK said that she did come to Canberra and had hoped to speak with teachers at the school the children were attending. Unfortunately, the school was closed as it was semester break and she spoke with a groundsman. It was at that time that she saw a man driving a car with JL in the car. SK followed the vehicle to Tuggeranong Shopping Centre. SK then followed them into the centre and at Kmart she approached JL. JL squealed, and the man came over grabbed hold of SK and pushed her to the ground and was choking her. Nobody came to help her, including the security guard. She believed the man was a friend of Graham Dillon. The man rang Graham Dillon and Graham Dillon called SK 'a bitch' and ultimately came to the complex. SK was told the

Police had been called but refused to come. SK described Graham Dillon as off his face and trying to get at her. He told her he was going to kill her, so security told her to leave, giving her a 15-minute start. SK then went back to Melbourne.

278. Shortly after her return to Victoria, SK had her baby who was born very premature, and SK suffered postpartum complications.
279. SK said that she had been speaking with UN about UN's relationship with Graham Dillon. UN told SK that Graham Dillon had been violent to her. BK had also told SK that she had witnessed Graham Dillon being violent to UN. SK reported her concerns in September 2013. SK became aware that UN and Graham Dillon had separated in December 2013. After that separation SK travelled to Canberra at Graham's invitation where she visited the children and Graham Dillon at his Ainslie address.
280. When she attended at the Ainslie house, she observed that the children were covered in bruises and were, in her view, extremely malnourished and would only answer when Graham Dillon gave them permission to speak.
281. SK then told the court that she came to Canberra after arranging the trip with Graham Dillon. When she arrived, she had been advised of something of a sexual nature in relation to Bradyn that concerned her, and she wanted to check on the children.
282. SK said that on 2 November 2014 she made Graham Dillon a cup of coffee and put some Seroquel in it so that he would fall asleep, and she could take the children without him harming them. Graham Dillon fell asleep, and she packed the children into the car and took them back to Shepparton in Victoria.
283. At the time, SK was living in a house but visited the caravan park where friends lived so the children could use the swimming pool and the park. At the time, SK had gone to the Victorian DHHS and spoke with two workers asking for the children to be placed back in her care. SK said that she had spoken to them prior to any Court involvement with Graham Dillon about his behaviour in the past.
284. SK recalled there was a time when she was in Canberra and the order which Graham Dillon was seeking did not have the children's name on it. SK also recalled that when Graham Dillon made an application seeking to have the children added to the order, it was adjourned to a later date as it was not agreed. SK did not recall the later date.
285. SK recalls ringing the Canberra Courthouse and advising them that she could not attend because of her pregnancy as she had been advised not to travel. On another occasion on 10 October, SK did attend court and was placed in one of the rooms where the speaker was not working and when her name was called, she missed it. The Court was advised but it would appear that the Judicial Officer had made the order in her absence. The children were placed on the order.
286. In September 2014 she sought to have the children's names removed from the order. SK recalls that she received an order from the Canberra Court which did not include the children on it. SK did not receive the amended order.
287. SK recalls that there had been conversations in respect to the DVO and at the conference which followed. There was an agreement in relation to SK spending more time with the children. SK said that she took Graham Dillon at face value when he said that if she dropped her order, he would allow her to see the children.

288. It appears SK had very little knowledge or recollection of the legal assistance she was entitled to received. It is clear that she had very little understanding of court processes.
289. Regarding the allegation made by Graham Dillon that SK was using drugs when caring for the children, SK denied using drugs when she had the children. SK consented to a drug test undertaken by Victorian Child Protection Services which indicated no drugs other than a trace of cannabis.
290. SK knew that Victorian Child Protection were seeking an order that she have the children reside with her. SK said she attended the Courthouse but did not attend Court because Graham Dillon was there, and the workers insisted that she did not go into the Court building. There was a safety plan put in place to keep her away from the Courthouse. SK thought, at that point in time, she had orders that the children could reside with her. It was not her understanding she had to return to court.
291. SK advised that it was her intention to return to Tasmania and seek assistance from her lawyer in respect to having full custody of the children. It was clear that SK did not understand the different types of courts in that regard.
292. SK said that she was present during some of the interviews conducted by DHHS workers. She recalls that Bradyn had told them that his father strangled him, kicked him, hurt them, and screamed at them. Bradyn also said that they were at times staying up all night and he just went on and on at them. The children were petrified of him. JL also told them that they had been drowned and that he drowns them in the bath until they can't breathe then lifts their heads out of the water. They screamed at the workers 'please don't send me back to daddy'.
293. SK said that in her experience you were not to talk about the abuse, and given the children had and that they were going back to him, they knew they would be in trouble SK had told DHHS of the history of abuse she had received at the hands of Graham Dillon. SK said she also told them about the abuse UN suffered as well.
294. SK said that in the children's minds they were finally free, no more hurt, they were safe back with their mother. Then the Police just rocked up and took them. SK said that she saw Graham Dillon and he said "*sucked in, you're fucking dead now*" it was at that point he threatened her, gesturing with his finger across her throat. He also threatened her partner as well.
295. After the children were returned to Graham Dillon, SK was entitled to phone access with the children. However, she was never allowed to talk to them, she could only talk to Graham Dillon.
296. SK advised that she did speak to Care and Protection in Victoria about messages she received from Graham Dillon that had guns and bullets in it saying, '*this is your Christmas present bitch*'.
297. SK said she went to see the Police in Shepparton to tell them that she had received these messages, those included a crossbow in December 2014.⁴⁴ SK also advised Victorian Child Protection Services that she had received this threat from Graham Dillon.

⁴⁴ Exhibit C 26

298. SK indicated that she had spoken to numerous agencies over a period of time about the concerns she had about the safety of her children. There were notes from various calls she made about the children and what was to happen. That included a note from Victorian Care and Protection on 18 December which recorded that ACT CYPS wants Victoria to send them everything they have in relation to the children and SK would appreciate a call from someone who knows her case.⁴⁵ SK said she did not ever receive a call from someone who knew her case. That appeared to be the case on a number of occasions.⁴⁶ Victorian Child Protection Services did not send anything to the ACT in respect to the case.
299. SK said that she was calling because she was concerned that she had not heard from the children. SK also said that she believed Graham Dillon had moved address and she does not know where they are.
300. SK also said that she went into the office wanting to speak to someone about her concerns. She ultimately said that it was a joke because she could not get anyone to listen to her.
301. SK also advised that she had spoken to Victorian Child Protection in June 2015 about concerns she had for the children after speaking with Graham Dillon's brother Michael.⁴⁷
302. It was suggested to SK that there had been a report by Graham Dillon who told the Victorian DHHS that placing the children in SK's care would be harmful given she had issues with ice addiction. SK denied that and said that was extremely false. SK also denied the suggestion that the Victorian Department had encouraged her to place Bradyn and JL with Graham Dillon.
303. SK said that she recalled speaking to CYPS on 30 July 2013 telling them that Graham Dillon refused to allow the children to be returned to her care. SK confirmed that she had spoken to CYPS and agreed she told them the following:
- "The reporter was previously in a relationship with the children's father for seven years. In that time, he was extremely violent and that is why the reporter left the relationship. When the reporter was pregnant with her son, the father physically attacked the reporter whilst holding JL as a baby and JL was thrown against the wall'. That's the incident that you've given evidence about earlier today, 'The reporter stated the children have only seen their father approximately three times since they separated, however the reporter spoke with his wife and she advised that he was being medicated for his mental health issues and was better'."*⁴⁸
304. SK was asked about Graham Dillon's mental state and whether she was aware he had been diagnosed as schizophrenic. SK said he told everyone he was but there was no documentation from a doctor saying he actually suffer from it. It would appear that Graham Dillon fabricated so many stories she did know which was truth and which was not.

⁴⁵ Transcript p 87

⁴⁶ Ibid

⁴⁷ See transcript p 90.5 and exhibit C27 - 31

⁴⁸ Transcript p 96-97

305. The rest of the note was read to SK who confirmed that it was what she had said on 30 July 2013. SK advise that to the best of her recollection; she was told that there would be no action just that they would take notes about the report.
306. SK did not receive any further response to the allegations made and she said that she would often ring them seeking information. It was her opinion that she antagonised them, and they would get crabby with her. The main offenders were CYPS.
307. SK confirmed that she called the Shepparton Police, the AFP, the DHHS in Victoria, the ACT Department, Legal Aid, and private lawyers including one from Tasmania as well as a women's legal advice helpline and DVCS in Canberra. SK also called Shepparton local Court and the Canberra Protection Unit. SK confirmed that she contacted Shepparton Police on 28 January 2016 in respect to her concerns for her children. SK confirmed that she provided NF with notes of all of the phone calls she made and the numbers that she called in respect to this matter.
308. SK confirmed that she had not seen the children for some time. SK offered Graham Dillon \$2000 to see the children knowing that he would be incentivised by it.
309. Graham Dillon set conditions that she was not allowed to bring any support persons or children other than her new baby. They stayed at the Comfort Inn for three days. SK confirmed that she had observed bruises in the forehead area near the hairline bruises on his leg and that Bradyn appeared very skinny. SK also observed at the time that the children were uncomfortable approaching her and would not touch or speak to her unless Graham Dillon gave them permission.
310. SK stated that the unit had two bedrooms and when Graham Dillon went to sleep, she and the children went to the second bedroom, closed it off and had some time together where they were free and open and cuddled up to their mother.
311. SK also confirmed that in her notes she had written about the evidence she gave including speaking with NE, Graham Dillon's brother, and reporting it to DHHS and CYPS on 22 December 2015.
312. SK confirmed that when she rang and spoke to a woman at CYPS she believed they were mocking her because after she had spoken to them they asked her what she had hoped to achieve from the report. They further stated that CYPS is in Canberra, a federal state and they could cause problems for her.⁴⁹
313. SK also confirmed that when she was dealt with by the court, she felt like she was being mocked because it was 2 ex-partners who were disgruntled parties, who were trying to cause problems for Graham Dillon.
314. SK confirmed that it was her impression that the people from those organisations looked down on her and that is why she did not get the help she wanted and had asked for. Much of the contact she had with those organisations was recorded in notes and diary entries.⁵⁰
315. Bradyn's sister JL wrote a poem on January 18, 2017 titled 'You Kill Me'

⁴⁹

⁵⁰ Exhibit C

*"You killed me when you loved me. You knocked me down. You broke me and you burned me without a sound. I gave you all and you threw it to the ground. Deep, deep down I saw the light. I saw the hope and now I am free from your curse and now I'm flying high and as you try to bring me down, down, down but you can't touch me now"*⁵¹

316. SK opined that JL has been extremely affected by the death of her brother as have all the family members. SK confirmed that her mother died when she was five years of age and she was raised by her mother's parents. SK said her family identified as Indigenous and that Bradyn was also indigenous on both sides.
317. SK was taken to a note she made in respect to 16 January 2016 where she recorded that the DV order expired that day and she sent Graham Dillon a message asking to see her children. Graham Dillon replied with an abusive and threatening voicemail. When SK replied asking for an explanation as to what he meant he did not respond.
318. SK also stated that she rang Graham Dillon in January 2016 and he said he was in the bath and she should ring back later. Graham Dillon did ring back and told her that he was mad at her and that's why he stopped contact, he was mad because she took him to court.
319. SK also had a note which reflected that on 28 January 2016 she rang Canberra Protection Unit and told them the DVO expired on 9 January and asked for advice. SK revealed that she was told something but in the end, the information was incorrect and didn't lead anywhere. On 14 February 2016 there was a diary entry where she recorded that she had a meeting with her lawyer that day in Shepparton.⁵²
320. Ms Davidson asked SK questions in respect to the time she had dealings with the DHHS in Victoria in November 2014. SK confirmed that when she went up to Canberra in early November, she had Graham's permission to visit. The reason she was there was because it was JL's birthday.
321. SK stated that there were a number of occasions when she believed Graham Dillon was using drugs from some of the things that he did which she picked up on. However, she did not believe in November 2014 that he was on drugs at the time.
322. SK stated that she assumed the reason why Police were looking for her was because she had taken the children and Graham Dillon had made a complaint. SK agreed that she and the children were taken back to the Police station where Child Protective Services interviewed them all.
323. It was suggested to SK that Victorian Child Protection had received information that she was consuming drugs and there were allegations about the children being safe in her care. SK said she was not aware of that allegation and in fact formed the impression that Child Protection thought that she should have the children.
324. It was also suggested to SK that it had been reported by the AFP that a current DVO was in place which included the children's names on it. The Order also included that she was not to be within 100m of them. SK said that she was not aware of that order. It was SK's view that the order had been amended to not include the children on it.

⁵¹ Transcript p 119-120

⁵² Exhibit C39

325. It was also suggested that ACT CYPS had reported to Victorian Child Protection that the children had made disclosures about being scared of their mother and that she had hit them. SK said she was also unaware of those allegations. It was also suggested that Graham Dillon had said she may have been using ice. SK denied using ice.
326. SK agreed that she and the children had been interviewed separately by DHHS. SK agreed that she provided a copy of an order which excluded the children from it. SK also agreed that she provided a urine sample for urinalysis which detected low-level cannabis but no methamphetamine.
327. It was suggested to SK that the children were happy and felt safe in SK's care but did not make any disclosures about Graham Dillon at that point. SK also agreed that she had told them about the violence in Tasmania and had shown them documents in respect to it, including documentation that Graham Dillon had been sent to jail. SK also agreed that Victorian Child Protection did get those records from Tasmania which confirmed her allegations of family violence. SK agreed that Child Protective Services after confirming those allegations believed her version and assessed her as being suitable to have the children in her care. SK also agreed that Child Protection had grave concerns about Graham Dillon having the children.
328. SK was taken through the process whereby an urgent application was made to stop Graham Dillon taking the children which included making arrangements so that she did not have to appear in court. This was as a result of the issues of safety. SK said that yes, but she was told that the judge was not happy that she was not there and that they apologised to her when he rejected her application.
329. When it was suggested to SK that the arrangements were made so that she did not have to go to court, SK said it was on their insistence that she stay in the room. When it was suggested that SK was at a serious risk of harm from Graham Dillon, she said
- "That's a double-edged sword. When you're a parent - you may feel it, but when it was for your children, I'd stand in front of him, and I'd cop a beating every time. So even though I felt scared, if it was what I had to do to go to that court to fight for my children, I would have done it."*⁵³
330. SK agreed that the Friday 14th of November order prevented Graham Dillon from having the children and placed them in her care.
331. SK agreed that the children over the weekend did not make any disclosures however she indicated that they were very withdrawn, and it was not her place to push them. It was her view that she should just show them love so they would feel safe.
332. SK said there was an incident where Bradyn had punched her in the face and the stomach and when she told him that it hurt and asked him why he did it he said that was because that's what dad and I do. SK said she did not question him any further because she did not want to push him.
333. In respect to where she was on the Monday during the court proceeding, she was unsure as to whether she was at home at first or whether she was in the room where she was told to sit. SK stated that there was no one that came to see her until it was at the end when they apologised.

⁵³ Transcript p 131

334. SK did not call or make any enquiries of UN or the workers coming back to speak with her. SK did agree that when the children were told about the decision they were frightened and made disclosures, asking not to be sent back to Graham Dillon. SK agreed that the children were crying, and BK was angry that the court could send them back and that SK was responsibly trying to calm everybody down.
335. It was suggested that SK had said that BP, a CanFaCS support worker, sells ice. SK said she did not know that but said in relation to BP she said that Graham Dillon had him under his thumb. She said that Graham Dillon used to laugh about it and mock and ridicule the men's group saying he could do what every wanted.⁵⁴
336. SK also confirmed that she had made reports to Victoria and also to the ACT telling them that Graham Dillon was not giving her the contact she was allowed. When it was suggested to her that DHHS would make a report to Canberra regarding her concerns she stated that she recalled one of the workers was leaving Shepparton to get a job with Canberra CYPs and not to tell anyone because it could cause problems. That was confirmed by counsel for the DHHS. SK also confirmed that she had spoken several times with CO, a DHHS case worker, after the children had gone back with Graham Dillon. SK confirmed that CO had been more accommodating of her needs and her impression was that she was the only one who actually listened to her.⁵⁵
337. It was suggested that DHHS did make a report about the disclosures to the ACT and SK stated that would surprise her as she was not aware of that fact. I question whether they had any record that she was advised of that fact and there was none.⁵⁶
338. SK agreed that she had attended Victorian Child Protection on a number of occasions asking for the record to be transferred to the ACT. SK also agreed that she had said that JL had advise that her father hits her and kicks on the head, legs, and arms and that she is sore after he had done so.
339. Further allegations made by Bradyn and his sister were put to SK however she was unable to confirm these. There were further allegations and evidence of abuse by Graham Dillon to his ex-wife and SK agreed that those records were available. SK also stated that as she walked past Graham Dillon in the office when he collected the children, he threatened to kill her.
340. SK confirmed that when the court proceedings was on foot, she was in the DHHS building which was right beside the court and was willing to go to court if she was called. SK agreed that she was then advised that the court had ordered the children go to Graham Dillon and she said yes but with no explanation. SK also confirmed that was when the children disclosed the violence perpetrated against them by Graham Dillon.
341. SK confirmed that she was not aware that UN had given a statement on her behalf nor had she seen it. However, she did confirm that she told the Child Protection staff that UN could support her and make a statement. SK also confirmed that her cousin would also be willing to support her in some way. SK confirmed that she understood that the

⁵⁴ Transcript p 135

⁵⁵ Transcript p 146

⁵⁶ Transcript p 136

Victorian Child Protection were gathering this information to assist her to keep Bradyn and his sister.

342. SK stated that she was aware that the Victorian Magistrate had concerns in relation to her unilaterally taking the children from Canberra. SK was aware that he thought she had no right to take them from the father.
343. SK said she could not recall that she was advised by BN and CO to go to the family law court but does recall that she went to the Shepparton courthouse around that time. SK agreed that BN and CO were still concerned for the children's safety at that point.
344. SK also accepted that Graham Dillon was most likely collecting material to use against her in Protection Order application. She added that that is what he tried to do throughout their relationship, painting a poor picture of her to get notice. It was her view that this was done by him to get more power over her.⁵⁷
345. SK agreed that she had phoned Victorian Child Protection telling them about the disclosures made by the children. SK also agreed that she reported the gun and bullets information to Victorian Child Protection, Victoria Police, ACT Police and ACT CYPs.
346. SK also agreed that she had made a phone call on 14 January 2015 to query ACT CYPs telling them that she would contact Victoria to release the documents the worker told SK that if children did not disclose to them, there's not a lot they can do because they need evidence to back up action. SK also said that she told that person that there was probably a zero chance that the children felt safe enough to disclose anything to them because of Graham Dillon.⁵⁸
347. It was suggested to SK that the Victorian DHHS had told them that they would transfer the case to the ACT and that it was an open case. SK was not aware of that although she had spoken to CO who advised that she would keep an eye on what was happening with the children.
348. In relation to questions from counsel for the Territory, SK agreed that Graham Dillon was not only violent, but was also a master manipulator.⁵⁹ SK also stated that Graham Dillon had a very good knowledge of the system and he knew how to work in it and play it in his favour.
349. SK explained what she meant by 'its embedded in us that we are not allowed to talk' saying if you talk you get beaten, you're not allowed to say anything, everything has to go with what he says. That includes anyone that has a close relationship with him. SK opined that he did this because he wanted everyone to perceive that they had the perfect family.
350. In relation to her notes and diaries, SK agreed that by the end of July 2013 she had expressed views to get the children back from Graham Dillon and that he resisted.
351. SK accepted that she had some confusion in her notes about the difference between Canberra Care and Protection services i.e. CYPs and the Canberra Protection Unit (at the court).

⁵⁷ Transcript p 159

⁵⁸ Transcript p 161

⁵⁹ Transcript p 173

352. In respect to the entry that recorded that she rang quite regularly, SK said that in the end they were mocking her and threatening her, because she had confused the Canberra Protection Unit with CYPS.
353. When asked whether there was a system which she thought may have helped her she said
- “just somebody to listen to me from the beginning when there was so much obvious evidence of what was happening. As I was told, we fell through the cracks”.*⁶⁰
354. In respect to questions asked by her counsel, SK said that she recalled the evidence she gave about the voicemail she received from Graham Dillon which was actually directed to a person called XJ. SK stated that she did attempt to contact Graham Dillon’s brother RE so that she could find out more about what was going on with the children and their safety. SK said she did this because he had previously provided information as to his concern for their welfare. RE replied and said he would write a letter to the court to assist her in getting the children back.
355. SK was re-examined in respect to the 14 and 17 of November 2014 dates when an Interim Accommodation Order was made and when the further proceedings occurred. SK said that she stayed in the office of the DHHS next to the Shepparton court, at the DHHS’s insistence. SK said that she did not understand that she could have attended court and that she did not have a lawyer with her on that day.
356. When it was suggested to SK that she had a Legal Aid lawyer approved to be there, SK said she did not know anything about that, nor had she met Mr ZB who had been apparently assigned to her. SK denied that she had ever spoken to a lawyer representing her between the dates of 3 November and 17 November when she was in Shepparton. SK said she did not receive any letters from a lawyer reporting the results of the proceedings. When it was suggested that it might be possible that she could have had a lawyer in the room she said she did not know.
357. In respect to the notes that she made and had referred to, she accepted that her memory of dates was quite poor which is why she has her diary to act as her “brain”. But in terms of the actual events, her memory was very clear and in terms of what was said in the office of the DHHS on 17 November that is something she will never forget.⁶¹
358. The reason that she was told why the children were given back to Graham Dillon was because the Magistrate did not take too kindly to her not being in court attending. SK also said that she was not aware of any documents which were placed before the Magistrate.
359. SK said that in her diary where she wrote Canberra Protection Unit she meant CYPS. And in respect to a note of a conversation on 14 January 2015 at 9:06 AM with PG in relation to SK contacting Victorian Care and Protection to send documents to ACT CYPS. SK did go in and asked that they send the documents through to CYPS.
360. In reference to the conversation with PG where she said that SK should just let her do her job, in SK’s view she meant that she should stop wasting PG’s time.

⁶⁰ Transcript p 173

⁶¹ Transcript p 173

361. In respect to the application to vary the order to remove the children it was her understanding that that's what had happened, but she was not sure that the matter had been adjourned. She was not sure why she had to return but she did receive a copy of the order which had the names removed from it.
362. SK said that she never saw a document with the children's name on it. In respect to questions asked of SK in relation to calls she had made, she said she had called many people in Child Protection, domestic violence, and other organisations and that's why she was confused with them at the time.
363. SK was asked whether there were any comments she would make in respect to her difficulty navigating the system and whether there was some way of making it more workable, SK said

*"guess that with a lot of people in my position, we don't know the law courts. We don't know what procedures to take. We don't know what's available for us so maybe - I don't even know what you can do but when you get into that situation, you're helpless and when you have so many organisations that tell you one thing and then when you contact another one it's completely different so, you're back at square one."*⁶²

UN – Bradyn's Step-mother, ex-wife of Graham Dillon

Statement

364. UN provided 2 statements which reflected Graham Dillon's violent behaviour toward her. Graham Dillon commenced a relationship with her when she was only 15 years of age and they have three children together. Their relationship when he was working was a loving one, but he changed when they moved to New South Wales. Despite everything she tried he continued to be violent toward her. UN described years of violent behaviour very similar to the type of behaviour SK had endured. The type of abuse experienced by UN included threatening her life and making threats that he knew people who could kill her. She was fearful because she knew the threats could be true and that he could carry them out. She also knew that people feared him. There were times when she observed his behaviour and was extremely fearful that he would hurt her or her family.
365. UN was told by nurses at the NICU that, when she had her daughter, Graham Dillon was observed by the nurses to be violent toward their two-year-old son, by using excessive force upon the child.
366. UN describes meeting SK and the three children, and all of the children got to know each other. UN described that Bradyn and JL came to live with her and Graham Dillon on the basis that Graham Dillon would help SK for a short period of time and that the children were there on an extended holiday. It was supposed to only be for six months.
367. UN indicated that during that time the children witnessed extreme violence perpetrated by Graham Dillon. That included physical, psychological, and verbal abuse. UN indicated that SK had asked that the children be returned to her earlier than had been previously arranged.

⁶² Transcript p 178

368. UN identified that Graham Dillon had made threats to harm SK and her partner if they were to collect the children. He then went to the Magistrates Court and obtained a DVO against SK preventing her from collecting the children.
369. It was UN's view that the reason Graham did this was both out of vindictiveness and for financial reasons, as he was going to get a parenting payment, she would lose the government benefit she had, and he would be paid child support.
370. UN was aware that SK applied to the Victorian Court for a recovery order for the children, but Graham Dillon convinced SK to drop the court proceedings to make a deal about the children instead. That deal was that they would both drop their court orders. However, Graham Dillon reneged on that agreement and continued with his DVO.
371. UN indicated that Graham Dillon would tell the children (that being, the children of UN and Graham Dillon) when they said they would like to see their mother that: their mother took drugs, she doesn't contact them because she doesn't love them, and that if they went back to her place they would never see their family again.
372. UN described Graham Dillon as being very harsh in his punishment and that he used items to do so. It was, in her view, more force than necessary and she had to intervene on many occasions to redirect his abuse away from the children.
373. UN identified that Graham Dillon was unable to care properly for the children because of his aggressive, controlling, and violent outbursts as well as his excessive use of discipline when dealing with the children.
374. UN ended her relationship with him in 2013. Police called Domestic Violence Crisis Service (DVCS) who assisted her with emergency accommodation. At that point UN said that she was concerned for JL and Bradyn, and that she was told by police that CYPS would be advised as it was a mandatory report.
375. UN said she spoke with CYPS but despite her attempts to ensure the safety of all of the children, CYPS told her that the case would be open for 30 days and then closed if no further concerns were raised.
376. UN had an arrangement with Graham Dillon in relation to her children visiting him every second weekend. However, she became growingly concerned for their safety when they were not with her. Her concerns were that he had weapons in the house, he was regularly using drugs, and he appeared to be more aggressive and erratic in his behaviour since the marriage ended.
377. UN obtained a DVO against Graham Dillon in late 2014 by consent and for a period of 24 months.
378. UN resumed contact with SK advising her of her concerns. SK advised that she was not receiving any support and, despite her best efforts, felt her concerns were being ignored.
379. In 2014, UN assisted SK at the Magistrates Court while she attempted to have a DVO removed or at least to have the children's names removed. Her concerns were dismissed by the court.

380. UN said that she was advised by the AFP that SK had taken the children. She said she had told the officer that if the children are with their mother then they are safe, they are not safe with their father. During the period that the children were with SK, UN noticed they became happier and more comfortable the longer they were with her.
381. After Graham Dillon was given the children back, UN decided to assist SK by getting some legal advice. Given she was not the biological mother of the children, she was told that information would have to come from SK. Despite that recommendation, UN contacted CYPs and told them what she knew about Graham's violent behaviour, his drug use, manipulation, intimidation, and her serious concerns for the safety of the children. She also told them that she had a DVO in place for herself and her children because of his violent behaviour.
382. UN indicated that when she told the worker this, the worker said words to the effect of "what do you and SK have to gain from this". UN indicated that she told her it was the safety of the children and nothing else. That worker advise UN that unless the children told them directly about the abuse there was nothing that she could do. The worker also advised her that a community service worker had said that he was of good behaviour and was a good father. UN commented that if something happened to those children it will be on your heads.
383. UN felt that she and SK were not being listened to. The last time she saw Bradyn and JL was at the court ordered hospital visitation with her and Graham Dillon's son who was being treated for pneumonia. UN observed the children to be withdrawn and they looked smaller than she last recalled them. Given it was cold they were fully clothed, and she was unable to see any bruising on them. She hugged and kissed them and told them that their mother loved them and missed them. They left with Graham Dillon soon after.
384. SK kept in contact with UN advising her that she had been continually trying to get the children back. She said she was clutching at straws as agencies kept advising her of one thing and another before passing her off with no actual assistance having been given. SK told her that the children would not speak about the abuse because of what happened in Victoria when they were given back to Graham despite the disclosures they had made.
385. UN said that SK contacted her and advised her that Graham Dillon had requested \$10,000 and that, if she gave him the money, he would give her the children back. The most she could get was \$2,000 and she advised Graham Dillon that he could have this. Graham Dillon said that would pay for a four-day visitation. UN saw the letter signed by Graham Dillon acknowledging he received the money from SK.
386. UN said she received a call from SK after that visit and that SK was very upset. It appeared that the children were bruised, JL had a cut lip, and SK was of the view that Graham Dillon had hurt them. She was concerned for their safety. She was not allowed at any stage to be by herself with the children during that visit.
387. UN had a call from SK on the birth of her child in January 2016. UN advised SK that the DVO Graham Dillon had sought against her would be finished. UN said that SK advised her that she had been to a few meetings and she was due to travel to Melbourne to attend court to obtain a court order to recover the children.

388. UN said that she received a call from SK telling her that Graham Dillon had murdered Bradyn and JL was in hospital.
389. SK arrived in Canberra on the 16th of February 2016 and went to the police station with UN. They were contacted by CYPS who said that JL wished to see her siblings, but they would not allow SK to visit her. The children attended with UN to visit JL and, at that point, JL was not aware that Bradyn had passed. CYPS reiterated that JL would not be informed of Bradyn's death unless a family member was present. No family member was present when CYPS informed JL that her brother had died, despite JL's mother, SK, being present in Canberra.

In Evidence before the Inquest⁶³

390. UN confirmed that she had three children to Graham Dillon, a boy born in October 2010, and twin girls born in 2012. UN confirmed that she provided a detailed statement of facts to the police in relation to the offences committed by Graham Dillon upon her. UN also confirmed that she was aware he was convicted and sentenced for those crimes.
391. UN confirmed that she first met Graham Dillon when she was 14 years of age and they commenced a sexual relationship soon after. At the time he was 28 years of age, although he told her that he was much younger. UN confirmed that the first year two of their relationship there was no significant violence., However, over time, she became isolated from her family and friends as Graham Dillon became very controlling and abusive to the point where he controlled what she wore and how short her skirts were.
392. Graham Dillon accused her of giving him a sexually transmitted disease. She had not done so as she had never been unfaithful.
393. Very soon after that he became physically violent, eventually hitting and smashing into her. The physical and verbal abuse began to occur daily. At one point, UN realised that Graham Dillon was still in a relationship with SK. She discovered this while she was pregnant. Shortly thereafter she had a miscarriage which affected her mental health. She subsequently attempted suicide.
394. Ultimately, she returned to Graham Dillon as he convinced her that he would behave in an appropriate way. He did so for a short period of time before he went back to his old ways. He choked her, threatened her, and refused to let her leave the house. On one occasion, when she was being choked, she fell unconscious and, when she awoke, Graham Dillon was threatening her with a big kitchen knife. UN begged for her life.
395. UN became pregnant and the violence did not stop. He continued to strangle her, throw her against walls, smack her across the face, and call her derogatory names. He threatened her family and friends. Those threats concerned getting bkie friends to carry out the threats, including that they would provide him with an alibi. On another occasion he said that he would slit her throat and watch her bleed.⁶⁴ UN believed that he was capable of carrying the threats out. Once UN told Graham Dillon that he was having a son, his controlling, abusive and manipulative behaviour increased significantly.

⁶³ Transcript p 182 – 241.

⁶⁴ Transcript p 188

396. During this time Graham Dillon was using marijuana and, quite possibly, given his erratic behaviour, other drugs as well. During that period, he was not on any medication for any mental health issues.
397. After the birth of their son, and while they were living in Queensland, Graham Dillon became aggressive and started to hit UN with a guitar. The guitar broke into pieces. Graham Dillon then proceeded to smash a rack across her body. He threw a knife at her which missed and stuck into the bedhead of the bed.⁶⁵ Graham Dillon then grabbed a metal coat hanger, opened it up, and wrapped it around her throat until she couldn't breathe. After this assault, UN wanted to see a counsellor and went to her GP's surgery. While she was there Graham Dillon came into the reception and became loud and aggressive because he thought she was seeing a doctor in relation to the child, not a counsellor.
398. UN described significant periods where Graham Dillon was extremely violent. She was isolated and could not leave because of his control over her. UN also knew that he would not let her take the child with her and that, if she tried to, he would kill her.
399. UN described a time when she and Graham Dillon were living in Canberra. He was meant to go get groceries and had gone out gambling instead. When he returned an argument occurred and he threw a knife at UN. It lodged in her leg. He refused her medical treatment and told her to put a Band-Aid on it. UN said she was too scared to tell her father what had happened. Graham Dillon had threatened that he would blow up her father's truck and get his bkie mates to beat him up. Graham Dillon had also threatened her mother in a similar manner as well.
400. UN found out she was having twins and she and Graham Dillon married in 2011. Once they had been married the frequency and significance of the beatings and violence increased and became more regular.
401. UN recalled that there had been at least two incidents where the AFP had attended the house. Once, a neighbour called and once when she contacted her sister who lived in a different state. UN said that she was not allowed her own phone and that she and Graham Dillon shared a phone. They shared all electronic platforms. UN said that at one point she grabbed the shared phone, raced to the toilet, locked herself in and sent a message to her sister asking her to call police because of the domestic violence. When Graham Dillon realised this, he smashed the toilet door in to get to her. He took the phone and threatened UN that there would be consequences if she had called the police.
402. On another occasion, when the twins were born, CYPS was contacted after one of the nurses saw Graham Dillon being rough with their male child. UN does not recall any follow-up from CYPS after this report.
403. During the time she was in hospital with the twins, there was an incident when Graham Dillon's brother NE and his partner came to visit. Graham Dillon assaulted UN while she was in hospital recovering from a caesarean section.
404. When she was discharged from hospital the violence started again.

⁶⁵ Transcript p 190

405. Around May 2013, BK came to visit. During that visit UN said that there were a number of incidents of violence including one occasion where Graham Dillon threw a knife at her while she was holding one of the girls in her arms. On another occasion Graham Dillon threw tongs at her. The tongs lodged in her hand. Another occasion he threw a packet of Seroquel at her and told her to take it and kill herself. On yet another occasion, he chased her with a knife outside and she ran down the road and hid behind a power box.⁶⁶
406. UN recalls meeting with SK in 2012 when she also met Bradyn and his sister. In 2013, Bradyn and his sister came to stay with UN when SK required time alone with her teenage daughter, who was having problems. UN said that it was for a visit rather than a permanent arrangement. As far as UN recalls, it was SK's decision for the children to live with them and she knew nothing of any involvement with Victorian Care and Protection in relation to the children.⁶⁷
407. UN also recalled that during the time that Bradyn and his sister were there, Graham Dillon continued with to be violent. Graham Dillon would always tell Bradyn and his sister to go to their room before he behaved violently. UN opined that this was because while the younger children could not say anything, the older children might.
408. On yet another occasion UN recalled that there was an incident when Bradyn and his sister were living with her when Graham Dillon slashed her little finger with a knife and threatened to slit her throat. He said that if she left him, he would make sure that she did not get the children as he would tell CYPs about her mental health issues and how she acted in the hospital. UN believed that if she left him, she would have to do so without the children as otherwise she would leave in a body bag.⁶⁸
409. UN stated that a couple of weeks after Bradyn and his sister came to visit, SK contacted her wanting the children to be returned to her as she missed them. Graham Dillon threatened SK and her partner and said that he would kill them if they attempted to come near the house.
- Graham Dillon then applied for a DVO against her stating that he feared for his life. The application included himself, all of the children, and UN. The Court advised him that as UN was over the age of 18, she had to apply for an order herself. UN refused to do so because she did not fear for her life because of SK. Graham Dillon was granted an order that included the five children.
410. UN said that SK's daughter BK had spoken to her mother. BK said that her mother was coming up to Canberra. UN said Graham Dillon was aware of this. An incident occurred and UN said she did not see anyone although she heard noises in the backyard. Police were called.
411. UN said that the children were scared of their mother because Graham Dillon had told them that she was on drugs, was a drug addict, and that she was not the same mummy she was before. Graham Dillon also told them that she was trying to take them back.

⁶⁶ Transcript p195

⁶⁷ Transcript p196

⁶⁸ Transcript p 197

It was UN's view that these comments altered the way they felt about their mother.⁶⁹ Despite this, Bradyn still told UN that he wanted to see his mother as he missed her.

412. UN stated that during this time Graham Dillon was very heavy-handed with the children and, in her view, he was not disciplining the children but was abusing them. UN stated he would often smack the children with kitchen utensils. She relayed a particular time when he slapped JL up to 10 times until UN stepped in and told him to stop. UN also gave examples of his cruelty to the children when they had slight misdemeanours such as not eating their dinner fast enough or not listening.⁷⁰ When Graham Dillon meted out this punishment, he would tell Bradyn that he was not allowed to cry, and that he had to suck it up.
413. UN described that when Graham Dillon became angry, or when he was in a bad mood, he would yell at the children, abuse them, and manipulate them. She would have to step in to redirect the abuse towards her to protect the children. She would be beaten by Graham Dillon as a result.⁷¹
414. Given that Bradyn really wanted to go back to see his mother an agreement was reached, and it was decided that Bradyn could go home. This did not occur as Graham Dillon manipulated Bradyn, telling him that he would miss JL as she didn't want to go. Graham Dillon asked Bradyn why he didn't love his father anymore. He also told Bradyn that he would not have food, nice clothes, or toys and that his mother was not the same. After that Bradyn no longer asked to go home to his mother.⁷²
415. During this period and towards the end of 2013 the violence perpetrated by Graham Dillon against UN continued. UN's mother was ill in Queensland and she went to spend time with her. At one point, UN travelled to Melbourne as it was her belief that SK had taken out a recovery order for the children as Graham Dillon had been served paperwork. UN then gave details about a court appearance and that there was discussion that if SK dropped her order, he would drop his and that they could then work things out for the children's sake. UN has since understood that it was a DVO that SK sought. Graham Dillon did not discontinue his order and it continued as, when SK did not appear in court, the court made a final order for 2 years.
416. UN was aware that after several incidents of domestic violence in the home a mandatory report was made to CYPS. The only conversation she had with Child Protection was that if there were no further complaints after 30 days the case would be dismissed as the children were no longer at risk, or something to that effect.⁷³ UN recalled that this was after she separated from Graham Dillon.
417. UN was unaware of a report made about Graham Dillon around the time that she separated from him, that said that he was particularly hard on Bradyn.

⁶⁹ Transcript p 199

⁷⁰ See transcript p 199

⁷¹ Transcript p 200

⁷² Transcript p 200

⁷³ Transcript p 202

418. UN agreed that there were several reports about Graham Dillon's violent behaviour which were investigated by a number of agencies including the AFP, CYPS, and the Domestic Violence Crisis Service.
419. After the separation, Bradyn and his sister stayed with UN and her children until 10 January 2014 when they moved to the Ainslie address. An arrangement was made between UN and Graham Dillon that he would have their three children at his place and that Bradyn and JL would then go to UN's place, so they all got to see each other.
420. During this period there were arguments. Graham Dillon threatened to take her children and said that he could get custody of them if he wished and have them full-time. Given his ability to manipulate and threaten, UN did not do anything about this threat as she was scared. During this time UN did not observe any signs of physical abuse on Bradyn or JL.
421. Even after UN left, Graham Dillon continued to be controlling, threatening and abusive, also at times asking UN to return to him. UN did not wish to return to the life she had of control, abuse, and misery.
422. UN described his behaviour following a weekend where he had the children, and she went out at night with some friends. When she attended to pick up the children, he threatened her with a brick, was extremely abusive and refused to hand the children over. Graham Dillon threatened UN with a gun that he said he had inside. He got in the car and pinned her against the centre console and threatened to strangle her.
423. UN managed to get away and rang the police telling them what had happened and advising that he had a gun inside the house. The Police told her that they couldn't do anything about that as they would need a subpoena to enter the house.⁷⁴ The Police also said that they could not retrieve the children. Eventually, Graham Dillon allowed her to retrieve the three children. UN applied for a DVO against him the next day.⁷⁵ Despite the order in place, Graham Dillon threatened UN with a knife at the Tuggeranong shopping precinct.
424. UN described a time when her son was ill in hospital with pneumonia. Graham Dillon told people that he was dying. He went to the court and stated that UN was refusing to allow him to see the child. UN had to leave her son in the hospital so that Graham Dillon could have a visitation with him. It was ultimately arranged that he have a 30-minute visitation with Bradyn and his sister.
425. That was the last time that UN saw Bradyn and JL.
426. In August 2014, UN attended the Magistrates Court in Canberra with SK so that UN could take SK off the order that was in place at the time. UN supported that all five children be taken off the order, including the premises where they lived. UN said that she had seen SK with the children, that she knew that SK was a good mother and that she deserved to have the children with her.
427. UN also spoke about her contact with police following Facebook posts by Graham Dillon where he posted photographs of bullets with comments on it. UN also describes

⁷⁴ I assume she meant a warrant to enter

⁷⁵ Exhibit C52

her contact with police telling them that Graham Dillon had been driving by her house and that he had breached the order in place.

428. It was her understanding that he had been cautioned for some of those breaches and that others were placed on the record. She said that she had been advised that unless Graham Dillon actually does something, the Police could not act on the breaches. It was her view that until he physically harmed her, or murdered her, there was nothing that could be done.⁷⁶ Court records show that while the DVO was made on 26 May 2014, the police had not served it until 31 May 2014.
429. UN said that she spoke to a constable in relation to the Facebook posts with the bullets, as well as other messages that included a hunting bow, and threats against her. She said she forwarded screenshots of those posts to that Constable. This was around 17 May 2015. Despite sending those to the police and providing them with information about his behaviour in the past, the police did nothing as they said they could not substantiate that it was his post.
430. UN said she was concerned for the children as Graham Dillon was becoming more erratic. Further, he had lost control of UN particularly in relation to her getting a DVO against him which stopped him from seeing his children. In her opinion, that contributed to his erratic behaviour. She had serious concerns for Bradyn and JL's safety as they were staying with Graham Dillon.
431. On 22 September 2014, both SK and UN attended court for SK to vary the order so that she could have the children. UN said she attended to support SK. Graham Dillon was there on that day. UN formed the view that SK was not listened to by the people that she was speaking to at the court. She felt that neither of them were listened to at all. UN thought that was unusual given that she also had a DVO out against Graham Dillon at the time.
432. After court, UN saw Graham Dillon abusing SK outside of court room. It was UN's understanding of the proceedings that the children had been taken off the DVO which had been in place. UN was also aware that in November 2014 SK took the children back to Shepparton with her.
433. In November 2014, UN was contacted by the police as Graham Dillon had told them that she had helped SK take the children. UN had not known that SK had taken them but told police that she believed the children would be safer in their mother's care.
434. UN said that she spoke with Child Protective Services in approximately January 2015 and voiced her concerns about Graham Dillon. UN said that she told the female on the phone that he was abusive, that he took drugs, and of her fears and concerns for the children. She said that they were not safe with him. UN also told them that she had a DVO against him, and he wasn't allowed to be near her or the three children that they shared together.
435. UN said that during the course of the conversation the woman she spoke to asked her what she had to gain from calling CYPS. It was UN's opinion that the woman thought UN was being vindictive because she was his ex-wife and that she was attempting to get back to Graham Dillon. UN said that she told this woman that she did not have

⁷⁶ Transcript p 214

anything to gain from reporting this material other than the safety of the children, which was her prime concern. The woman then told her that unless the children themselves voiced concerns about violence there was nothing that could be done. This woman also said that Graham Dillon had a support letter from someone. UN told the woman that if anything happened to the children it would be on CYPs's head.

436. UN said this conversation made her very angry as it was just another brick wall that she and SK encountered. She said that everyone thought that Graham Dillon was the victim. UN said

"I had gone through court and I had secured a DVO. I got my children safe. I wasn't used to seeing someone who was with someone that had such an extensive history of violence, whose ex-wife had a DVO against him, whose ex-wife he was no longer allowed near nor their children, I was not used to coming up to people that made me feel like I was in the wrong, that I wasn't being honest or truthful so, yes, I was angry".⁷⁷

437. UN indicated that she had help to navigate around the legal system, but unfortunately SK did not.

438. The note made about that phone call was put to UN and UN stated that she does not recall ever having a photo of Graham Dillon's drug use or that she would have been able to get it given she had not seen him for an extended period of time.⁷⁸ UN stated that she did not recall anyone asking her to provide evidence of photographs, although she did have screenshots of what she had talked about. UN said that she, in fact, did not recall CYPs asking her to do anything.⁷⁹

439. UN recalled that SK had discussed with her the incident where Graham Dillon asked her to produce a significant amount of money to get the children back. UN recalled that SK was able to raise \$2,000 and, for that, Graham Dillon allowed her to spend a day or two with the children.

440. UN said that SK contacted her, very distressed, telling her that the children had injuries, that they were skinny, and that she was not allowed to be alone with them. SK described that the children were like little soldiers, every time he came into the room they became still and stiff and SK knew that he was hurting her children. SK also, on occasion, rang UN distraught and overwhelmed as she had a feeling that something had happened to the children and that he was hurting them. UN said that SK said to her

"He's hurting them, I know he's hurting them, and nobody will help me".⁸⁰

441. UN said that when they were living in Beaudesert in Queensland, Graham Dillon went to Centrelink as he wanted to get a disability pension. In order to do so he was told that he must have a formal diagnosis. He attended a psychologist and UN observed his demeanour to instantly change prior to getting to the psychologist's office. She said:

"he had one session with said psychologist, his demeanour changed significantly from when we were leading up to the actual office to getting in there, he became very withdrawn, like holding his head down, like muttering to himself, told the psychologist that he couldn't do very much because of the schizophrenia and the - what was it, it was like a personality - I

⁷⁷ Transcript p 220

⁷⁸ Transcript p 221

⁷⁹ Ibid

⁸⁰ Transcript p 222

*don't know, some kind of personality suppression thing where he couldn't really socialise with people. And he told the psychologist that like he heard voices and stuff and they tell him to do things, like Google - like if you could Google what the symptoms for psychiatric disorders would be, he named them. Hearing voices, erratic behaviour, outbursts towards his family, his partner, how it wasn't fair on me because, you know, I shouldn't have to go through that and I have to be his voice everywhere we go because he can't really talk to people, he's not very all good at talking. The psychologist gave him his diagnosis of, 'Yes, I believe that this is potentially what you could have', and then he was subscribed Seroquel and then he went and got all of that and then went back to Centrelink with his letter from his psychologist and got his disability pension.'*⁸¹

442. UN said that she never saw any of that behaviour on an ongoing basis and that Graham Dillon said he had these conditions, as well as antisocial tendencies, so as to get the disability pension and other benefits.
443. In respect to the November 2014 statutory declaration, UN stated that it could have been possible that someone from Victorian CYPS asked her to write it on behalf of SK, but that she could not be sure who asked her. When asked by Counsel for Victoria DHHS about a phone call SK made to UN while SK was at Child Protection UN accepted that there may well have been such a call.
444. UN stated that she was aware of the Facebook message from 2010 and believed that was the only evidence that Graham Dillon would have had on SK. She said he would have relied on that as that was the only evidence he had against SK. That is why UN wrote the second statutory declaration putting that message into context.
445. Counsel for the ACT questioned UN in respect to the history of how she met Graham Dillon and the description of him being her 'knight shining armour'. UN described that she had already been living with domestic violence and alcoholism, so Graham Dillon appeared to be protective, in a way, by not allowing her stepfather to abuse her any longer. She said that at first, he was very kind and protective to her. She said that she was naïve and had no one else.
446. UN was asked questions in respect to Graham Dillon being violent and that he described himself as a bad guy. UN stated that he did portray himself as that but not to those that he loved. UN also stated that he told her that he had been violent to others and that he told her stories about it, though she was unsure as to its truth.
447. Ultimately his lies and stories became apparent, and UN gave the example of Graham Dillon going to the doctor to get a diagnosis of schizophrenia. UN agreed that Graham Dillon embellish the truth and lied. She agreed that he was extremely manipulative and was usually able to get what he wanted.
448. UN agreed that when she did try to seek some assistance from counsellors and the like. She said that when Graham Dillon found out he convinced her that seeking counselling or telling somebody would have a bad effect on her and she would lose her children. UN said that he threatened her and her family. For example, he threatened to gut her.⁸²
449. UN agreed that Graham Dillon's violent tendencies were able to be switched off instantaneously when it suited him. She said that his violent tendencies were generally

⁸¹ Transcript p 223

⁸² Transcript p 231

toward intimate relationships, women and children and occurred inside the home or in the car. She said that Graham Dillon determined where it was safe for him to behave in that violent way and when it was not safe to do so, such as in a hospital or a police station.

450. UN stated that Graham Dillon always blamed her for his behaviour. It was suggested to UN that Graham Dillon engineered the circumstances in a way to get UN to act on his behalf, for example, getting UN to call the police when SK had driven past the house. UN agreed and said that if she had known the true state of affairs, she would have jumped in own car, taken all of the children with her, and gone to another state.
451. Counsel asked her questions in relation to the period in 2013 when she divulged to police some information about the domestic violence she was suffering. When she returned home Graham Dillon was able to tell her 'word for word' what she told police. After that she did not disclose things to Police.
452. UN was shown a note from a Care and Protection worker about a visit they conducted in December 2013. UN agreed that she had said to them that Graham Dillon was in Sydney with the children and that they had decided to amicably end their relationship and remain friends. UN said that she did so to keep the peace. It was suggested that she had given a rose-coloured description to the worker. UN agreed with that description and suggested that this often occurs in domestic violence relationships.
453. UN agreed that she may have described Graham Dillon as 'not a good partner but a good father'. She said that statement was made just after she had left him in 2014. That was also prior to her advising anyone of the domestic violence she suffered and prior to her getting a DVO out against him.
454. It was suggested to UN that the reason Care and Protection was there was because of the domestic violence and the volatile relationship between the parties. UN stated that she believed that it was a mandatory report and Care and Protection got called out, and that the case stays open for 30 days unless there was another complaint.⁸³ UN also stated that the CYPS workers told her there was no concerns for the children whilst in her care.
455. UN agreed that a document shown to her, which stated that Graham Dillon helps where he can, and that he will regularly bring groceries and buy items, including petrol, was not accurate as he never paid petrol for her. Indeed, she paid for them to go to their father's and return when necessary. She said he did help where he could because he wanted to come home to the family.
456. UN stated that, at the point when she said those things about him, things were not at a state of serious concern. UN did not recall the conversation she had with Graham Dillon whilst the CYPS workers were in attendance but agreed that he may have asked her whether she needed anything and if she was okay.
457. UN also agreed that on 18 February 2014 a phone call was made to her from CYPS where they contacted her in respect to childcare. UN agreed she would have been extremely grateful for any help that had been given to her at that point. UN agreed that she may have been advised that the appraisal had been marked for closure but could

⁸³ Transcript p 236

not recall the conversation. UN also said that she would have been happy to have Child Protection Services offer assistance.

BK – Bradyn's Older Sister, Daughter of SK, Step-daughter of Graham Dillon

Record of Conversation

458. BK was Graham Dillon's stepdaughter, and her mother was SK. BK was a small child when SK and Graham Dillon were together. BK said that Graham Dillon was always extremely violent, and she had seen him abuse his mother to a point where she was black and blue and couldn't breathe. BK also advised that he had done the same to her and when he was punishing her he would use his fists not just smack her. BK recalled that Graham Dillon was always angry and when he was angry he would hit them for very little if any reason and then later on when he calmed down would come and apologise trying to assuage the situation, pretending that it didn't happen. BK recalled that he got to the point where they were so scared of him that they didn't tell anyone about it because they feared him coming back to hurt them more.
459. BK also recalled that he stole things particularly when they were in the caravan park in Queensland and made out that someone robbed them.
460. BK told Police that when she was living in Melbourne with her mother, she went through a very bad patch- stealing cars, smoking crack. This was when Graham Dillon was married to and living with UN in Canberra. SK decided to send the children, JL and Bradyn, up to stay with Graham Dillon in order for her to assist SK to get back on track. BK told Police that her mother did get her back on track.
461. BK also recalled one instance where she was in Canberra and saw Graham Dillon pick up one of the twins and throw her away like a toy doll. UN and Graham Dillon got into a fight and he picked her up, strangled her and threw her over the back of the couch. BK said she tried to get all of the children away from them and to the other end of the house. BK saw Graham Dillon throw a pair of tongs which stuck into UN's hand that she had up in defence. BK said she saw Graham Dillon chase her around the house, hit her in the head, punch her and beat her until she ran out the door and he then threw a kitchen knife at her (barely missing her).
462. After that BK asked her mother to go back to Melbourne with her and they were trying to get the children, JL and Bradyn back, but Graham Dillon refused and would not let SK see the children.
463. BK also recalled that at around Easter of one year she went up to see the children and Graham Dillon in Canberra. She said he looked like he had been abusing drugs because he had stolen goods everywhere and was abusive toward the children and being hard on them. The children had bruises on them, and BK told her mother that they had to get the children out of there. BK said she got a sleeping pill and told her mother to put it in Graham Dillon's drink. They pretended to go to sleep and then when he fell asleep BK suggested that they get out of the house as soon as possible. They packed clothes for JL and Bradyn and drove back to Shepparton.
464. BK recalls that the children were given back to Graham Dillon and that they were very upset when told they were going back to live with him. BK recalls that after that they

didn't have any contact with children until he made SK pay him \$2000.00 so that she could see the children.

465. BK recalls when they spoke to the children on the phone Graham Dillon was always there on the loudspeaker basically telling them what to say. In her view Graham Dillon was an evil monster.
466. BK recalls that when they were living in Tasmania, Graham Dillon got angry because she had the heater on and he blamed SK and beat her up, so BK called Police and Graham Dillon was arrested and went to jail for that beating. BK also recalled that when she was small Graham Dillon made her promise that she would never tell anyone what he had done to her.
467. BK describes Graham Dillon as the big person who had control of everything, and they were just defenceless against him.
468. BK identified that when the children were told they were to be returned to Graham Dillon they became hysterical. BK said that she and her mother had told them everything that he had done to them and they said *"he's a changed man people change. And then just handball them off to him"*.⁸⁴
469. BK suggested that when she took the children back to Shepparton, they were very skinny and looked miserable and they were afraid of Graham Dillon.
470. When BK arrived and spoke with JL after Bradyn's death and she asked JL what had happened and whether her father had done it she said JL told her, *"daddy, daddy didn't do nothing unless we deserve it"*, however since his death and after much time she was now slowly talking about what actually did happen.

JL – Bradyn's Sister, Daughter of SK, and Graham Dillon

Record of Interview

471. When police spoke with JL, she told Police a story about what happened to Bradyn that was not dissimilar from that which Graham Dillon had told Police in his interview. Particularly, when she was asked about how she got her black eyes, she said she did not know she just woke up with them.
472. At first, she appeared to not be able to tell Police how she got the injuries she had sustained. Demonstrably (given the horrendous injuries she suffered) that was significant. Throughout her narrative she was clearly protecting her father. After a while, she did at least explain as to how some of the wounds and bruises were inflicted by her father. Even then she minimised his involvement.

NE – Younger Brother of Graham Dillon

Statement

473. NE is a younger brother of Graham Dillon. NE lost contact with his brother for many years but contacted him in 2012. When he came to visit, he observed Graham Dillon

⁸⁴ record of interview – question 242

to be very volatile and saw him abuse a person working in a butcher shop at a shopping complex in Banks.

474. NE also observed Graham Dillon behaving in a controlling manner towards his wife UN. He would also speak to her very angrily, swearing at her. After that time NE kept in contact with his brother and his partner became friends with UN.
475. When UN gave birth to the twins, NE and his partner visited them at the hospital. Whilst visiting her NE went in the bathroom and NE said he heard Graham Dillon in the bathroom swearing at UN calling her 'a fucking dog' and then heard two or three, what he said sounded like 'hard slaps' and then heard UN crying.
476. When they returned home NE asked Graham Dillon what was going on and he said, "I taught her a lesson". After that NE and his partner left and did not contact Graham Dillon again. A few months after that visit he received a phone call from Graham Dillon telling him "*I am going to run through your house cunt and beat the living shit out of you*". NE said, "*my door's open man*" and Graham Dillon hung up.
477. Sometime later Graham Dillon and UN and the children visited NE in Coffs Harbour and that is the very first time he met JL and Bradyn. NE noted that Graham did not treat JL and Bradyn very well, in his view. He noted that if JL or Bradyn did anything wrong, Graham Dillon yelled and swore at them and slapped them around the upper legs.
478. NE became aware that Graham Dillon had separated from UN when Graham Dillon asked him for money to feed the kids. NE sent him \$150.00. Later, Graham Dillon would ring and abuse NE and then after calming down would ask for more money.
479. NE said that he would ring Graham Dillon every second night to speak with both children because he wanted to ensure they were safe and alright.
480. During these phone calls the phone would be on speaker and NE observed that when the children said that everything was all right, they appeared to have been coached to say that by their father.
481. Graham Dillon rang him in order to advise him that SK had drugged him and kidnapped the children. NE contacted Shepparton Police and told them that they should not return the children to Graham.
482. SK contacted NE and he spoke with both children. He observed that both children appeared happy. NE advised SK that he had spoken to the Shepparton Police and told them that the children should not go back to Graham.
483. The next day Graham Dillon rang him and told him that he was on his way back from Shepparton with the children. After that NE sent Graham Dillon some money and occasionally spoke to him.
484. NE came to Canberra with some friends and his children and partner. He arranged to meet with Graham Dillon at the Woden shopping centre with JL and Bradyn. When he saw the children, they came up to him and gave him a cuddle. NE observed that they were skinny, and that Bradyn had a black eye.

485. When NE asked Graham Dillon what had happened, he pulled Bradyn close to him and said, “tell Uncle Mick what happened to your eye”. Bradyn said that he had fallen over, however NE observed that Bradyn appeared scared when he said so.
486. NE offered to buy the kids a milkshake and hotdog. Graham Dillon said, “you don’t got to feed the kids and they don’t deserve a treat”. NE said, “I’m their uncle and I am allowed to”. They then sat at Doughnut King to eat the food. NE heard Graham Dillon whispering to Bradyn “when you finish eating you can go into the shop and steal daddy some Oakey Sunnies”.
487. NE then pretended not to hear what Graham Dillon had said and told Graham Dillon that he had to leave, he gave the children a kiss and left. When his friend came to meet him he told her what happened, and she advised him to ring Child Protection and the Police.
488. NE said he phoned Child Protection and spoke to someone who informed him to phone the Police. It was about 4 PM in the afternoon and he spoke to Police and told them what he had heard and that the children concerned him.
489. He hung around for a while waiting for Police, they didn’t come, and he then saw Graham Dillon walking with a new pair of white sunglasses on his head. NE said, “that’s right I am reporting you mate” and Graham Dillon said, “fuck off you dog your no sort of uncle”. He then got in his car and drove away with his wheel spinning really fast.
490. At approximately 04:00 hours the next morning he received death threats via text from Graham Dillon stating, “I’m going to fucking kill that dog partner of yours Sheena and your fucking kids and you’re a dead man when I get hold of you”. He then went on to express that he knew where his brother was staying. NE sent him a text message warning him to not threaten his family. His phone was rung constantly by Graham Dillon and at approximately 14:00 hours he answered the phone and Graham Dillon said, “I’m coming for you cunt I have a gun here and I’ll get you before you leave Canberra”.
491. NE hung up without saying anything to Graham. NE was aware that the Christmas prior, Graham Dillon had put on a Facebook page photos of bullets saying that they were for UN and her new partner.
492. On 25 December 2015, NE rang Graham Dillon and asked if he could speak to JL and Bradyn. Graham Dillon said, “it’s your uncle you have one minute”. NE said, “Merry Christmas I love you guys”, and Bradyn and JL replied “Merry Christmas, love you”. NE then told them he was coming down for a visit, JL sounded excited and then the phone was hung up. That was the last time he spoke with the children.

Neighbours, Friends and Associates of Graham Dillon

Overview

493. I received several statements from Graham Dillon’s neighbours in Jacka. Many said they had heard yelling and screaming coming from the house. Some indicated they had seen the children and then had not seen the children for some time. One neighbour saw JL crying, curled in a foetal position but when she went to see if she was okay Bradyn puffed his chest out as if to protect his sister. The neighbour then continued walking back to her home and did not inquire any further.

494. Another neighbour said that he heard yelling and screaming and heard the noise of a slap as if someone was being hit but did nothing about it and went home.
495. One particularly close neighbour made contact with Graham Dillon and the children and noted that the children were very polite and that when she spoke to Graham, he was excited to have the children in his care.
496. The particular neighbour said that she had a strange sense about the children but was not really concerned for their safety. The neighbour noted that the children did not appear to be going to school and that they had been acting in a very unusual way.
497. That neighbour said that she heard arguing and also heard Graham Dillon yelling "*leave me the fuck alone*". She also heard Graham Dillon telling the children to clean up their room.
498. In late 2015 she had not seen either JL or Bradyn coming to or from school and she did not see them playing at the front of their house. Their house was very quiet, and this was a change in habit. The neighbour spoke with a work colleague about that because she was concerned in relation to the children, but ultimately felt that she should respect their privacy and did nothing.
499. Three weeks prior to Bradyn's death the neighbour saw JL on the footpath drawing with chalk. She was singing to herself and the neighbour expressed delight that she was outside. However, within moments Bradyn came outside and said something to her in a hostile tone. A short time later she heard glass smash and JL ran back inside the house. The neighbour cleaned up the mess but did not hear anything else from the house and she then went back to her home.
500. The next thing she heard in relation to the family next door was the ambulance and the Police arrive and seeing Graham Dillon handcuffed in front of his home.

TH – Close Neighbour of Graham Dillon

Statement

501. TH was a neighbour of Graham Dillon. He and Graham Dillon became friendly, and he knew that Graham Dillon had two children, JL and Bradyn, living with him. TH observed that JL and Bradyn were always polite and quiet and both of them were very skinny.
502. TH recalls that only after a few weeks of knowing Graham Dillon he showed him a single barrelled shotgun which had been cut down and Graham Dillon told him that he was taking it to Sydney that night.
503. He told him that the kids' mother was dead and had died of cancer. When he asked the children whether they missed their mother they would say yes. Graham Dillon told him that when the kids' mother had died his father had bought him the house to raise the children in.
504. TH considered that Graham Dillon was very hard on the children and would often have a go at them for not washing the car properly or not eating all of their dinner. Graham Dillon would get very angry with the children, typically Bradyn, although both children would get into trouble for even the smallest slight.

505. TH recalls that on one occasion in 2015, he saw Bradyn with a massive black eye. When asked what happened Bradyn told him that JL had hit him with a golf club. TH spoke with his partner about this, and they concluded that it was likely that Graham Dillon was hitting the children. TH noted that often Graham Dillon would tell the children to go to other rooms in the house, away from where he was.
506. TH was aware that Graham Dillon was smoking ice and was also scared of him because he was associated with bikies and had spent time in jail for hacking someone with a hammer. After hearing the stories and seeing the gun and the way he would behave he didn't want anything to come back on his family, so he did nothing.
507. TH moved out of the area but still received messages from Graham Dillon asking him if he wished to buy clothing or shoes. He had not seen JL or Bradyn for about nine months.
508. He received a Facebook message from a friend on 16 February 2016 asking him if he had heard what his mate had done. TH said when he heard it his heart skipped a beat.

SQ – Friend of Graham Dillon

Statement

509. SQ was married to Graham Dillon's ex-wife's cousin and got to know Graham Dillon. After Graham Dillon broke up with UN, SQ became more friendly with him. SQ assisted Graham Dillon with money when he moved into Ainslie and also provided him with a fan for the house.
510. SQ would visit them every couple of weeks as he had a child, and his child would play with the children. Graham Dillon had informed him that he had schizophrenia and if he did not take his medication, he would go crazy and he felt like he would hurt somebody.
511. SQ often got phone calls from Graham Dillon where he was agitated after him seeing a girl called XJ, who lived next door and who was on ice. During those phone calls he would threaten to kill XJ because she stole from him.
512. SQ assisted Graham Dillon in moving to his house in Jacka. SQ would visit him every few weeks and at first, said he was doing well. SQ was aware that the children were going to ACT Primary School 2.
513. After six months of living at Jacka, SQ noted that the house became cluttered with lots of items. Graham Dillon advised that he purchased the items and then sold them for profit on gumtree. He tried to sell SQ goods, but he didn't purchase anything from him.
514. SQ observed the children to be in good spirits although very quiet and they were always well behaved. During the last six months prior to Bradyn's death SQ said that he would see the children less and less and recalls only seeing them twice during that period.
515. During those last months when he visited the Jacka house, Graham Dillon would tell him that the children were either at their Nan and Pops in Victoria, or at a friend's place. SQ observed the house becoming more and more cluttered with items Graham Dillon had for sale.
516. In early January 2016, SQ tried to contact Graham Dillon on a number of occasions and was unable to contact him. In early February 2016 he went to the house in Jacka

with his son. He observed that the place had become overgrown and SQ had concerns for Graham Dillon's welfare. SQ knocked on the door and as no one answered, he was about to leave when Graham Dillon answered the door.

517. SQ asked if the children could play with his son and Graham Dillon told him that the children were not at home. Later he spoke with a friend who advised him that he thought Graham Dillon was losing it as he seemed angry with everybody. SQ told his friend that he appeared okay when he saw him last.

518. SQ tried to call Graham Dillon on a number of occasions for the next week (most likely every day), however, was unable to get in touch with him. SQ was in Newcastle when he was rung by a friend who advised of the murder. SQ said he was in disbelief that Graham Dillon could do such a thing.

TS - Friend of Graham Dillon

Statement

519. TS and her partner met Graham Dillon toward the end of 2008. Her impression of him was that he portrayed himself as 'the bad boy' telling her that he had schizophrenia and that he had spent time in jail. Graham Dillon also told her that he had kidnapped a judge. She thought this was a wives tail.

520. Not long after she met Graham Dillon she observed that his relationship with his partner UN was fairly normal, however, they did have problems and on one occasion he came down to see her and told her that he had just hit UN with a hammer. Graham Dillon also said that he had shoved Seroquel down her throat. When TS suggested she go and check on UN, Graham Dillon said that the Police would be there. TS suggested that she take the child as he appeared very scared. TS looked after him for a while until Graham Dillon returned and when he did, he appeared calm, so she gave him the child.

521. TS also had an experience when UN asked her to give Graham Dillon Seroquel tablets if he became upset and aggressive. TS said she did give him on two occasions that drug and he seemed to calm down after 15 to 20 minutes.

522. When Graham Dillon moved into the Jacka home he would drive to see them in Gowrie, often bringing the children with him. On one occasion when driving with Graham Dillon he received a phone call from a girl called XJ. Graham Dillon became very aggressive and was driving erratically- punching the steering wheel and the like. TS took the phone from him and told XJ to "fuck off". She then tried to calm Graham Dillon down. TS kept hold of the phone, but Graham Dillon advised her that he knew she had the phone and he looked cranky, so she gave a back.

523. On another occasion they were driving in the car when Graham Dillon was out the front of her house screaming that he was going to burn the house down.

524. On another occasion, toward the end of 2015, Graham Dillon drove to their home in Gowrie and when she asked where the children were, he said they were in the car and were not allowed to come inside as they were in trouble. TS approached the car which was parked in the driveway and was about to open the door when Graham Dillon yelled at her to get away from the car as the kids were in trouble.

525. TS looked inside the car and saw that Bradyn had a whopper of a black eye which was swollen and looked painful. When TS asked Bradyn what had happened, he looked down to try and hide his face. Graham Dillon became angry, so she left the kids and went inside. TS asked Graham Dillon what happened, and he said that Bradyn had fallen off his bike. TS took the view that that was a load of rubbish and that the next time she had the opportunity she would ask Bradyn what really happened.
526. Two weeks later TS took the opportunity to visit Graham Dillon with her partner and another friend at Jacka. When she arrived she asked Graham Dillon where the children were. He said they were in their rooms as they were in trouble. When TS asked whether she could speak to them just briefly he said no they were in trouble.
527. When they were leaving it was dark and Graham Dillon called the children out of the house. Ms Robson said she could see that they had their heads down. They got into Graham's car and she went over to look at them and saw that both children had bruises to their faces, they looked like deep bruises. Bradyn had two black eyes and JL had one big bruise across the right side of her face. TS said she would talk to them later.
528. After discussing these observations with her partner and her friend, ultimately she did nothing about what she had seen. On 13 February 2016 she, with a friend, drove to Graham's house because the friend wanted to purchase a phone. When she asked about the children, Graham Dillon told her that she could not see the children as they had been in trouble. Graham Dillon also said that he was organising for the children to live with their grandparents. TS said she did not see the children as Graham Dillon said they were in their room and he would not let her speak to them.
529. On 15 February 2016 they were advised that Graham Dillon had murdered his son and badly injured his daughter.

BT - Friend of Graham Dillon

Statement

530. BT was an acquaintance of Graham Dillon and as of 2016 had known him for approximately four years. Around September 2015 she contacted Graham Dillon and they arranged to meet at his house. When BT arrived she noted that the house was in good order and the lawns were mowed and there was no excess clutter. About a month prior to December 2015 Graham Dillon called her about some items he had for sale. She went over to have a look at them and when she did, she observed that the lawns were overrun, and the house was quite cluttered. At this time she did not see the children.
531. On 26 November 2015 BT arranged to go to Graham Dillon's place to buy some things. It was between 12:30 PM to 2:30 PM in the afternoon and at no time did she see his children at the home, however, she had heard them while she was talking on the phone to him on a number of occasions.
532. On all the occasions when she went to Graham Dillon's home, she did not see the children until the beginning of February 2016 when he invited her to say hello to them. She saw both of them in his bedroom. BT did not observe any injuries on the face or head of JL, but her body was otherwise covered with a blanket. Bradyn was also under the covers of the blanket and she could only see his head and she did not observe any

injuries on him either. Graham Dillon continued to speak to her in respect to the selling of the goods that he had for sale.

533. On 15 February 2016 he had sent her a number of text messages and phone calls in the early hours of the morning. She received a call from him at 4 pm that day. Graham Dillon had advised her that Bradyn was unconscious and making funny gurgling sounds. Graham Dillon denied hitting Bradyn, then said he didn't hit him hard and that he and JL has been stealing stuff a lot lately, that they had tried to kill him, and he had caught Bradyn stealing from him that night and again this morning. He said that Bradyn was trying to take stuff from his wallet, so he gave him a clip on the ear, asking Bradyn what he was doing and said he then gave him a backhander to the chest.

534. Graham Dillon said Bradyn stumbled back but didn't pass out but sat on the lounge instead. Graham Dillon thought Bradyn was playing silly games and ignored him. Bradyn laid down and closed his eyes and that was it. She then heard a child's voice in the background saying that Graham Dillon hadn't done anything wrong.

535. BT suggested that she could get a lift to come over once she had a sitter arranged. Graham Dillon said, "yeah that would be good, I don't know what to do, I swear I didn't hit him that hard, he didn't pass out, not down, if you can't get out don't stress".

536. BT said that Graham Dillon then spoke to her and she advised that she hadn't been able to get a lift or organise a sitter as yet and suggested that he call the ambulance or an after-hours Doctor service. BT said that Graham Dillon said:

"ahm, don't stress about it if you can't, I just didn't know who was to call because I didn't want CPS involved after everything the kids have been through, honestly I don't beat my kids, I just really don't know what to do and then he said "you can even asked [JL], she will tell you, I didn't hit him hard, I didn't hit him hard isn't that right [JL]" BT said she heard a girl's voice in the background say and "yeah you didn't dad" and then Graham Dillon said "and he didn't get knocked out did he [JL]" and BT heard a female child's voice say "no dad".⁸⁵

537. Graham Dillon then said:

"I've been giving him water, I've taken his clothes off because he felt hot, and I've been giving him sips of water, it just sounds like he's got something on his chest"; BT asked whether he could wake him up or is he responding and Graham Dillon said "no, he is not answering but it's like he knows I'm in the room, will give a little grunt, I'm just really scared"⁸⁶

538. BT advised that she try to get over there as soon as she could, and Graham Dillon said "I'm going to try and get money off this cunt that owes me money so I can go get him some ice blocks or something"; BT advised that she would call him as soon as she heard anything.

539. BT then made some enquiries by online searching for concussion and children with head trauma and the like.

540. About half an hour later Graham Dillon called her back and told her that he had some money, that he was going to Woolies to get some water ice blocks because it seems like he may wake up soon, saying:

⁸⁵ Paragraphs 51 – 56 Statement of BT

⁸⁶ Ibid paragraphs 57-59

“because it seems like he may wake up soon because he stopped the gurgling, he had a bit of a cough and stopped the gurgling, so it must have just been something on his chest”;

541. BT inquired as to whether Bradyn had woken up at all and Graham Dillon advised that he had slightly opened his eyes when he had asked whether he was okay, and he gave a little noise.

542. BT then asked further questions about Bradyn’s response as she had made some enquiries on the Internet and Graham Dillon said:

“no, he hasn’t woken up, but he didn’t get knocked out, honestly after I tapped him, he stumbles back and sat down on the lounge, staring into space for a bit, laid down on the lounge went to sleep, didn’t he [JL]”

543. BT said she heard a little girl say, “yeah dad”.

544. Sometime later Graham Dillon called back and said:

“okay, I think he is doing much better, [JL] is in sitting with him at the moment, I’ve been checking on him like every five minutes, he still not making that noise and his eyes are slightly opening. I think he knows that [JL] is with him, it seems like he is doing better”.

545. Graham Dillon then said when asked whether he had answered any question or fully opened his eyes:

“no he just seems a lot better, I checked his chest because I know the sound of punctured lung, sound the chest makes when you can punctured lung, like a hollow sound when you tap on the chest, I know this because when I used to play football, it doesn’t sound like that’s the case, his chest sounds normal, the gurgling has stop and hasn’t come back for. I really need to get their ice blocks for when he wakes up.”

546. Graham Dillon then said:

“I think they hate me just things have been doing, I mean they’re tried to kill me, they keep stealing, I just don’t know how to handle it”.

547. BT said that she had contacted a number of places to get some advice. All of them wanted to know the child’s name and details which she did not have but they did advise that Graham Dillon should call them back.

548. At 9:45 PM BT texted Graham Dillon because she had not heard from him. The following morning, she saw an article in the ACT policing Facebook page stating that Graham Dillon had killed his son.

DT - Neighbour of Graham Dillon

Statement

549. DT was a neighbour of Graham Dillon’s at Jacka. DT got to know Graham Dillon as a result of Graham Dillon helping him with his daughter’s pushbike and DT helping Graham Dillon with his motor-vehicle as DT was a mechanic.

550. Graham Dillon would often come over late at night to speak with DT as DT often worked on his vehicle late at night. He observed that Graham Dillon appeared sedated at times. He knew this through his experience as a mental health support worker.

551. Graham Dillon told him that he had schizophrenia and he was fine providing he took his medication. Sometime in January Graham Dillon had given him some money to

service his vehicle for a trip away, but then took it back the next day saying that he would be taking the train instead. Two or three days after that, Graham Dillon came to his house and said that he was supposed to be going away camping, but he slept in and missed the train. DT said he heard JL telling Graham Dillon off because they had missed the train and wrecked their holiday. DT said he was across the street from her and could see JL clearly and she appeared fine, and he did not observe any injuries on her.

552. In early February 2016, DT said he saw Bradyn and JL playing out the front of their house. JL was using chalk on the footpath and Bradyn was using a Nerf gun. He recalled that JL was wearing a little skirt and a singlet top, and Bradyn was wearing shorts and a singlet top. He did not see any injuries on the children, nor did he ever recall seeing injuries on the children.

553. Two or three days later JL came over to his home and asked for some cigarettes for her dad. At that time, he did not observe any injuries on her, and she had a summer dress on at the time. After that time, he only ever saw JL twice and she was blocked from his view on both occasions.

554. On 15 February 2016 he observed Graham Dillon riding his pushbike along Bitterman Street at around 6.30 in the evening. Graham Dillon waved at him. The next thing he knew was his wife woke him up and told him that something bad happened. DT heard sirens in the distance. Both DT and his wife went outside and saw ambulances and Police cars arrive. His wife then went over to see JL who was sitting in a Police vehicle.

SX - Acquaintance of Graham Dillon

Statement

555. SX was an acquaintance of Graham Dillon and his girlfriend XJ.

556. SX provided a statement giving some detail about the relationship between XJ and Graham Dillon. It was clear that Graham Dillon was abusive to XJ and had threatened to kill her and had threatened to burn down SX's home.

557. SX had dealings with Graham Dillon in relation to purchasing items that he had for sale.

558. On 15 February 2016 at approximately 3.30 to 3:45 PM he knocked on her door. He spoke about his relationship with XJ but said he was there to sell an Xbox 360.

559. SX purchased it for \$80.

560. He also spoke about a Nerf gun and wanted it for Bradyn. Graham Dillon was there approximately 20 to 25 minutes talking to her about the Nerf gun,

561. XJ did not speak about the children.

CI - Friend and Flatmate of Graham Dillon

Statement

562. CI met Graham Dillon in late August 2014. In April 2015 CI needed a place to stay and he moved in with Graham Dillon and the children. After shortly moving in CI observed that Graham Dillon had a very short fuse and would get angry very easily.

563. CI said that Graham Dillon would tell him he was involved with “heavy people who were involved in the drug ice”. CI also noticed that Graham Dillon would bring items into the house such as shoes, sunglasses mobile phones and household goods.
564. CI did not know where he got these items from as he never had any money and would often hit him up for money. CI assumed this was a result of Dillon dealing drugs although he never saw him do so.
565. CI said that Graham Dillon had told him about the kidnapping incident and that he had full custody of the children and that their mother was not a fit person.
566. CI observed that on an occasion when he moved clothing items in a cupboard, he observed syringes in the cupboard. When questioned, Graham Dillon said that they were from his ex-partner.
567. Over time CI noted that Graham Dillon was not coping with being a father to the children. CI recalled the time when he had to put the children to bed after cooking the evening meal and then had to get them ready and drop them to school because Graham Dillon was not around to do so. He thought this odd.
568. CI also noted from that time on Graham Dillon was very tough on the children. CI confronted Graham Dillon about it which made Graham Dillon calm down a bit. CI made the observation that the children were fearful of their father and obeyed him instantaneously.
569. CI also noted that the children on occasion did not attend school. CI also recalls instances where Graham Dillon was trying to control him, and it made him uncomfortable. From that time forward he decided to move out.
570. CI said that at the end of January 2016 he went back to the house to get the last of his property and despite having access to the property wanted Graham Dillon to be there when he did. Graham Dillon was not at home and CI decided to wait till he came home to get his property.
571. CI found out through a friend that Graham Dillon had killed Bradyn. CI rang Police to advise them that he had been living there.

Canberra Fathers and Children Services (CanFaCS)

BP – CanFaCS Worker

Statement⁸⁷

572. BP provided a statement dated 17 July 2019 and gave evidence before me. BP was employed as a family worker with the Canberra Fathers and Children’s Services. His role was to assist single fathers with their families, to end their homelessness and engage them into community services.
573. The focus of a function of his work included outreach support such as obtaining housing, financial planning, parenting skills and community engagement. CanFaCS supported short-term crisis accommodation.

⁸⁷ Transcript pp 248 - 324

574. BP had a two-day induction and attended training courses with other community organisations. BP did not have any tertiary qualifications.
575. BP described his role as a family worker simply put, he helps families create routines such as the kids going to school, to more complex issues such as dealing with addiction, financial hardship, mental health issues and obtaining long-term housing. On average BP would have 18 to 20 families to work with at any given time.
576. BP's first contact with Graham Dillon and his children was in early 2014 when they attended his office in Mitchell. Graham Dillon was looking for accommodation for himself and the children. Dillon indicated they had nowhere to stay that night and they managed to get them into 'dad's place' and assisted them with clothing and food. When BP took over as case worker for the Dillon family they had already been allocated crisis housing in Ainslie.
577. Graham Dillon advised BP that he was a sole parent with two dependent children, he was unemployed, and he was homeless.
578. Graham Dillon advised that he was on medication for schizophrenia, that he was open about his condition, the medication he took and indicated the importance of maintaining the regime. Graham Dillon also advised BP that he was having trouble with the children's mother and that Graham Dillon had been granted custody of the children by the Child Protection agency from Victoria. Graham Dillon also advised BP that the mother had abducted the children and he had them returned to him. Dillon also advised that the children's mother is a drug user and was a danger to the children and that he had gone through all the correct avenues to have custody of his children.
579. Graham Dillon often spoke about his past to BP indicating he was sexually abused in foster care, moved around a lot as a child, and that he had turned his life around. Graham Dillon also claimed to be a stand over person who would at one-point set fire to the rear of your house and stand at the front with the bat to stop escape. Graham Dillon told him this to indicate how he had changed, and he appeared to be seeking praise and acknowledgement as to how far he had come. He was very polished in the delivery of his stories and he appeared to be the poster child for our organisation.⁸⁸
580. BP described Graham Dillon as very charismatic and praised the children and showered affection upon them whilst he was there. Graham Dillon also advised that he had done numerous parenting classes and that he wanted to work for Mary Mead and help other fathers better themselves.
581. BP indicated that Graham Dillon appeared to be an experienced service user and knew what to ask for and did so in respect to support services. He often complained and vented after he had argued with teachers, the doctors, CYPS or his partner.
582. It was BP's view that Graham Dillon seemed aware of what angered him and what his triggers were and was also aware of warning signs such as breathing heavy and that his ears got hot.⁸⁹ It appeared to BP that Graham Dillon was very proactive in managing relationships in the community where he lived. He mowed other residents' lawns, walked their dogs, and offered to cook meals for them in order to make friends. BP visited him often and saw him preparing meals as he was an experienced cook. On

⁸⁸ statement – paragraph 15

⁸⁹ Statement paragraph 21

one occasion, he recalled that Graham Dillon was preparing a roast dinner to share with the family next door. He offered to help teach other fathers how to cook.

583. BP indicated that he thought that he was far too open with information sharing with the children and expected a lot from them emotionally. Graham Dillon advised that he had kept the children home from school because he was feeling sad.
584. BP had a conversation with Graham Dillon about not keeping the children home from school when NL and KE from CYPS were present. BP was advised that CYPS were investigating a claim that Bradyn had turned up to school with bruises. Graham Dillon advised CYPS that they had been play wrestling and he accidentally hit his head on the lounge at a point where it was less padded. Graham Dillon advised them that Bradyn was a boy who always played rough. When Graham Dillon was advised that he should not play so roughly with his children he became agitated and said “you don’t know where I have come from”
585. Following the return of the children from Victoria after SK had removed them, Graham Dillon was given a brand-new home in Jacka. Once Dillon had been given this new house CanFaCS started to scale back their input and contact with him. This would have taken 3 to 6 weeks, although Graham Dillon took longer because he required further assistance.
586. BP advised that once the Dillon family were in their new home, they were secure in the home, the children were at school and they were immersed in the community, then the CYPS case was finalised. The last face-to-face involvement BP had with the Dillon family was on 17 February 2015.
587. BP advised that the day of the visit to the house on 17 February the house was clean, and the children were playing in the garage riding their bikes. BP had no concerns for the family.
588. BP advised that during his involvement with the family he never saw anything that gave him concern in relation to the safety of children with their father as he presented as a model father.
589. BP stated that when he heard of the death of Bradyn it affected him immensely. He said that he now pays attention to detail and although he believed he had a good radar when it came to trusting people, Graham Dillon convinced him that he was a good father and that as a result he had no concerns.

In Evidence before the Inquest⁹⁰

590. BP said that he was employed by CanFaCS between 2012 and October 2016. His role comprised of being a family worker and solving housing issues for single fathers and their children. This also involved assisting with children’s schooling, outreach programs and he also became the occupancy manager for the houses in the program.⁹¹
591. BP explained that the housing stock was for medium-term accommodation for those fathers in need of assistance.

⁹⁰ Transcript p 248

⁹¹ Transcript p 249

592. BP stated that he had two days induction training and also attended risk community programs and training modules. These programs and modules occurred throughout his time at the Organisation, and he would attend at least every couple of months.
593. BP suggested that examples of the programs were things such as cultural awareness, DV alert through Lifeline and some mental health first aid and such like programs. These were in person, course oriented, not online.
594. BP did not receive any training for mandatory reporting however had done so in his previous work. BP was, at the time he worked for CanFaCS, aware of his obligations in relation to mandatory reporting.
595. BP suggested that he was an advocate for his client but also provided information to organisations as required.
596. BP agreed that he had met Graham Dillon and the children in early 2014 and had met them first in December 2013. The 2013 meeting was after Graham Dillon and the children attended the officers of CanFaCS seeking assistance.
597. BP became their worker when they were given a house. The specialist homeless information platform (SHIP) was a platform used to make notes when contact was made with clients.
598. BP was given a verbal handover in relation to the family from a colleague. BP at that point had not read the notes. BP was taken to a particular note where the referral from SHIP was located. Where it indicated that Graham Dillon had full custody of JL, and Bradyn and it was a voluntary arrangement with his current wife.
599. BP confirmed that all of the notes were in electronic form and he was able to look at the file including documents which were provided.⁹² It was BP's practice to read the historical information on the file.
600. BP gave an account of the information Graham Dillon gave to him in respect to his situation. Graham Dillon told him that at the time he became homeless he was living in the ACT with his wife and three children. BP also advised that Victorian Child Protection had removed Bradyn and JL from their mother and asked if he would have full-time care of them.⁹³
601. BP said that Graham Dillon told him that they had been left alone in the house for a few days, were experiencing neglect and exposure to domestic violence and drug use. As a result of that Victorian Child Protection had asked Graham Dillon to take the children.
602. BP confirmed that that was the same story he told the first caseworker on 17 December 2013. That was his belief that the children had been placed with Graham Dillon.
603. BP confirmed that that sort of information is generally confirmed and was done so by Centrelink statements which would have the children's names on it. There was no other confirmation sought by BP.
604. Generally, when clients are given assistance there would be between three and six months of assistance prior to being housed and then three months following housing.

⁹² Transcript p 253

⁹³ Transcript p 253

That was done to ensure that the clients had referrals to community supports and the like. At the end of that time, they would step away.⁹⁴ That also applied to the Dillon family, although they did require somewhat more time than the usual. BP was the family worker from 2014 to April 2015.

605. BP described the children as “incredible kids”, he described them as being animated and heightened in a funny way. BP described that when he came into the house and saw that Graham Dillon appeared flat, that is he was not having a good day, he was crying, and the kids would act sheepish around him. They did not appear to be their usual cheery selves.

606. BP formed the view that it was the children, particularly JL, who appeared to need to cheer him up when he was down. He formed the view also that it was JL who “kind of managed everything on the home front”.⁹⁵

607. BP described discussing with Graham Dillon coping strategies because of his emotions and feelings of being flat and low. BP stated that he would go to see the family at the home on average once per week. A number of these were random.

608. BP described times when he visited Graham Dillon and saw the children would be home from school. They were kept home because Graham Dillon was upset and wanted the children with him. The children even gave information to BP that

*“Daddy's depressed', you know. You know, 'He doesn't want to live anymore. He's feeling really dark today’”.*⁹⁶

609. BP said that he advised Graham Dillon that he should not share so much with the children. BP said that Graham Dillon told him that he had changed his behaviour in this regard. Despite this, BP observed that he was continuing to behave in the same way. When BP suggested that he had a plan to deal with this issue, Graham Dillon told him that his psychologist was booked out, and it was suggested to him he should go on a waitlist.

610. BP also assisted Graham Dillon in filling out documentation for ACT housing. BP agreed that he also assisted Graham Dillon by attending appointments with him. Some of those appointments included assisting with groceries at the food co-op et cetera. BP stated he never attended any medical appointments or school attendance. However, he did attend when Care and Protection came to the house because they asked him to be there.

611. In relation to accommodation, the Organisation provided support letters on behalf of the clients. The information in the support letters came from the client and the information that they could verify.

612. The information that BP gave ACT Housing was a Mary Mead letter of support, DVO against the children’s mother, AFP incident number, identification Centrelink income statement which showed he had 100% care of the two children.

⁹⁴ Transcript p 256

⁹⁵ Transcript p 258

⁹⁶ Transcript p 260

613. When asked in respect to the more complete information in the SHIP system, BP was unsure as to where it came from. It was explained that it could have been anyone of the workers or interns who would take turns at writing the notes.
614. BP was unable to say where he found out that Graham Dillon was awarded full-time custody of JL and Bradyn and made the decision to move them to Canberra. Given that the Centrelink paperwork would not have that information on it, BP agreed that he interpreted that it 100% meant that.
615. BP also confirmed that the story he got in relation to the attempted kidnap by JL and Bradyn's biological mother and the information that there was a second attempt of a home invasion was from Graham Dillon. BP agreed that he had placed in his letter to the housing that the reports were given to police, and incident numbers and reports had been written in respect to those attempts.
616. BP said that all of this material was confirmed, with documentation provided by Graham Dillon. BP agreed that the information given would be on the system.⁹⁷
617. BP confirmed that he still worked for CanFaCS, at the time of Bradyn's death. BP agreed that all information held by the Organisation was provided to police. When BP looked at the material there were no such documents provided by the Organisation of that nature.
618. BP confirmed that the letter sent to housing was signed by him and included information that Victorian care and protection had been contacted. In the letter BP also referred to providing the family with three months outreach once permanent accommodation is given. The letter also held the contents
- "Abandonment of the children when in Melbourne. Mother's care confirmed by Victorian Police."⁹⁸*
619. BP confirmed that Graham Dillon had told him about his past and that up until about eight years prior to him coming to Canberra he was a bad guy. A horrible man who wasn't scared of much. BP formed the view that he was proud of this. Graham Dillon also told him that he had changed and had not committed crimes for seven years because he had become a father.
620. BP confirmed that Graham Dillon told him that he had once threatened a magistrate, he would set fire to a house and stand out the front with the bat, that he was a hard man. Graham Dillon also told him that he had changed and was not like that anymore.
621. BP recalls Graham Dillon calling him about a visit from his wife's boyfriend who he felt belittled him and that he had received threats of violence. One of the factors that Graham Dillon talked about was that he would turn into the person he used to be and that he was losing it and, on the edge, and that scared him. BP advised Graham Dillon on strategies to de-escalate the mood.
622. It never occurred to BP that the children were in danger when Graham Dillon described these feelings to him. At a home visit on 29 April 2014 BP stated that Graham Dillon was praised by him because he was able to keep his emotions in check.

⁹⁷ Transcript p 264

⁹⁸ Transcript p 265

623. In respect to another incident where Graham Dillon had a violent outburst toward his ex-neighbour, BP said Graham Dillon had his neighbour's little girl over and was cooking for the children when the neighbour's daughter told him that her father had his partner over and they were both using drugs.
624. BP said that Graham Dillon told him that he went to see the man and threatened that he would bash his head in if he saw him using drugs again or the partner at the home.
625. BP confirmed that on 4 August 2014 Graham Dillon phoned him telling him he had received a visit from CYPS. He also told BP that he had been reported for child abuse and drug dealing. BP visited Graham Dillon's home in the morning after the phone call.
626. In the notes, he wrote he referred to CYPS wanting to speak with a family worker regarding the family and their situation. There was also a note in respect to a CYPS worker contacting the Organisation asking if there were any concerns in respect to the family. The note also reflected that NL, the CYPS worker, was happy to close the report after discussions with BP about Graham Dillon's proactive attitudes, involvement in regular outreach and home visits, and that the identified needs were being addressed. BP advised that he would be happy to have contact with CYPS if any concerns were raised.
627. BP was unable to say whether he had also vocalised his concerns in respect to the anger, emotions, and threats of violence that he had been made aware of from the 28 April and 11 June conversations. BP advised that he would generally do so
628. In respect to a phone call BP made to Graham Dillon about an outreach appointment he said that Graham Dillon was upset because CYPS were at the school for children due to another report about a mark on Bradyn's ear. Graham Dillon told BP that he was struggling to keep himself in control.
629. BP recalls that Bradyn was taken to CARHU and that Graham Dillon was in a very heightened state. BP said that he attended Graham Dillon's residence. A note reflecting that visit included the following;
- "By this stage, Graham Dillon had escalated to a stage where he was unable to control his anger and told the COS workers this. He had threatened the life of one of the workers. The worker called the police for her own safety". "The police and COS explained to Graham Dillon that the children were going to be transported to the hospital. They offered to bring Graham Dillon along, but he said he couldn't promise that he would not harm someone touching his child'. In that conversation is it correct to say that Graham Dillon told you that he had - was unable to control his anger, had threatened the life of one of the COS workers and said that he could not go to the hospital because he could not promise that he would not harm another person?"*⁹⁹
630. Despite circumstances of the concerns in relation to Graham Dillon's aggressive behaviour BP stated that he still did not have any concerns in respect to the children. It was his view that Graham Dillon loved the children and would hurt anyone who hurt them. BP stated that he could not even fathom that Graham Dillon would ever harm his children.
631. BP noted that he had asked CYPS for financial assistance with counselling as well as activities for the children 'due to the trauma brought on again by the reports'.

⁹⁹ Transcript p 273

Apparently CYPS had been asked for this previously and they had not assisted in this way.

632. BP was taken to a report he wrote concerning a phone call by Graham Dillon on 1 September stating that he was worried about Bradyn's mental health ever since the CYPS visit to the school. Graham Dillon was disappointed that the primary school (**ACT Primary School 1**) had made a report which resulted in more trauma for himself and the children.

633. As a result of that phone call BP emailed CYPS caseworker NL stating that

"I have pretty large concerns for the ongoing welfare of this family should they be put through anymore short notice check-ups"

634. BP said he contacted CYPS because it had really upset the children and they did not want to return to school.¹⁰⁰ It was BP's view that these things could have been handled at home. BP recorded a phone conversation he had with CYPS worker who explained to him that this was now the fourth report on the family for facial marking which is why they were compelled to act. BP said that he did not know this fact.

635. I note that when questioned about whether this raised a red flag with him given he thought there was only one incident, he said it did not. When it was suggested to him that Graham Dillon may have been moving the children to a new school to avoid another school knowing about the alleged abuse, BP said he didn't actually think about that.

636. BP was taken to another entry where he made reference to Graham Dillon speaking with him and telling him that he has decided to take the children out of there school and enrolled in another school. BP later then reported to the CYPS worker this fact.

637. BP was also taken to an email reply informing that the case would be closed, after they had spoken with Graham Dillon they all agreed it would be great for the family to have a fresh start.

638. Graham Dillon also advised that he was going to leave the ACT and stay with his stepsister at Wyong. NL advised Graham Dillon that the medical assessment was all good and that there were no concerns reported.

639. BP was taken to an entry made by his brother regarding an incident that occurred at Graham Dillon's house where Graham Dillon told him that he punched the brother of his ex-wife and that his unconscious body was placed in an SUV and that he fled the property. It was noted that Graham Dillon had spoken with police and CYPS about the incident. This incident occurred when the children were at home. BP could not recall whether he had contacted CYPS in relation to this violent event, however he also expressed that that would be a serious flag in relation to the children witnessing this event.

640. BP stated that that information that Graham Dillon had spoken to the AFP regarding to the incident was written by his brother and he knew this because it was included in the handover from his brother. However, BP did not verify with police that Graham Dillon

¹⁰⁰ Transcript p 276

had actually spoken with them in regard to this incident. Nor it appears, did he confirm that through any other independent source.¹⁰¹

641. BP was taken to a note regarding the enrolment of the children in a school and noted that there was nothing in respect to the event (punching the brother of his ex-wife) which occurred the previous week. BP could not explain why that was the case, but he thought he would have shared that information.
642. BP stated that Graham Dillon had rung him on the morning the children were taken interstate saying that the children were gone, and he did not know where they were. He also said that SK had drugged him. BP said that he went to see Graham Dillon at his home and then dropped him at the Magistrate's Court. He received a call from Graham Dillon to say it was the Family Court, so he dropped him at the Family Court.
643. BP stated that they assisted Graham Dillon to get to Victoria to sort out the problem which arose. BP confirmed that he received a phone call from one of the case workers, CO.
644. It was also confirmed that he was made aware of the extremely violent history relating to Graham Dillon. BP said that was just history. BP gave the reason that because of the positive attributes he related to Graham Dillon and the family and his efforts to change that it was horrible, but history.
645. BP also said the following:
- "I remember mentioning all the - like all of their - the Canberra CYPS workers who been involved with this family and I said, 'I'm happy to give you all their phone numbers and emails and you guys can discuss whatever it is that you have to do' because like obviously I'm just an outreach worker in a homelessness service so it's like I can't speak to any of that stuff".*
646. BP stated that he did not share with CO the violence involving Graham Dillon in April, June, and September. This was despite CO advising him of the extreme level of violence perpetrated by Graham Dillon. BP stated that was because the worker launched into Graham Dillon and it was not an amicable conversation.
647. BP could not recall whether he was aware that there was a DVO out against Graham Dillon by his ex-wife. BP asked CO whether she had heard the story from both sides and when questioned whether he had heard both sides he said it was mostly from Graham Dillon although he had once spoken to Graham Dillon's ex-wife.¹⁰² BP agreed that he was taking on the role of advocate on behalf of Graham Dillon. BP also agreed that he had spoken with CO and told her that CYPS had been involved with the family twice and had close the case as CYPS had no concerns.
648. BP spoke with FL the solicitor tasked with representing Graham Dillon in Victoria. BP stated that he had a chat with her in respect to Graham Dillon. BP was unaware whether he sent a letter to FL and thought it was only a conversation over the phone.
649. When Graham Dillon returned to Canberra with the children CanFaCS assisted them in getting priority accommodation. BP assisted in getting that priority because of the abduction which sped up their accommodation request. They were accommodated in a brand-new home in Jacka.

¹⁰¹ Transcript p 296

¹⁰² Transcript p 283

650. In relation to the letter that he sent to FL (although he has no actual knowledge of doing so), he stated that he did not advise FL of the emotional outbursts and volatile and violent incidents in Graham Dillon's recent history.
651. BP received an email from PG requesting information about whether there were any concerns in respect to the children's safety. BP believed he would have replied to her email but said he did not relay concerns referred to by CO from Victoria about the children's safety to PG who was now taking over from NL at CYPS.
652. The formal safety plan says that CanFaCS will remain involved with the family for at least the next three months and that BP would check to ensure the children went to school. The safety plan also included the Bungee Program by Belconnen community service, it was also recorded that BP would check to make sure of attendance.
653. BP said that after Bradyn died CanFaCS focused more on domestic violence training rather than just homelessness and the training now reflected how to handle domestic violence situations and what to look for. That training was not available to BP prior to Bradyn's death. BP did have training in relation to violence and the impact on families prior to Bradyn's death as he was a residential youth worker for some years.
654. BP stated that the last involvement with the family was when he visited their home on the 17th of February 2015, a year before Bradyn's death. BP noted the children had uniforms for school, the house was clean and tidy, and he had no concerns for the family.
655. In respect to seeking any independent information about the family, BP said that the only person he got his information from was Graham Dillon. BP agreed that when raising issues about disagreement was his ex-wife, Graham Dillon portrayed himself as a victim every time.¹⁰³
656. BP said that he did not make any external enquiries about whether Graham Dillon was in fact the perpetrator of the abuse in the relationship. He said in hindsight given the only discussion he had with the ex-wife was that she was happy for Graham Dillon to have the house because she was now safe, and he wasn't in her house.
657. Graham Dillon was required to provide CanFaCS with certain information, including whether there was family violence, a current DVO or AVO, bullying, issues of self-harm or suicidal ideation. Graham Dillon stated that over a decade ago there was domestic violence in relation to Bradyn and JL's mother, but he had successfully completed an anger management program. This program was where he met his current wife. He said that there is a restraining order out on Bradyn and JL's mother. BP did not make any further enquiries as to the veracity of Graham Dillon's assertions.¹⁰⁴
658. BP stated that CYPS did not give him any of this information either and in his view it would have been very helpful if CYPS had given him information. BP was also unaware of the psychological issues and mental instability allegedly reported on Graham Dillon. This information was available to ACT housing, yet BP was not aware of it and considered that it would have been very helpful to have known these things.¹⁰⁵

¹⁰³ Transcript p 300

¹⁰⁴ Transcript p 301

¹⁰⁵ See pp185 and following Exhibit C. page 301 Transcript

659. BP was also not aware of Graham Dillon's significant history of drug use. BP advised that that would have been very important to know.
660. In respect to specific family violence training, as of November 2014 BP had not had any training. While BP was aware that given he worked for a homeless father's organisation and that majority of his clients were homeless as a result of domestic violence and that domestic violence was generally perpetrated by males. BP agreed that he was working with potential perpetrators because of those facts.
661. At the time, BP was not aware that intimate partner violence can include children, although he stated he is now aware through training.
662. BP was aware that he was working with someone who had perpetrated family violence. Even though it was in relation to Bradyn's mother, he noted it was some 10 years ago.
663. It was suggested to BP that there is a training manual from Victoria which outlines the issues identified in domestic violence, which workers in fields involving perpetrators should be advised of. BP was not aware of those issues such as self-entitlement, denial, and underreporting of violence at the time. However, he stated that he is now aware of them.
664. BP was also not aware that any information provided by perpetrator should be verified by another source, including the partner or children. BP stated that because CanFaCS is a voluntary service they had limited ability to be able to ask for such material.
665. BP was aware that it was not wise to take a perpetrator's statement about his parenting or his relationship with his children at face value. BP stated that he took Graham Dillon's ability to look after the children at face value as he saw they appeared to be happy, and he thought that Graham Dillon was an '*amazing dad*'.¹⁰⁶
666. BP accepted that Graham Dillon did display a number of the attributes outlined in the circle of violence, and that he wasn't aware that he should have been concerned.
667. BP was asked whether he regarded Graham Dillon as a perpetrator of family violence and he said he had said that but that it was previous behaviour from 10 years before.

Child at Risk Health Unit (CARHU)

Doctor OQ – Paediatrician at the CARHU, The Canberra Hospital

Statement

668. OQ gave two statements outlining the assessments she made of Bradyn Dillon. OQ outlined the examination, took photographs, and spoke with FQ, who was supposedly a family friend.
669. OQ advised that FQ was extremely obstructive and interrupted the assessment.
670. OQ was satisfied with the explanation given by both Bradyn and JL as to how some of the injuries were sustained. However, she concluded that there was some bruising of concern. This was noted in her report.

¹⁰⁶ Transcript p 307

671. OQ stated that when there is a concern, or if there is insufficient evidence she will mark the assessment as incomplete and require that the child comes back for further assessment in a few weeks' time.

In Evidence before the Inquest

672. OQ was a paediatrician at The Canberra Hospital. OQ examine Bradyn Dillon on 28 August 2014. OQ was briefed by a CYPS caseworker, as well as an Intake Worker, at the CARHU. The information reported on the document was less than what is usually provided in terms of information.

673. OQ received information about the bruising but was not given any other information in relation to neglect or any other concern. In fact, there was very little in the way of information on the 5 pages of the referral document. OQ was shown page 2054 of the subpoenaed documents, and in response she stated that is just the usual amount of information that is given to the Department.

674. OQ confirmed that JL was present as was a family friend, FQ, as well as NL. OQ confirmed that FQ spoke on behalf of Bradyn, interjected, interrupted, and was frustrating the assessment process. FQ was speaking to her partner during the consultation and trying to get OQ to speak to the partner. OQ confirm she was able to complete the assessment despite FQ's behaviour. OQ stated that she had not experienced a person behaving in the way FQ behaved before or after that assessment.¹⁰⁷

675. OQ stated that Bradyn appeared reluctant to speak and was quiet. She stated that usually when children are quiet, or blank she tends to pursue them and give them an opportunity to say something. She stated that "*I think silence says a lot as well*".¹⁰⁸ In OQ's opinion silence tells her something has happened, or that the child is too scared to say anything.¹⁰⁹

676. OQ noted that JL was also present, and she was answering questions for Bradyn and was quite convincing. She stated that usually children who may be experiencing similar things are quiet also.¹¹⁰

677. OQ confirmed the comments she made in her report stating that the bruises were as a result of blunt trauma, some of which are partially explained and others, such as a bruise on his left cheek, left ear and red marks on his arms were of concern. That was the conclusion she reached after examining him. Her conclusion was because of injuries suffered to the cheek, ear, upper arms, upper thighs, buttocks, back and abdomen are areas likely to be nonaccidental.¹¹¹

678. OQ confirmed that she would now not describe this as 'areas of concern'. She stated that reports are written generally for non-medical persons and the idea is to provide explanations that they can understand. What she meant by 'areas of concern', meant

¹⁰⁷ Transcript of Proceedings, p 341

¹⁰⁸ Ibid

¹⁰⁹ Ibid

¹¹⁰ Ibid 341

¹¹¹ Ibid 343

that there was an expectation that they would be investigated further, and that the child needs to be on '*their radar*'.¹¹²

679. OQ said that she explained to NL that there were areas of concern and indicated that some of the areas where the bruising was unexplained. OQ also stated that FQ's behaviour was obstructive which also concerned her, and NL agreed.¹¹³
680. OQ said that the issue of previous reports was raised in the referral but because that was hearsay she wanted to get information directly from the caseworker and she did not get that information.
681. OQ said that generally doctors wish to have a whole picture view of the child, including education development, immunisation history, birth history and where he lived among other things. At the time there was no background information provided by CYPS, including about Bradyn's education and home life.¹¹⁴
682. OQ also stated that she received no further information from CYPS prior to her providing her report.
683. OQ stated that had she been provided with the information that the children had been observed with bruises between June and August that would have been very significant and would have magnified the issue.¹¹⁵
684. OQ was not aware that the teacher had reported that Bradyn had marks on his face resembling finger marks, that he freezes up when he thinks is in trouble, and that he often shuts down and won't speak, that he appears jumpy in class especially when the teacher raises her voice.
685. The teachers reported that Bradyn needs lots of reassurance and was always checking to make sure he was not in trouble and whether he has been a good boy.¹¹⁶ OQ opined that that appears to be a child who is traumatised, and she was not provided with that information.
686. Similarly, regarding the information about the disclosures of abuse, such as Graham Dillon hitting them in the face and head and kicking them with the boot on was also information that would have been useful and valuable and should have been included in the report. This information had all the hallmarks of abuse and family violence.¹¹⁷
687. OQ opined that previous reports of bruising would have been significant, and it raises a question as to why those instances were not referred to CARHU.¹¹⁸
688. Similarly, all reports in relation to the prior bruising to both children, as well as the history of domestic violence with two ex-partners would also been of assistance to OQ in completing the report.¹¹⁹

¹¹² Ibid 343

¹¹³ Ibid 344

¹¹⁴ Transcript of Proceedings, p 344

¹¹⁵ Ibid 345

¹¹⁶ Ibid.

¹¹⁷ Ibid.

¹¹⁸ Ibid 346

¹¹⁹ Ibid 347

689. OQ opined, and agreed with her Director, that a National Database of Children at Risk would be very useful tool as it would be useful in raising alarm bells particularly when children live in various areas.
690. OQ understood that Bradyn was invisible for quite a period of time and that it is necessary to prevent children becoming invisible.
691. OQ suggested that the schools have a system of being able to keep track of children and where they may be. OQ also stated that it is a community effort and therefore everyone needs to notice children.¹²⁰
692. OQ further stated that it is important to get a balanced view of the entirety of the information. However, observation is also important and despite being well-groomed and well-dressed, you can still be hit and abused, and whilst there may not be physical neglect there certainly could be physical abuse. OQ said if you're seeing a bruise or fracture or scratches that are in unusual places, *'you can't make that any rosier than what its is'*.¹²¹
693. OQ accepted that had there been patent bruising or cigarette burns or significant bruises marks abrasions that would clearly be abuse which would not be reported as of concern.¹²²
694. OQ was asked about her comments that if she had all of the information it would have allowed her to make a more powerful report. Counsel for the Territory suggested to OQ that having received additional information including about the opinion of the GP that the children saw, there were potential 'positive' factors that could have increased the 'grey area' for her in making her report. OQ stated that she thinks that in this case, with all the things that have been raised they negatives *'outweighs the good stuff quite significantly'*.¹²³
695. OQ advise that there has now been some formalisation of forms, so that the provision of information is improved. This involves ongoing discussion with Police, FaCS in New South Wales and CYPS in the ACT, and other different services as well.
696. There is also the process of making a preliminary view, with a follow-up consultation sometime later. That will keep the patient on CAHRU's radar.¹²⁴

Education Witnesses

NI – Executive Group Manager, School Improvement, ACT Education Directorate

Statement

697. NI set out the requirements that children over the age of six and under the age of 17 must attend school unless there is a reasonable excuse for them not to do so according to the legislation.

¹²⁰ Ibid 349

¹²¹ Transcript of Proceedings, p 353

¹²² Ibid 354

¹²³ Ibid 355.

¹²⁴ Ibid 357 – 358

698. NI also advised that Principals are required to monitor attendance of students enrolled at their schools. It is a requirement that the children attend daily, and a recording of their attendance is maintained. Any unexplained non-attendance should be followed up with letters.
699. It is a requirement that parents ensure their children attend school, parents may be prosecuted if their children do not. However, NI advised that in the ACT *“it is intentionally a facilitative approach designed to engage the cooperation of families”* and taking a compliance action would be a last resort.¹²⁵
700. NI referred to a letter from the Deputy Principal of ACT Primary School 2 to Graham Dillon in August 2015. This letter noted that the children were to be enrolled from that school and were going to Wyong. It is apparent that this never happened, and the children were not enrolled in any school in the ACT. NI referred to the Glanfield Inquiry in respect to this particular issue. NI advised that there have been amendments to the Education Act to give the Director-General the ability to provide certain information to other states in respect to enrolment and attendance of children particular those who are of concern.
701. It would appear that cases such as Bradyn’s where the school had prior engagement with CYPS and there was an un-enrolment midterm they would comply with one of the recommendations to confirm attendance at the interstate school to minimise risk to students. There is also an embedded education officer within CYPS who can act proactively as a conduit between organisations particular the connecting with schools and other Education Directorate staff as required.

In Evidence at the Inquest¹²⁶

702. NI was, at the time of giving evidence, Executive Group Manager for School Improvement. This role provides oversight of ACT public schools.
703. NI was able to assist by providing evidence in respect to school attendance. In the period of 2014/2015 attendance records were largely a paper-based system. Attendances would then be taken to the school administration officer to enter into the database. NI indicated that now there is an electronic system and implementation began in 2018.¹²⁷
704. NI stated that this system will eventually be fully automated in a central repository. During the period when the paper attendance record was utilised, the teacher would mark off attendances and that would then be sent to the administration office.
705. Any non-attendance was managed by the classroom teacher initially, and then escalated to the executive. There was a threshold which, when reached, would lead to the matter being escalated to the executive or the Principal being informed by the teacher of the non-attendance. The threshold was currently seven days, which did not have to be sequential. The threshold is set out in the current guidelines.
706. The current guidelines set out that the action to be taken is that a letter is sent to the parents. If there is no change in the behaviour it will be further escalated with a follow-

¹²⁵ statement paragraph 12

¹²⁶ Transcript pp 359 - 377

¹²⁷ Ibid 360

up with the Network Student Engagement Team. A similar program would have been available in 2014 – 2015.

707. NI agreed that the upscaling of resources was implemented as a consequence of the Glanfield Inquiry.¹²⁸

708. NI stated that at the time Bradyn's father enrolled him, when the school was notified by a parent that a student was to be un-enrolled, the school took the parent's word at face value.¹²⁹

709. NI stated that now the Education Directorate deals with un-enrolment of children in a different way. NI stated

"if a child is un-enrolled now, we – through the implementation of the new school's administration system we actually have a greater oversight of when that occurs and we also have a better understanding of the risk profile attached to the individual students, and that is also being strengthened in terms of the oversight of that information as well. That previously wasn't in existence".¹³⁰

710. NI stated that if the schools have concerns in relation to the child they will contact the Network Student Engagement Team. This allows much greater visibility of students who might be at risk and who have had non-attendance issues.¹³¹

711. NI stated that there is now a system which can identify unenrolled students, and if there is a risk profile on the students, that information will then be passed through to CYPS through the Liaison Officer.¹³² Currently, this system is not fully automated however the process of automation is currently ongoing.

712. NI stated that if the child leaves one school to go to another in the ACT the information travels with the student in the public system. In 2014/15 that was a manual process. In 2014/2015 the process was that the new school who accepts the student will then requests the file from the old school.¹³³

713. NI stated there is also a student transfer register, which is used to track student movement between all schools, both public and private.¹³⁴

714. In relation to interstate transfers, if a parent unenrolled their child stating they are moving to another jurisdiction, that information would still be placed on the file and that would be the end of any action by The Directorate.¹³⁵

715. NI confirmed that, following the passage of the amendments to the Education Act, there were a number of updated policies and procedures. NI agreed that cross-border information sharing relies on the goodwill of the parents to give accurate information as to the attendance of their children.¹³⁶

¹²⁸ Ibid 364

¹²⁹ Ibid 364.20

¹³⁰ Ibid

¹³¹ Transcript of Proceedings, p 365

¹³² Ibid

¹³³ Ibid 366

¹³⁴ Ibid

¹³⁵ Ibid 367

¹³⁶ Ibid 367

716. With the introduction of the new system, The Directorate is looking at the risk profile of children and through the use of a CYPS liaison officer, concern can be followed up. The system is designed to ensure that children do not fall under the radar. Strengthening the policy, practice, and procedures is part of the next phase of improvements to the system. The intention of the system is to focus on those who have a risk profile.
717. NI stated that absences are an indicator of concern and that they are taken very seriously. If there are concerns, CYPS would be engaged. That could be done through the Education Officer embedded with CYPS.¹³⁷ There are also the mandatory reporting obligations which sit outside that process.
718. However, where follow-up is required, the Network Student Engagement Team would provide support. If required, the team would also consult with the Education Officer embedded with CYPS. With the new central database, the Engagement Team would be aware of the non-attendances and offer support where required, rather than a request/reactive oriented application of the system.
719. NI was asked about the absences recorded in relation to Bradyn in term one of 2014. NI stated that the 13 non-attendances would automatically signal a flag to follow-up with correspondence and gain further explanation as to why the children had not attended. This would occur automatically, and information would be sent to the Executive and Principal of the school as well as the Education Directorate.¹³⁸
720. NI stated that where the threshold of absences has been crossed and the school has not followed up, there would be a response from The Directorate to the Principal notifying them of the requirements to follow-up the non-attendance. NI stated that this process is a work in progress, in his view it would be another 12 months until the system was fully automatic and operational.
721. NI agreed that if the move of a child is interjurisdictional it is commonplace for the receiving school to make contact with the previous school and ask about the student and their achievements. However, that requires the consent of the parents and the student as there is no formal arrangement. NI stated that generally this is what happens. However, the previous school may not be surprised if they do not hear anything from the new school.¹³⁹
722. NI opined that it is a grey area, and it depends on the school, as some reach out and some don't. NI stated that it appears to be an issue of privacy.
723. NI opined:
- “that greater information sharing nationally at a common-sense level would be a very worthwhile thing, however, at the moment our legislation allows the Director-General to ask for enrolment confirmation only and no more”.¹⁴⁰
724. Presently the Director-General may be able to ask for confirmation of enrolment.

¹³⁷ Ibid 369

¹³⁸ Transcript of Proceedings, p 370

¹³⁹ Ibid 372.30

¹⁴⁰ Ibid 373.12

725. Regarding the amendments to the Education Act in 2019, NI agreed that the amendments provide the power to share information with other jurisdictions, providing the threshold is met. There is also a threshold test for the Director to consider that consent is not required if there is a concern about the best interests of the children.¹⁴¹
726. NI confirmed that following the Glanfield Inquiry there is a greater level of analysis at the corporate level, not just at the classroom level. There are early intervention with support services from the Education Directorate, as well as an Education Liaison Officer who is to liaise directly with CYPS and the Education Directorate.
727. NI confirmed that there is also information-sharing available between Directorates when considered to be in the best interests of the children.

SL – Deputy Principal of ACT Primary School 1

Statement

728. SL is a Deputy Principal at ACT Primary School 1. She is an experienced teacher. In February 2014, Bradyn and JL were enrolled at ACT Primary School 1. Bradyn had previously been enrolled at a Victorian Primary School, but SL did not receive any reports or other documentation noting any concerns from that school.
729. When they attended at school Bradyn and JL were always well dressed, well-presented, and generally well behaved. They always arrived with lunches.
730. Over the course of 2014, SL became seriously concerned in relation Bradyn's welfare. Her concerns stemmed from haphazard attendance, and, on occasions, visible bruising to Bradyn's face. This was also true of JL, however, the bruising to Bradyn was prominent and regular. The reasons provided for the non-attendance were varied and unusual.
731. SL recalled an incident where Bradyn had taken a five dollar note from his teacher's desk. Graham Dillon was informed and seemed to be calm and well presented during the conversation.
732. On 17 June 2014, SL made a report to CYPS in relation to bruising she noticed on Bradyn. She noted he was very reluctant to say how he got the bruising before later stating that he had been play wrestling with his father. Later that day she received an email from CYPS advising that, given there was no disclosure, no action would be taken.
733. SL also received a letter from CYPS advising that the case would not go to an appraisal.
734. SL contacted CYPS Intake Officers and asked whether there had been any prior reports for Bradyn and JL. She was told that prior reports were in relation to domestic violence and not specifically to the children's welfare.
735. On 2 July 2014, SL made a further report in respect to bruising on JL and her absence from school on 1 July 2014. CYPS again advised that they would not be proceeding to an appraisal. This was despite mounting concerns raised by SL.

¹⁴¹ Ibid 375

736. On 28 July 2014, another report was made to CYPS by SL again in relation to, bruises on both JL and Bradyn. LC from CYPS spoke to the Principal of ACT Primary School 1 in relation to JL's report. LC suggested that more evidence other than bruises was required and that she would raise the matter with her supervisor.
737. By this time of the school year in late July 2014. The children's teachers and SL were purposefully vigilant about checking on JL and Bradyn's welfare, making a point to check on them every morning.
738. On 28 August 2014, a further report was made to CYPS in relation to bruising and discolouration to Bradyn's nose, cheek, and ear. Bradyn could not recall how he hurt his ear but said he that he hurt his nose when he hit it on the couch while play fighting with his father. SL was very concerned about the bruising and demanded CYPS to come to the school to look at Bradyn.
739. CYPS asked that the school keep either the children there, or Graham Dillon and the children there, until they arrived. This was concerning to the school as the children were to be collected at 3 PM. It meant that staff confidentiality related to mandatory reporting would be compromised. SL expressed those concerns to CYPS.
740. CYPS also asked SL to take photos of the injuries. SL refused and said that it was not her role to investigate matters.
741. CYPS arrived before 3 PM. SL and BU provided information to CYPS in relation to Bradyn such as the fact that he always wore a jumper, that there were historic reports of bruising in relation to both children, and the impression they had that Bradyn was scared of his father.
742. Graham Dillon was agitated when he saw CYPS at the school. Eventually he agreed to the children having health checks.
743. As a result of CYPS attending the school, Graham Dillon threatened SL saying that he may hurt somebody and that he would probably remove the children from the school.
744. By 10th of September 2014, it was apparent that the Dillon children were no longer attending the school. SL telephoned CYPS to inform them that the children had not been attending school. CYPS advised that the children were at ACT Primary School 2. SL telephoned ACT Primary School 2 and was advised by them that the children were not enrolled there.
745. The children returned to school in October 2014 and another report of bruising had been made by another teacher.
746. SL was made aware that there were some issues in relation to JL and Bradyn having been kidnapped by their mother toward the end of 2014.
747. After some time, as the children still had not returned to ACT Primary School 1, SL made further enquiries of CYPS. She received an email from PG to say that each case had been closed.
748. SL wrote a note to her Principal that day referring to the "poor children". It appeared to SL that now no one had any oversight of the children anymore, as the staff at the school could not keep an eye on them nor could they contact whichever school the children were now attending.

749. SL referred to her contact with CYPS as less than helpful.

750. SL said that in her view when children who have previously been subject to CYPS involvement move schools, whether interstate or not, that information should be passed on to the new school and to any welfare agencies.

751. Further when there are reports of repeated bruising to children, those files should never be closed.

In Evidence at the Inquest¹⁴²

752. At the inquest, SL gave evidence that Bradyn was enrolled at ACT Primary School 1 on 10 February 2014, having been previously enrolled in another primary school in a different area.

753. At the time of enrolment, she was unaware of any issues concerning Bradyn. SL stated that it was the practice at her school to, where a child was moving to another school, contact that new school to inform them if there were any concerns about the child.¹⁴³ The child's file from the previous school would also have been sent to the new school. Generally it was the receiving school who requested the file.

754. SL remarked that over the course of 2014 she had concerns in relation to Bradyn's welfare because of his haphazard attendances and the occasion to bruising to his face. In her view the level of non-attendance was high and the reasons for non-attendance were varied and unusual.

755. SL stated that as Deputy Principal she was made aware of any significant periods of absences of children. The benchmark would be 7 days absence.

756. SL stated that once it was apparent to her that Bradyn and JL had repeated bruising, she made daily checks on their welfare by attending their classrooms every morning. If the children were not present in class, she would contact the father. This checking began after she made her first report about the children to CYPS.

757. SL recalled an event where Bradyn was accused of stealing \$5. Graham Dillon was advised and attended the school. He told the teacher that he was taking the children to speak to a police officer at a police station and that he also had someone from the church to speak to the children about stealing.

758. SL was shown a note that she had written in respect to her observations of the children's bruising. The note read "faint black eye, under eye bruise has moved, JL finger marks on jaw line and faint bruise round on forehead."

759. The note was made as CYPS had requested for SL to write down details of any bruising to the children that she observed.

760. SL recalled making a report on 17 June 2014, and that she received an email from CYPS as a result. The email response notified her that there would be no further action taken due to no disclosures by the children having been made.¹⁴⁴

¹⁴² Transcript 385 - 407

¹⁴³ Ibid 388

¹⁴⁴ Transcript of Proceedings, p 391

761. SL recalled making a further report on 2 July 2014 notifying CYPS that she had observed a large bruise on JL's cheek and that JL had been absent from school the day prior. SL also, in that report, confirmed that her 17 June 2017 report was in respect to Bradyn.¹⁴⁵ SL stated she did so because she was very concerned for the welfare of the children.
762. SL recalled that she was advised by CYPS on 3 July 2017 that the report was not proceeding to an appraisal.
763. SL stated that she spoke to CYPS many, many times and that they repeatedly told her that as the children had not disclosed anything, they would not be doing an appraisal.
764. SL recalled CYPS saying that it was very difficult for them to proceed unless the children made disclosures.¹⁴⁶ SL recalled that the CYPS workers did speak to the children on at least one occasion in her presence.
765. On 28 July 2014, SL made another report to CYPS in respect to bruising that she had seen on both Bradyn and JL's faces. She stated in that report that they had been away from school for one week. The children did not want to speak about the bruising and suggested that they did not know how it happened. Graham Dillon advised the school that the children had been away in Sydney for the week.¹⁴⁷
766. SL was taken to a note written by the Principal that read "spoke to her, but she needs more evidence than bruises to action. She is raising this with her supervisor. Not for us to look for evidence though."¹⁴⁸
767. SL stated that at this point she was checking on the children every single morning, and that it was the first thing she did.
768. SL confirmed that Bradyn did not start the first school term until day 8, and, that term, he had 2 sick days, 3 absences with leave, and 8 unaccounted absences. In Term 2, Bradyn had 1 absence with leave, 1 sick absence, and 10 unaccounted absences. The absences typically occurred on a Monday or a Friday.
769. This information was raised with CYPS.
770. SL also confirmed that the Principal had spoken with Graham Dillon in relation to the absences.
771. SL confirmed that she made a further mandatory report on 29 July 2014, where she reported changes to the bruising on Bradyn and JL's faces. At the time of the report, SL was aware that CYPS were undertaking an appraisal of the children.
772. SL made another report on 28 August 2014, in relation to bruising on Bradyn's face which included: *a black and purple ear, bruising to the bridge of his nose, and bruising to the cheek on the same side as the ear injury.*
773. SL said that she asked the children what happened, and that Bradyn gave her a version of event where, whilst play fighting with his father, Graham Dillon threw Bradyn through

¹⁴⁵ Ibid 392

¹⁴⁶ Ibid 392

¹⁴⁷ Transcript of Proceedings, p 393

¹⁴⁸ Ibid 393.40

the air and he hit his nose on the couch.¹⁴⁹ SL said that she rang the CYPS and told them she had extreme concerns about the children and encouraged CYPS to come out to see the children.¹⁵⁰

774. SL was advised that CYPS would not be able to arrive by the school finishing time of 3 PM. SL said that she rang CYPS in the morning after checking on the children. CYPS asked that she keep the children at school and asked Graham Dillon to keep the children at school also. SL said that she did not want Graham Dillon knowing she had made a report and that she was very concerned about this request.
775. SL stated that the CYPS workers arrived at 2:55 PM and were in her office when the school bell sounded. Graham Dillon was agitated when he arrived, though he allowed the children to receive health checks.
776. SL stated that Graham Dillon told her that the children had been through hell getting health and sexual checks when he had already been found innocent two weeks before that.
777. The next day, Graham Dillon attended the school and spoke with SL as the Principal was away. He was angry as the school had made reports to CYPS for the second time in two weeks.
778. SL informed Graham Dillon that she took his behaviour as a personal threat. He denied that he was being threatening and said that he planned to remove the children from the school as the school had broken his trust.¹⁵¹
779. SL stated that she informed CYPS of the conversation she had with Graham Dillon and reported it to the Education Directorate.
780. SL gave evidence that she sent a letter to CYPS stating "we informed the workers of the following: Bradyn never takes his jumper off. We have made numerous reports regarding bruising on the face of both children. Bradyn is scared of his father. He always checks in with his teacher 'have I been a good today?'".
781. SL, in the letter, also referred to the \$5 note incident and informed CYPS that the father had told her that the children were not safe with the mother. He gave examples of poor living conditions and the like.¹⁵²
782. SL stated that by 10 September 2014, both Bradyn and JL were not attending school. SL made enquiries and was informed that the children were attending ACT Primary School 3. SL made enquiries with that school and was informed that the children were not enrolled. SL requested that, if they become enrolled, the school contact her as a matter of urgency.
783. SL stated that she contacted CYPS to report to them that she followed up with ACT Primary School 3 and that the children were not enrolled at this school. She told CYPS she did this as she was so concerned for the welfare of the children.

¹⁴⁹ Ibid 396

¹⁵⁰ Ibid 396

¹⁵¹ Transcript of Proceedings, p 397

¹⁵² Ibid 398

784. SL opined that if she knew where the children were, she would have felt able to ensure that the new school could be as vigilant as she had been.¹⁵³
785. Ultimately, the children returned to SL's primary school in late September. They had been away for a couple of weeks. Overall, during their time at the school, the children had 22 unaccounted for absences.
786. SL confirmed that in October 2014 a further report was made to CYPS in respect of bruises down the left-hand side of Bradyn's face.
787. SL said that while she generally was present for the reports, she asked the teacher who observed the bruising to, on this occasion, make the report.
788. SL said that she did this as she felt that if another person other than herself made the report, the reports would show more than just her evidence, and it would support the observations she had made.
789. SL stated that she felt that the reports weren't being followed up to the extent that she wanted them to be and that, in her opinion and noting the number of reports, more could have been done by CYPS to check on the welfare of the children.¹⁵⁴ In relation to the October report, SL advised that she did not recall CYPS coming to see the children after that report.
790. In February 2015, the children did not attend ACT Primary School 1. SL stated that she had been told that the children would be moving to New South Wales and she advised CYPS of that information.
791. CYPS replied by email to SL, stating that the case had been closed as the family had moved to another area. That email was sent by PG.
792. SL was very upset as she had '*reached the end of the road*' and could not trace the children. Despite it not being her job to do so, she had explored as many avenues as she had available to her.¹⁵⁵
793. SL stated that she reached out to Bradyn's mother to let her know that she had tried to do everything she could to look after the children.
794. SL opined that the appointment of the Education and CYPS Liaison Officer role has greatly assisted in improving communications between the Education Directorate and CYPS. She has used the officer in that role on a number of occasions and feels that this role has benefited a number of the recent cases that she has been involved with.¹⁵⁶
795. SL agreed that the changes to the Education Directorate, particularly in relation to enrolments, has been beneficial and that the liaison role is a positive development.

¹⁵³ Ibid 399

¹⁵⁴ Transcript of Proceedings, p 407

¹⁵⁵ Ibid 404

¹⁵⁶ Ibid 405

OF – Bradyn’s PE Teacher, ACT Primary School 2

Statement

796. OF gave a statement in respect to her contact with Bradyn in 2015. She was his PE teacher. On 4 August 2015, she observed bruising to Bradyn’s left cheek and four spots deep yellow colour on the left side of Bradyn’s face. Bradyn refused to speak about how he got those bruises but later said he fell off his bike and hit his cheek on the handlebars.
797. On 11 August 2015, OF observed Bradyn with bruises on his right cheek. When she asked how he got the bruise he said he did not know and that they would just come up. She observed that he became tense when talking about the bruising. OF submitted a Child Concern Report to CYPS.
798. OF further submitted information in respect to Bradyn’s father having a breakdown and that his mother had no access to the children by order of the Family Court, she noted that the children had been kidnapped by the mother in the past. She considered that to be unusual given that Bradyn told her how wonderful his mother had been.
799. She also was asked to check on Bradyn because he appeared to be hungry, and she would make him toast. There were times when he appeared not to have food but generally he was provided with lunch.
800. OF only recalled meeting Graham Dillon once and thought he was a bit odd and that he was over demonstrative and over the top.

BE – Bradyn’s Classroom Teacher (Term 1 & 2, 2015), ACT Primary School 2

Statement

801. BE recalls that Bradyn was in her class in 2015, commencing in week three of term one. She met Graham Dillon and advised him that Bradyn had excellent manners. BE recalls that Bradyn was very quiet and always very well behaved. Bradyn would ask whether he had been naughty during the day, but he never had been. Academically he was at a low level.
802. Bradyn’s attendance was haphazard, and his attendance slipped further in term 2. There were 18 absences during the semester. Absence slips were sent to Graham Dillon. However, nothing was returned to the school to explain those absences.
803. In term 2, Graham Dillon was invited to a parent teacher interview. Graham Dillon did not attend, and the teachers found it difficult to make contact with him. There were occasions when he answered the phone and he either hung up or dropped out. Despite attempts at emailing him for better contact information he never responded. BE recalled seeing a bruise on Bradyn’s cheek, but he gave an explanation to her and a colleague. It did not appear to be a fresh bruise and they believed Bradyn’s explanation.

DI – Bradyn’s Classroom Teacher (Term 3 & 4, 2015), ACT Primary School 2

804. Bradyn was in DI’s class at ACT Primary School 2, class 3 because BE went on maternity leave in July 2015. DI was aware of Bradyn and his difficult background from

other teachers, which included that he had frequently changed schools prior to attending ACT Primary School 2. She also noted that he was a student in need of support, had poor school attendance, and on one occasion noted he was absent for four consecutive days without explanation. Where students have absences without explanation teachers are required to contact parents. She contacted Bradyn's father who told her that he and the children were in Melbourne visiting Bradyn's mother.

- 805. On 4 August 2015, DI observed bruising on Bradyn's face which appeared to her to look like finger marks. Bradyn said that he had hurt himself on his bike.
- 806. DI was not convinced of the explanation because the bruises look fresh. DI questioned Bradyn about the bruises, and he said that he hurt himself during his holidays and hit the handlebars of the bike.
- 807. DI also thought that Graham Dillon acted quite strangely when dealing with her.
- 808. DI spoke to the executive teacher about making a Child Concern Report. DI checked with other teachers because of her newness and having never completed report before.
- 809. DI completed the report and checked with staff. She submitted the report the following week to CYPS. A further report was sent in relation to concerns about Bradyn not having his lunch. Both reports were submitted via the online portal in August. DI received tracking codes confirming delivery, however she cannot ever recall hearing anything about those reports from CYPS.
- 810. DI received an email on 9 September 2015 requesting that she check to see if Bradyn and JL had enough food to eat. She made sure she checked on Bradyn each day. They were the only two concern reports she submitted to CYPS.
- 811. She called Graham Dillon when Bradyn did not turn up for school on three consecutive days. DI recalled Graham Dillon often would not answer the calls placed to him. DI recalls she met him once at the school and considered his behaviour to be odd and that he had an exaggerated manner when interacting with Bradyn.
- 812. DI also noted that Graham Dillon failed to attend parent teacher conferences or sign Bradyn's personal learning plan.
- 813. DI was made aware that Bradyn was going to transfer to New South Wales School in October 2015, and she did know whether she had any further obligation toward Bradyn in respect of that.

SU – Principal of ACT Primary School 2

Statement

- 814. SU was the Principal of ACT Primary School 2. SU indicated that she had requested the names of students with unexplained absences of more than seven days during the term on 1 July 2015. Bradyn's name came up and SU contacted CYPS.
- 815. CYPS asked SU to get some further information such as observations about food, clothing, and engagement of the father. That information was sent to CYPS that day.

816. On 7 August 2015 a warning letter was sent to Graham Dillon in relation to the children's non-attendance.
817. From 11 August 2015, two teachers had made mandatory report in relation to bruising observations on Bradyn.
818. Following that SU wrote to CYPS regarding the concerns about the poor attendance of the children and the explanation given by father.
819. Bradyn did not attend school after the Friday of the first week of term beginning 6 October 2015. It had been advised that the children were no longer attending the school and that they were to leave the school. It was SU's understanding that they were moving to Sydney.
820. Given the explanation by the parent, which was accepted by the school, that the children were going to be relocating to Sydney, no notification of that fact was given to any organisation.
821. It would appear that it is the role of the school who is accepting the new students to contact the previous school. There are no checks to ensure that the children are in fact attending that school.

LE - Education Directorate Liaison Officer with CYPS

Statement

822. LE is the Education Directorate Liaison Officer With CYPS. LE's role came about as a direct recommendation of the Glanfield Inquiry. Her role is to engage with the Education Directorate and CYPS. She assists with provision of fieldwork, including attendances at schools, homes, and service providers. LE provides direct assistance regarding report making to CYPS or other interventions.
823. Having been made aware of the circumstances of the reporting made by in particular the Deputy Principal at ACT Primary School 1, SL, and the response she received from NL, LE stated that she would have been able to directly liaise with both of these parties and give advice as to the correct procedure.

In Evidence at the Inquest¹⁵⁷

824. LE is a liaison officer between CYPS and the Education Directorate. LE has experience in both education and Child Protection. Her role was created in February 2017, after Bradyn's death and as a recommendation from the Glanfield Inquiry.
825. Her role essentially involves schools contacting her regarding the making of mandated reports seeking advice as to whether the reports actually fall within the legislation for a mandated reporter or whether the report would be a voluntary report.
826. Her advice is utilised by CYPS, teachers, and the Network Student Engagement Team. Her role may include assisting in managing relationships between teachers and CYPS, particularly if there is a difference in opinion. Her role also involves assisting with

¹⁵⁷ Transcript pp 409 – 420.

funding grants for children with special needs. It is also part of her role to address school attendance issues.

827. In relation to non-attendance at school in particular, her role is to enquire as to why the children are not attending school. She also liaises with CYPS in respect to whether there is a history indicating abuse or neglect. Once she has been provided the information by CYPS, she can then better make decisions in relation to the advice sought. She can also use this information to determine whether she needs to attend the home address of the child herself.¹⁵⁸
828. LE stated that her role fits perfectly between both organisations, as there may be insufficient evidence for CYPS to act but there is still a concern of children falling between the cracks in relation to the two departments. In cases such as those, LE would then go to the home and engage with the parents in relation to strategies to ensure the children are sent back to school.¹⁵⁹
829. LE set out the circumstances where children are not attending school. The first port of call is that the school would send letters and information notices regarding the failure of the children to attend. If there is no response, the Education Directorate would seek to utilise the Network Student Engagement Team to become engaged with the parents. That would require the parents' consent. If there was no consent CYPS would become involved.¹⁶⁰
830. In order for the Network Student Engagement Team to become involved with the parents the school would need to refer them. The Network Student Engagement Team triage each case. However, the parent must consent before the team can then work with that family.¹⁶¹
831. LE stated that The Directorate is presently able to capture data more successfully than it could in the past. Where a child is unenrolled, the school chases up to see where that child has gone. If they are unable to do so, a process is put in place with the Interstate Liaison Team to find out whether the child or children have been enrolled somewhere interstate and trace the children. Utilising the Interstate Liaison Team to trace the children generally would be part of the CYPS system.¹⁶²
832. LE stated that it would be very easy to check to see that a child that had been unenrolled from one school was enrolled in another within the jurisdiction, as there is a database of information in relation to that.
833. LE stated that there is a system of tracing the children. She gave an example that, just recently, there was a child who was unenrolled from school in the ACT on the premise that they were to be enrolled in a school in New South Wales. A call was made to LE about the fact that the child had not been enrolled in the school they were supposed to be an enrolled in. LE generated a Child Protection Report and ultimately it was found through the ILO that the child had enrolled in a different school and was safe and well.

¹⁵⁸ Ibid 411

¹⁵⁹ Ibid 412

¹⁶⁰ Transcript of Proceedings, p 413

¹⁶¹ Ibid 413

¹⁶² Ibid 414

834. That system of tracing is now best practice, but it is not mandated practice. In LE's opinion it should be.
835. When a child is still in the ACT but there are a number of absences which have been referred to CYPS, but the agency has taken no action, the matter remains with LE and she can then make the case to re-establish care and protection, or the next step may be to visit the family.
836. LE opined that
- “I believe that as a community we need to take non-school attendance more seriously and that care and protection – as much as I try and train and coach staff around – that non-attendance is often a symptom of lots of other things, that often it's not taken seriously. I would like it to be more seriously taken by care and protection, as it is a welfare issue.”¹⁶³
837. LE stated that the reason it is important to follow up is because schools have eyes on the children and if they are consistently not at school they cannot keep eyes on the children. She stated that absences from school can be an indicator of abuse and neglect.¹⁶⁴
838. LE agreed with the proposition that best practice is for information to be shared, including the children's file and other relevant social, economic, financial, or care concerns with the new school. However, she states that this is not mandatory practice to her knowledge.¹⁶⁵
839. LE stated that when she was in the role of Team Leader at CYPS, if a child was in another state or territory and it was felt the child was at risk, they would report that to that state or territory.¹⁶⁶
840. LE agreed that if a parent refuses to send their children to school they would be in breach of the Education Act and that would be a matter for the Education Directorate.¹⁶⁷ LE stated that generally they would utilise their experience as social workers to assist the families to send their children to school. She stated that in some circumstances there may not be financial support or transport and the parents need to have support so they can send the children school.
841. LE agreed that it would be good practice to oblige parents to inform the school they were exiting of the new school that the children would be attending.¹⁶⁸

¹⁶³ Ibid 416

¹⁶⁴ Ibid

¹⁶⁵ Transcript of Proceedings, p 417

¹⁶⁶ Ibid 418

¹⁶⁷ Ibid 419

¹⁶⁸ Ibid 420

Department of Health and Human Services Victoria (DHHS)

HS – In-House Counsel for DHHS

Statement

842. HS is in-house legal counsel for the DHHS. Her statement was provided to give an understanding about what occurred in relation to the Protection Application in the Shepparton Court, made on behalf of Bradyn Dillon.
843. Protection Applications were made in respect of both Bradyn and JL on 14 November 2014. The grounds relied upon were that the children were likely to suffer significant harm or had suffered significant harm and require protection.
844. The applications listed before the Children's Court on 14 November. The children had been placed in Emergency Care pursuant to section 241 of the CYFA Act. The application was required to be heard as soon as practicable or within one working day after the children were placed in Emergency Care.
845. The application was served on the father at the Canberra Police station on 14 November, and on the mother, SK, on 14 November 2014.
846. A summary information form (also known as a Form B) dated 14 November 2014 was filed with the application. This outlined the basis for Protection Application on the grounds upon which the apartment formed the belief that the children were in need of protection. It also stated that the Department was seeking an Interim Accommodation Order for the mother.
847. The matter was heard on 14 November 2014 and Interim Accommodation Order was made to the mother with certain conditions. It appears that the orders were made by consent. The matter was adjourned to 17 November 2014. An interim order was made at that point in time.
848. On 17 November 2014 the matter was again heard by the Magistrates Court. TQ appeared for the Department, ZB appeared for the mother and FL appeared for the father.
849. Records indicate that both the mother and father were at court. However, given security concerns the mother was not at the court but in the DHHS offices next to the court.
850. Noted in the Form B was that the father is identified as a security risk. Also noted was that the father was aggressive violent and had an extensive history of family violence, breaching orders and had served time in jail for family violence.
851. Material was provided to the court including material from BP. After FL had spoken with BP, she advised her client Graham Dillon that he should not agree to the adjournment and that he should be the carer for his children.
852. DHHS had asked for a four-week adjournment and were initially granted that adjournment. However, FL made further submissions to the Magistrate. It was submitted that the children's abductor, being the mother, had given advice to the DHHS and that FL would strongly submit the father have custody of the children.

853. It was noted that after the hearing that Magistrate admonished DHHS Victoria for their part in the whole situation, indicating there would likely be charges laid against the mother. It was also noted that Graham Dillon was advised to quickly leave the State because of threats from the boyfriend of the children's mother.
854. The notes on the legal file were very scant. However, the usual course is that, if the mother contested the application, submissions in a contested hearing would have been made.
855. In the course of that hearing, submissions are made from both parties. A court is not required to make any formal findings of fact, rather they determine whether there is an unacceptable risk of harm to the child in considering whether to place and with a parent.
856. The court had several documents which painted SK in a poor light, together with two versions of an ACT DVO, one which included the children and the other which did not.
857. There were statutory declarations and letters from UN outlining the violence perpetrated against her by Graham Dillon.
858. There was also a statutory declaration from ND who gave first-hand accounts of Graham's physical violence perpetrated toward both SK and UN. She also outlined a conversation she had with Graham Dillon where he clearly lied about SK being on ice and BK being on ice.
859. The Magistrate also received a letter from BP about Graham Dillon's ability to care for his children. Given that he was supposedly an independent person, his views were accepted over those of UN and ND.
860. Ultimately the Magistrate decided to give the children to the father because of his perception that SK had 'kidnapped' the children.
861. On 11 December DHHS withdrew its application because the children were no longer in Victoria having been returned to live with the father in the ACT

XB – Operations Manager at Victoria Child Protection East Division, DHHS

Statements

862. XB provided a statement where she indicated that she was the Area Operations Manager at Victorian Child Protection East Division at the DHHS.
863. XB outlined the responsibility of the Goulburn Area Child Protection Program. Child Protection Investigation and Assessment Teams receive cases that have been assessed by the Intake Team as requiring investigation, due to the significant risk of harm, abuse, or neglect to children. The investigations are designed to substantiate whether there is a need for ongoing Child Protection involvement or community support and safety plans.
864. XB stated that at the time when Bradyn and JL were subject to investigation the area had a consistently high workload. There were staffing difficulties within the Shepparton Investigation and Assessment Team, which led to a high awaiting allocation list. Essentially the team were understaffed.

865. The Shepparton office had a very brief, direct involvement with the family over a period of six days from the time the children were located on 12 November 2014 until the return of the children to the father on 17 November 2014.
866. XB was advised of the situation by BN. XB was aware that there was a current Family Violence Order against SK and that there was a Safe Custody Warrant in relation to JL and Bradyn, due to serious concerns that SK had abducted the children from the ACT. There was also information that SK was the perpetrator of family violence and that there was a current order against her.
867. XB was advised by another caseworker, CO, that she had conducted an interview and she was satisfied the children were safe to remain in the care of SK until a more detailed assessment could be completed.
868. An application was prepared for an Interim Accommodation Order because of concerns regarding Graham Dillon's history as a perpetrator of family violence as well as substance abuse. There was also an allegation that SK and her partner were also perpetrators of family violence and were users of illicit drugs.
869. XB was also aware that the father was intending to travel to Shepparton to collect the children. She was aware that there were court proceedings and that ultimately the Magistrate granted custody to Graham Dillon.
870. Following that decision, BN spoke with XB in relation to disclosures made by the children and their distress at leaving their mother. Given that the children were on their way back to Canberra, and they had limited information available within that short period, it was her view that the most appropriate course was to make a report to ACT CYPS. It was her view that that would enable investigations in relation to the disclosures made by the children and therefore a full assessment of their safety of in their father's care.
871. XB became aware that BN had made a report to ACT CYPS regarding the disclosures made by the children.
872. BN also advised that the Protection Application should be withdrawn as the children were living in Canberra. The application was ultimately withdrawn.
873. SK attended the Shepparton Office of the Victorian Child Protection service and XB spoke with her and explained that as the children were now in Canberra the Victorian Office would close the case.
874. SK advised her that she wanted to make a report to the ACT CYPS regarding Graham Dillon but that she did not have the correct phone number for them. XB advised that she would find the phone number on the Internet. However, XB never made a note saying that she had called SK back to advise her of that number.
875. SK asked XB whether Victorian Child Protection had faxed through documents to ACT CYPS. XB said she was not aware of any documents. SK and the male with her were very upset and left.
876. In her second statement, XB clarified some issues in respect to conversations with BN. She also advised that she was aware that there were allegations both ways as to family violence and drug use. This was despite BN having assessed the children as being

safe in the care of their mother. There was also concerned in respect to the father's family violence history.

877. BN also advised XB that the children had made disclosures as to their father's violence but when he came to pick them up the children had hugged him and seemed comfortable in his presence.

878. XB indicated that she wanted to know whether the children had left the jurisdiction because the disclosures required further investigation. XB said ordinarily, if the children had resided in Victoria, DHHS could have contacted the local Sexual Offences and Child Abuse Investigation Team at Victoria Police. The Police would determine whether there was a need to interview the children which could then be used in a prosecution. If there was a lack of evidence to assist prosecution the Department could then reinterview the children.

879. It was XB's view that given the children had returned to the ACT there was very little ability to conduct any investigation or interview of the children. XB advised BN to contact ACT CYPS and make a report because they needed to ensure a full assessment of the safety of the children in the father's care.

880. It was XB's view that there was no realistic prospects of appealing the order to the Supreme Court given the limited, confusing, and conflicting information in relation to both parents. Irrespective of whether the children were in Victoria, given the disclosures it was her view that a report should be made to the ACT and that they would then investigate the matter.

In Evidence before the Inquest¹⁶⁹

881. XB was area Operations Manager for DHHS Victoria. XB has worked in the Child Protection Service for 35 years.

882. The area she managed covered the south of Mitchell, from the outskirts of Melbourne to the Murray River. There were approximately 50 staff in what was an extremely busy office.¹⁷⁰

883. XB explained that the office in the Shepparton area was extremely busy and that there were a high number of cases requiring investigation. The team were often managing caseloads between 280 and 300 cases.¹⁷¹ XB agreed that the caseload could be described as unsustainable, and therefore a major workload review was conducted. As a result of the review, there was been a significant strengthening of staff allocations and resources.

884. XB outlined that all new starters, regardless of experience, must participate in a three-week induction training program as part of the new training scheme. There has also been increased supervision of new practitioners.

885. XB stated that when a report comes in it is uploaded to the Client Relationship Information System (**CRIS**). The system then allocates the case to a caseworker. The

¹⁶⁹ Transcript pp 1065 - 1147

¹⁷⁰ Ibid 1059

¹⁷¹ Ibid 1060

Dillon matter was allocated to BN. XB stated she became aware of the Dillon matter when the children were located.

886. XB stated that the issues raised were concerning the mother's care of the children. However, DHHS caseworkers assessed that the mother was very protective, and that the situation was safe for the children.¹⁷² The mother did not appear to be affected by licit substances and agreed to undertake urinalysis.
887. XB stated that DHHS remained involved and sought an Interim Accommodation Order in favour of SK because Graham Dillon had a history of domestic violence that was confirmed. XB explain the process of undertaking the Interim Order application performed by CO.¹⁷³
888. XB explained that the Form B was new and at the time of the Dillon matter was not as fulsome as would be expected presently.
889. XB also explained the process of briefing of in-house solicitors and what material they would likely be given when briefed in a matter.
890. XB agreed that an Interim Order was made at first instance and the matter was adjourned for a further hearing on 17 November 2014.
891. XB was aware that the magistrate on 17 November ordered that the children be returned to Graham Dillon.
892. XB was also aware that the children had disclosed matters prior to being returned to Graham Dillon. She agreed that further investigation clearly needed to be undertaken. However, she stated that given the children had been placed with the father, who returned them to the ACT, a report should be made to the ACT.
893. XB was also aware of information from BP and CYPS (who had not substantiated the reports of abuse upon the children).
894. XB agreed that given the new facts it was possible to go back to the court which issued the order. However, the circumstances and the very limited timeframe were complicating factors that made it not possible.
895. XB stated that generally if the children had remained in Victoria, DHHS would have had a supervisory role under the order made by the magistrate. However, it was difficult because the children were returned to another jurisdiction.
896. XB stated that generally contact with interstate jurisdictions would be conducted through the ILO but a report could also be made directly to the Child Protection office in that jurisdiction.¹⁷⁴ At the time of this incident the ILO was a new process and was not fully understood.
897. XB was of the view that if there was a request for a report, she would expect a follow up to clarify exactly what was being requested. It would also be appropriate to involve the ILO. XB stated there is now a written report prepared when making an interstate report.

¹⁷² Ibid 1066

¹⁷³ Ibid 1070

¹⁷⁴ Transcript of Proceedings, p 1079

898. XB recalls dealing with SK on 6 January 2015 in the offices in Shepparton. XB stated that she would advise SK of the phone number for the ACT CYPS. Unfortunately she did not make a note of it and overlooked the possibility of contacting SK with that information because of her limited time.
899. Regarding a report that incorrectly stated that there were no immediate concerns, XB stated that it may well have been that the evidence was insufficient by the standards required by the Magistrate to substantiate the claims.
900. XB agreed that section 270 would have given them an option to make a new Interim Order if the children remained in Victoria. However, given the circumstances of this case, particularly that the children were on a bus with Graham Dillon back to Canberra, there was limited time to do anything.
901. XB opined that having considered all the relevant facts it was better to contact ACT CYPS and they could then do the assessment.
902. XB explained that there were difficulties uploading documents to the CRIS database but agreed that there should be some indication of documents received even if not uploaded.
903. XB stated that in her view the 12 reports to Child Protection Reports from ACT CYPS were overlooked because they were not uploaded to the system.
904. XB also agreed that the Form B, which was the primary document for the court and solicitor, did not record that there had been 12 Child Protection Reports from Canberra.¹⁷⁵ However, XB explained that some of the information in those reports had been verbally communicated to the caseworker.
905. XB agreed that had the Form B contained more information it would have completed the narrative as to where the children originally were living and why they were with their father.
906. XB stated that if there had been reports of bruising to the face, she would assume that would have been thoroughly investigated by ACT CYPS and the children would only still be in the father's care if it had been verified that there was an alternative reason for the bruising.¹⁷⁶
907. XB stated that information about the recordings of prior injuries to the face would have assisted with them interpreting the disclosures made by the children on 17 November 2014 as it would have formed a further piece of the jigsaw puzzle.
908. XB opined that
- “I think children often love and abusive parent. There is – disorganised attachment is all around children who have a relationship with a parent who is abusive, but children still, you know, love their parents so yes, it is a factor”... That’s why in a Child Protection investigation you don’t normally rely on disclosures alone. There’s a whole range of factors that you would rely on; you know, reports from other professionals, forensic assessments, observations, and he would try very hard to build up a relationship with the child over a period of time so you could understand what was happening with that child. .¹⁷⁷

¹⁷⁵ Transcript of Proceedings, p 1103

¹⁷⁶ Ibid 1111

¹⁷⁷ Ibid 1114

909. In relation to the return of the children after they had made disclosures, XB suggested that they were significant disclosures. However, whilst they were dealing with a substantial risk, there were a number of factors such as timeframes, allowing fairness to all parties, and trying to make sense of the situation. It is easy with hindsight, knowing the ultimate outcome, to see that the threshold had been met, but this was not as clear at the time.
910. XB agreed that if a report has been made of abuse DHHS would generally involve the Police. However, this was a tricky situation given the Magistrate's order and the fact that the children were on their way back to the ACT.
911. XB stated that there was a principal practitioner who was available for consultation around difficult points of practice. However, the practitioner had a significant area to cover and was spread "*far and wide but would be available*"¹⁷⁸
912. In relation to the report about physical abuse to ACT CYPS that not been substantiated, XB opined that bruising to the head is always suspicious because of the high risk of injury and the allegations should be thoroughly investigated.
913. XB stated that if allegations had been made and the alleged perpetrator stated that he had been attending social groups with the children, the information would have been followed up in order to substantiate the assertion.
914. In respect of the report made on 14 October about finger marks to the face, XB opined that one would immediately assume them to be finger marks and it would be appropriate to seek an expert opinion.
915. XB opined that had they been made aware that the medical opinion stated that there was suspicious bruising which could not be explained, that would have immediately instigated a protective action. In such circumstances, the children would be placed in alternative accommodation until it was very clear about what it happened.¹⁷⁹

BN – Team manager of the Investigation and Response Team, Victoria Child Protection, Shepparton

Statements

916. BN was The Team Manager of the Investigation and Response Team at Victoria Child Protection Shepparton in 2014.
917. BN was responsible for a team of seven Child Protection practitioners. Each had approximately 20 children or less to manage. BN was responsible for all unallocated cases (and there were many).
918. BN first became involved with Bradyn and JL when she received a call from Shepparton Police to say that their mother had kidnapped them. BN was advised that safe custody warrants had been issued in respect of the children.
919. CF spoke with NL from Child Protection in the ACT who advised her that Child Protection had ceased its involvement with the children on 14 October 2014 and the

¹⁷⁸ Ibid 1140

¹⁷⁹ Transcript of Proceedings, p 1146

case was closed. NL advised that there had been recent concerns which had been investigated by ACT CYPS in relation to the children presenting with bruises whilst in Graham Dillon's care. BN said she been advised there had been two reports made in relation to suspicious bruising on the children.

920. According to ACT CYPS the injuries were considered not suspicious, and the abuse was not substantiated. There was some issue in respect to whether the children had advised that they were scared of their mother. BN asked NL to confirm whether there were any disclosures made by the children in respect of SK.
921. Throughout her full involvement with the Dillon family she at no time received any copies of ACT CYPS history which was received by the after-hours Child Protection service and the Victorian ILO on 5 November 2014.
922. On 6 November 2014 she received a call from Graham Dillon. He advised that he was willing to come and collect the children and had had difficulty sleeping because they had been taken from him.
923. She recalled that CO had attempted to contact him on two or three occasions but was unable to make contact with him as he did not answer his phone. BN said that she and CO went to the Shepparton Police station after being advised that they had found SK and the children and interviewed them.
924. BN was told by SK that the children were in her care and had been throughout their life until she sent them to have holiday with Graham Dillon 18 months ago. Graham Dillon then refused to return the children since that time. SK indicated that she could not leave Melbourne because she had been pregnant.
925. SK identified that Graham Dillon used ice, had a significant history of family violence, and had had sex with a 14-year-old girl when he was 28 years of age.
926. SK also said that Graham Dillon had lied about her supplying ice to her daughter BK. That allegation had been investigated and the Department closed the investigation.
927. SK also said that he had been violent toward his ex-partner UN (with whom he had three children) and that UN had taken out a Domestic Violence Protection Order against him preventing him from seeing her and the other children.
928. SK stated that it was her belief the children were unsafe in Graham Dillon's care and that she had a tape of Graham Dillon threatening her with a crossbow. She also indicated that she had a rental home in Shepparton and was living there with all four of the children. The property was assessed by CO and BN and there were no concerns in respect of the children residing there with SK.
929. SK had also provided a criminal history excerpt indicating that Graham Dillon had a record in Tasmania for domestic violence. BN asked Shepparton Police to get a copy and understands they subsequently obtained that copy.
930. SK also advised that she would get UN to contact her and advise of Graham Dillon's previous violent history. As they had no concerns for the children remaining with their mother and had concerns in respect to Graham Dillon's violence the children were allowed to stay with their mother.

931. The Child Protection file included statutory declarations in relation to Graham Dillon's long history of drug use and violence and also a letter from BP who stated:
- "all cleared on both occasions, and Care and Protection have said that they are very much in support of Graham Dillon and his children"
932. BN advised that on 14 November 2014 Protection Applications were prepared and served on both SK and Graham Dillon. The Form B was not accurate in relation to the history of violence suffered by SK perpetrated by Graham Dillon. However, the Form B indicated that there were no concerns with Bradyn and JL being in SK's care. The Form B indicated they did have concerns that Graham Dillon had care of the children and that they would be at risk and that they were seeking an Interim Accommodation Order for SK.
933. BN indicated that she was of the view that the Form B ought to have made reference to the particular instances of violence perpetrated by Graham Dillon towards SK, and that ACT CYPS had advised the Victorian Child Protection unit that recent concerns had been investigated in relation to Bradyn and JL presenting with bruising whilst in Graham Dillon's care. It did not do so.
934. BN was aware that CO had contacted BP who stated that the children had been involved with Child Protection and that the case had been closed as there were no concerns.
935. BN then outlined what happened at the court on 17 November 2021, when the court made the order placing Bradyn and JL into Graham Dillon's care.
936. BN was aware that despite their concerns, Magistrate 2 noted that SK had unilaterally removed the children from Graham Dillon's care, and she needed to go through the proper process in order for Bradyn and JL to be placed with her, and because she had failed to attend the domestic violence application hearing in the ACT he considered that the children should be returned to Graham Dillon.
937. At the conclusion of the hearing, she met with SK, JL and Bradyn to advise them of the outcome of the hearing. At that time JL hid under the chair because she did not want to go back to Graham Dillon and advised that he hurts her, kicks them in the head, legs, and arms and punches them. Bradyn said that Graham Dillon picks him and JL up and throws them onto the couch. Although this does not break bones Bradyn does experience bruising. Further he said that Graham Dillon calls people and yells and goes out with knives and that Graham Dillon has said that he is scared he will have to go to jail and that we would go to a boys' home. Bradyn said that sometimes he and JL would go for a walk at night when Graham Dillon was angry. Bradyn said he was too scared to tell them this the other day
938. BK (who was also there) stated that she had voice recordings from UN to prove Graham Dillon's abusive nature. Unfortunately BN did not obtain a copy of those recordings because Bradyn and JL went to the ACT and the Victorian file was closed. BK questioned how the Department could return the children to such danger.
939. BN said that the meeting was particularly distressing, and she explained to SK and the children that she felt her hands were tied in that the information provided was not available to Child Protection for the hearing on 17 November.

940. BN said she recalled telling SK that she needed to report her and the children's current concerns to ACT CYPS and to make the relevant application to the Family Court, as well as applying for DVO in the ACT.
941. BN also advised SK that she would report her concerns raised by the children during the meeting to ACT CYPS. BN said she also advised the children as to who are safe people.
942. BN observed that when Graham Dillon came to pick up the children they ran to him and hugged him. She felt confused by this given what she had heard previously.
943. BN contacted NL of ACT CYPS on the 23rd November by telephone. BN did not make a note of the telephone call, however there was a note taken by NL in the ACT CYPS Services intake form dated in November 2014.
944. BN said she told NL she would arrange for the relevant documents regarding Bradyn and JL's recent disclosures to be forwarded to the ACT CYPS Services. NL then emailed BN and asked for her to prepare a Child Protection Report. For some reason (which she did not recall), she did not prepare the relevant documentation nor fax the relevant documentation to ACT CYPS. She is unaware if she delegated this task to another practitioner. BN was also unaware as to whether the ACT and Victorian ILOs were in communication.
945. BN identified that ultimately, a request was made to withdraw the Protection Application that was done, and the case was closed. BN recalls that SK contacted the Child Protection Services and advised that the ACT wanted Victorian Child Protection to provide an oral report and written documentation in relation to Bradyn and JL.
946. On 29 December 2014 SK attended the Victorian Child Protection office in Shepparton and asked whether they had sent the documentation to ACT CYPS. BN said that she received an email noting the call which enclosed photocopies of text messages sent from Graham Dillon to SK.
947. BN cannot recall what action she took in relation to that email. However, she stated that it would be her usual practice to ensure SK was advised of the phone number of ACT CYPS and/or the Police due to the concern being for SK's own safety.
948. On 6 January 2015 SK again attended the Victorian Child Protection office in Shepparton. BN was on leave on so XB attended to SK. SK asked questions about transferring the documentation. XB was unaware whether it had been done. On 21 January 2015 the Child Protection file in relation to Bradyn and JL was closed. BN prepared the closure report (which contained extensive evidence of family violence from Tasmania in relation to Graham Dillon) that Victoria had no concerns in regard to SK having Bradyn and JL with her and that they had serious concerns regarding Bradyn and JL being in Graham Dillon's care due to his extensive history of family violence. It was also noted that contact had been made with ACT CYPS who would follow up with Graham Dillon.
949. On 26 June 2015 SK again reported to the Child Protection office in Shepparton and advised that both Bradyn and JL had previously disclosed that they had been abused by Graham Dillon and nothing was done about that. SK indicated that ACT CYPS had been asking for documentation to be sent from Victoria however none was sent. BN does not recall what action she took following receipt of that email.

950. BN noted that she did actually receive copies of the ACT CYPS reports which were emailed to her on 5 November 2014. She has no recollection of receiving them. She indicated that she would have received a high-volume of emails.
951. BN advised that had she known the information in that email she would have put that information before the court on 17 November 2014. It was her view that that may not have ultimately had any effect on the outcome as the Magistrate had a clear view about SK's conduct of taking the children.
952. BN stated that she also noted that there were two further Child Protection Reports made to ACT CYPS between 30 July 2014 and 3 November 2014 which were not included in the material provided. She also reviewed the report of Dr Payman, which expressed the view that there were unexplained bruises, and which were of concern (contrary to what had been told earlier).
953. BN also advised that she spoke with SK prior to the hearing on 17 November and saw that she was fearful of seeing Graham Dillon at court, and that fear appeared to her to be real and sincere. Based upon the level of violence that was outlined in the Tasmanian Police report, it was her view that SK was potentially at risk of further violence from Graham Dillon if she were to see him at court. For those reasons they arranged for her not to attend court on 17 November. She was represented by a duty solicitor.
954. BN also advised that she had concerns about the serious violence perpetrated by Graham Dillon in the past and concerns of significant risk to the children. They had also been advised of his long drug use history.
955. BN referred to the meeting with SK and the children to advise on the outcome of the court proceeding. She said that she observed SK try and calm BK down and reassure the children who were crying and close to hysterical. She tried to hold it together despite her own tears streaming down her face.
956. Her view was that all of the family were very fearful of Graham Dillon and that was prevalent and appeared to be shared by the whole family.
957. BN was asked about the notes made by NL containing her advice about the children's disclosures. The note said that the from the disclosure "[it] was *not clear whether this was done in fun*". BN stated that this note was not generated by her and appeared to be something that NL summarised as her view.
958. BN also said that it wasn't her view that she had said that she would generate a Child Protection Report and email the details in case note to assist CYPS with the assessment. That's not part of her recollection and does not make sense because she was effectively the person generating a Child Protection Report for the ACT by telephoning the notification through.
959. BN also did not understand NL's reference to a Child Protection Report because she had already done so by way of the telephone. She does not know what generating a report would be because they do not generate reports.
960. The usual process for obtaining information is through the ILO. BN was not aware of any request via the ILO for any material on the Child Protection file from Victoria.

961. BN also has seen a file note from PG which indicated that she telephoned BN and asked her to telephone her back. BN does not recall telephoning her back but given that she had already reported the disclosures to ACT CYPS that was the report they required.

In Evidence before the Inquest¹⁸⁰

962. BN was Team Manager for rural and after-hours teams for DHHS in Shepparton. In 2014 she was the team manager for the investigation and response team in the Shepparton office.

963. The role involved receiving intake reports and allocating staff for those particular cases. Any cases that were not allocated sat with her. In 2014 there were approximately 300 children with open cases of which between 142 and 160 were allocated to BN. The role also involved supervision of staff, including wellbeing and workload.

964. BN described the workload as unsustainable in 2014. During that time the workload was unsustainable, and BN was both physically and mentally exhausted. This, combined with Bradyn passing led her to take some time off given the circumstances.

965. DHHS have now tripled the numbers of staff members and teams within the Shepparton office to deal with about the same number of cases.

966. BN explained that there were difficulties uploading large documents to the CRIS system.

967. Another of BN's responsibilities included ensuring that her staff participated in informal training including 'beginning practice' and other courses in respect to legal processes.

968. BN stated that the principal is available for urgent consultation but that in reality it would require days rather than hours to get the advice.

969. BN confirmed that safe custody warrants were issued for Bradyn and JL. BN was aware that BE had been contacted by NL advising that the children's file had been closed. BN believe there was a note on the system in that regard.

970. BN stated that she is now aware that she had documents emailed to her on 5 November 2014 from the ACT ILO via Intake Worker, however, she has no recollection of opening that material. She said she would receive in excess of 100 emails per day.¹⁸¹

971. BN stated that it was a duty of the Intake Officer to upload onto the system material sent to them by CYPS.

972. BN stated that she did contact Graham Dillon on 6 November 2014 in respect to the children purportedly being in Victoria. Graham Dillon told her how he had been having difficulty sleeping because of the children being taken from him. BN described Graham Dillon's demeanour as insincere.¹⁸²

973. BN stated that the case remained unallocated and, given that CO was a new practitioner, BN had the responsibility of managing the case herself.

¹⁸⁰ Transcript pp 1160 - 1256

¹⁸¹ Transcript of Proceedings, p 1171

¹⁸² Ibid 1173

974. BN stated that on 12 November 2014 she was advised by police that they had found the children and their mother. Both BN and CO interviewed the mother and the children.
975. BN recalls observing SK's presentation and that it appeared to her that SK held genuine fears in regard to Graham Dillon and that she appeared to care very much for the children and their well-being. BN had no concerns in respect to the children being in the care of their mother. That was her gut instinct of the situation.¹⁸³ The children also appeared to be comfortable in her care.
976. BN gave a summary of the history given to her by SK about the situation with Graham Dillon and the children. BN stated that they did follow-up on those allegations.
977. BN stated that she was aware of the allegations against Graham Dillon, in that he was violent and a drug abuser. She had made enquiries in respect to Graham Dillon's criminal history from Tasmania and had been provided with a statutory declaration by both UN and SK's cousin.
978. BN also received a letter from BP which supported Graham Dillon. BN said she quickly formed the view that Graham Dillon was a concern in respect to whether the children were safe in his care, given the information, which had been to some extent substantiated, of domestic violence in his past. BN agreed that she quickly formed the view that the children may be at risk in his care.¹⁸⁴
979. BN stated that she assisted CO in preparing a Form B for the Interim Accommodation Order application. Form B is a document to provide a court with summary of the events relied upon.
980. BN agreed that the Form B could have had more comprehensive information upon it, including the material received from the ACT ILO of prior reports of abuse in the ACT.
981. BN stated that she developed a safety plan for SK which involved her being off-site from the court when the application was made due to the genuine fear she felt regarding Graham Dillon. At that time the Shepparton courthouse did not have security screening on site and there was little in the way of security guards or private rooms.
982. BN gave a history of the court proceedings heard by Magistrate 2 and identified that the matter was adjourned that morning so that Graham Dillon could obtain legal representation - which he did.
983. BN said that the Form B goes to the Magistrate in the morning prior to court. BN stated that her recollection was that Magistrate 2 said that SK had unilaterally removed the children from their father, and that she should have done that through the correct process to retain the care of the children. BN recalls that the Magistrate had the referral letter from BP which he considered.¹⁸⁵
984. During the course of the proceedings, BN recalled making a telephone call to NL. She left a message. The assumption was that she did so to get some knowledge or information about the family.

¹⁸³ Ibid 1174

¹⁸⁴ Transcript of Proceedings, p 1179

¹⁸⁵ Ibid 1186

985. BN opined that it was her view that the solicitor acting for the Department did not make fulsome submissions and she felt frustrated that he did not argue, in her view, quickly enough for the children.¹⁸⁶
986. BN reflected that the children were extremely distressed when they were informed that they would be returned to their father. BN stated they were hysterical, and it was distressing for everyone. BN also said that SK was remarkable in trying to calm them and reassure them, while holding it together.¹⁸⁷
987. BN reflected that the information she got from the children fit the history of family violence alleged about Graham Dillon.
988. BN said she was very concerned about the disclosures made, but given the time of day, and as Graham Dillon was to pick up the children, she felt she did not have much in the way of options. BN also stated that when Graham Dillon arrived the children ran to him, hugged him, and made a big fuss.
989. BN stated that it crossed her mind that JL and Bradyn were doing so because they were protecting themselves from getting into trouble with Graham Dillon if he knew they had disclosed the abuse.
990. BN stated she recalled advising SK to report her concerns about the children to CYPS, to make the relevant applications to the Family Law Courts, and also to apply for a DVO in the ACT.
991. BN stated that she does not recall CO saying, “we need to fight this”, or that they need to take the matter back to the court.¹⁸⁸ It was BN’s view that to take any further action would be going against what the court had directed to occur. It did not, at the time, cross her mind that she had other options available.
992. BN stated that after the decision of the Magistrate, both she and CO were visibly upset and spoke with their manager XB.
993. BN agrees that she did make a phone call to NL but disagreed some of the content putting that down to comments made by NL.¹⁸⁹
994. BN agreed that she received an email from NL on 20 November 2014. She cannot recall if she replied to it but does not believe that she did. BN agreed that she received a further email on 24 November 2014. BN stated she was confused about the term ‘report’ because she had already given a report verbally. BN stated that it was not general practice to provide a formal written report, and this is what confused her. BN stated that if the ACT wish to have any further documentation, they needed to go through the ILO process.¹⁹⁰
995. BN was taken to a telephone call from 25 November 2014 from NL. However, she stated that she did not recall this call.

¹⁸⁶ Ibid 1188

¹⁸⁷ Ibid 1191

¹⁸⁸ Transcript of Proceedings, p 1195

¹⁸⁹ Ibid 1197

¹⁹⁰ Ibid 1198

996. BN agreed that she had significant amount of information available to her which could have been provided to the ACT, which was more fulsome than the information included in the verbal report.
997. BN did not recall receiving any request from an ILO from either the ACT or Victoria that requested further information.¹⁹¹
998. BN was not aware that SK had telephoned CYPS asking that they send information to CYPS in the ACT. She said that if she had been aware, she would have allocated someone to do go through the ILO process in order to provide the information.¹⁹²
999. BN was not aware of any further contact by SK to the Shepparton office in respect of the documentation she requested.
1000. BN stated she had no recollection of a telephone call from PG. That call was in relation to follow-up action Victorian DHHS took in relation to the children's disclosure.¹⁹³
1001. BN agreed that she had not made a note of the phone call and best practice would be to do so. BN also stated that if she was at her desk, she would have made a note, however, she receives a significant number of calls throughout the day and she may not have been able to make a note of the call.¹⁹⁴
1002. BN agreed that as a protective intervener she was able to make a further application where new facts or circumstances arose whilst care proceedings were currently on foot.
1003. BN agreed that the disclosures made by the children were of significant concern. However, she said that she needed to take into the account the context in which they were made, with the children not wishing to leave their mother.
1004. BN stated that she would have been reliant on Canberra to put support services in place.
1005. BN said she made the assumption that the document provided by UN was given to the solicitor acting on behalf of the Department. BN also assumed that it would have been tendered into evidence by him.¹⁹⁵
1006. BN agreed that the material provided UN and SKs cousin would add weight to the children's disclosures.
1007. When it was pointed out to BN that the documents were not provided to the court, nor to the solicitor acting for Graham Dillon, BN stated that they were definitely given to the Department solicitor by either herself or CO.¹⁹⁶
1008. BN accepted that the material she had received from the ACT in July 2014, had she read it, would definitely have been information that she would have provided the court.

¹⁹¹ Ibid 1201

¹⁹² Ibid

¹⁹³ Transcript of Proceedings, p 1205

¹⁹⁴ Ibid

¹⁹⁵ Ibid 1211

¹⁹⁶ Ibid 1213

1009. BN accepted that had she was aware of the disclosures made by the children to ACT CYPS Services and that would have assisted her in assessing the reliability of the disclosures made by the children on 17 November 2014.¹⁹⁷
1010. In relation to the disclosures the children made to ACT CYPS, BN agreed that the statement '*hit and kick lots of days ago*' would be an indication of the timeframe in a child's mind and that '*in the new house*' would also give a location and time reference to when the alleged assaults took place.¹⁹⁸
1011. BN agreed that the information about the timeframe in which the allegations were said to have occurred would have been relevant information. She agreed that it was possible that she did not pass that information on to PG.¹⁹⁹
1012. It was put to BN that there had been several phone calls and attendances in relation to requests that information, such as Child Protection Reports be forwarded to ACT CYPS, and that these requests were made to BN in particular. BN agreed that that information was there and that she did not follow up.
1013. BN agreed that the requests were all prompting her to provide something. It was her view, given she had made a report to CYPS, that they would have followed up in that regard.
1014. Further, she said her workload did not allow her to return the call.²⁰⁰
1015. BN agreed that sending the actual case note through would have been a better option and more helpful to the parties.²⁰¹
1016. BN stated that she had examined all of the emails sent to her and she was not able to find an email dated 5 November 2014 from the caseworker. There are emails from that day but not from the caseworker.²⁰²
1017. In relation to not making a fresh application for a new order, BN stated that this was very unusual and had not occurred either before or since. It was the timing of the matter being so short after the first order was made that was most unusual part and posed the greatest difficulty.²⁰³
1018. In relation to her belief that Graham Dillon was a risk to the family, BN stated that
- "it was primarily because Mr Dillon appeared to have complete and utter lack of insight in regards to he assaulted SK when she was pregnant and for someone to do that to his own child just shows total disregard both for the mother and for the child that she was carrying at the time"²⁰⁴
1019. BN went on to say
- "the biggest impact it has is in terms of the power and balance and that SK would have no doubt felt completely disempowered in her position and I would imagine from the trauma

¹⁹⁷ Ibid 1216

¹⁹⁸ Ibid 1217

¹⁹⁹ Ibid 1219

²⁰⁰ Transcript of Proceedings, p 1220

²⁰¹ Ibid 1223

²⁰² Ibid 1226

²⁰³ Ibid 1232

²⁰⁴ Ibid 1236 – 37

that she would have received when she was assaulted that – Mr Dillon was imprisoned for that assault back in 2006 – that she may not have been able to function to her full capacity as a parent, I suppose, due to her disempowerment from her partner.²⁰⁵

1020. BN stated that, had she had the time, she would have conducted lengthy interviews with the father particularly in relation to police history, drugs, and the like. BN also stated that she would have wanted to interview the teachers and principal of the schools.²⁰⁶

1021. BN was asked questions about what she would do if there was information on the children that they had not disclosed. BN stated that she would get information and evidence from other sources. If she was unable to get that information, she said she would not have just closed the file if she suspected that they were being abused. It is important, she said, to have people who have eyes on the children on a daily basis. BN stated that it would be a red flag if the children were not going to school and were not being independently watched.²⁰⁷

1022. BN confirmed that in Victoria they do not obtain the consent of the alleged perpetrator parent for interviewing the children. They would perhaps conduct the interview at the school prior to the perpetrator attending. If it were school holidays, arrangements would be made to interview the children independently at home or in the DHHS office but not in the presence of a parent.

1023. BN confirmed that it is difficult to get skilled workers, particularly in rural areas.

1024. She said there is the pressure of retaining staff which can be difficult and adds pressure to the team managers, particularly in relation to their caseloads.

1025. There was inconsistency between the report from NL and the CARHU report. The CARHU report suggested that there were concerns in respect to the bruising. BN stated that if that information had been provided to her, she would have put before the magistrate.²⁰⁸

CO – DHHS Case Worker During Shepparton Incident, Later a CYPS Case Worker

Statements

1026. At the time of the events, CO had only just begun to work for the DHHS in Victoria. She worked with BN. BN was leading the case involving Bradyn and JL Dillon when they received a report alleging that SK had kidnapped the children after allegedly spiking the father's drink with ice.

1027. CO said that when the children were found by Police, she and BN went to the Shepparton Police Station and interviewed the children, as well as SK, and her eldest daughter.

1028. CO also said she received Graham Dillon's extensive criminal history from Tasmania.

²⁰⁵ Ibid

²⁰⁶ Ibid 1237 – 38

²⁰⁷ Transcript of Proceedings, p 1242

²⁰⁸ Ibid 1255

1029. She said that SK was cooperative, explaining that Graham Dillon had invited her to Canberra for the children's birthdays. While in Canberra she had found Graham Dillon passed out in a chair and that he had used ice. She denied spiking his drink. CO said that SK took the children because she was concerned, and they were not safe with Graham Dillon. SK told the workers that the children had been in Graham Dillon's care as he had never returned them after contact visit a year earlier.
1030. CO asked SK to agree to urinalysis which was conducted. The test revealed a low dose of marijuana. It was her view that Graham Dillon was asked to also undergo urinalysis, but he did not do so.
1031. CO issued paperwork which overrode the recovery order, and they advise that SK could keep the children.
1032. CO's recollection of Magistrate 2 was that he stated that SK should have followed the court proceedings and not taken then children and that she should not be rewarded for her behaviour and therefore the children were to be returned to their father in Canberra.
1033. CO said that she sat with SK and the children in a small meeting room waiting for Graham Dillon to pick them up. It was then that the children disclosed that the father had hit them, and that they did not want to go back to him. They were both crying. They stated that he had hit them and thrown them onto beds and lounges.
1034. CO said that she took BN aside and told her that they could not send the children back given the disclosures. It was her view that they should take the matter back to the court to fight the decision. She was advised by BN that the decision was final. When Graham Dillon turned up the children hugged him.
1035. CO said that she recalled BN was not in agreement with a court decision and said that she was going to contact Canberra CYPS to transfer the case and to express concerns regarding the children being in Graham Dillon care.
1036. CO so that she recalls advising SK she was moving to Canberra to work for CYPS and that she would look out for the children.
1037. CO said that she accepted a Senior Caseworker position with CYPS in Canberra and left Shepparton in early December commencing in Canberra shortly thereafter. During her first week she went to collect work and saw a paper with JL and Bradyn's name on it and there CYPS worker PG. CO said she approached PG and told her that she been involved with the children in Victoria and was glad that the case had been allocated.
1038. CO advised that PG told her that the case had been closed because there was no risk. CO told PG to contact Shepparton DHHS as they had information regarding the risk that Graham Dillon posed to the children.
1039. CO also advised PG that she should get the criminal history from Tasmania and not to close the case until she had the evidence and had reviewed and reassessed case.
1040. CO believed the case was closed. She was aware that only the caseworkers were entitled to access the files. She recalled that LT was the manager at the time. She believed that although she told PG her opinion it was not taken into account.
1041. CO stated that she had heard in early 2016 that there had been the death of a child. The case was secured on the system and she googled the Canberra Times and saw

Graham Dillon's picture in the headline regarding Bradyn. CO said she felt sick, angry, and shocked and approached a woman who she believed was PG and advised her that she had been working on a case in Victoria and she would like to share her assessment of SK as being a safe and protective parent. She was never contacted by anyone.

In Evidence before the Inquest²⁰⁹

1042. CO had worked with DHHS in Victoria for two and a half months toward the end of 2014. At the time she was a caseworker.

1043. CO recalls that she was aware there was a warrant out for the children and was advised that police had found them, and they were taken to the Shepparton Police Station. The children were interviewed, and CO took notes of that interview. CO advise that BN was the principal assigned case worker and that she was the second.²¹⁰

1044. CO stated that she was advised by SK that she took the children from Canberra because she was concerned about their safety as Graham Dillon was an ice user and had a violent history. That history included Tasmanian records. SK also said that she had raised the children mostly herself. CO stated that SK told her that the children went to see their father for a holiday, but he never returned them.

1045. CO stated that the children spoke about wanting to live with their mother, but also talked about wanting to stay with their father but mostly they wanted to stay with their mother.

1046. CO stated that after she had considered all the material, and interviewed the children and SK, it was her view that SK was the safe and protective parent not Graham Dillon.²¹¹

1047. CO stated that both she and BN were satisfied that it was appropriate to obtain an Interim Accommodation Order. They had also visited SK's home and were satisfied it was an appropriate place for the children.

1048. CO had a recollection that she attended court on at least one of the occasions. On that occasion SK was not present at court because it was deemed to be too dangerous for her given Graham Dillon would be there. It was also CO's recollection that he was represented by a lawyer and there was a lawyer for the children.

1049. CO also had a recollection that they were not given very much time to finish their investigation and she felt they were not given time to be heard by the magistrate either. CO's memory was that she was thinking why isn't anyone fighting for the children.

1050. CO stated that after the children made disclosures and were upset by the fact they had to be returned to Graham Dillon, she said '*we need to fight this we cannot allow them to go back*'. However, she was told that the court's decision is final. Graham Dillon turned up fairly quickly and the children both ran to him, hugged him, and he walked out with the children.

²⁰⁹ Transcript pp 995 – 1047, 1323 - 1338

²¹⁰ Ibid 1000

²¹¹ Transcript of Proceedings, p 1004

1051. CO also stated that because she had secured a job at the ACT CYPS, she told SK that she would look out for the children. CO also stated that she had some contact with SK prior to moving to Canberra and it was her view that SK appeared to be very confused about the legal system. CO stated

“my impression was that [SK] had tried many times to – and cried out many times, to get help through family law court and also through Child Protection in Victoria and in Canberra and I feel that she never really assisted”²¹²

1052. CO also stated that she had spoken to BP and advised him of the situation. He said to her that there were two sides to every story, and he had no concerns for the children’s safety. CO formed the view, having considered all the material before her, that BP had no understanding of what was going on.²¹³

1053. CO stated that she commenced work on 9 December 2014 and worked at CYPS for approximately two and a half years. Her role was as a Child Protection worker HP3.

1054. CO stated that not long after she commenced at CYPS, whilst at the photocopier she encountered a person at the photocopier who had Bradyn and JL’s file. CO recalled that she said to that person that she was glad the case was open as she was involved with the children in Victoria. The person told her that she was closing the case. CO told her that she could not do so because the children were at risk because the father is an ice user and is extremely violent toward his partners and the children.

1055. CO stated that she advised that the person should speak to those involved in Victoria and that SK was a protective parent. CO stated that the person refused to engage with her in conversation and walked away. CO clarified that she told this person that Graham Dillon uses ice and she told her that his drink was not spiked by SK.

1056. CO was advised that SK did indeed spike his drink contrary to what SK had told her. CO stated that she had no ability to be able to chase up this matter with anyone and that she would have lost her job if she had looked on the system in relation to Bradyn and JL.

1057. CO stated that she was working at CYPS at the time of Bradyn’s death. CO stated that she reported to LT that she had worked with the family in Victoria and was extremely impacted by the death.

1058. In relation to the teams, her Team Leader left unexpectedly after a family tragedy and didn’t come back. There were numerous acting Team Leaders who worked in the role. During the period she worked for CYPS it was her view that the workload for caseworkers was very hard and very busy.

1059. Given that CO had worked in DHHS, CYPS and DOCS New South Wales, she was able to identify that the workload in the Shepparton office was crazy and unsustainable. DOCS and CYPS were similar in that there were very high caseloads and reports, it was full on.²¹⁴

²¹² Ibid 1014

²¹³ Ibid 1015

²¹⁴ Transcript of Proceedings, p 1019

1060. CO agreed that she had written the Form B document. CO also agreed that she had taken all of the protective steps that she could have to protect both the children and SK. That include applying for an Interim Accommodation Order.
1061. CO agreed that it was her assumption after the matter being adjourned until the Monday that the Magistrate would adjourn the Protection Application for further assessment. Generally, that would be a four-week adjournment.
1062. CO also assumed that the Interim Accommodation Order would be continued. CO agreed that her view was the court would have given great weight to the Department's position. In fact, she has said she has never seen anything like this in any other Children's Court.²¹⁵
1063. CO opined that in other jurisdictions you're always given an adjournment to conclude your investigations, that also includes Canberra.²¹⁶
1064. CO agreed that her impression of Magistrate 2's decision was more about punishing the mother, rather than what's in the best interests of the children.²¹⁷
1065. CO stated that the children made disclosures of violence when SK and BK were present. When SK and BK left, the children were pleading with the workers, stating they didn't want to leave and wanted to stay with their mother.
1066. CO also agreed that the children had not been with their mother for very long and it would take time before they felt safe and secure enough to speak frankly.
1067. CO, having been taken to the New South Wales Government Family and Community Services module in relation to disclosures for physical and sexual abuse of children, agreed with the proposition that the way people react when a child discloses has an impact upon how much information they go on to disclose.²¹⁸
1068. CO agreed that one of the most important considerations when listening to a child is the fear that the child may have about disclosing the information. CO also agreed that in those circumstances, the child may only partially disclose so as to test the reaction of the people they are disclosing to. CO also agreed that the initial disclosure is extremely important because the child may make disclosures that may never be revealed again.²¹⁹
1069. CO also stated that it could be the case that they had told someone, and nothing had been done, children would then be highly unlikely to speak again.²²⁰
1070. CO disagreed with the proposition that she wanted to go back to court after the children had disclosed and said that was not part of her decision-making. She stated it was because she had already determined the children were unsafe with Graham

²¹⁵ Ibid 1034 – 1035

²¹⁶ Ibid

²¹⁷ Transcript of Proceedings, p 1038

²¹⁸ Ibid 1041

²¹⁹ Ibid 1041

²²⁰ Ibid 1042

Dillon and that she never expected the decision would be made by the court that the children would be returned to Graham Dillon.²²¹

1071. It was suggested that because the major concerns focused on the children's physical, personal, and emotional safety and that they had disclosed but had not yet been returned to the alleged perpetrator, the chance of them disclosing could evaporate. CO agreed and said that as part of a safety plan regular eyes should be on the children, such as when they attend school.
1072. CO agreed that if she had records from CYPS in November 2014, they would have assisted in the investigation, and they could have helped as they could have been placed before the magistrate.²²²
1073. CO stated that the police report come through that Graham Dillon had alleged that SK had spiked his drink with ice. However, CO was suspicious of that because you can't spike a drink with ice.
1074. CO was asked questions in relation to the conversation she had about SK spiking Graham Dillon drink with ice. It was suggested to her that the timing was not correct given she work had only just been allocated the case that PG would not be considering closing the case. CO suggested that it was at the commencement of her time at CYPS that the conversation took place.²²³
1075. It was suggested to CO that given her level of concern for the children and her experience caseworker; she should have raised the matter with a supervisor. CO disagreed and said that because it was an open case, she was not able to speak to anyone about it and that was the culture of the workplace.²²⁴ Given the case was still open and they were continuing the current investigation there was no information to give.²²⁵
1076. CO confirmed that she was not aware that she could have applied for a new Interim Accommodation Order after the disclosures in Shepparton because of the new facts, and questioned why it wasn't done by a more experienced person such as BN.²²⁶
1077. CO was of the view that the report that BN was to make to CYPS was either a phone call or email or both. Her understanding was that a transfer of documents would also occur.
1078. CO was referred to the records that were available regarding reports from CYPS referring to facial bruising on the children and stating that there was an open appraisal. CO stated she was speechless about the fact that she did not have those records, particularly given that there was an open report and that would have been relevant to the magistrate.²²⁷

²²¹ Ibid 1045

²²² Ibid 1316

²²³ trench page 1321

²²⁴ Transcript of Proceedings, p 1321

²²⁵ Ibid 1322

²²⁶ Ibid 1325

²²⁷ Ibid 1330 – 31

1079. CO stated that it was her view that if a report is made in relation to bruising for a child the previous history must be considered and reconsidered in light of the new information whether the report is substantiated or not.²²⁸
1080. CO gave an explanation of the role of a second, which was essentially as a backup to the primary worker. The second would take notes particularly on home visits or when interviewing but aside from that they would not be involved.²²⁹
1081. CO also stated that she could not recall having any training when she commenced work with ACT CYPs, but she essentially learned on the job.²³⁰
1082. CO also understood that the Team Leader's role was to support the caseworker, to guide them, and to approve or not approve the work they had done. During her time at CYPs she investigated matters and discussed those cases collaboratively with her Team Leader.
1083. CO also stated that she would get directions from the Team Leader and would seek information from the Team Leader. CO also recalled that if there were further enquiries that need to be made, the Team Leader would recommend that she do so.
1084. CO also stated that when examining the previous investigations, she would look into the source, "*in super detail, everything*"²³¹ that included the electronic file and the paper file.

DO – Senior Child Protection Practitioner, Shepparton, Duty Officer in 2014.

Statement

1085. DO recalled SK attending the Shepparton office informing her that Graham Dillon had ceased taking her telephone calls and she was unable to make contact with her children. Her last contact with the children was 24 December 2014.
1086. SK advised that she believed the case had been transferred ACT Child Protection, but the ACT had not received any relevant documentation from Victorian Child Protection.
1087. SK advised that she wanted BN to know that Graham Dillon had been threatening her because he knew that there was an investigation continuing and he had sent text messages to her containing bullets.
1088. SK provided pages containing the posts Graham Dillon had sent on Facebook.
1089. SK also advised that she had been assaulted by Graham Dillon when she was pregnant, and he had been jailed for it.
1090. DO stated that she emailed BN and advised her of SK's attendance.
1091. On 6 January 2015 SK again reported to the Victorian Child Protection Shepparton offices. It was noted that JL and Bradyn's file had closed at that time.

²²⁸ Ibid 1331

²²⁹ Ibid 1334

²³⁰ Ibid 1334

²³¹ Transcript of Proceedings, p 1335

1092. SK advised that children have disclosed that Graham Dillon had hurt them and abused them, and nothing had been done about it. She also advised that ACT Child Protection have been asking for documentation to be sent from Victoria and it had not been sent.
1093. SK also advised that Graham Dillon had changed his phone number and address and she was now unaware of where the children were. SK said that she had received a telephone call from Graham's brother NE who said that the children were in a "*horrible situation*" and that he had observed that they appeared to be hungry, and that Graham Dillon had left them inside the car whilst he was gambling.
1094. Graham's brother also advised that the children were directed about what they should and shouldn't say and that the children had not been attending school.
1095. NE also advised that he had observed Graham Dillon stealing and when NE told Graham Dillon that he shouldn't he became abusive he put the children in the car and drove off erratically.
1096. NE believed Graham Dillon was using drugs and SK advised that he did not have a current license at the time. SK also advised that his ex-wife, UN, had an intervention order against him and their children because he was unstable and unbalanced.
1097. DO stated that she emailed BN to advise of SK's attendance. DO said she was unaware whether the Interstate Liaison Officer had been informed of ACT Child Protection's request for documents.

CF – Senior Child Protection Practitioner, After-Hours Service, DHHS.

Statement

1098. CF has no independent recollection of dealing with Bradyn and JL. However, she recalls that on 4 November 2014 she was asked by her team manager, NX, to apply for a Safe Custody Warrant in respect to Bradyn and JL. CF also advised Police of the application. CF advised that Victoria Child Protection had no record of Bradyn or JL.
1099. CF contacted Child Protection in the ACT and spoke with an Intake Worker. She was advised that ACT Care and Protection had a case open in respect of Bradyn and JL. CYPS advise that NL was the case manager, and that NL would telephone her.
1100. NL advised CO of ACT CYPS's involvement but stated that the case was currently closed, with the last involvement being on 14 October 2014. NL also advised that there had been an investigation regarding the children presenting with bruising while being in Graham Dillon's care. However, these reports were not substantiated and were not considered to be suspicious. NL advise that the children had been staying with Graham Dillon for approximately one year.
1101. NL also advised that there was a current intervention order in place against the mother, SK, who reportedly attempted to abduct JL and Bradyn in the past. NL further advised that the children had made disclosures that they were scared of SK and that she hurt them.
1102. CF and her manager discussed the need for a Safe Custody Warrant and decided to proceed with that action. At the time CF and her manager were unaware that there

was an allegation that SK had drugged Graham Dillon and abducted the children and that there had been safety concerns identified by CYPS.

1103. NL advised via telephone that the usual course in these circumstances is that the ILO in the relevant state would contact the ILO in the other state to share relevant information. However, given there appeared to be immediate concerns she was willing to discuss the ACT's previous involvement with Bradyn and JL via phone and email.
1104. CF advised ST, another CYPS worker, that she was preparing and applying for a Safe Custody Warrant. Given the information she had in relation to both JL and Bradyn, she considered there was imminent risk of significant harm to the children. The application for a Safe Custody Warrant was granted, and CF advised Police in Shepparton that the warrants were active.
1105. CF contacted Graham Dillon to advise him that a Safe Custody Warrant was active. Graham Dillon advised CF that he believed he had been drugged by SK and he had given blood to Police so that they could investigate.
1106. Graham Dillon also advised that SK had made false accusations against him, but that Child Protection had cleared him as a good father.
1107. CF said that she forwarded a copy of the email from ST to AC who was Intake Officer for Bradyn and JL in this matter.

In Evidence before the Inquest²³²

1108. CF was a Child Protective Services after hours officer. Her office was located centrally in Melbourne not in Shepparton. CF stated she worked as a shift worker, working afternoon and night shifts and occasionally day shift.
1109. CF was working on 4 November 2014, which was the Melbourne Cup public holiday.
1110. CF has worked in the field for 23 years. Her role was explained as an after-hours service which receives reports of children at risk of harm. It's a centralised service. This can also involve reports about existing clients. The caseworkers are responsible for documenting all information on a state-wide system, which is then passed on electronically to divisional and local offices.
1111. A determination is made as to whether the matter is urgent, and if so whether it requires urgent follow-up. Notes from the conversation with the person making a report is recorded on the database system, which is known as CRIS or Client Relationship Information Service.
1112. CF stated that sometimes she typed directly into the system or sometimes she might type it into a Word document which is then uploaded to the system.
1113. CF stated that the Dillon file was handed to her on 4 November 2014, but she has no independent recollection of it. Generally, the management team would meet to discuss the business and allocate the jobs at the beginning of a shift. That allocation is dependent on workload demands and priority.

²³² Transcript pp 869 - 906

1114. CF stated that she received a report that police were looking for the children. Based on the material before her there was a concern that they needed to apply for a Safe Custody Warrant. CF then made a call to New South Wales, but they did not have any record she then made a call to ACT CYPS and spoke with NL.²³³
1115. CF stated that after speaking with NL, she was advised that there was a history of involvement with ACT CYPS, but the case was currently closed.²³⁴ After further discussion, NL advised that any further material or information required would need to go through the ILO.²³⁵
1116. CF agreed that she received a further phone call from NL confirming that because the matter was urgent, and she had confirmed with the ILO, she was willing to discuss the ACT's involvement directly with CF.
1117. After further conversations she prepared an affidavit in support of an application to issue Safe Custody Warrant. These matters are done on the papers with the Duty Magistrate. CF said once the order was granted she would notify the police and also the father of the children that the warrant was active.
1118. Once the two children were located an immediate response was required to commence proceedings for a Protection Application to bring the children within the jurisdiction of the Department.
1119. CF agreed that she forwarded information she received from the ILO to AC. However, she has no recollection of reviewing the information sent to her as it was her position to hand over the information to the allocated worker, who was AC.
1120. CF stated that there was difficulty uploading large documents to the CRIS database and she would not have the capacity to do so.²³⁶
1121. CF stated that in relation to the difference between the two DVOs, one that did not include the children in her opinion it would not have made any difference given that there was an allegation she had drugged the father and the person that she was partnered with at the time was of concern to the Department.²³⁷
1122. CF agreed that having further information, even though she had already made the decision to apply for the warrant, would have been very helpful for both the warrant and the protective assessment once the children had been located.²³⁸
1123. CF agreed that when forwarding on the email to AC she did not include the attachments because of the difficulty with uploading it to CRIS database. However, in hindsight she said she could have placed a note on the system advising that there were a large number of attachments.²³⁹ CF agreed that that would been 'best practice'.

²³³ Transcript of Proceedings, p 875

²³⁴ Ibid 876

²³⁵ Ibid 877

²³⁶ Transcript of Proceedings, p 885

²³⁷ Ibid 890

²³⁸ Ibid 899

²³⁹ Ibid 902

1124. CF agreed that she was not told that the information she had received from NL or the ILO was incorrect.²⁴⁰

1125. Regarding the blood test Graham Dillon said he had participated in, this raised concerns in respect to the mother. CF was not aware that there were allegations that Graham Dillon was using methamphetamine.²⁴¹

1126. In relation to the documents sent by ACT CYPS to the Victorian ILO, CF stated that were also not uploaded to CRIS.²⁴²

Shepparton Children's Court Proceedings

TQ – Former DHHS Solicitor, Appeared for DHHS in the Shepparton 2014 proceedings

Statement

1127. TQ is the Principal Solicitor at a private law practice in Shepparton. In November 2014 TQ was working as a solicitor employed by the DHHS. TQ was instructed in relation to a protection application in November 2014. TQ used his notes for the purpose of his statement as he had no independent recollection of the matter.

1128. TQ outlined the applications filed in respect of both Bradyn and JL on 14 November 2014 and the grounds upon which the Department relied on for that application. That is that the children had suffered or were likely to suffer significant harm as a result of physical injury or emotional psychological abuse.

1129. The protection application was filed on the father and the mother. A summary information form also known as a Form B was also filed in support of the application.

1130. The Form B document filed with the application outlined documents in the possession of the Department. These included Graham Dillon's Tasmanian Police records, concerns regarding Bradyn and JL being in their mother's care, and concerns about their father. The application was in relation to an Interim Accommodation Order for the children to live with their mother, as their father was considered to be a security risk because he was very aggressive and violent and had an extensive history of family violence.

1131. The application was successful, and the court made the order. The matter was adjourned to 17 November and was heard in front of Magistrate 2.

1132. TQ noted that the notes he took contained the application he made and that the Form B, together with instructions he received from the Department formed the basis of his submission. TQ requested an adjournment. Magistrate 2 made a comment in respect to the mother not abiding by the court in the ACT and noted that Magistrate 2 said any investigation in respect to the father could continue whilst children were in his care, and needed more than suppositions, suggestions, and possibilities. He believed those comments were in respect to the application for an adjournment.

²⁴⁰ Ibid 904

²⁴¹ Ibid 904

²⁴² Ibid 906

1133. TQ received instructions to withdraw the protection application dated 12 December 2014 given that the children were no longer in the jurisdiction. The application was subsequently withdrawn on 15 December 2014.

In Evidence before the Inquest²⁴³

1134. In November 2014 TQ had been working as a lawyer for approximately four years, having been at the DHHS for a period of approximately 12 months.

1135. TQ stated that in the period he had been at the DHHS prior to November 2014 he had received no legal training in relation to his role as a solicitor in Children's Court matters. He stated that the only training he underwent was the 'Beginning Practice' training relevant to child protection workers. This training was a module that took about three to four weeks to complete.

1136. Prior to appearing in the Shepparton Children's Court, TQ stated that he had experience in appearing in Children's Court matters as a private solicitor for about two years prior to his joining the Department.. This experience was at a firm in Hamilton, in South West Victoria.

1137. TQ stated that he first started appearing in the Shepparton registry in the last Court sitting week of 2013, which would have been around 20 of December that year.²⁴⁴

1138. TQ said the volume of matters in the Children's Court list was quite high, with the average number of matters on any given Friday being around "four to five" matters.²⁴⁵ It was TQ's recollection that matters were listed on Fridays from 9:30am, with emergency applications being listed around 11am and occasionally other matters listed around 2pm.

1139. TQ told the inquest that in November 2014 the number of files he held was 'very, very high' stating that:

'the case load in Shepparton was very high. It would be in excess of 20, 30, possibly up to 50 at a time'.²⁴⁶

1140. TQ also gave evidence that particularly when the matter was an emergency matter, he would be receiving instructions 'just before appearing in court'.²⁴⁷ These instructions were received orally and in the form of a summary information form, known as a Form B. TQ confirmed he received instructions in the form of a Form B in the matter of the Dillon Family.²⁴⁸

1141. In the matter of the Dillon Family, TQ also spoke to the case worker in the matter, who is recoded in his statement as being a case worker by the name of CO.²⁴⁹

²⁴³ Transcript of Proceedings, p 1666 – 1718.

²⁴⁴ Transcript 1667

²⁴⁵ Ibid.

²⁴⁶ Ibid 1668.

²⁴⁷ Ibid.

²⁴⁸ Ibid.

²⁴⁹ Ibid.

1142. TQ stated that he has no recollection independent to his statement of speaking to CO prior to his first appearance in the Dillon matter on 14 November 2014.²⁵⁰
1143. After reviewing his statement, TQ confirmed that on 14 November 2014, there was an application under s 162(1)(c) of the Children, Youth and Families Act Victoria 2005. TQ explained to the Court that:
- “The threshold test is that there has to be a significant risk of harm for the Department to file an application. The threshold shifts subject to the degree of risk as to whether the children remain in the care of their parents or they are removed from their parents’ care, and for them to be removed, the level of risk has to be unacceptable.”²⁵¹
1144. TQ said that having refreshed his memory with his statement, the orders that he would have been seeking in the Dillon matter were that the children be placed into the mother’s care on an Interim Accommodation Order.
1145. TQ said that he couldn’t recall the submissions he made on the day but that the submissions would likely have been around the risks that the father posed given the allegations of family violence against him, as well as in relation to the drug use.
1146. TQ, having been shown a copy of the Form B in the Dillon family matter confirmed that the information at point 9 on the Form B would have formed the basis of his submission regarding the risk of family violence posed by the father. Point 9 of the Form B stated:
- ‘Child Protection have obtained documents from Tasmania Police 15 detailing a significant family violence history perpetrated by Mr Dillon towards Ms Jones. The violence was significant and included Mr Dillon assaulting Ms Jones when she was pregnant in 2006. Mr Dillon was charged and served gaol time for this offence.’
1147. TQ stated that he was not able to access the Tasmanian Police material. This was because of the nature of emergency care applications and the timing of them. TQ explained that the solicitor acting for the Department has very little opportunity to review any evidentiary material, and the fact that the timing of the instructions would have been very late and as such TQ “would have simply had to rely on the instructions from the ... protective worker.”²⁵²
1148. TQ gave evidence that the entirety of the submissions made on 14 November 2014 would have been based solely on what is recorded on the Form B and any further verbal instructions received from the case worker on the day.
1149. TQ confirmed, based on his statement, that the matter was heard at 2pm on 14 November 2014 by Magistrate 1 and that the Interim Accommodation Order was made.
1150. According to TQ’ statement, SK was represented on 14 November by R Higgins and Graham Dillon was not at court and not represented.
1151. TQ stated that in cases where there is one represented party, other than the Department, the orders may be made by consent.

²⁵⁰ Ibid.

²⁵¹ Transcript p 1669 at [25].

²⁵² Transcript p 1670

1152. After the hearing on Friday 14 November 2014, the Dillon family matter was put over to Monday 17 November 2014.
1153. TQ stated that the reason for the matter being put over for such a brief time may have been to allow the father to attend. He stated that *'otherwise the matter would have been adjourned for anywhere up to three weeks.'*²⁵³
1154. Regarding reporting the outcome of the 14 November hearing to the Department, TQ stated that in the first instance the worker would have been present at court and therefore aware of the orders made and the adjournment date.
1155. The interim order on 14 November was made with eight conditions. These included that the mother must accept visits and cooperate with DHHS. TQ stated that it may have been the case that these conditions were made by consent, given the absence of the father.
1156. TQ further stated that while he had no specific recollection about what he did after the 14 November court appearance, it was his practice following a court date or mention to send an email to the case worker advising of the outcome, any issues that the worker would need to be aware of and when the next court date is. However, he stated that on the occasion of 14 November it is unlikely that he would have done so on this occasion.
1157. TQ stated that in an ideal world after reading a Form B he would provide advice to the case workers about what further information might be provided or what documents might assist him in appearing on behalf of the Department on the next occasion to satisfy the court that the orders sought are appropriate and supported by evidence. However, he stated that working for the Department as a solicitor was not an ideal world.
1158. The factors that made the Department not the 'ideal world' were articulated by TQ as being :
- "the volume of the work, the timing of the instructions, on occasion the quality of the instructions, the lack of departmental support for myself as a lawyer would make it very difficult to provide proper and timely advice. I also include in that that I had no administrative support to assist me with processing legal files, so it would have been very difficult – not to mention that it would have been a Friday afternoon, and the matter would have come back on the Monday morning. So, very little opportunity."²⁵⁴
1159. TQ stated that he had no independent recollection of what occurred in the Dillon matter on 17 November but noted that as Monday is mention day in the Shepparton Children's Court he would have had a number of other matters on that day. After consulting with his notes, TQ confirmed that he dealt with six matters on 17 November in the Children's Court.
1160. TQ agreed, based on his notes and statement that he initially sought to obtain an adjournment and orders on behalf of the Department on 17 November. At some stage he became aware that the father was at the court and represented by Ms FL and that the father was opposing the orders sought by the Department and that the father was

²⁵³ Ibid 1671.

²⁵⁴ Ibid 1672.

seeking the restoration of the children to his care. Following this, the matter was set down for a submissions contest at a later point in the day.

1161. TQ stated that submissions contests usually occur in the context of an emergency application. The issues to be dealt with would either be placement of the child or contact between the child and the parent. When the Department makes submissions, they are in the context of removing a child from a parent's care, these submissions would go to the issues of risk and whether it was acceptable or unacceptable risk.
1162. Again, TQ stated that the Department's submissions would be based solely on material contained in the Form B and/or oral instructions. He stated that it was not ordinarily the case that evidentiary support of submissions is provided by or on behalf of the Department or other parties in a submissions contest.
1163. Counsel Assisting showed TQ the statement of FL in which she recalls that Graham Dillon attended court on 17 November with a number of documents, being a letter from BP at CanFaCS, an email from NG the Principal of Boronia Heights Primary School, and a DVO dated 26 September 2014.
1164. TQ stated that he did not personally recall whether documents referred to by FL were provided directly to him at court. He stated that he would often find that as a solicitor for the Department the Shepparton Children's Court was a very '*antagonistic working environment*'.²⁵⁵
1165. In response to a question from Counsel Assisting in which it was suggested that FL would not ambush him with the documents, he said he could not comment.
1166. TQ said that he believed the lawyers for non-DHHS parties were antagonistic towards the Department and that he felt that he '*was the meat in the sandwich on many occasions*'.²⁵⁶
1167. TQ again stated that he felt there was minimal support for him in his role as a solicitor.
1168. In terms of whether he felt supported by the case workers if he needed to take further oral instructions or give them advice as to what further material might assist him in his submissions before the court, TQ said that it would depend on the case worker.
1169. With respect to CO, the case worker in the Dillon matter, TQ said he had a vague recollection of CO. He said that she was perhaps a fairly new worker, at least in Shepparton, and that she was not difficult to deal with.
1170. With respect to another case worker BN, TQ said that he did have recollections of her and that he would characterise her assistance in Children's Court matters as '*not helpful*'.²⁵⁷ He elaborated that:

"...if I gave her advice that wasn't consistent with her point of view she would not accept my advice."²⁵⁸

²⁵⁵ Page 1676.

²⁵⁶ Ibid.

²⁵⁷ Ibid.

²⁵⁸ Ibid.

1171. TQ stated that instances of BN not accepting his advice occurred 'with some regularity to say the least'.²⁵⁹
1172. TQ said that he would rarely have the opportunity to note down all the submissions he makes before the Court on any given day in a submissions contest. With respect to the notes he made about the 17 November appearance, he stated that what is recorded in his notes would not be a full record of all the submissions he made on that day. Rather, it would be a recording of what others may have said.
1173. Counsel Assisting highlighted that there was no transcript of the proceedings from the Children's Court on 17 November, and as such the inquest has been relying on witnesses to ascertain what documents may have been tendered, if any, and what submissions were made on behalf of the parties.
1174. TQ was shown an annexure to HS's statement that included the criminal history and criminal involvement of Graham Dillon in Tasmania.
1175. In response to a question as to whether he had any recollection of seeing or reviewing those documents prior to the first mention on 14 November, TQ stated that he has no recollection of seeing those documents.
1176. TQ was taken to an application for a FVO in 2006, and the following extracts from that FVO application was read to him:
- "on 16 February 2006 at approximately 8.30 am, the victim and the offender were going to see victims (sic) for her first day of school. Victim and the offender had been arguing earlier that morning. The victim was afraid to get into the car with the offender. The offender, 'if we can move to the next page, 'the offender became angry, said to the victim, 25 "Get in the car you stupid bitch,"" we move down to the next paragraph, you can see there is more language used by the offender where he says, 'you've got something to fucking say,' and some further lines down, the fifth line from the bottom of that large paragraph that says, 'The offender continued to threaten to kill the victim'. If I take you four lines further down, it says 'In 30 the afternoon, the victim was on the front veranda carrying a basket of washing. The offender approached the victim and kicked it - kicked at her. The victim moved out of the way and the offender kicked the basket of washing... The offender came into the room behind the victim, took hold of 35 her by the arm and threw her across the room. The victim, um, ah, got caught in her daughter's clothing and this caused the child to be thrown across the room with the victim. Both the victim and the child hit the wall.'"260
1177. In relation to the above extract, TQ was asked whether he would have used this information in his submissions on 17 November if he had it to hand. In response TQ said he doubted he would, because the allegations were from 2006 and the Department's application was in late 2014.
1178. TQ was asked whether the fact that the child JL was the infant mentioned in the 2006 allegations would have been something of importance to a magistrate in considering whether that child should be placed back in the father's care. TQ stated that it would be relevant to a current application if it was to support current allegations that could be relied upon.
1179. TQ stated that the legal file when he was brief to appear in a matter would only include limited documentation and that documentation would be in a Form B.

²⁵⁹ Transcript of Proceedings, p 1677.

²⁶⁰ Transcript of Proceedings, p 1679.

1180. TQ stated that the file he had at court and the file that the case worker would have had at court are two separate files. He further stated that the lawyer and the case worker did not have access to each other's files.
1181. In response to a question from Counsel Assisting, TQ stated that he could not recall whether he was provided with the Tasmanian Police notes, as well as a number of other documents referred to in paragraph 7 of his statement on 17 November.
1182. In relation to a statutory declaration from UN, TQ said he had no recollection as to how or why that statement might have been produced on 17 November.
1183. TQ agreed that information regarding Graham Dillon's threats against the life of SK and UN would be current and relevant to the proceedings on 17 November.
1184. TQ stated that he recollects that Magistrate 2 made the decision to place the children back in the father's care on 17 November.
1185. TQ stated that given it was a busy list, the applications were quite quick. He agreed with the characterisation of Magistrate 2 as getting straight to the point.
1186. TQ stated that he had no recollection of receiving any post mention instructions from case workers relating to disclosures made by the children that the father hit them.
1187. TQ was asked that if he had the information that after the Magistrate made the order returning the children to their father, the children expressed, very forcefully, that they were fearful of their father and that he hit them, whether that would have caused him to go back before the magistrate and seek to vary the order pursuant to section 268 of the Children, Youth and Families Act.
1188. In response TQ stated that if it were possible to get the matter back in that day he certainly would have attempted to. However, if that was not possible and if it was brought to his attention, he stated that he certainly would have advised the workers to consider having the matter abridged and brought back in a day or two of the 17th.
1189. Counsel Assisting then provided the following timeline to TQ; that the children were taken by the case worker back to their mother, SK, and advised that a magistrate had made an order to return them to the father, the children respond by stating:
- "he hurts me, don't want to say, he kicks us, punches us. Dad picks us up, throws me out on the couch, daddy apologises."²⁶¹
- However, very shortly following these statements being made, when the children are restored to their father they run to him and hug him, indicating behaviour that may be inconsistent with the comments they had made. The father leaves for the ACT very shortly after, leaving a very small period of time in which the Department can take action prior to the father leaving the jurisdiction.
1190. In relation to the above timeline, TQ was asked what his advice would have been in relation to the children at that time. TQ stated that his advice would have likely been to file a fresh emergency care application.
1191. TQ highlighted that in Victoria the workers operate in a similar fashion to police, they file and serve the applications on the parents or relevant parties. He stated that it was

²⁶¹ Transcript of Proceedings, p 1684.

very rare in his experience that a worker would come and see him for advice before filing an application. So a lawyer's input, in his experience, was often minimal and usually the first opportunity to review a matter was when it was either heading to court.

1192. TQ stated that where the application is served on the parents, they are given approximately 2-3 weeks before the matter comes in. However, even in those instances the worker prepares a report. They are supposed to file and serve at least three days before and provide their lawyers with those documents two or three days before.
1193. TQ said in his experience he wouldn't get those reports until, whether it was an emergency or by notice, the morning of the court day. As such, he said the opportunity for him as a lawyer to participate in those processes was minimal.
1194. TQ was asked whether he has ever in his practice gone back before a magistrate in the Children's Court to make an oral application to vary the order under section 268 or to seek a new accommodation under section 270 of the Children, Youth and Families Act.
1195. In response, he stated that he has gone back to court as a lawyer for the Department when the Department has filed an application for a new Interim Accommodation Order to either change the placement of the children, or to vary the orders.
1196. He stated that in his role as a private practitioner he has not filed an application on behalf of a client to either vary an Interim Accommodation Order or to change placement.
1197. TQ stated that he has participated in submissions contests where a party has filed for a new Interim Accommodation Order to change or vary, and he has made submissions in those matters. However, he has not filed either of those applications.
1198. TQ was asked if, when working for the Department, he ever advised the Department to withhold the children against the order of a magistrate if new information provided to him led him to form the opinion that the children had suffered or were likely to suffer significant harm, as set out as the threshold in section 1621 of the Children, Youth and Families Act.
1199. In response, TQ stated that he does not recall ever advising a worker to act contrary to a court order. In relation, to advising a client to withhold a child given fresh allegations, TQ stated he does not ever recall anyone coming to him with a question like that.
1200. Counsel Assisting asked TQ about whether he had any recollection of two phone numbers written on the top of his court book and who they belonged to. TQ stated that he had no recollection, but that the '02' tells him that the numbers are not Victorian.
1201. Counsel Assisting stated that the numbers belonged to two case-workers from the ACT CYPS and asked whether he had any recollection of speaking to or contacting them, to which TQ stated he did not.
1202. TQ said that he believed the names and numbers would have been provided to him at court on the 17th. He said that it is not uncommon for him to write a name or phone number that he is given on the top of his court book.

1203. TQ confirmed in response to a question from Counsel Assisting that he did not recall anyone advising him that the children had made disclosures that their father hit them after the conclusion of the proceedings on 17 November.
1204. Counsel Assisting asked whether TQ received instructions from XB advising him to withdraw the protection application on 12 December, to which he stated that he did.
1205. TQ said he believed that these were the only further instructions he received from child protection in relation to the Dillon children after 17 November.
1206. In response to a question from SK's legal representative as to whether when acting for the Department he would contact that mother directly or if the mother was legally represented if he would contact the legal representative, TQ stated that he would always communicate with a lawyer not a party unless the party was unrepresented.
1207. TQ also commented that in the context of a solicitor for the Department, if he had a question for the mother and she was unrepresented, he would have put that question to the worker rather than the mother or a parent.
1208. TQ agreed that on 17 November his application was for an adjournment so that the Department could continue their investigation into the father. He also said that this was in amongst other assessments that the partner may have sought to pursue.
1209. TQ was asked if it was his impression that the Magistrate believed that the Department would continue to investigate the children's father if they were returned to the father's care in Canberra, TQ stated that he thought that was a fair or reasonable impression to make.
1210. After reviewing part of an email sent by XB, TQ agreed that there was no mention in the email of any further investigation done by the Department into the suitability of the children's care by their father.
1211. TQ confirmed in response to questions, that he had been previously involved with other matters where one parent resides in Victoria and the other parent resides interstate. However, he said this was not often.
1212. TQ was asked whether in his experience it was the case that if an interim order was made for the children to reside interstate, that the Department would simply withdraw any protection order application they had filed. TQ responded that he couldn't give a definitive answer as he doesn't recall any particular matters. However, he stated that he can only comment what he thinks the practice may have been. The Department's practice would have been to refer those allegations to the authorities in the relevant jurisdiction. TQ stated he couldn't comment on the practice beyond that.
1213. TQ was asked whether he thought it was odd that XB's email stated that "*the matter should be left with the Federal Family Court*" rather than another jurisdiction like the ACT's equivalent of DHHS, to which he answered that with the benefit of the materials he had reviewed that morning he would say yes. However, he shouldn't comment too much on something he doesn't know too much about.
1214. TQ was asked how many matters he had worked closely with BN on, to which he answered that he could not say.

1215. TQ was also asked about what his general practice was after an application did not go the way he had hoped it would in court and whether he would give advice to the case worker about the capacity to make an application for a review or a new application under section 268 or 270. He answered that he can't say that was his practice at the time. He did give advice to the Department when he felt that there was an issue that they needed to follow up on.

1216. He further stated that specifically in 2014 it was

"it was a very, very, hectic year. My workload was severely overloaded and opportunity to sit down and write emails or even give advice, I would say would have been – opportunities would have been minimal."²⁶²

1217. In relation to BN, TQ stated that he recalled she was a Team Leader. As to whether she was experienced he stated that she was certainly a very confident person, and repeated as he had earlier stated that when she had a view she stuck with it.

1218. When asked whether it was his expectation that BN would have known about the opinions of the Department with respect to an application for a review of the Interim Accommodation Orders or the capacity of the Department to file a fresh application for interim orders, TQ stated that he would think BN would be aware of those processes.

1219. He further stated that if there was a question of law in dispute, he believes BN would have been aware of appeal process.

1220. In terms of the word, 'review' he stated that the word is used in the context of case planning rather than litigation. The case planning is the internal administration process. However, he stated that he would have expected that someone in BN's position would have had the training to know what avenues would have been open to her.

1221. TQ stated that while he was working for the Department he was located in the same building as the case workers, however on a different floor.

1222. TQ stated that it would have been unusual for a case worker to personally come and see him while he was at his workstation about a matter.

1223. Counsel for the Territory asked TQ whether he had access to the Client Relationships Information System (CRIS) in his role at the Department, TQ stated that he did not have access to that system.

1224. In response to being shown a portion of the transcript of CO's evidence in which she states that she did not understand the court system in Victoria, TQ agreed with Counsel for the Territory that it was consistent with his recollection of CO being new. TQ also went further to state that this would have been the case with a number of workers.

1225. TQ agreed with the Counsel for the Territory that a protective intervenor would be someone who could give him instructions in advance of applications or make certain submissions.

1226. TQ further agreed that CO was relatively inexperienced when it came to the Victorian legislation and her knowledge of what it could empower her to do. However, he notes that he makes no comment on her experience as a social worker more broadly.

²⁶² Transcript of Proceedings, p 1692.

1227. Counsel for the Territory highlighted that CO had specific concerns in relation to the safety of the children due to the disclosures made and that CO likely would have done something, but she didn't seem to understand what the powers under the legislation were. Whilst in the same room you also have BN, who had a greater knowledge of the legislation in place but viewed the position of the court as final. TQ agreed with Counsel for the Territory that there is a tension between these two positions.

1228. TQ was asked whether in the above circumstances he would have been willing to provide CO some advice if she had come to him about what her options were, to which he stated that if she had come to him he thinks he would have.

1229. TQ stated that if he had provided her with advice relating to the relevant parts of the act, that there is a chance she may not have understood due to her being a new worker, in a new environment, with a new language and new terminology. However, he said that he thinks CO would have taken that information back to BN or asked him to speak to BN who would have explained it to her.

While ss 268 and 270 applications are being prepared, settled filed or served, TQ stated that case workers had the option of taking emergency action in the interim, that is take them into safe custody pending the hearing of the application for the new Interim Accommodation Order.

1230. TQ further stated that given how late in the day it would have been, the case workers could have filed an application, taken the matter to a bail justice, and the bail justice could have made an order for a new Interim Accommodation Order changing placement and removing the child from a parent's care. He further advised the matter would have then had to be brought back in 24 hours to the Children's Court.

1231. In answer to a question as to whether this process could be undertaken while the children were in the safe custody of the DHHS, TQ stated that he couldn't give a definitive answer, but he can't see what would stop them from doing that.

1232. TQ stated in answer to a question about the documents including the Tasmania Police criminal history and the letter of UN, that had it been pointed out to him that those documents were available to the workers and therefore to him, he would have used them.

1233. He further stated that the other issue would have been a matter of whether he would have had time to review the documents and mentioned that it was rarely the case that he had such time.

1234. TQ further noted that the documents may have been placed on the legal file after the appearance on 17 November.

1235. TQ was asked what made him say that the documents may have been placed on the file after the 17th, to which he responded that it is because documentation at an emergency application stage was rarely available to him, and he relied on information in the Form B and oral instructions.

1236. TQ stated that if a worker had said to him that they have the information on their file, he would have asked them for it and then placed it on his file. The reason TQ would have placed this information on his file was if there was a need to review the material, for example if the matter was to be brought back to court, he would have had the

information available to him and it would be available to counsel as part of a brief if that is how the matter progressed.

1237. TQ was asked by Counsel for the Territory whether he would have made some use of the documents if they were available to him in the proceedings on the 17th, to which he responded that if they were available he thinks he would have been bound to use them. However, again he emphasised that as a general rule the opportunity he would have had to do so in these types of applications would have been very limited.

1238. TQ was asked whether he has any reflections on how the functions between the DHHS and the solicitor could be improved. TQ stated that the issues were systemic, particularly around processes, providing proper and timely instructions and giving advice.

1239. TQ stated that he felt he needed administrative assistance in his role as a solicitor, particularly in relation to the filing. He also believed there needed to be another solicitor in that office.

1240. He stated that where improvement certainly could have been made is where solicitors could have the opportunity to have one-on-one conferences with workers at the earliest stage.

1241. TQ provided the following example:

“the Department gets reports come in, they – they do a risk assessment, they investigate, they make enquiries of, for example, medical practitioners, schools, all of that sort of thing. If – if it were open to a solicitor to get in on the ground floor of those reports and have an opportunity to become familiar with the facts of the matter, the issues that might arise in relation to those facts, certainly. The solicitor a) would be more familiar with the matter and have a better understanding of what the complaints were about, or the allegations were about, and also have an opportunity to advise the workers as to the merit of the substantive application. Both in terms of the voracity of the allegations, and also the evidentiary base – basis for the allegations, and where there – and have the – the solicitor have an opportunity to point out the flaws in that allegation – in those allegations on the application.”²⁶³

1242. TQ agreed that the above improvements would put the solicitor who appears on the day in a better position to deal with applications that are made on the run or to deal with the events as they unfold in court that day.

1243. TQ further stated that there are other processes that he understands are available to the Department, for example working with parents on a voluntary basis for a period of time. This would provide the lawyers an opportunity to become familiar with these matters even if they are not taken any further.

1244. He stated that by the time it got to the point where a case worker viewed that court orders would be necessary, he thinks that the lawyer would be familiar with those matters. So that a lawyer could advise the workers as to whether the risks are acceptable or unacceptable, and what type of application they should file.

1245. TQ reiterated that if he could recommend anything, it would be that the lawyers are better supported, specifically with administrative support, have more manageable caseloads and have the opportunity to consult with the workers. He also recommended that lawyers have the time to explain process and procedures to new workers and

²⁶³ Transcript of Proceedings, p 1703

allow those workers the time to absorb that information so that when they deal with matters that are going to court, the case workers are better prepared.

1246. TQ stated that the way he attempted to describe it while he was at the Department was that the problem for a lot of the workers, especially when they're new is that they have little or no understanding of court process and procedures. For example, with filing an application they often didn't know that they had to serve the application on a parent and then file an affidavit of service before the matter was listed.
1247. TQ stated that he often found that the workers were distressed due to their lack of understanding, where it affected their abilities to function in the jurisdiction. He re-emphasised that it is about supporting the lawyers, including allowing more time for the lawyers to engage and consult with the workers about the issues they are dealing as well as education for the new workers so that they have a better understanding.
1248. TQ also emphasised that this would assist in matters being dealt with expeditiously and ensuring case workers felt comfortable going to their lawyers for legal advice and then when they get that advice the case workers have a fairly sound understanding of that advice.
1249. In response to a question about where the unacceptable risk test referred to throughout his testimony came from, TQ stated that it is provided for under section 10(3)(g) of the Children, Youth and Families Act.
1250. TQ agreed that he can only remove a child from a parent if there is an unacceptable risk of harm.
1251. TQ also agreed that he was familiar with the research materials from Magistrate Peter Powers, and that he would agree that they are sort of the bible of child protection solicitors and barristers.
1252. He stated that he did regularly have regard to those materials in his practice with the Department. However, the Department didn't provide those materials, he researched them himself. TQ agreed that they are available on the Children's Court website.
1253. TQ agreed that unacceptable risk forms part of the best interest principles that have been referred to as the central consideration whenever you are looking at the removal of a child from a parent.
1254. TQ agreed that he was aware of a DVO that Graham Dillon had against the mother in the ACT that also named the children.
1255. In answer to a question about what would happen in circumstances where there is a DVO out against the mother and she is not allowed to have contact with the children, and an Interim Accommodation Order was made that the children were to be removed from the care of their father, TQ agreed that it would likely that out of home care would be the appropriate option. However, he stated that this does vary or change.
1256. When asked about unacceptable risk in the context as outlined above, TQ stated that the Department would have to make an assessment, as to whether, notwithstanding the Family Violence Order, the children were at risk in the mother's care. He stated that his reading of the materials was that the children weren't at risk in the mother's care.

1257. TQ was asked whether he was aware if the Victorian Magistrates' Court could have varied the ACT Court's DVO that prevented the mother having contact with the children. He stated that he was not, however he would be surprised if they couldn't. However, he didn't know the answer to the question.
1258. TQ agreed that, assuming the court had the power to vary the ACT order, to have kept the children with the mother, the court would have to be satisfied that there was an unacceptable risk to the children in their fathers care, and therefore satisfied to remove them from the father.
1259. It was then put to TQ that it would have to be either out of home care or if the court had the ability to vary the ACT order, then they could put them with their mother. In response, TQ stated that he would think so, but he is not across the areas given the interstate nature and jurisdictional issues. However, thinking that the children being in Victoria, and the allegations having been raised in Victoria, he would think that the Victorian Children's Court would have jurisdiction to take an interstate order into account when making an order.
1260. TQ further stated that in Victoria as he understands it, the Children's Court can hear family violence matters. So he thought it may be open but reiterated that he was not sure.
1261. TQ agreed that the jurisdictional issues would have been an added complexity for any kind of decision he might have had to make on the run-on 17 November.
1262. TQ agreed that Child Protection as a whole, but particularly in Shepparton was under a lot of pressure in terms of workload. He stated that in 2014 they were always understaffed and there was high staff turnover. He stated that there was low morale and that he found that workplace to be dysfunctional and chaotic.
1263. TQ was asked about the context with the Royal Commission into Family Violence in Victoria, and whether he was aware that there had been an enormous increase in demand in family violence matters. He stated that it was a long time ago, and that he knows that family violence was a significant concern for the Department, and he would say that it played a role in the high volume of matters that came in.
1264. TQ agreed especially around 2014 that there were issues with the drug use, particularly ice in Shepparton. He stated that it was the first year of his employment with DHHS and he said that before coming to Shepparton, he was vaguely familiar with the term ice but once he came there he would hear the term ice almost daily.
1265. In response to a question as to whether the ice usage placed additional demands on Child Protection, TQ stated that it was a feature of many of the applications, particularly in Shepparton.
1266. TQ was asked if he was aware of what has happened since he left the Department in terms of addressing the workload issues. He stated that he knows that it has two practising solicitors and that it also has administration support in the Shepparton office. He further stated that to the best of his understanding the two solicitors work only in the Shepparton office and Shepparton Magistrates' Court, but they may go to other courts from time to time.

1267. TQ said that as far as the staffing situation for Child Protection goes, it is his understanding that it have increased the number of teams that are there, but that he doesn't have much more detail than that.
1268. TQ was asked about evidence given by other solicitors that at the time the Form B was relatively new in Shepparton and that people were not familiar with it, but that now there has been quite a lot of improvements to the form and how much information is now included in it for solicitors. TQ responded that the Form B was new when he was there but certainly the instructions were not as detailed as they could have been.
1269. He stated that since leaving the Department he noticed a couple of things, particularly in the last several months, that there has been an improvement in the detail in the Form B and the layout of both the protection reports and disposition report.
1270. In relation to the timeframe for emergency applications, TQ stated that there is very little time for the workers to make any meaningful enquires and certainly less time for the lawyer to come to terms with the significance of the allegations.
1271. TQ agreed that based on his written notes and earlier statements, that the father had made a new interim accommodation application on the 17th, and that this was granted.
1272. TQ agreed that this application would have been made by FL without any earlier notice to him. He agreed that this meant that he was effectively having to do the application on the run.
1273. He agreed that the extent to which he had the material at that time, to which he cannot recall, the amount of time he would have had to review it would have been very limited.
1274. TQ agreed that the court process of allowing an oral application to be made by the father on the day and expecting a response from the Department on the same day as contributing to the lack of time.
1275. TQ agreed that there are some parts of the court process that also place pressure on solicitors. He stated that the matter should have been adjourned to allow the Department and perhaps the mother an opportunity to prepare submissions in relation to the father's oral application.
1276. TQ stated that he thought that he did not ask for an adjournment at the time, as on reflection he does not think he was aware of a 2012 decision around opposing submissions for change of placement in the context of the Children's Court jurisdiction.
1277. TQ was asked about how the existing Interim Accommodation Order could have continued to be in place given that there was a DVO against the mother preventing contact with the children. In particular, whether it was open to the court to have actually been able to adjourn the hearing given that the order currently in place was in breach of the ACT DVO.
1278. TQ responded that he thinks it would have been open to the Department, notwithstanding the DVO, to at least make some enquiries about the allegations that the mother was making and to do an assessment, and then bring the matter back. He stated that they would assess the risk that the mother may have posed to the children, then sought that the children – given their assessment that there wasn't unacceptable risk- be placed in the mother's care.

1279. TQ was asked about the documents on the paper file, which he states he cannot recall when they were placed on the file, and whether someone else could have received the documents. In response, TQ stated that he was the only solicitor sitting in the office at that time, that there was a Mr Gladstone who was in the Wangaratta office but that he can say with confidence that it would be more likely than not that he would have placed the additional documents on the file.
1280. TQ stated that the legal unit was in complete chaos and he had spent most of 2014 re-ordering it. He would have asked for copies of those materials at some point, and then placed them on the file. In relation to when he would have put the documents on file, he said that would be as soon as possible after he had obtained them..
1281. TQ was asked about a letter from CanFaCS that was on the physical file and that from other evidence appears to have been given to him by FL. He was asked whether FL had given him the document and how it got on file. TQ stated that this was certainly possible, and that if she had given him a copy then he would say it is more than likely where he got it from.
1282. TQ was asked whether he would agree that the letter from CanFaCS was an unusually supportive letter. TQ agreed, noting in particular the timing being 13 November. He agreed that ZB said in light of that kind of evidence the Department really ought to have something very compelling to get an Interim Accommodation Order removing the children from Graham Dillon's care.
1283. TQ was asked if it would be fair to say that the letter put the Department on the back foot, and he agreed.
1284. TQ specifically pointed out the following paragraph, as he stated he thinks that the fact that he is engaging in these services would have satisfied the magistrate:
- "During the support period Mr Dillon has actively engaged in family case plan, our family case plan formulated by both himself and his family worker."²⁶⁴
1285. TQ was asked if it was the case that when he was given a phone number that he would have the passed it on to the caseworkers. He agreed and stated that he couldn't think of any occasion where he would have telephoned a person who was not directly involved.
1286. TQ was asked whether it would be a reasonable inference to draw from the fact that the phone numbers of two ACT CYPS workers were written in his court book that they were provided to him by FL so that the case workers could telephone the ACT and get the story for themselves, and he agreed that this would be likely.
1287. TQ agreed that in light of the material that was provided by BP and in the absence of being able to get information from the ACT CYPS that disputed BP's letter, that the Department would have remained very much on the back foot in this case.
1288. Regarding his relationship with BN, TQ agreed that he had issues with her in other cases. However, he stated that he did recall having any specific issues with her on this case, but that this could be due to the fact that he does not recall this case independent of his notes.

²⁶⁴ Transcript of Proceedings, p 1712

1289. He was asked whether the fact that he didn't recall any particular difficulty with BN in relation to this matter meant that there must not have been any particular difficulty as it would have been memorable. He advised that he can't recall anything about the matter as a whole.
1290. TQ was asked about whether he knew of Magistrate 2 having a particular view of people who breached or contravened court orders. TQ agreed that Magistrate 2 did take such a view.
1291. TQ was asked whether the fact that SK was supposed to be back in the ACT Court in relation to the DVO on the day after she took the children from Canberra would be something that Magistrate 2 would look dimly upon, and he agreed that Magistrate 2 would.
1292. In relation to advice that TQ may have been able to provide to CO, TQ was asked if he would have needed to be in his office for CO to come and ask him. TQ stated that this was not necessarily the case, that he doubts whether he would have returned to the office before 4pm or 4:30pm on that day, noting that it was a Monday and that he had seven matters.
1293. He agreed that if the disclosures of the children were made late in the day, the chances of having the matter back before Magistrate 2 would have been very, very minimal.
1294. TQ was asked that if he were to abridge the matter whether that would also be an application under section 270 for a new Interim Accommodation Order. TQ stated that this was not correct, that the emergency care application would have been the appropriate way to go because to abridge the matter would have most likely needed consent of all the parties. He stated that he thinks while the mother would have consented it would have been unlikely that the father would have consented.
1295. In response to a question as to whether he would regard a section 270 application as being an unrealistic application to make late in the day, TQ stated that he thinks a section 241 application would have been the appropriate application. He stated that under a section 241 a protective intervenor may place a child in need of protection in emergency care.
1296. TQ agreed that from his perspective the only real avenue would be a further safe custody application, given that Graham Dillon was on his way back to the ACT and there was an order of the magistrate requiring the kids to be placed back in his care..
1297. TQ stated he does not recall whether he was apprised of all the material that the Child Protection workers were aware of and the matters that they would have had to take into account in determining whether to take that action, or whether the issue was even raised with him.
1298. TQ agreed that he was not in a position to express a view about whether on the particular facts of the case that a successful safe custody application could have been done.
1299. TQ reaffirmed that in the circumstances he would have thought that the Department would have notified ACT Child Protection of those concerns.

1300. In re-examination TQ was asked to review the two different DVOs, one dated 26 September which had the children's name on it, and one dated 12 November which did not have the children's name on it.
1301. TQ agreed that there would be scope for some confusion as to the status of these DVOs, and that they could be read very differently.
1302. TQ stated that from the date the legal file is opened until the date it was closed on 15 December 2014, that it was his responsibility to populate the file both electronically and in hard copy.
1303. TQ agreed that he believed that the documents on the legal file would have been material obtained in between the date the file was opened and the date the file was closed.

FL – Solicitor for Legal Aid Victoria, Duty Lawyer for Graham Dillon

Statement

1304. FL was employed by Legal Aid Victoria and was specifically tasked to represent Graham Dillon on 17 November 2014 at the Shepparton Children's Court. This was in relation to a protection application proceeding before the family division of the Shepparton Children's Court. FL regularly performed that role in that area of the law.
1305. Upon reviewing her file, she had a meeting with Graham Dillon as well as copy of the Form B information on the safe custody application.
1306. She took instructions from Graham Dillon who advised that the mother had drugged him and run off with the children after a visit for the daughter's birthday. She took the children without permission; the children were on a DVO in the ACT that he had been undergoing management and rehabilitation and had been cleared by DOCS twice that the children had been placed in his care for 18 months and were going to school regularly which was not the case when living with their mother some charges were dropped against him and he did not assault the mother when she was pregnant.
1307. FL said she also received a letter from BP from CanFaCS, an email from Mark Flack, the principal of Boronia Heights primary School and a DVO dated 26 September 2014.
1308. FL also spoke with BP about his work with Graham Dillon. BP told FL that the kids must go back to Graham Dillon, he had handed them a year and half ago and he dropped everything to get them into school. FL then set out what she most likely would have submitted in the application to have the children returned to Graham Dillon. That included letters in support of him being able to look after children.
1309. FL remembered that the Magistrate viewed the unilateral decision of the mother to remove the children as conduct that should not be rewarded and that is why the Magistrate made an accommodation order placing children in the care of Graham Dillon and adjourn the matter further to 15 December 2014.
1310. Graham Dillon then requested the bus fare for himself and the children to return to the ACT from Child Protection however they refused.
1311. FL stated that she did not receive any letters from UN nor of the proceedings of 22 September 2014 nor the statutory declaration of the ND or the statutory declarations

of UN on the 13th and 17th of November 2014 nor did she receive Tasmanian Police file.

1312. FL made enquiries of TQ in respect to the adjournment of the application and was advised that DHHS has withdrawn the application.

In Evidence before the Inquest²⁶⁵

1313. FL represented Graham Dillon in relation to legal proceedings in November 2014.

1314. FL was asked about a two-page note that she sent through, which she stated were taken on the morning of her evidence from the Victorian Legal Aid file.

1315. FL also agreed that she was told by whoever had provided her the file that she was not permitted to copy the file.

1316. FL agreed that the notes record everything as best she could from her notes that was taken on 17 November 2014. She stated that there were a couple of things in her notes that even though they were her own handwriting, she was unable to read, so she didn't write those notes down.

1317. FL was a duty lawyer working for Legal Aid Victoria in November 2014.

1318. FL agreed that in her role as a duty lawyer, from time to time she would see people who were at the court and needed duty advice.

1319. She stated that at Legal Aid there are two ways in which you can commence acting for someone. The first is if they make an appointment at the office and then you take their matter on as a file. The other way is through assisting them at court initially as a duty lawyer and then if the matter continues you can take it on an ongoing basis.

1320. FL stated that in this case she was at court for other matters, and that she cannot recall whether she was the duty lawyer for the Children's Court or if she was simply there and this case was allocated to her.

1321. FL agreed that the first time she met Graham Dillon was on 17 November 2014, and that this was the only time that she met him in person.

1322. FL stated that the notes she had taken that morning before she gave evidence included a summary of notes she had taken in a conference with Graham Dillon. She stated that Legal Aid have a form called the 'DLR' which stands for the Duty Lawyer Record and that on the front page it will have the details of the matter, who the client is, who the magistrate was, what the date was and what the outcome was.

1323. FL stated that the DLR form opens out and on the internal side there will be all of the client's personal details and then there are two lined pages where she would ordinarily take notes as she is talking with the client, and then she would take notes on that page of things that had occurred in court and that she had jotted down at the time.

1324. FL was asked about two names she had written down, those of was a lawyer in the ACT and that of BP, the CanFaCS worker.

²⁶⁵ Transcript 907 - 935

1325. FL was asked whether she recollects why she made a note of BP's name. She stated that it was because she spoke with BP to discuss the contents of his letter. FL stated that she recalls having a phone conversation with BP but that she does not remember exactly what he told her or what she asked him.
1326. FL was asked whether she recollected speaking with the ACT Lawyer, to which she responded that she didn't specifically recall speaking to him. However, she said she thought it was possible that she called him at Graham Dillon's request. She thought this because the way she had written the note is not as though she was taking instructions, but rather that she is speaking to someone who is speaking about Graham Dillon.
1327. FL stated that she thinks she did speak with the ACT lawyer and that it was probably to clarify what had occurred in the ACT given that the DHHS Form B has very limited information. Additionally, as Graham Dillon was telling her things which were contrary to that document, FL was trying to find sources of information to confirm her instructions.
1328. FL stated that from her experience in other Children's Court matters she is familiar with the Form B.
1329. FL was asked if she recalled which parts of the document she was instructed by Graham Dillon were inaccurate. FL stated that, from her notes, she recalls that she had put a cross next to a number of comments, and that she remembered one such comment being about Graham Dillon assaulting SK while she was pregnant. However, she could not remember which other comments she had put crosses next to.
1330. In relation to a note that says '*on 26/9/2014 the order was varied to exclude the children [JL] and Bradyn*' FL stated that she recalled having a written note stating that the application to vary was thrown out. However, she did not know if that was in relation to the September application.
1331. In relation to there being two DVOs on file, FL stated that she didn't realise that there were two on the same day, but she was pretty sure that there was only one on her file at Legal Aid. FL stated that it was hard to recall because she wasn't able to take a copy of the file with her to give evidence, so she is not sure if they are both on there.
1332. FL was asked about whether she recollected the following instructions from Graham Dillon that she had recorded in her statements, '*that the mother had drugged Graham Dillon and run off with the children after she had come to visit for JL's birthday and that she took the children without his permission.*' FL agreed that she did recollect this.
1333. FL was asked whether Graham Dillon gave her a history of how long the children had lived with him and the circumstances of them coming to live with him. FL replied that she had written a note that Graham Dillon had told her that the children had lived with him for 18 months and that they were 'placed with him'.
1334. FL was asked what she meant by 'placed with him', to which she stated that her notes state:

'there was a call from DHHS and Boronia police that BK was on ice and the children were placed in the fathers care 18 months ago.'²⁶⁶

1335. FL stated that while she doesn't recollect Graham Dillon saying that welfare or DHHS were involved in some way in placing the children in his care, that she acknowledges that it what her note seems to indicate.
1336. FL was asked about a note that stated, *'the children are on the order'* and underneath it the note states, *'amendment to have time with the kids; no amendments'* and whether she recollects what that might be referring to. FL replied that it meant to allow the mother to have time with the children.
1337. However, she stated that she doesn't have any recollection of seeing both those orders at the time, nor that they were key features of the proceedings.
1338. FL was asked about a note that recorded that Graham Dillon had been doing anger management and rehab, and whether she had any other information about that note. She stated that she did not, only what Graham Dillon had told her about the services he had engaged with currently or in the past.
1339. FL was asked about a note that states *'cleared by DOCS by two'* and whether DOCS was recorded in reference to NSW Child Protection or ACT Child Protection. FL stated that she did not have any recollection but agreed that she was aware that the children were living in Canberra.
1340. FL was asked about another note in which she states that *'some charges were dropped against him'* and whether she had any recollection as to what that means. She stated that she thought it might have been what she was writing down while she was reading the Form B to Graham Dillon. Given that Graham Dillon had indicated that he disagreed with some of the matters about him being charged, he may have said they were dropped, she had just noted that down as a response to the Form B.
1341. FL was asked if she recalled what time of day she called BP, to which she stated she thought it was either mid to late morning or perhaps before lunch.
1342. She was then asked if she recalled what time of day she went before the Magistrate on the 17th in relation to this matter, to which she stated that she believed it was in the afternoon.
1343. FL was shown notes taken by BP in relation to the conversation he had with FL on the 17th. She stated that she believed that his notes were his interpretation of what she said, because she would have been very surprised if she would have said for example that she strongly recommended seeking a counterclaim for defamation to cover extensive costs. She stated that she would never say something like that as she is not a defamation lawyer and wouldn't give that advice.
1344. FL was asked about a note in which it was stated that the *'judge admonished DHHS Victoria and stated that he would like charges to be laid against the children's mother'*. She stated that she recalled that court appearance but that she couldn't independently recall those comments. She stated that she remembers Magistrate 2 being generally unhappy and annoyed about the case but not that he admonished DHHS or that he

²⁶⁶ Transcript 912

said he wanted charges against the mother. She further stated that it doesn't make sense and she doesn't know how the mother could be charged.

1345. FL was asked to explain what it was like appearing before Magistrate 2, she stated that he likes you to get to the point, he doesn't like too much introductory information. She stated that he didn't shut people down from putting their point if they needed to but that it was a fast-moving court.
1346. FL was asked about Magistrate 2 on the 17th in particular, FL stated that as it was a Monday there would have been a lot of work to get through and other cases he still had to deal with for the rest of the day.
1347. FL was asked whether she remembered what submissions were made on the 17th, she stated that she had tried really hard to recall but that she couldn't and that she didn't really make any notes in the court of what was said.
1348. FL was asked whether she recalled which documents were tendered, she stated that she recalled tendering the letter from BP, and that she may have tendered others. She did not think she tendered the DVO.
1349. FL was asked if she could recall whether she was the first lawyer to address the court, to which she stated that she could not but that the usual practice is that the Department lawyer addresses the court first. However, she said that from note by BP where she said that the first order was made in her absence it may have been that she addressed the court first to tell the Magistrate why she had requested that the matter be recalled so shortly after the last appearance.
1350. FL stated that she did not have a copy of the original order on her Legal Aid file which indicates to her that it was never provided to her by the Department. She stated that may be because she had not yet been approached by Graham Dillon asking her to act for him and therefore her appearance had not been noted on the file, or it could be simply due to the fact that the nature of court means that lawyers are often running around trying to find all the parties, who is represented etc.
1351. FL was asked whether she recalled any interaction within the court with the Magistrate in relation to BP's letter or any other documents she may have tendered. She stated that she did not recall anything specific from Magistrate 2 about the letter.
1352. FL stated that the letter from BP was significant because it was from a professional service provider, it was written very close to the court date, and it looks like it was written for the purposes of Graham Dillon attending court on that date, or very close to it. FL said it makes reference to Care and Protection being in support of Graham Dillon and his care of the children.
1353. She was asked if she could recall any other features of the submissions made on that day, to which she replied that she was very much focused on the issue of the mother removing the children without the father's permission and that she recalls the Magistrate taking the view that the mother had taken things into her own hands and that she shouldn't be rewarded for that conduct, as she ought to have gone through the appropriate channels.
1354. FL stated that she didn't have any recollection of submissions being made about the history of family violence and given that she was not provided with the Tasmanian prior

history she can't imagine that it was put before the court, if it was not also provided to the parties. She stated that material other than Child Protection CRIS notes generally was not placed on the court file unless it is also provided to the parties.

1355. FL was asked if she recollected any interaction she had with Graham Dillon after the court proceedings. She said that Graham Dillon had to figure out how he was going to get back to Canberra with the children and that she recalls having a discussion with him about whether the Department were willing to fund his travel back to Canberra. She stated that she thinks that she either asked the protective worker or the DHHS lawyer or that Graham Dillon asked them for that funding. She said her recollection was that DHHS refused to provide that money, however that position could have changed after that conversation.
1356. FL said that she was not involved with the arrangements of Graham Dillon to collect the children, that she remembers saying goodbye to him at the front of the court and that she either went back to her office or back into court to collect her files for the day.
1357. FL said that she did not go with Graham Dillon to Child Protection, but that she told him he would have to talk to the workers about how he was going to collect the children and how he was going to get back to Canberra.
1358. FL agreed that she next appeared in court for Graham Dillon on 15 December. She stated that this was for an application by the Department to withdraw the protection application and that Graham Dillon was not present on this occasion but that she sought instructions prior to that happening.
1359. FL stated that she did not recall having any further involvement with Graham Dillon after that.
1360. FL said it was possible that she received a call from an ACT based Care and Protection worker to discuss Graham Dillon's matter.
1361. FL was asked whether a note that stated *'DOCS had originally sided with [SK] however, she left out a lot of significant information and the matter was brought before the magistrate'* accorded with her recollection. She stated that it was possible that she might have described something to that affect but that given the Form B was lacking information and that the original order made by the court was to the mother she was probably trying to put in context why there was such a change on the next court date.
1362. FL was asked about another statement that *'the Magistrate stated that [SK]'s behaviour was not to be rewarded'* and she said that she did recall that comment and thought it was in relation to SK's unilateral removal of the children and not going through the proper processes.
1363. FL was asked whether she recalled seeing SK at court on that day, to which she stated that she did not.
1364. FL was asked about what the security was like in the old court-house, to which she replied that she was pretty sure that in 2014 there was no security at the door. There were sometimes police officers in the foyer, and the police officers had to be in the court room when the Magistrate was sitting but there was quite often a lack of presence of any security and that people were not searched when they came in.

1365. FL agreed that at the time she tendered BP's letter, ZB or TQ would have also been able to tender any documents they were in possession of.
1366. FL stated that she is sure she would have provided a copy of the CanFaCS letter to the other parties prior to going to court, and that it is not her practice to hand things over at the Bar table.
1367. FL was shown a document exhibited at page 4640,²⁶⁷ to which she stated that she had never seen the letter before. FL was asked that given the nature of the document she would have expected that if ZB or TQ were in possession of the document that they would have tendered it in the proceedings. FL said that would be a forensic decision for them, she said they might have decided not to do it for their own reasons and that she didn't know.
1368. FL was asked that given the allegations made in the document against her client would she have expected that, on the face of the document, that it would be something that would be tendered. FL responded that it is possible, that if she was in the shoes of SK's lawyer she probably would have handed it up but that she doesn't know how she is meant to reflect on someone else's judgement.
1369. FL was asked about the form of the document in respect to how much weight it could be given. She agreed that if it was in the form of a statutory declaration rather than simply a letter that would give it some weight. However, she stated that the submissions contest did not involve evidence, it involves submissions.
1370. FL was asked about the fact that the CanFaCS letter was tendered and whether that would be something the magistrate would use to help make the decision on the Interim Accommodation Order. FL stated that yes, documents are often handed up by the parties in support of their client's position.
1371. FL was shown the two statutory declarations by UN and asked to look specifically at the one dated 13 November 2014. She was asked to look particularly at a line that says,
- 'I hold great concern for Bradyn and [JL] should they be taken from their mother and placed back in Graham's care ... Graham also has a history of drug abuse'.²⁶⁸
1372. FL was asked by counsel for SK, whether given this document was a statutory declaration it would seem to be fairly powerful material, and if the document was in the possession of either ZB or TQ would FL have expected them to tender that document on 17 November 2014, to which FL replied that she would.
1373. FL was also asked about the Tasmanian Police file, and whether she is aware that there is a criminal history of Graham Dillon in Tasmania. FL stated that yes, she has seen what is annexed to HS's statement, but she assumes that is not the entire record.
1374. FL was asked if she accepts that it shows a history of violence by Graham Dillon, to which she said that she did.
1375. FL was asked if she would have expected either ZB or TQ to have tendered that document had they been in possession of that criminal history on 17 November 2014.

²⁶⁷ Transcript p 922

²⁶⁸ Pages 4760 and 4761 of the Subpoena Material

FL responded that she wouldn't have thought that ZB would have been in possession of the document. In regard to TQ, she stated that if he was in possession she would have expected him to tender the document because it is relevant to that application. However, that she has never seen documents from police tendered on submissions contests, rather it is usually Department case notes that are tendered. She stated that she would expect those documents might have been subpoenaed at a later point and presented at an evidence-based hearing.

1376. FL was asked by Counsel for the territory whether she could outline what she meant about the Form B lacking a lot of information. FL stated that in her experience, the Form B normally has a lot more information than what was contained on the form in this case. She stated that there would usually be maybe two or three pages full of information.

1377. FL was asked what sort of other information she would expect to be included in the Form B that wasn't in this case. FL stated that she would expect specific examples of concerns the Department holds, the wishes of the children, any views the children had expressed to child protection workers. As well as a summary of interviews child protection had with parents or other carers or family members. She stated that it is a precis of the case but that it usually provides you with a lot of information about how it has come to the point where the Department has determined to bring a protection application by emergency care.

1378. FL was asked whether the fact that the Form B was so short would be of a forensic advantage to her pursuing the Interim Accommodation Order. FL said that it would have but that the contents of the Form B refer to Graham Dillon having a significant criminal history and do not refer to him working with BP or any of the other matters he told her he had been doing. She said it was probably an advantage that they didn't '*go chapter and verse about every single court appearance he had in Tasmania*'²⁶⁹.

1379. FL agreed that the BP letter gave her a fairly comprehensive advantage with respect to the absence of detail from the Form B.

1380. FL was asked whether she had any general recollections about how TQ was putting the position of the Department on the 17th, to which she stated that she had no recollection.

1381. FL stated that she would have expected that there would have been no problem to the tender of the statutory declarations and the letters, so long as those documents had been shown to all of the parties beforehand. She confirmed that it was her position that because she didn't have the documents on her file that they probably were not tendered.

1382. FL was asked what her general impression was of Graham Dillon as a client to which she stated:

"Well, he was organised in the sense that he came to court with supporting documentation, which is often not the case with clients attending court at short notice. He seemed, I don't know, very sort of upfront and a bit rough around the edges, not dissimilar to many clients I represent on a daily basis. In the criminal law child protection proceedings, they might have had drug use and matters in their past and been quite rough, but he was very polite to me

²⁶⁹ Transcript 926.

and seemed very concerned for his children and was annoyed that he had had to come to Shepparton but was glad that he got the outcome that he wanted.”²⁷⁰

1383. FL agreed that it was common for her to have clients that she meets on the day who tell her all sorts of things that become difficult to independently verify.
1384. She agreed that she would put Graham Dillon in the special category that he was one of the few who had material with him to support his position. She stated that it was even more unusual for her to be able to call the author of the document to confirm those instructions, usually she would only have what her client is say for her to go by.
1385. FL agreed that having Graham Dillon in court while she was doing the submissions contest would have been useful but stated that she does not recall speaking to him during the hearing.
1386. FL also acknowledged that not having your client in court with you can be a forensic disadvantage as a hearing was progressing. She stated that you might need to ask for time to call your client if something arose that you were not aware of.
1387. FL was asked whether you would usually expect that you would be able to get time to speak with your client if something did arise in court and you didn't have your client with you. FL said that ordinarily you would. However, late in the day in a busy court sometimes you are not afforded that opportunity.
1388. FL stated that she believed that the hearing occurred after lunch based on the timing she was speaking with Graham Dillon out the front of court she was sure it was later in the day.
1389. FL was asked if that memory exhausted all the reasons she could think of as to why it would have been in the afternoon, to which she stated that she supposes only from some of the material that she has been provided which refers to the matter having been called on earlier in the day, but that she doesn't know.
1390. FL was asked whether if she had been provided the statutory declaration and the Tasmanian criminal history that would have constrained her from making positive assertions on her client's behalf to the magistrate against the effect of those documents. FL said that if the documents were being tendered she would show them to Graham Dillon and take instructions on that basis and if his instructions were in contradiction she would challenge those instructions before she put them to the court because it would be disadvantageous to him if she put matters that were in direct conflict to the court. However, she said it is quite possible that his view of the statutory declarations would have been in conflict because of the people making the declarations so he may have instructed her to put matters that were contrary to those documents.
1391. FL was asked, looking at the statutory declarations on the face of them, whether the statutory declarations would have constrained her from saying to the magistrate for example *'there is no evidence that this man has been violent in a domestic relationship'*, to which FL agreed, but stated that she didn't recall putting that type of statement to the court.

²⁷⁰ Transcript 927.

1392. FL was asked by Counsel for PG whether she had any recollection of the conversation between herself and PG, to which she stated that she had a vague recollection of receiving a call but that she didn't remember who it was or what she said or how long it lasted for.
1393. FL was asked by Counsel for Victorian DHHS whether the courts in Shepparton had been upgraded since 2014 and whether there were more resources to provide greater security for opposing parties in family law disputes etc., with which FL agreed.
1394. FL was asked whether she recollected that in 2014 there was a Royal Commission into Family Violence in Victoria, and she responded that she did.
1395. FL was asked if she was familiar with the name Fiona Warzywoda and her case. Ms Warzywoda had attended the Family Law Court and shortly thereafter was murdered by her partner outside a solicitor's office in Melbourne. FL said she thought she recollected this case.
1396. FL was asked whether, in her experience in Shepparton, there has been quite significant improvements to address the safety of women and children in relation to these types of matters. FL said yes, there is now security on entrance, so everyone's bags are scanned and their body as well, they walk through like an airport. There is a separate entrance and waiting area for the party where they will attend the courtroom from that area and that is in line with the recommendations from the Royal Commission.
1397. FL was asked whether she would agree with ZB's evidence that the Form B was a new innovation around 2014, to which she replied that prior to her work at Shepparton she was based in the Children's Court team in Melbourne Legal Aid for a period of six months and that Form Bs were used in every case in the Melbourne Children's Court. FL stated she was very surprised when she started as a lawyer in Shepparton to see that Form Bs were not regularly produced. She stated that she took it on herself to improve the proceeding in general that the Department fill out a Form B and provide it to all parties because it's the way in which you can take instructions. She stated that Form Bs are used everywhere now but she doesn't think that they were always used in Shepparton. FL said she started saying to the Department that *'I'm not seeing my client... until you give me the Form.'*²⁷¹
1398. FL stated that the Form B is a critical document because how else do you take instructions from your client other than what is on that document.
1399. She agreed that it would be fair to say that since 2014 the quality of the Form Bs used by the Department has vastly improved, at least in Shepparton.
1400. FL was asked whether she recalled that the Department hadn't had time to assess the father in this matter and that they were seeking an adjournment to assess him. FL replied that she didn't recall the reason for the adjournment specifically, other than that matters are always adjourned after the initial hearing for the purpose of the preparation of the reports created by the Department in these cases for court. She stated that given the father had just arrived she thinks it is probably fair to say that the Department hadn't

²⁷¹ Transcript 931

assessed him yet, but she assumes they would have had the opportunity to speak with him via phone.

1401. FL was asked about TQ' notes in which it is reordered the following '*extend IAO [Interim Accommodation Order] to mother, adjourn to allow time for DHHS to carry out assessment on father, adjourn for four weeks to 15 December 2014*'.²⁷² FL was asked, in light of the notes, whether she would dispute that the Department were seeking an adjournment and an IAO to the mother, which FL said she did not dispute.
1402. In relation to handing up police records at a submission contest, FL stated that it would be unusual for child protection to be in possession of the records at that stage in the proceedings. She said that they might have access to criminal record checks of people, but that she has never seen a worker at court with the actual record printed off.
1403. FL agreed that the Form B did refer to the criminal record and that there was an allegation that Graham Dillon had engaged in serious family violence in 2006 when SK was pregnant.
1404. FL was asked if, as far as she was aware, that the information in the Form B was before the magistrate in the form of the Form B. FL stated that she couldn't recall whether it was referred to directly in submissions or whether the magistrate was asked to read the Form B, as she had no recollection of what submissions were made at all.
1405. FL was asked whether she would agree that UN's statutory declaration was an attempt to respond to the allegations that were being made about SK perpetrating abuse towards Graham Dillon via Facebook messages. FL stated that it was possible, however, she doesn't know.
1406. The fax time on the top of the statutory declaration was pointed out to FL that read '2.35pm' on the afternoon of 17 November 2014. FL was asked whether she could recall if this would have arrived before or after the magistrate made his decision. FL stated that she is not sure, she stated that they could have been in court after 2:35pm but that she really doesn't know or have much else to go on.
1407. FL was asked whether she accepted that there was probably some submissions that related to the allegations of past family violence, concerns about drug use and concerns in relation to Graham Dillon having the children in his care. FL responded that it was possible that those matters were put.
1408. In relation to Magistrate 2, FL stated Magistrate 2 would listen to people in court, he just didn't want you to be too long in your submissions. She stated that she didn't think he would have made up his mind before coming on the Bench because he may not have seen the letter from BP before then, so he would have listened to matters put in court.
1409. FL was asked about correspondence between herself and TQ on 11 and 12 December, where she was asking the Department's position and he advised that they were withdrawing because the children were no longer in the Victorian jurisdiction. FL stated that such correspondence was something she would regularly do if she hadn't

²⁷² Ibid.

heard from the Department, coming up to a busy Monday she would regularly email the Department lawyer and ask what their position was.

ZB – Solicitor given a grant of Legal Aid to Represent SK in Shepparton Proceedings

In Evidence before the Inquest²⁷³

1410. ZB is an Australian legal practitioner working in Shepparton, Victoria. ZB represented SK in the Shepparton proceedings in November 2014.

1411. ZB stated that he spent 10 years working for the NSW Attorney General in local courts. He stated that he qualified and was admitted in Victoria in 1999 and has worked at his current employer in excess of 20 years now.

1412. ZB agreed that he would regard himself as a relatively experienced legal practitioner.

1413. ZB stated that he did not recollect the events of November 2014, but he has had a chance to review his file.

1414. ZB confirmed that he received a grant of Legal Aid to assist SK effective from 17 November 2014.

1415. ZB agreed with his recollection outlined in his 19 December statement that stated

'I recall little of what was said in court that day other than the magistrate was not impressed with the mother acting unilaterally and commented that he will not reward bad behaviour'.²⁷⁴

1416. ZB was asked about details recorded in HS' statement such as that the Magistrate admonished CPS Victoria and the evidence that FL presented about BP's support of Graham Dillon. ZB stated that he did not recall any of this information.

1417. ZB agreed that in the proceedings before Magistrate 1, SK was represented by QG, who has since been appointed as a Victorian Magistrate.

1418. ZB agreed that given the circumstances, being that there was no agreement about how to proceed with the Interim Accommodation Order and there were competing applications, that a submissions contest would be the normal course.

1419. ZB was asked whether he recollected seeing or having access to any particular documents. ZB stated that he had recollections of seeing the following documents;

- (a) A letter from Canberra Fathers and Child Services;
- (b) An email from NG, the Principal of Boronia Heights Primary School to Graham Dillon regarding absence records and concerns relating to Bradyn and JL;
- (c) A statutory declaration of UN dated 17 November 2014;
- (d) A letter from SK on 15 December addressed to the court seeking an adjournment when the final order was made.

²⁷³ Transcript of Proceedings, p 788 – 868.

²⁷⁴ Transcript p 791.

1420. In relation to the letter from SK, ZB was asked whether he remembered how the document came to be in his file. ZB stated that he assumes he was provided a copy by the court, but that he couldn't remember.
1421. ZB stated that as he had no recollection of proceedings or SK, he was unable to provide the Court with his impression of her.
1422. ZB agreed that he wrote to SK on 19 November but said that he does not believe that he made any further attempts to contact her before 15 December.
1423. ZB stated that generally speaking Magistrate 2
- ‘was a magistrate who would get straight to the point and if he came to a decision prior to coming onto the bench or upon reading material, the submissions may have been very short, if any submissions were made at all.’²⁷⁵
1424. ZB was asked what his usual practice would be in relation to notes if there was more detailed contest submission. ZB stated that he would imagine there would be more notes if it had been a longer submissions contest. He said that his note that stated ‘*will not reward bad behaviour*’ in relation to Magistrate 2’s comments in relation to SK was indicative of the fact that the magistrate had a certain view prior to coming on the bench given that it was the first note he had taken.
1425. ZB stated that he did not believe that he had seen the ACT Magistrates Court DVO in relation to SK before, nor did he recollect there being any discussions in relation to DVOs.
1426. ZB stated that he did not recall giving SK any advice at the end of the 17 November proceedings as to what would occur next.
1427. Regarding his letter dated 19 December, ZB agreed that this was the letter he endeavoured to send to SK.
1428. ZB was asked about the line at the end of the letter that stated ‘*this is a matter that should be pursued through family law proceedings*’. ZB agreed that this was his view. He stated that he could not recall why he wrote it but suggested that it was his understanding that there would have been no other proceedings on foot or that if there were then they should chase up the proceedings.
1429. ZB confirmed that the letter was returned back to his office. He confirmed that there was no indication on his file that anyone endeavoured to find an accurate address for SK.
1430. ZB was asked whether he recollects whether SK was contacted by phone to ask if she could provide an updated address. ZB stated that he did not believe she was contacted, but that he had no recollection of whether she was contacted or not. ZB agreed that he would expect that there would be a file note, amended address or some other notation on file if he did have any contact with SK.
1431. ZB agreed that it would have been important for SK to know what happened in court, particularly in circumstances where she had asked for an adjournment, ZB stated ‘*that’s why I wrote to her*’.

²⁷⁵ Transcript 796

1432. ZB further agreed that when the letter was returned it was understood that SK had not received the information and that it would be important to inform her of the outcome of the court proceedings. ZB agreed that it appears there were no indication that there were further attempts to inform her.
1433. ZB stated that he didn't know whether SK had contacted the Court or DHHS to ascertain what had happened.
1434. ZB outlined that at the time of this matter, from his recollection, there was no direct referral from Legal Aid in most cases. He stated that quite often someone would ask you if you were available for a child protection or DHS would contact someone asking about their availability to assist.
1435. ZB agreed that it was most likely the case that 17 November was the first time he had been notified of the matter, because his file was opened on that date. He stated that an application was filed with Legal Aid on 17 November, aid was granted on that date and the first appearance was on that date.
1436. ZB stated that he did not recall how he took instructions from SK on that date.
1437. ZB was asked whether it was possible that he had made a phone call to SK as she was in a remote location, to which he responded that he doesn't see how he can reconcile that with a signed application on the same date, but that it was possible that he spoke with her via the phone.
1438. ZB was asked whether he recalled where he first saw the documents, including the letter from BP and the statutory declaration from UN, to which he stated that he did not.
1439. ZB further stated that he did not recall taking instructions from SK about those documents.
1440. ZB was asked whether he recalled when he was first shown a Facebook message from SK to Graham Dillon that was sent in 2010, that was on his legal file. ZB stated that he did not but that he assumed that all documents were shown to him on 17 November. He stated that he did not recall taking instructions from SK in relation to that document.
1441. ZB was asked about the statutory declaration from UN, and whether he recalled making any attempt to contact UN to see if she had any further information that she could provide. ZB stated that he did not recall making such a call.
1442. ZB further stated that he did not recall whether he met with or phoned SK after the appearance on 17 November 2014, to tell her what had occurred in court on that day.
1443. ZB was taken to the Legal Aid application which contained a mobile phone number for SK, he was asked whether he accepted that he had a phone number for SK that he or his office could use to contact her. He accepted that he did and that he did not contact her.
1444. In relation to a letter dated 18 November that started '*Dear Practitioner*' ZB explained that what happens is he would have received the letter via email confirming that a grant of Legal Aid assistance was granted, and a hard copy of the letter would have also gone to the applicant, in this case SK.

1445. ZB was asked why another letter was sent to the same address for SK knowing that it wouldn't arrive, given the first letter was marked '*returned to sender, no such number*' on the envelope. ZB stated that he was under an obligation from Legal Aid to send a letter to the client informing them of what happened and that he sent it to the address he was given and that it was returned.
1446. ZB was asked why, given the previous letter had also been returned, no inquiry was made as to what the correct address would be. ZB stated that it was probably due to issues about time and the fact that it is '*up to the client to provide me with appropriate address and details and I'm not really obliged to go chasing those*'.²⁷⁶
1447. ZB was shown a document that contained notes from whichever practitioner saw SK on that particular day. It was suggested to ZB that this appeared to be from Legal Aid Victoria about a conference they had with SK on 3 December 2014. ZB stated that Legal Aid would have had the capacity to enter the client's details and if there was a grant of Legal Aid open at the time, it would have been ZB appearing on the record.
1448. ZB was shown an email chain between him, FL and TQ and asked whether he recalled having any conversation with TQ about the decision to withdraw the protection application. ZB stated that he did not recall having any conversation with TQ.
1449. ZB was asked about the portion of TQ's email to FL that stated *the reason for withdrawing is that the children have returned to live with the father in the ACT and no longer within Victoria's jurisdiction*'. ZB stated that he did not have any contact with SK to take instructions in relation to that email from TQ.
1450. In answer to a question from me about why the letter to SK was sent to the street number 35 rather than 36 as was recorded in the Legal Aid application form. ZB stated that when he took instructions from SK the address she gave him was for number 35.
1451. I asked ZB whether he knew of any explanation for the discrepancy in the street number, to which he responded that maybe SK had not been in Shepparton long and was perhaps unsure as to whether it was number 35 or 36.
1452. ZB was asked about a remark made in his statement in which he stated that he viewed TQ as a relatively inexperienced practitioner in his position. He stated that TQ came to the law later in life, which he did too. ZB stated that TQ had a prior job prior to joining the DHHS as a solicitor and that TQ had told him that he didn't have much experience in the Children's Court.
1453. ZB agreed that he had lengthy experience as a solicitor that involved a lot of Magistrates Court work in Victoria. He stated that he had also had extensive experience in the Children's Court jurisdiction in child protection.
1454. ZB stated that in 2014 he could not recall whether he was practising family law at that point in time but that he did practice family law for a number of years. ZB also agreed that he had some experience in criminal law and he still practices in that area.
1455. ZB agreed that as part of his practice he was relatively used to going to a list day at the Children's Court and receiving a client on the day, taking instructions, making an appearance, and making an application for legal aid.

²⁷⁶ Transcript p 801

1456. ZB agreed that he had a fair idea of what both Magistrate 1 and 2 were like.
1457. ZB stated, in response to a question, that he could not afford to be a shrinking violet as a legal practitioner, especially not in criminal law as you wouldn't get too far.
1458. It was put to ZB that he would not be shy about approaching the bar table to mention a matter for example. ZB explained that they have a different system in Victoria, in that the court list is controlled by the clerk and they call the matters rather than the practitioners as is the case in NSW. He stated that you go to the registry and tell them a matter is ready to go and they will bring it into the court and then the clerk decides the order in which the matter is called.
1459. ZB agreed that he understood that there is no transcript or audio recording of the proceedings that occurred on 17 November 2014.
1460. ZB stated that all the parties would agree that the matter is ready to be called, then someone would go and approach the clerks and let them know that the matter is ready to go. After that it would be conveyed to the in-court clerk who sits in front of the magistrate and then the matter would be called in due course.
1461. ZB was asked if that system was fairly set in stone, in that you can't jump ahead of those processes. ZB stated that it depends how much the court staff like you.
1462. ZB stated that generally speaking it is the court clerk who controls the calling of the list and the order that the files are called in the court.
1463. ZB agreed that he received a fairly favourable reception with court staff, stating that he had worked in courts before, so he knows *'how to butter people up'*.
1464. ZB agreed that in some respects the court staff are the most important people to be nice to when you are dealing with a busy list.
1465. ZB was asked whether that was because when you are in a 'pickle' and want to get someone done quickly, the court staff would be the people who can help you to reach that objective. ZB agreed and stated that he believes that would have been subject to submissions because it wasn't conceded to. He stated that it wasn't a consent order so the court would have been made aware that some time was required for the magistrate to come to a decision, hence his note that the Magistrate did not want to reward bad behaviour. ZB stated that this note indicated to him that the matter was not by consent, as he said he would have written 'by consent. ZB further stated that it is his reading of the notes that the Magistrate came to his decision fairly quickly.
1466. ZB was asked about what a day in late 2014 in the Shepparton Children's Court would have been like for him. ZB stated that it would have been pretty busy. He stated that he was not sure who went up and told the clerk that the matter was ready to proceed.
1467. ZB agreed that he had experience where there might be an error or for whatever reason a matter that has already been mentioned might need to be re-mentioned before a magistrate.
1468. ZB gave the example of having had people turn up unrepresented and not telling the magistrate that they have a solicitor and then the lawyer for one of the parties shows up and says that there is a need for the matter to be re-mentioned because their client

wasn't sure of what to say. He stated that the matter might be re-listed in those circumstances.

1469. ZB agreed that to get a matter back in front of a magistrate after it had already been heard you would need to go back through the clerk system. He stated that you would need to go to the registry and see the co-ordinator and explain why the matter needs to be relisted, for example if a warrant has been issued and then person then shows up half an hour later, you would have the matter re-listed, and the warrant might be recalled, or the order might be revoked.
1470. ZB was asked whether it would be usual, once a protection application has been filed, on the first return of the matter before a magistrate for people to then list the protection application for its next mention and to also consider what Interim Accommodation Orders should be in place for the children. ZB stated that this was certainly the general course of things. He stated that if there the matter is not finalised then generally speaking the Interim Accommodation Order would be extended until the next court date or varied until the next date. He stated that the interim order would be in place until the matter is finalised.
1471. ZB stated that he was aware that under the Children, Youth and Families Act 2005 there are particular circumstances that would enliven a magistrate's jurisdiction to entertain an application by a party to amend an Interim Accommodation Order. He stated that you can either file an application or quite often an oral application is made to vary an existing order.
1472. In relation to what sort of things would allow such an application to be made, ZB agreed that a change in factual circumstances that gives rise to a need to amended the Interim Accommodation Order would be sufficient. He stated that for example a change in address because a child is placed in care but that placement has now come to a close so there may well need to do a new Interim Accommodation Order placing the child elsewhere.
1473. ZB was asked about circumstances in which a parent has become legally represented and they were not legal represented on the last time an Interim Accommodation Order was made. ZB stated that if the order is in place and they don't want to change it, the mere fact that they become represented doesn't meant the order will be amended. Whether they are represented or not there has to be something with an application made to amend that order.
1474. ZB stated that in circumstances where a parent has instructed their solicitor that they are not happy with the current Interim Accommodation Order and they wish terms or conditions of that order to be varied then they can make an application to vary the order, but it is not necessarily the case that the application will be heard on that day. ZB stated that it depends on the list and the nature of the variation and whether the variation is by consent, and whether there is court time to hear the application. He stated that there are a number of factors that will govern whether the application can be determined on the day.
1475. ZB was asked whether it was normally the case that if a parent was now represented and they want to vary the IAO would that normally be canvassed with the other practitioner, the lawyer for the DHHS and the lawyer for the other parent. ZB stated that his practice is that he canvasses before he goes in so that he knows what the

parties' position is because it may well be by consent. He stated that generally you don't 'drop bombs like that' from the bar table without canvassing the other practitioner's views and working out whether it's going to need time from the Magistrate and whether that time is available. He stated that generally speaking you don't just stand up and say 'I'd like to vary the IAO' without running it past everyone first.

1476. ZB said that normally to vary an IAO you would have to complete the application and serve it, the matter would then only be listed if services has been completed on all parties. He stated that generally speaking if you wanted to vary an existing order on the day that the matter came back before the court, the mechanism to do so would be an oral application. If you were going to do a written application to vary it would be for a future court date, generally speaking.

1477. ZB was asked about his experience with oral applications before Magistrate 2, he stated that an oral application is made at the bar table, the magistrate doesn't necessarily grant leave to hear the oral application, that they may refuse to hear the oral application, especially if it was opposed by other parties.

1478. ZB was asked whether he had any experience working with FL before, ZB stated that FL was a personal friend.

1479. It was put to ZB that he wouldn't expect FL to 'drop that kind of bomb on you' with respect to an application to amend an IAO from the bar table, to which ZB responded that he wouldn't but stated that this goes for most solicitors who practice in a small town, he stated that there are certain curtsies that perhaps don't exist in bigger cities.

1480. ZB was asked, generally speaking, if FL had a client in a matter when he also had a client and the two clients were opposing parents and FL wanted to bring an application to amend an IAO, would he expect that she would have come to him and had a conversation about it before he appeared before the magistrate. ZB replied that he would, and he would also expect that the department and anyone else appearing that day would be notified.

1481. ZB agreed that FL would be honest with her fellow colleagues.

1482. ZB was asked what he would do in circumstances where his client had the children and FL came up to him and stated that her client wants to have the children, before the matter was before the magistrate. He stated that it would be his normal practice to take instructions from the client, but that in this case it was the Department's application and, generally speaking it is the Department that suggests where a child is going to live. He stated that it is then for the parties to work out whether they agree or disagree with the Department's proposition.

1483. ZB agreed with Counsel for the Territory that his charge was to represent the best interests of his client at the time.

1484. It was put to ZB that his previous answer had been qualified, and he was again asked that if FL came to him and his client currently had the children and stated that her client wished to make an oral application to vary the IAO would it have been in his general practice to go and obtain instructions from his client. ZB stated that he would.

1485. ZB stated that practitioners would generally tell him what they were seeking before they went into court and that generally they would give a basis for the orders they were seeking as well.
1486. ZB stated that most times matters are called in court all parties are ready, he stated that there are times where everyone is getting sick of working it out and they say 'let's call it on' but generally speaking it is the case that everyone is ready at the bar table and everyone is on the same page when they get called in about whether the matter is ready to go or not.
1487. In response to a question ZB as to whether it was unlikely that he would be at the bar table and have to say 'this was put to me outside, and I need to go and get some instructions' because you would be wasting time in front of the magistrate in the list. ZB agreed that he would try get it sorted before you go in. He stated that you hope you would be on common ground, but it has happened that people drop things at the bar table which you haven't heard, and you may ask the magistrate if you can have some time with your client to take further instructions.
1488. ZB was asked whether Magistrate 2 was the type of magistrate who would have given you that extra time if you needed it. He stated that the difficulty is with this case, as he said that the mother had acted unilaterally and he didn't reward bad behaviour, he thinks that *'that was the hurdle that the mother [SK] faced in this matter'*.²⁷⁷
1489. ZB agreed that Form Bs are a familiar format to him and that they are regularly used.
1490. ZB agreed that you would usually be provided a copy of the Form B and that would be on your file.
1491. In relation to the alleged drugging of Graham Dillon by SK, ZB agreed that the allegations of SK and Graham Dillon were quite the opposite. He further agreed that it was not uncommon in his general experience to have two completely different narratives coming from opposing parents.
1492. ZB agreed that the historic records from Tasmania Police that detailed significant family violence history perpetrated by Graham Dillon towards SK would have been something that on the face of it would have fallen against the father's interests and into his client, SK's, interests.
1493. ZB also agreed that the fact that Child Protection record on the Form B that they have concerns regarding the children living with Graham Dillon would also be something that would likely fall in favour of SK. ZB further agreed that the fact that Child Protection had no concerns about the children being in the mothers care as something that would fall in his clients favour as well.
1494. ZB agreed that on 14 November, looking at things from the mother's perspective, things were looking better for her than they were for the father. With regard to the Form B on 17 November in isolation, ZB agreed that the same could be said. ZB agreed that there would have been a copy of the document before the magistrate on 17 November as well as 14 November 2014.

²⁷⁷ Transcript p 816

1495. ZB agreed that other documents including the letter of BP would have been in front of Magistrate 2 on 17 November 2014 and that he believed that the letter from BP had significant impact on Magistrate 2's decision. ZB stated that he had re-read the letter and that it is 'certainly persuasive'.²⁷⁸

1496. ZB was asked whether he had any recollections of getting instructions in relation to BP's letter. ZB stated:

All I would say, as I've said before, is this is a very persuasive document and probably played heavily on the magistrate's decision in the absence of anything else from the department. Mind you, a Monday is a list day in Shepparton and it's a very busy list day. There might be 15 Children's Court - well Mr O'Callaghan may have been sitting as a Children's Court magistrate that day where there would be both criminal matters and family division matters and as such, it's a very - day and busy day and the - and generally speaking the magistrates don't have a lot of time and can't just set aside two hours to hear an application. It's a - time is a bit of a precious commodity on a list day.

1497. ZB stated that he believes at the time that in Victoria children over the age of 10 were entitled to be legally represented but that they are not legally represented if they were under 10. ZB stated that he recollects that Bradyn and JL were eight and nine years of age respectively at the time of the Shepparton proceedings.

1498. ZB agreed that the narrative in the Form B relating to the children's views would have been important to his representation of SK.

1499. ZB stated that he had no independent recollection of the fact that when the children were informed of the decision of the Magistrate to return them to their father that they started to make certain disclosures against the father.

1500. ZB confirmed that he had no knowledge of the disclosures whatsoever

1501. ZB was asked questions about what he would have done if he had been given the information about the disclosures after the IAO was made and the children were ordered to be returned to the father.

1502. ZB stated if he had been informed of the disclosures, he would assume that TQ, the lawyer for the Department, would have also been informed. He further stated that he would have canvassed the issue with TQ and then he would have expected TQ to call the matter the matter back, because it is the Departments case, either because there is fresh information that has a direct bearing on the case or if the department think that the decision is incredibly erroneous that they would have appealed the decision.

1503. ZB was asked whether he would have supported the re-listing of the matter in such circumstances, to which he responded that he would have expected that having spoken to the client he would have supported the relisting because of the importance of the Court being apprised of all the facts. He stated that he was not sure of the weight that the Magistrate ***'would have placed on some disclosures by an eight and a nine-year-old That's probably something the magistrate might have to be asked'***²⁷⁹

²⁷⁸ Transcript of Proceedings, p 823

²⁷⁹ Ibid [my emphasis].

1504. ZB stated that he was unable to say what Magistrate 2's general practice was at the end of a contested hearing in terms of whether he handed all the documents back to the parties from which they came or whether he kept them.
1505. ZB was asked about the detailed guidance materials provided by Magistrate Peter Power. ZB stated that Magistrate Power was a long-term Children's Court Magistrate and that he *'kind of wrote the bible and its very comprehensive notes and procedure guide'*.²⁸⁰
1506. ZB stated that in terms of reliability about Children's Court processes that this guide would probably be the best tool but that they are quite lengthy materials.
1507. ZB agreed that the notes of the orders made on 17 November 2014 indicate that there was an application for a new IAO by the father. He further stated that having had the opportunity to consider the material and following the previous day's cross examination he recalls that the matter was called on by the clerk after he believes TQ asked it to be called. He stated that there was no appearance of FL at that time, that she was either on her way, was there or had been interviewing the father or something similar. He stated that an order was made in FL's absence which probably should not have been made. He stated that the matter was then recalled by Magistrate 2 and he was pretty sure that was after lunch. He stated that it was at that point in time that the supporting material from the ACT (particularly the CanFaCS letter) was presented to the Magistrate and that it was at this point that he made the comment about not rewarding bad behaviour and made the order that the children be returned to the father.
1508. ZB stated that it was his understanding that an appeal from the Children's Court would go to the Supreme Court but that he hasn't personally be involved in one. He further stated that if he was lodging an appeal it would have been heard in Melbourne, not Shepparton.
1509. ZB agreed that it was his understanding that on 15 December 2014 the application was withdrawn by the department. He further stated that when the parent is out of the jurisdiction it is difficult to object to the Department withdrawing the application because the Department has no powers to deal with the matter in a different jurisdiction.
1510. ZB stated that Magistrates in the country sometimes do family law matters, sometimes do Children's Court matters, and sometimes do general Magistrates Court matters so they have to 'straddle' a number of different areas. ZB agreed that both Magistrate 1 and Magistrate 2 were appointed and did both, Children's Court and Magistrates Court work.
1511. ZB stated that in terms of whether he had taken instructions from SK via phone or in person he had looked at his notes and that he believes that he had gone to the Department's office and spoken with SK in the morning, taken the written instructions and returned to the Court. He further stated that he recalls that when Magistrate 2 made his decision SK was still in the Department's office with the children and he would assume that it was at that point where the Departmental workers would have explained what order had been made as to the return of the children to the father.

²⁸⁰ Transcript p 840.

1512. ZB clarified that the reason SK wasn't present was because of fear of the father, Graham Dillon.
1513. ZB further stated that he thinks that he probably spoke to SK via phone because she was in the office and he was in the courts, likely with other matters and that he wouldn't have had time to return to the office to speak with SK to obtain further instructions.
1514. ZB was asked whether he recollected speaking with SK via phone, as there are no records of him having done so. He stated that he believes he would have done so, particularly because the old courthouse was a very un-secure building, there were only a couple of police officers but there was no safe area for a victim or mother in that type of setting. He stated that if SK had shown up, they would have all been in the foyer together.
1515. ZB agreed that the circumstances in the court had improved and that it was now a much more safe and secure place. He stated that in 2014 there was no independent security, no scanners, no searches, only police officers assigned to court duties but that they were often escorting prisoners so that the security at the time was unsatisfactory.
1516. ZB stated that it would be very rare for the type of really persuasive letter, such as the one written by BP with regard to Graham Dillon to be produced in these types of proceedings.
1517. With regard to the email from the Principal of Boronia Park Primary School, he stated that he wasn't sure who tendered it because *'quite frankly really isn't on the point too much. It's about them not going to school'*.²⁸¹
1518. ZB stated that from memory the rules of evidence don't apply in these circumstances.
1519. With regard to the statutory declaration from UN, ZB stated that he did not seek that from UN but that he did not recall who it was provided to in the first instance.
1520. ZB agreed that it would be reasonable to conclude, given this, that the document was sought by the Department.
1521. With regard to the letter from BP, ZB stated that everyone, himself, and the Magistrate included, relied on its accuracy. He agreed that he had no information to refute it, specifically in regard to the fact that the letter was dated 13 November 2014 and says specifically to liaise with ACT CYPS.

Child and Youth Protection Services (CYPS)

NL - CYPS Case Worker (HP 1 Level)

Statements

1522. NL commenced at CYPS as an HP one case work in April 2014. She was the lead worker in relation to the Dillon children in July 2014 until they returned from Victoria where the lead was given to PG and NL became the second after concerns for her safety because of threats made by Graham Dillon toward her.

²⁸¹ Transcript p 847

1523. Prior to working with CYPS she worked as a support worker with communities at work. Her role at that organisation was to interact with families connecting them with appropriate community supports and advocate on their behalf when required, as well as liaise with government agencies including CYPS. She had worked with them for eight years.
1524. NL was the case worker for Bradyn and JL from July to December 2014. KE was her secondary work and mentor, and BU was her Team Leader. From December 2014 all files were allocated to PG and she was reassigned as a secondary worker. BU remained Team Leader.
1525. NL became aware of Bradyn who was at that time eight and his sister JL who was then nine she was also aware that they lived with Graham Dillon who was their biological father and their biological mother lived in Victoria.
1526. NL was assigned to appraise the children for bruising reported on 28 July 2014 in a Child Concern Report. The initial report had been made on 28 July by the deputy principal ACT Primary School 1.
1527. Once allocated NL advised she would have accessed the electronic records in relation to the children. Her practice was to review the files which would have included prior reports made to CYPS.
1528. NL advise that she was aware that there was a prior report made in relation to bruising on Bradyn's face on 17 June 2014. That had not proceeded to an appraisal. There was also a report in respect to bruising to JL on 2 July 2014 where it was said that she had fallen over. NL advised she would have reviewed those record held by CYPS from 2013.
1529. NL set out the usual process for an appraisal which consisted of interviews field work, engagement with other providers including discussions between caseworkers and Team Leaders. Ultimately a determination was made about whether to take further action or not depending on the findings.
1530. NL advise that on 28 July 2014 a referral to SACAT had been rejected as there had been no disclosures by either child. Usually SACAT would reject the referral if there had been no disclosure.
1531. NL advise that she would have also consider the Child at Risk Health Unit (**CARHU**) report if there was one, however she said the injuries were "not of the kind" that would require an immediate referral to CARHU.
1532. On 30 July 2014 NL attended ACT Primary School 1 with KE and spoke to the teachers. They also spoke to JL and Bradyn. NL recalls that Bradyn had bruising on his jaw line and cheekbone near his eye. JL also had round marks on her jawline as well. Both appeared to be the same age of bruising and were faint rather than dark giving the appearance of being a few days old.
1533. Her impression was that both children appeared well groomed, were healthy and polite and engaged well in the interview. There was no disclosure made by them. NL and her offsider went to visit Graham Dillon at home in Ainslie. When they arrived, he was on his way to collect the children and asked for them to wait until he had done so.

1534. When he returned, he invited them both into the house. NL observed that the house was tidy and clean, the children well behaved and interacted well with their father. Graham Dillon appeared to be in a heightened emotional state however did not appear to be under the influence of anything. Her impression was he appeared worried sometimes tearful and sometimes apprehensive.
1535. NL became aware that Graham Dillon had engaged with CanFaCS and the residence was one of their homes. NL was also made aware that his worker was BP.
1536. NL knew BP as she had completed a three-month placement with him and had done a number of home visits with him shadowing him and other workers during her placement. NL had a favourable impression of BP. She was reassured that he was involved with the family.
1537. Following the home visit a case consultation meeting was held between KE, herself, and BD where it was revealed that NL had concluded she was confident of the children's safety with their father and that he was willing to engage with them. She also observed a good attachment between him and the children. Further her notes indicated that the children did not appear to be neglected "*however they were very compliant*". NL also formed the view that JL in particular was affectionate and caring toward her father.
1538. It was decided that further measures were to be taken including a request for Graham Dillon's mental health records, his drug and alcohol history, his criminal history and Police records and any other records held by Department of Child Services in New South Wales. NL was also to liaise with BP and the school and obtain further information from them. NL cannot now recall whether she requested the records or discussed the children with the staff at ACT Primary School 1.
1539. On 31 July 2014 she and KE returned to the Dillon residence and spoke to Graham Dillon. Graham Dillon denied being violent towards his children and told them of his ambitions for the future and the support he had in place.
1540. NL requested that Graham Dillon consent to the children seeing a medical practitioner. Given the case did not warrant CARHU intervention, NL suggested their GP. Graham Dillon sought to defer it to the following Monday however this would have been too late as the bruises would have faded. An appointment was made for the following day 1 August. NL spoke to the Doctor who saw the children on 1 August and who considered that there was nothing wrong with them. NL noted that was a first time the children had been seen by that doctor.
1541. NL was of the view that the bruises were not suspicious, and an appraisal would be no further action.
1542. NL spoke with Graham Dillon on 4 August and BP on 7 August and then visited the home on 8 August. BP had assured her that he had a very good relationship with Graham Dillon and said Graham Dillon had engaged well with his organisation and he considered him to be a "really good dad".
1543. On 11 August, after a case consultation, it was considered that the matter should be closed. Generally speaking after that decision has been made the caseworkers should sight children once more before closing the intervention. This did not occur as they had visited the home on 8 August 2014.

1544. NL considered that the involvement of the school, the positive report from BP the state of the home and the attachment of the children to the father comforted NL in her view that no further action should be taken and that they were eyes on the children.
1545. NL said that she relied on Graham Dillon self-reports in respect to the support he had in place. NL considered that there was no actual abuse and there was no risk of future abuse and therefore the children were not in need of Care and Protection. NL's review was endorsed by her Team Leader.
1546. On 28 August 2014 she received a further report from the school in relation to bruising to Bradyn's nose cheek and ear. NL received this report directly by phone and email from the school. An intake form was completed. It appears that Bradyn said he did not know how his ear was bruised but he had hit his nose on the couch when play fighting with his father. SACAT and CARHU were contacted.
1547. NL was aware that SACAT would not proceed as there was no disclosure. However she organised a medical assessment with CARHU.
1548. NL said that she tried to get to the school quickly because she wanted to get there before the father got there to pick them up. NL spoke with the children and observed the bruising. After some discussion, NL spoke with Bradyn and JL they both explained about play fighting and Bradyn hitting his face on the wooden bit of the couch. When JL was speaking Bradyn interrupted her and said, *"nothing happened did it [JL]?"* JL then looked at her and said *"no nothing happened we were all play fighting"*
1549. NL took the view that the explanation for the bruising was unsatisfactory and wanted him assessed by CARHU. NL spoke with Graham Dillon who refused permission at first. Essentially if Graham Dillon refused to consent emergency action could have been taken to allow the doctor at CARHU to examine Bradyn.
1550. Graham Dillon became very angry and was threatening them saying things like he'd been in jail before and "to be careful and just wait and see what I can do to you". He said that looking toward NL's direction.
1551. Graham Dillon then went to the teacher's office but then accepted that the children were going to go to CARHU. Graham Dillon then raised the idea of FQ going there as well. As a child usually has a support person preferably a familiar face and they asked the children who they would like to go with them the children appeared happy for FQ to go to with them.
1552. The children went with NL to CARHU and FQ met them there. They went in to see OQ. NL observed Bradyn was shy and reluctant to answer questions whereas JL sometimes answered them for him and FQ was overwhelming throughout the consultation. She was agitated, nervous, and spoke at a very fast rate. She tried to explain why there would be bruising claiming it was an insect bite. At one-point OQ had asked to not interrupt.
1553. NL formed the view that it would have been better had she not been there, but she felt that she did not have the ability to interfere.
1554. NL spoke with OQ afterwards without FQ and the children. It was her view that the bruising to the ear was unexplained but there were no positive findings of injury that was intentionally inflicted.

1555. Following that interaction NL considered she did not have any further grounds to take intervention or emergency action. There was some issue in respect to a complaint that the doctor had inserted something into Bradyn's bottom. Enquiries with the doctor revealed nothing was inserted into his bottom. There was a further meeting on 29 August 2014 with Graham Dillon and BP as well FQ at the home.
1556. At that meeting, FQ was very testing, telling NL that she was going to take him to her own doctor because the bruises look like wounds from spider bites.
1557. On 1 September 2014 an appraisal case supervision meeting with held. NL noted that in relation to risks, the report of CARHU said no significant concerns regarding bruising with no disclosures being made, NL said that she thought that the bruising to the ear meant that he was at risk or it was a risk. Having balanced that with the fact that the home had a good presentation, the appearance of the children was good, their interaction with their father was good and they had the support of BP it looked like it would become a closed case.
1558. BP then took on advocacy on behalf of Graham Dillon and sent emails to NL advising her of the various steps being taken by Graham Dillon and his connection with other services and organisations. NL took this involvement by BP into account throughout the appraisal and weighed that in favour of Graham Dillon. This also meant more eyes and ears in relation to the children.
1559. On 3 September 2014 ACT Primary School 1 advised her that Graham Dillon was moving outside of the ACT within days. NL telephoned Graham Dillon informing him that the case was to be close but was still open. She also advised him that he was to let her know what his plans were and what supports he had in place for himself and the children prior to closing the case.
1560. NL read the report from CARHU on 12 September and recall that there was no strong finding for the cause of the bruising on Bradyn's ear. It would appear that NL read the report as being of no concerns in respect to the bruising on Bradyn's face although she indicated that there were concerns in respect of allegations concerning physical abuse. There was an apparent contradiction in that view because it was clear on the report that there were concerns in respect to the bruising on his ear.
1561. NL was of the view that the CARHU report did not provide a basis for which she could seek a court ordered intervention. NL indicated that she continued contact with Graham Dillon, BP, and the teachers throughout September 2014. On 13 October the appraisal was completed and endorsed by her Team Leader. NL found that Bradyn had not been abused and there was no future risk of further abuse.
1562. On 14 October 2014 a further report of bruising on Bradyn by a teacher from Bradyn school was made. The report was described in the progress notes as a note only and there was no suggestion the bruising was nonaccidental.
1563. The report said that there were small circular bruises on the side of Bradyn's cheek and that they were a few days old. The teacher had noticed them on the first day back from two weeks school leave and they appeared to be fading, indicating that they were a few days old. The report was that Bradyn had said he had fallen at the shops.

1564. After receiving that report NL formed the view that there was not a reasonable suspicion that Bradyn may be in need of care and a decision was made not to reopen the appraisal process. This was endorsed by BU.
1565. CYPS received an after-hours report on 3 November 2014 stating that the children were removed from Graham Dillon's care by their mother. NL said she spoke with CF from Victorian Care and Protection who had telephoned her.
1566. CF required some information as to the situation with mother and the children and NL advised her that according to their records the children had said they were afraid of their mother and that she took drugs. The report made in regard to the father had not been substantiated and therefore no further action had been taken.
1567. NL provided details of the ACT ILO as ST.
1568. On 17 November 2014 an email was sent to NL requesting that BN from Victorian Care and Protection Shepparton requested a return call. NL was in training and therefore did not receive this email until 19 November. NL returned the call to BN who advised the children had already been returned to the ACT at this point.
1569. BN indicated that she had some concerns in relation to the safety of the children whilst in their father's care. On 20 November 2014 NL spoke again with BN. As a result of that phone call the Child Concern Report was created.
1570. BN identified that there had been an history of domestic violence perpetrated by Graham Dillon. BN also advised that the children had disclosed that Graham Dillon hits them and punches them. They reported that they did not want to return to their father, sought reassurance that what they were saying would not be reported to him and were devastated and cried hysterically when they were told they would be removed from their mother's care into their father's care. NL made notes in respect to this report
1571. NL said that BN would generate a Child Protection Report that would contain the details of their involvement and that that would be emailed to CYPS. NL emailed BN on 20 November and 24 November 2014 as she had not heard from BN. On 25 November BN was telephoned. NL was advised that a report was being generated and would be emailed that afternoon.
1572. NL then spoke to the teacher SL advising that Victorian Care and Protection had concerns in relation to the children's safety and that she was waiting upon the report. This report was never received (and nothing further was done by NL either) my emphasis.
1573. NL considered that if there was any such concerns then BN would have taken emergency action, and in the absence of that action and where the court had decided to give the children back to their father NL did not believe that was a basis to raise a concern for their immediate safety.
1574. NL identified that the disclosures made by the children whilst in Victoria gave new information on historic bruises and injuries reported and required some kind of intervention by CYPS. NL then on 1 December 2014 recommended that the report by BN required an appraisal.

1575. It was NL's view that for an appraisal to happen a new report would need to be made given the disclosures. Given that would require involvement by herself having personal contact with Graham Dillon, she was concerned in relation to his volatility. Particularly given he had acted in a threatening manner to her in August 2014.
1576. BN then identified there were safety concerns in relation to NL and on 3 December 2014 NL completed a Child Protection Report and recommended that the appraisal be done by a HP three worker with more experience.
1577. On 4 December 2014 BU assigned the appraisal to PG, but with NL as a second. NL said that the email was also sent to SACAT given that there were now disclosures of the bruising. The records show that SACAT effectively rejected the referral asking that CYPS take the lead.
1578. NL made a further request to the ILO for information from Victorian Care and Protection.
1579. SK contacted NL on 9 December 2014 where she made allegations in relation to Graham Dillon. On 12 December a case consultation was conducted, and an action plan was developed to the appraisal. NL recalls that they still had concerns about the children in light of the matters brought to the attention by Victoria.
1580. The files were then allocated to PG and NL had no further role in decision-making in relation to the Dillon children. NL recalls a home visit to the Dillon children on 19 January 2015 but no other independent recollection. NL became aware that in late January 2015 the intervention was going to cease.

In Evidence before the Inquest²⁸²

1581. NL is an Intake Officer at CYPS. At the time of Bradyn's death, she was a caseworker HP 1. In July 2014 she was assigned as a caseworker involving Bradyn Dillon and his sister JL. At the time, NL was the most junior level of caseworker having commenced in April 2014.
1582. At the time, NL was assigned approximately five cases given her junior status. KE was her mentor and secondary worker. NL stated that her role was to shadow KE and go wherever she went and watch whatever she did. It was essentially learning the ropes.
1583. NL stated that KE accompanied her to the Dillon household on a number of occasions as well as visiting the school. At that time BU was the Team Leader. NL stated that the Team Leader would assist her in her file management and guide her as well as showing her what was to be done. KE also performed that role.
1584. NL confirmed that she was the case worker from July to December 2014. At that point it was given to PG who was HP 3. NL was the secondary worker when they visited Graham Dillon's home to let him know that PG was taking over the case. That was the only purpose for being the secondary worker.
1585. NL confirmed that she was assigned to Bradyn and JL's case on 30 July 2014. That was a first time she had encountered the Dillon family. NL confirmed the intake report

²⁸² Transcript p 581 – 719.

which she utilised and the whole family were listed on the document, including the stepmother and the three children of that relationship.

1586. NL also confirmed that she understood that the intake originated from the ACT Primary School 1. NL also confirmed that she was aware that there were Child Concern Reports in respect to bruising on Bradyn's face from 17 June 2014 and in relation to JL on 2 July 2014. NL confirmed that she had also seen the reports from July 2013.

1587. NL confirmed that she had information that the children had returned to school and there was bruising on Bradyn and JL. NL confirmed that she was aware that Bradyn had refused to talk about how he got the bruising and JL did not know how she got it. There was also a report in relation to domestic violence, that the father raised concerns regarding the mother's drug use, and that the mother lived in Victoria.

1588. It was pointed out to NL that on the intake form there was a box which indicated a reference to cumulative harm and that the 'no' box was ticked. It was NL's understanding that cumulative harm meant:

"the re-occur in some of the bruise – of the abuse – alleged abuse and the impact that it was having on the children."²⁸³

1589. NL confirmed that cumulative harm is a flag that they would have considered. NL also confirmed there was information in respect to Domestic Violence Crisis Service. All of that information was in the document contained in the CHYPS database.

1590. NL also agreed that there was detail in the document about the history and the concerns of the mother, the ex-partner, as well as previous bruising incidents. NL agreed that she had all of that information of those past events available to her. NL also agreed that some of those aspects were that he was aggressive toward the children, was unsafe and neglectful of them and had threatened to throw a baby into a wall. Those were highlights apparent on the document.²⁸⁴

1591. NL agreed that SACAT had rejected the referral as no disclosures had been made. NL had an understanding of how the system worked between CYPS and SACAT. NL said that if she was the case worker generally, she would write the notes on the CHYPS database. NL also agreed that she wrote most the notes contemporaneously after engagement with the various parties.

1592. NL stated that the notes which she had written, and re-read were an accurate record of what had occurred at that time. NL agreed that the note she wrote referred to the phone call she had with the Deputy Principal, who had indicated that the children had come to school on two occasions in the past month with what appeared to be finger marks on the face. On one occasion the bruises appeared to be in the shape of a handprint across the face. It was also accepted that she had been told that the children had poor attendance at the school and the behaviour exhibited by Bradyn when confronted about stealing five dollars.

1593. NL stated that she and KE attended the school and spoke with the deputy principal and the children's teacher. A further more comprehensive note was made in regard to

²⁸³ Transcript of Proceedings, p 586.

²⁸⁴ Transcript of Proceedings, p 588

that conversation. NL also agreed that she was told that there were a lot of unexplained absences by the children.

1594. When asked whether that was a concern, NL stated that this is a situation with a lot of her clients, and it is more an education issue than a care and protection issue.²⁸⁵ NL agreed that there was both positive and negative information, but some was of concern. In relation to court proceedings involving the children and other family members NL assumed it was the family law court.
1595. NL was also made aware that Bradyn's behaviour had changed and agreed that would be a flag of concern. NL also recorded in the note that she observed bruises, appearing to be a few days old, on JL's cheek, small round bruises size of a 10-cent coin on the right jaw line, and a faint bruise on her left eyelid.
1596. NL agreed that she recorded JL telling her that her father gets angry, expects them to do a lot of things quickly, and if they don't, he hits them on the head and kicks them on the bum with his boot when they are not expecting it. NL agreed that she asked JL where her father hits her and JL showed her. NL agreed that she asked whether it hurt and JL replied "*not the boot hurts more*".²⁸⁶ NL agreed that was a significant conversation.
1597. NL agreed that she had spoken with Bradyn who told her that the bruises occurred when he had a fight with JL. When asked how it happened, Bradyn said he did not want to speak about it. When asked about when they got into trouble, Bradyn was reluctant to say anything and was clearly less forthcoming than JL.
1598. NL agreed that after speaking with the children they went to speak with Graham Dillon who was at home. He went to pick the children up, they waited for Graham Dillon at the home and when he returned he then participated in a discussion with NL.
1599. NL said that Graham Dillon gave an explanation as to how the children got the bruises and reassured NL that he would not hurt them and that he had been doing all he could for them. NL agreed that Graham Dillon also told her that BP was assisting him. NL said that she knew BP because she had worked with him when she was on placement with the Organisation. NL said she understood what services CanFaCS provided to single fathers and their children. That support involved accommodation, financial services, and that sort of thing. NL understood that the service was short to medium term.
1600. NL agreed that Graham Dillon had told her he was attending mediation counselling with Relationships Australia and a church support group. NL agreed Graham Dillon had also told her of his own history in relation to being a child in need of care and that he was beaten and abused whilst in foster care. NL agreed he also told her that he had full custody of the children to protect them from their abusive mother.
1601. NL stated that after speaking with the children she consulted her Team Leader BU. NL accepted that there was inconsistency between what the children had said about how they got bruises and what their father had said. That was concerning.

²⁸⁵ Ibid 591

²⁸⁶ Ibid 593

1602. NL agreed that nowhere in the consultation report did she say that JL had identified that her father expects them to do a lot of things quickly and, if they don't, hits them on the head and kicks them up bum with his boot.²⁸⁷
1603. NL identified that in the recording she would have said children were polite, however, she attributed the word 'compliant' to BU. NL did not consider that that was a particular flag it was just an observation. Good attachment observed and caseworker confident of children's safety and father is willing to engage with CYPS.
1604. NL agreed that where 'MH records' was written, that indicated mental health records were to be obtained. Drug and alcohol records were also to be obtained as well as a criminal history. I note that the PROMIS record was to be obtained for the purposes of identifying any police attendances at the home. NL agreed that was the plan moving forward. NL stated that those items were not obtained. NL agreed it would be the case worker's role to obtain that information. The reason that she did not obtain information, was because of she was new to the job and that she expected KE or BU to follow-up.
1605. NL agreed that the only organisation she called was CanFaCS. NL agreed that if the information had been obtained it would be on the CHYPS database and if it hadn't been obtained it would not be on that system.
1606. NL did not follow up with any of the other sources of information provided by Graham Dillon such as Relationships Australia, or the church group. Neither was there any follow-up in respect to the information given about having full custody of the children. NL agreed that it would be normal to seek that information. In respect to the reference of past family violence history involving two partners, NL did not seek any further information other than what was on the CHYPS database.
1607. NL did not agree that it was best practice to contact somebody who could give information in relation to history, such as a past partner, although they sometimes do if it is necessary to follow-up information. NL agreed that given what she knew about the bruising and background information, it would have been best practice for her to have made further enquiries in relation to the family violence history.²⁸⁸ However, NL did not contact UN, nor did she contact Bradyn's mother.
1608. In respect to the plan to get further information, such as mental health records, drug and alcohol history, criminal history and the PROMIS notes, NL would expect that those pieces of information would come up on the CHYPS database. NL did not make any enquiries as to why that had not been placed on the database. NL does not know why she did not chase it up.
1609. NL recalled Graham Dillon telling her that he was anxious and fearful that CYPS would take the children and told her about the support that he had in place such as joining a single man with children social group and the support of FQ. There was also discussion about a safety plan involving strategies Graham Dillon could use to manage stress situations.
1610. It was suggested to NL that Graham Dillon had told her about how he manages when the children are naughty, that he sends them to their room or the thinking chair and

²⁸⁷ Transcript of Proceedings, p 598

²⁸⁸ Transcript of Proceedings, p 602

when that does not work he may smack them on the bottom, but he doesn't bash them. Graham Dillon told her this the day after she had spoken to the children and there was an inconsistency with those two versions. NL said looking back at it now, that was a concern.

1611. NL stated that when they had indicated the children were to be given a medical assessment, Graham Dillon became aggressive, agitated, nervous and short of breath. NL stated that she had suggested to Graham Dillon that he could have his GP do the medical assessment. It was her memory that they could not access CARHU because CARHU required the bruising to be fresh. That is why she suggested the GP.²⁸⁹
1612. NL stated that she had not spoken to the GP prior to the children being reviewed. NL advised that the usual practice is the children are taken to the family doctor and when that happens, they then contact the doctor to get a report. It was not her view that they would contact the doctor prior to the visit to give them background information.
1613. NL did contact the doctor who advised that the bruising appeared to be accidental and was explainable by the five siblings fighting. What stood out to NL, was the fact that the children had not been seen by this doctor previously and, that the doctor observed that there was hardly any bruising and it was very faint. NL thought that was unusual because she had seen the bruising the day before. It was her view that the bruising to the face was significant. She was shocked at the doctor's comments and did not understand why the doctor would consider that it was from play fighting. NL said she discussed the doctor's comments with her supervisor.²⁹⁰
1614. NL said that she was concerned and was suspicious about the bruising and, that together with the discussion with the children and the school she raised a concern with the Team Leader. In relation to an email she received from BP about an incident which occurred over the weekend involving Graham Dillon and the children, NL had no recollection of receiving it or indeed calling to find out what it was about. NL accepted that best practice would be to call him back. NL does not understand why she did not follow up that incident but accepts that she did not contact him and in hindsight should have.²⁹¹
1615. NL agreed that there was a lot of information that she had on 4 August when she was in the process of assessing the situation but that she had not explored them, deeply nor could she explain why she did not follow up the source information.²⁹²
1616. In respect to the discussion she had with BP, NL agreed that he was an advocate and support for Graham Dillon, advising her that he was a good dad. NL also accepted that his interest was in assisting Graham Dillon and the children.
1617. NL agreed that BP had given her significant information about Graham Dillon's ex-wife and the troubles that Graham Dillon reported to BP about her. NL agreed that she had contact details for his ex-wife, yet she did not contact her to clarify or consider the veracity of the statements made by Graham Dillon. NL agreed that she should have

²⁸⁹ Ibid 606

²⁹⁰ Ibid 608

²⁹¹ Transcript of Proceedings, p 609.40

²⁹² Ibid 610

and would definitely do that now but that she didn't know why she didn't do it at the time.

1618. In relation to JL's parentification which NL described, it did not concern her because it was something that they would be able to speak with Graham Dillon about; in that the child is the child and the parent is the parent.²⁹³

1619. NL agreed that a safety plan was put in place so that strategies for coping with stresses would be enacted. It was planned that there would be a visit once per week with Graham Dillon and the children, and that he had agreed with that safety plan. NL agreed that the safety plan did not address the issues raised by JL in the principal's office

1620. NL said she understood that Graham Dillon was attending mediation sessions in respect to his other three children and their mother. When NL was asked whether she understood why that was the case, she said that Graham Dillon had told her that it was because of a family law dispute that he wasn't allowed to see the children.

1621. NL agreed that she had in the records information of historical family violence between them. NL said she did not obtain any further material from another source other than Graham Dillon or BP. The reason why she did not was because she was fairly new in the job and still trying to figure out things that she might need to do. NL stated that, at that point, she had had no training about her role as a caseworker with care and protection.²⁹⁴

1622. NL said that she did have some training on the job, but she relied on the Team Leader, who at that time was BD, for guidance. NL agreed that she had a case conference with BD advising BD that Graham Dillon was cooperative regarding appraisal, and that no disclosures had been made in relation to the father. It was suggested to NL that that was inaccurate because of what was said to her by JL in the principal's office about her father hitting her. It was pointed out to NL that nothing of the same nature as the disclosures made by JL in the principal's office was discussed with BD in the conference.

1623. When asked whether that was an important aspect of her assessment NL said;

"That's what we were honing in on. When it comes to the other disclosures of being hit on the bum and that type of thing or being hit on the head, when - a lot of children say that and their perception of what to them what was aggressive may not have been, so a lot of times what we need to do is we need to have a look at, when we're looking more into that, we have to have a look at is that a form of chastisement, how often did it happen, was it - what was the nature of it, was it brutal, was it a hit on the head, it was that type of stuff, so those type of disclosures are separate to this disclosure. This disclosure was about the bruises."²⁹⁵

1624. When NL was asked why BD recorded that children did not make disclosures about the bruising being related to the father, it was stated that the play fighting information came from NL. NL agreed that BD would have access to the notes she had written in relation to what the children had told her. NL stated that the reason BD wrote that note was because she told them that the children did not disclose about the bruises.²⁹⁶ NL

²⁹³ Ibid 612.15

²⁹⁴ Ibid 618

²⁹⁵ Transcript of Proceedings, p 619 – 620

²⁹⁶ Ibid 621

stated that CYPs were more concerned about the bruises than other matters, and that the other matters displayed something separate. NL said she was not entirely sure why she did not discuss that with BD. She agreed that the notes are a summary of the conversation with BD. NL agreed that the notes were a significant part of a consultation in relation to disclosures of abuse, but it was not there.

1625. NL agreed that they closed the case after that consultation because there were insufficient grounds to proceed because of the absence of disclosure and other factors.

1626. NL agreed that she had identified that the bruising, the finger marks, and the palm print on the face, were all concerning to her. NL said she saw those marks. She also agreed that the children stated that it happened in play fighting which was not consistent with what she saw. NL agreed that what she saw was consistent with what JL told her about what her father does to them; that is he hits them in the head, on the face, and kicks up the bum. NL agreed that at the time she did not put those factors together.²⁹⁷

1627. NL explained that the situation is generally that a hard case file note is kept in the office and after a consultation, if there has been a plan to seek further information, the Team Leader looks at the file and then asks whether those matters had been attended to. If not, a caseworker would then be asked to do it. NL stated that BU did not do that and given that she was still in training and not being reminded of follow-through she did not do so.²⁹⁸

1628. NL did not accept that JL had made a disclosure in relation to the bruising to the face when she told them about her father hitting her and Bradyn in the head and kicking up the bum.²⁹⁹ NL accepted that it was a disclosure of abuse.

1629. When NL was considering closing the case, she did not accept that there was a disclosure about the bruising but accepted that JL did disclose abuse. She accepts that the doctor's report said there were concerns about the children.

1630. The conversation she had with Graham Dillon where he talked about the fact he had endured abuse as a child, did not provide a trigger for NL to seek the relevant history in relation to Graham Dillon from New South Wales DOCS, however NL accepts that it should have.

1631. Regarding her comment regarding the GP who had seen the children, NL stated that she did not speak about her concerns about the bruising with the GP other than very briefly. Nor did NL provide any detail about the information that she had received in respect to the children or the observations by schoolteachers. This is despite NL relying on the doctor's opinion in respect to whether to keep the file open or not.

1632. NL agreed that her rationale was deficient insofar as she had not undertaken enquiries that were part of the plan before closing the case.³⁰⁰ The rationale is documented at

²⁹⁷ Ibid 622

²⁹⁸ Ibid 623

²⁹⁹ Ibid 624

³⁰⁰ Transcript of Proceedings, p 627.5

page 1203,³⁰¹ as to what material she relied upon to make her assessment. This included referring to the Children and Young People's Act and the definition of abuse.

1633. The closure report included that there was no recommendation for a care and protection outcome, the child or young person was not abused, reported abuse was not substantiated and the father was willing to engage with appropriate supports. NL agreed she completed that closure report. NL agreed that in doing so she knew she had not made any further enquires to appropriate services other than BP. NL also agreed she did not make any enquiries into whether Graham Dillon had attended counselling.

1634. NL agreed that she had stated in her report in relation to assessing future risk of abuse that she had determined no further action was necessary, stating "*finding the children were not in need of care and protection per section 345 was the inevitable result of the above findings*".³⁰²

1635. NL was taken to section 344 of the legislation where there was an example in a scenario in respect to a nine-year-old boy. NL accepted that there were parallels with that example and Bradyn's situation. In fact, it could be a far more compelling example in Bradyn's case of a conclusion that that the child would be at risk of abuse or neglect.³⁰³

1636. NL stated that because of her newness to the job she would have relied on her mentor being HP 3 and the Team Leader to check her work and ensure that she had completed all of her tasks and the assessment was accurate. It was somewhat of a safety net for her.³⁰⁴

1637. It was suggested to NL that she had not told BD about the disclosure, therefore, BD would not have had that information for her to consider. However, that disclosure was part of the case note and all caseworkers have access to those case notes.

1638. In effect, the review of the decision signed off on the 20 August 2014 was not made until 13 October 2014 and by a different Team Leader who had not had a conversation about the case with NL.³⁰⁵

1639. NL agreed that there were options other than closing the case she could have taken, however, at the time she did not know about them. NL also stated that she had discussed with both Team Leaders, BD, and BU, that she felt something was wrong and despite the children not disclosing she believed the father was causing the bruising. She said that BU and KE agreed with her, but she accepts that that was not endorsed on the documentation and the case was closed with no further action taken.³⁰⁶

1640. NL accepts that looking back she did have other options such as keeping a case open, seeking emergency action orders, or increasing the 28-day appraisal so that other enquiries could be made. NL stated that by the end of 2014 she had a case load which

³⁰¹ Exhibit C 5

³⁰² Ibid 628

³⁰³ Ibid 628 – 629

³⁰⁴ Ibid 629

³⁰⁵ Transcript of Proceedings, p 630

³⁰⁶ Ibid 632

had doubled in size despite her being relatively new. That may also have been a factor in her failure to obtain the information requested by BU. NL reiterated that her recommendations had been endorsed by a more senior person, being the Team Leader.

1641. NL accepted that eight days after she had made her recommendation, CYPS received a further report from the deputy principal of the primary school in relation to more bruising on the children. NL accepts that a phone call was made to SACAT who advised CYPS to conduct an appraisal as there had been no disclosure, therefore SACAT would reject the request.
1642. NL could not recall whether she had spoken with SACAT and told them about the disclosures that JL had made to her on the previous report. NL considered that it did not occur to her at the time to do so but in hindsight she should have.³⁰⁷
1643. In relation to the bruising that she saw, NL accepted and agreed with the Deputy Principal that the bruising was of concern and was suspicious. NL agreed that Bradyn had told her that he couldn't explain how he got his ear injury, but he moved around a lot on his pillow. NL stated that was not a plausible explanation.
1644. NL accepts that she then questioned JL with Bradyn in the room, which was unusual because it's normally when separated, and she doesn't know why she did so. At the time KE with not with her.
1645. NL accepts that her notes reflect what Bradyn and JL told her, that is that JL said they were play fighting and Bradyn interrupted her and said "*nothing happened did it JL*" [sic].³⁰⁸
1646. NL accepted that she was concerned about what she had seen and what the children had told her. NL said that at that time she decided to have the children medically assessed by CARHU. NL formed the view that Bradyn was too scared to say anything.
1647. Graham Dillon, who by that stage had arrived at the school, was very angry, running down the hallway speaking to someone on the phone and demanding to see the children. Ultimately Graham Dillon accepted that Bradyn could be examined by CARHU.
1648. NL met with OQ who assessed Bradyn. At the time, a friend of Graham Dillon, FQ accompanied the children. NL stated that she did have a discussion with OQ but could not recall whether she had told OQ about the prior incidence of bruising and other issues. NL was confident that she did tell her about how concerned she was about the child but was aware that they only had the referral Form to go on.³⁰⁹
1649. NL accepted that OQ did not have the whole 28 July report that included the past history of bruising of which NL was aware. NL was shown the document pages 2051 to 53 which shows that the only information available to OQ was the following;

³⁰⁷ Ibid 636

³⁰⁸ Ibid 639

³⁰⁹ Transcript of Proceedings, p 642

'Purposes of medical examination, physical abuse. Bradyn has bruises to the left ear, left cheekbone and bridge of the nose'.³¹⁰

1650. NL stated that she did not believe that she provided any further details other than the document to OQ. The hospital kept a record of the phone call that NL made in relation to organising an appointment for Bradyn to be examined. She advised that the school had notified CYPS of the bruising and that Bradyn had said that it occurred when he was play fighting and fell on his face. NL advised them that the children had bruising a month ago and Bradyn had stated he and his sister had been play fighting. NL also advised that the children had been taken a GP on that occasion and the GP had no concerns.³¹¹
1651. NL agreed that she did not give any further information to OQ but accepted that it would have been helpful for OQ to have more historical content that she was aware of. No senior person had discussed with her the type of information that she ought to give to the CARHU Doctor for assessment. NL stated this was the first time she had been to CARHU for a child assessment and at the time she had had no training in regard to this process. NL stated that she agreed that FQ was interrupting and was making the assessment far more difficult than it would have been, but she felt she was not in a position to tell her to leave. In hindsight, she would have taken FQ aside and explained to her that it is for the child to express itself to the doctor not her.
1652. NL agreed that she had a further conversation with OQ after her examination of Bradyn and agreed that OQ said the bruising had plausible explanations except for the ear. NL stated that she gave OQ no further information between the time of the assessment and OQ's report although she opined that had the doctor wished for more information she could have asked.
1653. NL contacted OQ the next day after a complaint had been made by Graham Dillon and FQ in respect to an assertion that the doctors had inserted something into Bradyn's bottom. OQ assured her that both she and the other medical practitioner who was with her did nothing of the sort. NL then contacted Graham Dillon to tell him of that fact. Graham Dillon said he did not want her help in the future and would prefer it if she left him alone.³¹²
1654. NL agreed that she had followed up on the complaint made and had spoken with BP who advised her that the family were very upset about it and that this had been traumatic. NL said that she had organised some counselling services details to provide to Graham Dillon.
1655. NL also was aware that the day after the report, Graham Dillon had attended the school and was angry, upset and threatening. That matter was reported in a separate document and then a further report stating that this was the fourth report of bruising between June and August. NL at the time was not aware of the concept of cumulative harm and even now whilst giving evidence struggled with the principle. It was NL's view that although she was unaware of the concept she was certain her Team Leader BU would be.

³¹⁰ Ibid 644

³¹¹ Ibid 644

³¹² Ibid 649

1656. NL accepted that the school had been in contact with CYPS on several occasions while she was the case worker. They had also been in contact with her in respect to a significant amount of non-attendance at the school and their related concerns. CanFaCS was still supportive of Graham Dillon and although the formal report from CARHU was not available it was understood that the bruising to the face was unexplained. There was also a reference to a report where bruising was of concern. At that point, whilst it was suggested that Graham Dillon had support from Communities @Work, NL had not confirmed that fact. Nor had she requested confirmation in respect to the other matters which had been raised in the very first assessment.
1657. NL confirmed and accepts that it was significant that *“father presents as volatile and aggressive. Makes threats to workers and school.”*³¹³ NL also accepts that she was aware that Graham Dillon had a criminal history and had been in prison. NL stated that even though that fact may not have been a flag to her at that point, it should have been for the Team Leader. NL did not agree that the mounting evidence of the bruising, disclosures and inconsistencies of explanations should have raised concerns that the causes were nonaccidental. NL was of the view that Graham Dillon having a past did not mean that he had abused the children in a way to bruise them. NL accepted that she had her suspicions but essentially couldn’t prove them.
1658. NL accepts that the disclosures, that she now accepts were disclosures, should have been examined and investigated but she didn’t do so, however, said that even if that were the case they must allow the parent to show willingness to act protectively and that emergency action is a last resort.
1659. NL suggested that even though JL had disclosed what her father had done to her, one would need to consider the context of the disclosure. NL said;
- “we have a lot of children that say all – that disclose these types of things and sometimes, depending on the level of understanding, their age and, you know – and what’s happened, you have to also look at the context of. You know, if they’re saying, dad bashes me, what doesn’t bash me mean”³¹⁴
1660. NL was of the view that she didn’t have sufficient evidence despite all the factors that she had before her as at the 1 September case conference with BU.
1661. NL agreed that because of her lack of experience she did not join the dots together to work out that indeed there was sufficient evidence to form a view that there were concerns. In her report she referred to the children as being protective of their father and showing loving feelings toward their father. NL accepted that a child fawning over their father with love and affection may well be afraid of their father.
1662. NL stated that both she and KE were concerned and spoke about it often, but they felt their concerns were not substantiated in relation to the bruising and looking at it in hindsight it was clearly cumulative harm that was building up.³¹⁵

³¹³ Transcript of Proceedings, p 651

³¹⁴ Ibid 653

³¹⁵ Transcript of Proceedings, p 657

1663. NL agreed that she had not received the reports which were now requested by two supervisors and she does not know why she did not obtain them. NL accepts that it would have been important to obtain those reports.
1664. In relation to the CARHU report, the assessment had already been completed by the time they received it and that did not affect the assessment they had already made. NL now accepts that it is best practice to clarify any uncertainty in the report.
1665. NL agreed that the deputy principal of ACT Primary School 1 had contacted her on 10 September to say that the children had not been attending school, and she was unsure whether they had changed schools. The schoolteacher advised that she chased up enrolment with another ACT Primary School 1, but they had not been enrolled there either.
1666. NL agreed that at that period of time there were no home visits by CYPS and given there was no school attendance no one had eyes on them. A further phone call from the school indicated that on 17 September the children had not been at school and had not been for some two weeks.
1667. In relation to the children attending the Bungee Program, NL was advised by Graham Dillon that the children were still attending on 23 September. NL thinks she tried to contact the program but did not make a note of it and was unsure. NL stated that she thought that BP was going with them so there was no further need for her to make any phone calls.
1668. NL was made aware that SK was going to court to have the Protection Order lifted against her. NL was aware that there was one in place but did not endeavour to contact SK to get any information.
1669. The case was closed on 13 October after endorsement of NL's findings that the children were not in need of care and protection. NL accepts that that was not a good decision.³¹⁶
1670. NL accepts that the very next day on 14 October another report was made and received by CYPS. NL agreed that should have been a red flag, but it wasn't. The report was from a teacher at ACT Primary School 1 stating that Bradyn had returned to school after two weeks holiday with bruises on the left-hand side of his face. NL accepted that given the reports of bruises to the face previously this must have been a significant flag. However, NL also accepts that from the contemporaneous notes nothing was done about it.³¹⁷
1671. The report from the school indicated that Bradyn had returned to school with what appeared to be five small circular bruises on the side of his cheek. They appeared to be fading and a few days old. The reporter stated that Bradyn's father was at the school that morning, however, he did not make eye contact or engage with her which is what he would normally do.
1672. NL accepted that there was a brief analysis in the report of current and previous contact. There had been 12 prior reports in respect Bradyn and JL, seven in relation to family violence and the mother's substance misuse in 2013. A Protection Order was

³¹⁶ Ibid 664

³¹⁷ Transcript of Proceedings, p 665

in place against Bradyn's mother. There had been five reports in relation to both children presenting with several bruises to the face since June 2014 and all reports received were in relation to allegations of physical abuse. On the report at the subject heading for cumulative harm it was marked 'no'. NL agreed, given the history, that should have been ticked as yes for cumulative harm.

1673. NL did not give an explanation as to why she had not contacted Bradyn's mother or Graham Dillon's ex-wife or any other family member for that matter, to confirm the veracity of claims.

1674. NL did not contact any of the supports, either formal or informal, that Graham Dillon had described to her and thus they were not verified. The report from the teacher was closed and endorsed the very day it was received.³¹⁸

The analysis for doing so recorded the following "at this time there is no need to suggest that Graham Dillon is not meeting his day-to-day needs. Concerns remain in respect of allegations concerning physical abuse. However, a CARHU medical assessment has been conducted. There were no significant concerns regarding the bruising on Bradyn's face".³¹⁹

1675. NL agreed that this report was written after she had received the CARHU report. NL also agreed that Bradyn had not been seen by CARHU in relation to this latest report of bruising. NL also agreed that despite her saying in the report that there had been no disclosures from the child to indicate physical abuse that was incorrect because JL had disclosed abuse on 30 July.

1676. The report goes on to suggest that whilst there may be future risk of abuse, the risk has been mitigated due to the existing protective measures including various community and informal supports. Despite there still being concern held by NL the report was signed off and endorsed.

1677. NL agreed that on that occasion no one went to see the children or ask about the bruises.

1678. In respect to when the mother took the children to Victoria, NL agreed that she received a phone call from BE, a Victorian care and protection worker. NL agreed that she spoke with BE and told her that while she had been involved with the family; the case had been closed. This call came from Victoria two weeks after no action had been taken in respect to the report of 14 November.

1679. NL agreed that she recorded that she spoke with BE, telling her that the children disclosed they were afraid of their mother, that their mother uses drugs and that there had been reports of bruising in relation to the children but none of them had been substantiated and no further action had been taken. NL stated that the children were in the full-time care of their father and a DVO was out against the mother for attempting to kidnap the children. NL said that she would have recorded everything that she spoke about to BE, and the record is an accurate reflection of that conversation.

1680. NL stated that she did not pass on any further information because she was unsure as to what she was entitled to say, however, she did agree that the information she

³¹⁸ Ibid 666

³¹⁹ Ibid 667

passed on could have been more detailed. It was her view at the time that any further information should be shared through the ILO.

1681. In relation to a message from a call made on 17 November from BN, NL did not receive that message until the following Wednesday due to being on training. NL accepted that the note indicated that the children were back with the father in the ACT and that BN had concerns in relation to the safety of the children with the father.³²⁰
1682. NL agreed that she received a call from BN who stated that; there was a DVO out against the mother, but the children had been taken off it, the mother had been allowed to see JL on her birthday, the kidnapping of the children and that Graham Dillon was incarcerated for six months in Tasmania for assault and violence. BN also said that the new wife had been a victim of domestic violence and had a Protection Order out against Graham Dillon. NL agreed that she already knew these facts but had not obtained any records in relation to them.
1683. The note further records that during the conversation it was stated that the court's returned the children to the father's care because they considered the mother had acted inappropriately. BN advised that the children were devastated when they heard they were leaving the mother and disclosed that they did not want to live with the father because he hits them. BN then advised NL that the children told them that the dad hits and punches them and that the father had thrown Bradyn on the couch.
1684. The note further stated that BN observed that the children repeatedly sought assurance from the workers asking if they would tell their father that they had made the disclosures. BN advised that the children's mother had significant information in respect to Graham Dillon's history and was happy to share it with CYPS. BK also said that she did not wish to have anything to do with Graham Dillon as he continually sends abusive messages while he is on ice saying that she is like her mother, SK, and had threatened to boil her mother's head.
1685. BN also stated that SK had a urinalysis conducted and that there was no ice present in her results and cannabis was detected. When the children were in the care of their mother, they presented as happy and clean and were articulate and well mannered. They strongly expressed that they did not want to return to their father's care. BN said it took 20 minutes to calm the children down.
1686. NL agreed that that conversation included significant detail and the disclosures were significant. NL suggested that she assumed that Victorian care and protection would pursue these things further when the children were in Victoria. It was pointed out to NL that indeed the children were now in the ACT's jurisdiction which she accepted.
1687. NL considered that the purpose of the call was to raise concerns with her. NL said that she created her report in respect to this report from BN. In the report, NL referred to BN saying that a care and protection report would be provided giving full, detailed information.
1688. NL wrote that if Victorian care and protection had assumed there was an immediate danger to the children they would have taken emergency action. Clearly NL was unaware of the specifics of the court order and admitted that she did not pay a lot of

³²⁰ Transcript of Proceedings, p 671

attention because she assumed that that information would be sent to her through the ILO.

1689. It was suggested to NL that despite her concerns and suspicions about Graham Dillon, particularly as a result of the disclosures made by JL, she had reported to a number of her supervisors that the children had not disclosed. Now someone from Victoria was saying that the children had disclosed and was contacting her to make a mandatory report. NL understood this as she made the report which was taken from BE as a mandatory reporter due to her role within Victoria Child Protection. .³²¹
1690. NL agreed that she had recommended that disclosure by the children should proceed to further investigation. That was on 1 December 2014 and the recommendation was endorsed.³²²
1691. NL said that the case was eventually transferred to PG who was HP 3. PG was fairly new at the position but did have a history of Child Protection work. NL recommended that the appraisal be undertaken by HP 3 level worker. NL stated that she would continue to act as a second for consistency until the new caseworker had met the family.
1692. NL recalls receiving a phone call from SK on 9 December 2014. SK advised that she had been unable to speak with children without their father listening. Graham Dillon dictates what the children are allowed to speak about and what they are allowed to say. SK gave a history of what the children had said to the caseworkers in Victoria which was consistent with the report from BN. This included things such as he punches them, strangles, and throws them around and that the children are too scared to talk.
1693. SK also advised in that phone call, that Graham's ex-wife has a DVO against him and that UN had a recording of Graham Dillon threatening to boil SK up, eat her face and cook her up. NL does not recall whether she followed up any of those matters nor did NL contact UN.
1694. NL was taken to a case consultation note that involved herself, BU, and PG. This consultation was three days after the phone call from SK. NL explained that she would have consulted with BU and PG about the call. NL agreed that in hindsight, after that call a child intake assessment should have been generated however she did not do so.³²³
1695. NL accepted that while she could not recall the meeting on 12 December 2014 she accepted one did occur and that included concerns about physical abuse, historic and current, and an appraisal was required to be undertaken to review cumulative harm, current situation, and physical abuse.
1696. In that note, it further considered that a home visit, a review of the previous concerns in respect to physical abuse, interviewing both children and consideration of a Child Protection case conference were required. That is a conference where all relevant services come together to discuss a way forward for the family. NL accepted that that was signed off by her and PG which is inconsistent with her view that she was only there to do a handover. However, she indicated that does not reflect the situation

³²¹ Transcript of Proceedings, p 675

³²² Ibid 675

³²³ Transcript of Proceedings, p 681

because she only attended that one home visit. NL could not recall whether she had spoken to PG about the phone call she had with SK.

1697. NL thought that the first-time home visit since 20 November 2014 was 19 January 2015. NL was unsure why it had taken two months since a report to visit the home.
1698. NL was of the view that in hindsight a case such as this with multiple reports of concerning bruising to the face of children should have been escalated to a more senior level on the second report. NL said the system has changed and if information which has been requested has not been followed up the Team Leader will get a flag to remind them of that fact.
1699. NL reflected upon the handling of this matter and questioned why more senior workers did not see her difficulty given she was such a new worker with little practical experience and a caseload which ultimately overwhelmed her. She said if she didn't flag it why didn't someone else flag it for her given her low experience level.
1700. NL accepted that she was not thorough enough with the information requested and follow-up. It was her view that this case escalated, and she wasn't sufficiently trained or experienced enough to carry out the work required. NL said she did not grasp the seriousness of it. She questioned why somebody else did not grasp the seriousness of it when they had consultations. NL stated that she reported things but did not make sense of them and she needed help to do that. She felt like it was all falling upon her shoulders and she should have been supported better. She was not criticising her Team Leader, however, looking back she felt like the work was too intense for her level.
1701. NL was unsure whether Graham Dillon had been notified that cases had been closed on 20 August 2014 and 13 August 2013. Generally a letter would be sent to the parents notifying them but not always.
1702. In relation to the report by OQ, NL agreed that she considered what the doctor had discussed with her rather than going to the actual report. NL also stated that she would have understood the term 'the injuries are of concern'. NL stated that this report would be entered onto CHYPS.
1703. NL was unsure as to who had actually seen the report, but it was standard practice for the Team Leader who was to endorse a recommendation to read that report and any other information recorded.
1704. In respect to the section 334 requirement, NL understood that the standard was a suspicion that the children were at risk of abuse. NL also understood that there were several factors to take into account in order to establish that risk.
1705. NL also accepted that using drugs was another factor which would come into play. She was advised that she was working with another family who had a connection with Graham Dillon and there was some issues in respect to supplying of drugs. NL understood those drugs to have been methamphetamine (ice). NL had considered that the association with this drug family by Graham Dillon would be drug related.
1706. NL was referred to a report from 15 December 2013 from a neighbour who made observations including that Graham Dillon was hard on Bradyn, that he didn't like Bradyn and that the reporter had concerns about the level of care that Graham Dillon

could give the children. Although it was the view of the reporter that Graham Dillon does try, it was also reported that the children were staying with him in a house where there was drug use.

1707. NL agreed that the reports were consistent with the idea that JL was his favourite, and he didn't much like Bradyn. The reports of bruising were consistent with that theme, in that most of them were concerning Bradyn.
1708. In respect to the reports NL, indicated that they do not generally go back through all of the reports because sometimes that can be very onerous and there often might be 40 or 50 reports to go through. They do not go through each and every one of them. It was suggested that was a potentially dangerous practice and NL said that when you're putting together an initial 'spiel' one looks at how many reports have been made, how many have been substantiated, how many interventions there have been, and the types of and nature of abuse being looked at. NL also stated that cumulative harm is something that you would consider as well as if anything stood out, that may require looking at the prior reports.³²⁴
1709. NL agreed that if a family had 40 or 50 reports that would be of significant concern and required careful review to assess cumulative effect of each and every single incident rather than glossing over them. NL agreed that it is possible that she glossed over some of the reports in this case.³²⁵
1710. NL agreed that she had closed the case where she had identified future risk of abuse, had significant concerns in relation to Bradyn, and without making any real investigations.³²⁶
1711. NL agreed that there was, despite these risks and concerns, no meeting with stakeholders such as the school or community organisations to discuss future plans in relation to the family. Neither was there a discussion with BP about what he needed to look out for. NL agreed that such a policy involves the Child Protection case conferencing. NL explained that to do such a conferencing the appraisal would be requiring another 28 days or perhaps more so that it could be organised.
1712. NL agreed that support services such as CanFaCS would not be expected to give ongoing support for Child Protection issues particularly if those concerns had been raised with CYPS.
1713. In respect to the assertion made by NL that she would not have referred to the injuries as not considered suspicious, because she would have said the abuse was not substantiated, it was confirmed that she had indeed said those very words in the intake report on 30 July in respect to Bradyn seeing the GP. After being referred to that passage NL agreed that she may well have said those words.
1714. NL agreed that she had assumed that SK had no lawful right to take the children when she used the words 'tried to abduct the kids.' However, she was unaware that at the time of the Tuggeranong incident there was no order in place preventing her from

³²⁴ Transcript of Proceedings, p 691

³²⁵ Ibid

³²⁶ Ibid

taking the children. NL agreed that Child Protection workers should investigate these claims and verify them.

1715. It did not occur to NL that by not investigating and verifying the claims made by Graham Dillon she was assisting him getting the children back when he had no lawful right to do so.³²⁷
1716. NL agreed that the appropriate way to disseminate information interstate was to use ILO.
1717. In respect to why nobody answered the call from BN on 17 November when NL was in training, NL stated that if it was urgent, one of the Team Leaders should have dealt with the matter.
1718. In the conversation with BN that NL recorded on 17 November the words that follow the statement “dad threw me on the couch” are not clear as to whether this was done in fun. It was NL’s interpretation of those disclosures because she was mixing her own thought was what was being said.³²⁸
1719. NL agreed that it was unlikely that BN would say that she would generate a Child Protection Report because that was the job of CYPS to do so not Victorian Child Protection.³²⁹ NL took the view that whatever it meant she was to send her further detailed information.
1720. NL was aware that there was a request made by BU to the ILO requesting notes from Victoria, however, she was unaware that Victoria did not receive a request from the ILO for material to be provided.³³⁰
1721. NL advised that in January 2015, PG was the worker who was to follow-up any information. In relation to the meeting of 12 December 2014, PG would be the worker to follow-up with the ILO.
1722. NL agreed that given she had direct contact with BN she had not considered that it would be difficult for her to send any documents or information by email.
1723. NL agreed that there were conflicts in respect to features of the case such as some were positive, some were not and there were competing interests as to the best course to take.
1724. NL also agreed that the children, aside from the one-time when JL made the disclosure about hitting in the head and kicking on the bum, did not make disclosures in the same when they had in Victoria.
1725. NL agreed that the questioning of the children was designed to get them to open up and to understand what exactly was meant by the words they used. NL also agreed that she did not consider that JL was unsafe with her father and did not have anything negative to say about him.

³²⁷ Transcript of Proceedings, p 695

³²⁸ Ibid 699

³²⁹ Ibid 700

³³⁰ Ibid 701

1726. It was suggested that the questions about what the children like about things were designed to get them to open up. However, I noted that the children were never asked in the meeting about what they don't like, they are only asked the three things they do like. NL agreed that even in that conversation there were conflicting examples to the questions asked. NL agreed also that the contrast between the schools concern and that of BP applied a tension to the information. It is clear from the questioning that the children wanted to express that they felt safe at home and school. Clearly this was a complex case, and a balancing exercise was required.
1727. In relation to prior notes on the CHYPS database, given the extent of information on the database it is difficult to determine how aware NL was that there was family violence of some kind between Graham Dillon and his ex-wife . NL agreed that was another positive report in respect to Graham Dillon.
1728. NL also advised that when she first went to the house all the children were comfortable in their environment, that the father was demonstrably very loving toward them and they were very clean and tidy, demonstrating another good positive feature.
1729. NL agreed that the children were appropriate for their height, weight and age and looked healthy. NL also agreed she had known BP and had learned from him and considered him to be professional and a good worker.
1730. NL agreed that in her experience Graham Dillon's house was not one where it was apparent there was indicia of child abuse and neglect. In relation to the report from OQ, NL agreed that the bruising to the ear had often plagued her and she expected that there would have been a better explanation of how the bruising occurred.
1731. NL agreed that had she kept the case open for longer, and had she referred to the records and received further information from other agencies, this together with better experience may have helped her form her analysis better.
1732. NL agreed that she has been greatly affected by Bradyn's death and that she has agonised over the decisions she made, whether she could have done better and whether she wishes to stay in the field because this case taught her the importance of how thorough the job must be.
1733. It was her view that Bradyn's tragic death will bring change within and outside of the Organisation with such things as improvements to communication with services, the documentation of information and interstate communication.
1734. In relation to her understanding of the role of BP and CanFaCS, NL was aware that it was a role that would cease once Graham Dillon had moved into permanent housing.
1735. NL could have done a lot more for Bradyn and JL, however, to her credit she accepted that she could and should have done more.³³¹

³³¹ My emphasis

KE – CYPS Case Worker (HP 3 Level)

Statement

1736. KE was employed as a HP 3 within CYPS between July 2014 and February 2016. On 28 July 2014 a report was made by the ACT Primary School 1 in respect of Bradyn and JL Dillon. NL was assigned this case and she was her second.
1737. KE noted that whilst events, decisions, and communications in relation to the Dillon family were recorded on the CYPS files the two would often confer in conversations which would not be noted.
1738. On 30 July 2014 she assisted NL on a trip to ACT Primary School 1 to see Bradyn and JL. She then recalls visiting Graham Dillon at his home after he had collected the children and on another occasion when they were not there.
1739. It was KE's view that Graham Dillon was eager to tell them about his personal circumstances, the support measures he had in place, the organisations he was engaging with as well as his determination to look after the children. His home was well-kept, and the children were observed to be normal in their behaviour.
1740. KE recalls that she spoke with NL on 1 August 2014 after she had spoken to the GP who had reviewed Bradyn and recalled that NL was surprised that the doctor thought there was nothing wrong, particularly given she had observed bruising on Bradyn's face the day before the medical exam.
1741. KE was there on 28 August 2014 when a further report was made from the school. She was with Graham Dillon and he appeared angry and agitated, but ultimately agreed for the children to be assessed at CARHU.
1742. KE read the report from CARHU and noted that the conclusions reached were that there was an explanation for some injuries but not to the ear. The report failed to mention that they were nonaccidental and it was her view that the report was not assertive enough to provide a sufficient basis for CYPS to intervene through the Children's Court.
1743. KE indicated that whilst there needs to be proper grounds for seeking a Care and Protection order, she had personal concerns in respect to Graham Dillon. It was her view that NL felt the same way, however it was felt that there were a number of features which weighed against bringing an application in the Children's Court.
1744. KE observed from her own interactions with Graham Dillon that he was quick to change his demeanour- he would swing from anger and aggression to crying and contrition and he did so quickly. It was her view that he seemed emotionally unstable.
1745. In addition to this issue there was the unexplained bruising to Bradyn as well as his poor attendance at school. KE then set out the risk factors to be weighed up in order to make an appraisal.
1746. The home appeared well-kept, the children were well fed and dressed, there was no signs of neglect, and although there were absences, the children were still going to school and CYPS had confidence in the children's teachers.

1747. Graham Dillon appeared to interact with his children and care for them and neither child made any complaint or disclosure about abuse and neglect.
1748. There was no exhibited behaviour by Graham Dillon which indicated an attempt at covering up any abuse, he was compliant to some extent and the medical assessments revealed nothing suspicious about the children. These factors, together with Graham Dillon proactivity in engaging with other organisations, in particular the support of the CanFaCS, and the fact that BP was in regular contact with both CYPS and Graham Dillon and was clearly supporting the family.
1749. It appears BP was a central part of the appraisal process given he had more to do with the family and had the benefit of being inside the house and regularly seeing Graham Dillon and his at interaction with children.
1750. Having considered all those factors it was thought that an application in the Children's Court for a Care and Protection order would not have any prospects of success. Graham Dillon appeared to be doing everything that he would be required to do-even if there had been an order in place.

In Evidence before the Inquest³³²

1751. KE is a Child and Youth Protection Case Manager for CYPS. She commenced working for CYPS in 2008. Her entry-level was Health Professional 2 (HP 2) and she rose through the levels, becoming an HP 3 in 2014. KE clarified that HP 4s are often Team Leaders, even though there are also casework positions at that level now. HP 5 is Operations Manager level but also reflect casework positions as well.
1752. KE said that she was assigned as a second to the primary worker allocated to conduct the appraisal in the Dillon matter. If that primary worker was HP 1 level it was also a mentoring role.
1753. KE agreed that NL was a HP 1 at the time and KE was her second and mentor. KE indicated that she would try to go on all home visits (if possible) when the worker was a low-level worker. KE indicated that she was the second to most of the case work NL conducted in relation to the Dillon family.
1754. KE agreed that she was the second to NL when a report was made by ACT Primary School 1 and was aware at the time that there had been previous concern reports received from the school. KE said that she did attend ACT Primary School 1 to see the children with NL.
1755. KE agreed that NL recorded notes of the interview with school staff and also the children. These were placed in the progress notes on the CHYPS system. Those notes were made contemporaneous with the attendance at the school and were accurate. KE explained the process of entering notes onto the system.³³³
1756. KE agreed that the note from 30 July 2014 indicated that the children had presented with bruising which appeared to be finger marks on their cheekbones and jawline. These bruises were of concern. KE was aware that there were also notes indicating that on another occasion there were bruises on the children's faces which appeared to

³³² Transcript pp 517 – 580.

³³³ Transcript of Proceedings, p 522-523

be in the shape of a handprint.³³⁴ There was also a concern as the attendance by the children was poor. There was also discussion in respect to the demeanour change and strange behaviour of Bradyn when \$5.00 had been taken from a teacher.

1757. KE indicated that she and NL would have discussed these concerns and reports with the school. KE was also aware that Graham Dillon admitted to having led a shady past and that there was a protection order out against his former wife and there were custody issues.

1758. KE indicated that she was in attendance when the Deputy Principal spoke to them about the unexplained absences of the children which indicated 13 days for Bradyn in term one and 11 days in term two, and for JL 13 days in term one and 15 days in term two. Both had missed five days in term three. KE agreed that that would have been taken into account. The absenteeism plus reports of bruising would have been of interest to KE and CYPS. KE also stated that there were some positive observations that would also be part of the analysis, such as they were well groomed and had clean hair and their lunch was provided.

1759. In relation to how relationships between families such as the Dillon family with two separate links would be made relies on the information being uploaded by caseworkers to the system.³³⁵

1760. KE agreed that the description noted in the notes would be something that she would consider, including the observations of the teachers which give a holistic picture of observations made of the children's behaviour.³³⁶

1761. KE also noted in the progress notes that both Bradyn and JL had been interviewed by NL and herself. It is usual practice to speak to children individually, however there was one point where they spoke to the children together.

1762. Given what JL had told her in respect to how she deals with her father, KE indicated that was a concern for her as it was almost a reversal of roles in the household. They spoke to BP from CanFaCS about that circumstance.

1763. KE stated that she did observe the bruises recorded as being on JL's right cheek as a small round bruise the size of a 10-cent piece on her right jaw line and a very faint bruise on her left eyelid. The bruises were light in colour and appeared to be a few days old.

1764. The note was put to KE about what JL had told them at the interview, the note reflects;

"When asked if her dad gets angry, [JL] stated that her dad expects them to do a lot of things and quickly and if they don't do it, her dad sometimes hits them on the head and kicks them on the bum with his boot when they are not expecting it. [JL] was asked to show us where she gets hit and she physically placed her hand on her left side of the head, on the right side of her head, and on the side of her face".³³⁷

³³⁴ Ibid 523

³³⁵ Ibid 527

³³⁶ Ibid 257.25 – 40

³³⁷ Transcript of Proceedings, p 259

1765. When asked if that hurt her, JL indicated *“not the boot hurts more”*.³³⁸ KE agreed that that was of concern.
1766. In relation to the interview with Bradyn and his replies as to why he had bruising on his face, it was clear that Bradyn didn’t want to talk about if he got in trouble at home and also about how he got some of the bruises. When Bradyn is scared he said he gets under the doona. KE agreed these admissions were of concern.
1767. KE knew that there were two occasions when the children were taken to either a general practitioner or CARHU, but she was unsure when that was. The progress notes written on 1 August reflected that CYPS were requesting a medical assessment of the children. Graham Dillon threatened he was going to speak to his lawyer. He was also informed that he could take children to a GP if he preferred. He then indicated that he was going away for the weekend and couldn’t answer until the following Monday. KE said that she recalled the incident and Graham Dillon initially refused to have the children attend CARHU, and it was at that point that the compromise was made for the children to be seen by a GP.
1768. KE stated that it is not unusual for parents to resist the notion of taking the children to CARHU and threatening to seek legal advice, however, it is less common to recommend that a GP be involved- but it can occur. The expectation is that if that is recommended then it should be the family GP. Best practice would of course be CARHU but if the GP is involved ideally CYPS would contact them prior to the children attending. KE was of the view that Graham Dillon had agreed to take the children to their regular GP.
1769. It was suggested to her that NL had spoken with the GP who had seen Bradyn and was shocked to learn that the GP could see nothing wrong with him given that she had observed bruising on his face the day before the medical examination.
1770. KE recalled that the children were at school when they attended the home and Graham Dillon picked the children up and came home. She recalled that the children were very quiet, very well behaved. KE was taken to the note which said that when asked about the bruises to the children, Graham Dillon had told them that the children were with their cousins in Sydney and that there was some fighting and rough play. Graham Dillon also protested that he would never hurt his children and loved them very much. KE recalls that conversation.
1771. During the interview with Graham Dillon, he was emotional and teary and spoke of his childhood experiences including being in foster care having been taken away from his parents and abused by his carers. Graham Dillon also told them he was obtaining support through BP at CanFaCS and when he found it difficult to cope, he would contact them for support.³³⁹
1772. Graham Dillon also stated he had a female friend who he would call upon to take the children so that he could have a break. That person was the person who accompanied Bradyn to CARHU. Graham Dillon also told them that he was attending mediation counselling with Relationships Australia. Graham Dillon also said he had been

³³⁸ Ibid

³³⁹ Transcript of Proceedings, p 533

attending church support groups. Graham Dillon also told them that he was joining a single man with children social group run by Relationships Australia.³⁴⁰

1773. Graham Dillon stated that in terms of curbing the children's behaviour he would often send them to their room or sit them in the thinking chair to have time out, and very rarely did he slap them on the bottom. He denied bashing or abusing them. KE agreed that Graham Dillon's version of how he managed the children was significantly at odds with how JL described his behaviour.
1774. KE agreed that the difference between the two versions would be of concern to care and protection when looking at all the information holistically and cumulatively. In the case consultation which followed the interview at the school it was noted that there was a discrepancy in respect to the children and Graham Dillon's account of how the bruising occurred. It doesn't appear that there was a note in respect to JL stating that her father kicked her in the bum with his boots, and it was also noted that the children were very compliant- which KE said was an overly compliant presentation which might suggest fear.³⁴¹
1775. As a result of the case consultation process on 30 July 2014, a number of matters were listed for investigation including mental health records, criminal history, and drug and alcohol history together with PROMIS notes from the AFP. It was also recommended that the caseworker was to liaise with BP from CanFaCS. There was also to be requests for New South Wales DoCS records in respect to Graham Dillon. The caseworker was to liaise with schools in respect to the emotional and physical presentation of the children, as well as the absenteeism and correlating them to previous reports of bruising. KE was unaware whether those investigations undertaken.³⁴²
1776. KE also acknowledged that there was a safety plan which Graham Dillon and the caseworker signed. This gave Graham Dillon information of what he could do to cope when he is stressed and the like. KE indicated that during the course of an appraisal home visits are conducted at least once per week. The appraisal is done over a 28-day period. KE indicated that there are scheduled and unscheduled visits and that that information is told to the parent at the beginning of the intervention.
1777. KE stated that during the course of an appraisal if any information comes to the caseworker about any involvement with police it would be standard and best practice to obtain police records in that event.
1778. KE confirmed that the follow-up with BP had occurred. The note also reflected that BP had stated that Graham Dillon was a really good dad and had been for the past six months. KE confirmed that she was not aware of any contact between CYPS and Graham Dillon's ex-wife or the mother of Bradyn and JL, but that it would have been the usual practice to be in touch with those persons.
1779. KE confirmed that the issues Graham Dillon raised in the home visit on 8 August 2014 are relevant and would be something that would be considered in an appraisal. KE also confirmed that the conversation with Graham Dillon where the caseworker

³⁴⁰ Transcript of Proceedings, p 535

³⁴¹ Transcript of Proceedings, p 538

³⁴² Transcript of Proceedings, p 239

advised Graham Dillon that their involvement would be for the duration of the investigation however once an appraisal was complete, they would close the case.³⁴³

1780. It was suggested to KE that by early August the following had occurred:

- (a) the school had made a number of reports of the children having bruising to their face which looked like finger marks and possibly a handprint
- (b) that Bradyn was exhibiting strange behaviours in that that he freezes up and shuts down and won't talk, that he is jumpy when the teachers raise their voice and is seeking constant reassurance
- (c) there was a protection order against the father, and he had on his own admission a shady past
- (d) specific details of unexplained absences correlating to the times when the bruising was observed
- (e) involvement with police over a particular weekend in August
- (f) a disclosure by JL that her father had hit her in the head and kicked her on the bum, identifying the areas where he hit her
- (g) the inconsistent version given by Graham Dillon of speaking of nonphysical options for punishment
- (h) claims by Graham Dillon that he was receiving counselling with Relationships Australia and a church group
- (i) claims by Graham Dillon to have full custody of the children
- (j) claims by Graham Dillon that he had had a heart attack
- (k) claims by Graham Dillon that he was getting support from a single men's group
- (l) claims by Graham Dillon that he was taking the children to see the GP

1781. KE was unaware whether any of those assertions were verified as to their veracity. Neither was she aware as to whether the plan for investigation of various of these matters noted by BD had been ascertained. KE was aware that the enquiry was closed.

1782. KE was also aware that there was a further report received by CYPS on 28 August 2014 from a mandatory reporter at the ACT Primary School 1. KE attended the school and was advised that the children had bruising to their faces. On that occasion KE spoke with Graham Dillon who escalated, became loud and basically lost control because they were there to speak with the children because of a report. Ultimately, he deescalated somewhat but remained heightened on the whole and on one occasion interrupted interviews with the children. KE said that they tried to explain the situation with him, but he was aggressive and would not listen. They advised that CARHU would have to examine them, and he refused consent for that to occur.

³⁴³ Transcript of Proceedings, p 544

1783. Graham Dillon then threatened to go into the Deputy Principal's office and take the children. He was advised that he was not to do so and that if he refused permission for children to be reviewed by CARHU then emergency action would be taken.
1784. Graham Dillon again refused and threatened to take the children from the school and threatened them by telling them he had been to jail and that they should be careful and that they would wait to see what he could do.
1785. Despite his behaviour KE said she did not feel threatened as she had encountered this type of behaviour before. Ultimately after calming him down he consented to the children going to CARHU but wanted someone to go with them nominating FQ. KE said that she did observe bruising to Bradyn's ear.
1786. KE stated that she was unaware what Dr OQ from CARHU had been provided with, but she would have been provided with a history with some level of detail, which should have been provided by the caseworker. It would be a surprise to her if that hadn't been done. KE was of the view that if that had not been done CARHU would have collected that information prior to examining the child.
1787. In respect to emergency action being taken, it lies in a spectrum as to one end no action and at the other emergency action and there's nothing really in the middle other than offering some community supports or keeping the case open for the next four weeks to see if the situation can be resolved. KE also discussed that there could have been a court ordered supervision order where CYPS would have access to the home and to the school to speak with the children if required. A mechanism for keeping "eyes on". It was her view that Graham Dillon was doing everything that was required of him so that the supervision criteria had been achieved.
1788. KE indicated that she had her own personal concerns about Graham Dillon, and they were that the children had presented on couple of occasions with bruising and the reasons given were not consistent and these raised concerns for her.³⁴⁴
1789. KE indicated that in respect to assertions that there were supports in place made by Graham Dillon it would be best practice to contact those organisations to ensure that indeed they were supporting him and the children. Likewise, in respect to the custody arrangements that Graham Dillon asserted he had if it were possible to do so.
1790. In respect to the balancing exercise that caseworkers need to engage in when weighing up the factors as to whether they should take emergency action, KE agreed that things such as a neat home, well-dressed children, well fed and no signs of neglect, would be factors to be taken into account as well as (despite some absences) the children were still attending school.
1791. KE also stated she had confidence in the teachers who had engaged with CYPS. KE was of the view that the incidences which had been reported may have been inappropriate chastisement rather than physical abuse. It was suggested to her that hitting a child in the head was not physical chastisement, but abuse and KE replied, "*I guess so*" and "*yes*".³⁴⁵

³⁴⁴ Transcript of Proceedings, p 552

³⁴⁵ Transcript of Proceedings, p 554

1792. KE was alert to the fact that when a person is vulnerable and has no one to help (particularly a parent who has a history of abuse), it affects their ability to self-regulate emotionally and they may not have strategies to deal with their behaviour. KA agreed that ultimately it was important for counselling services to be available to him and following up those organisations was important.
1793. KE advised that BP from CanFaCS was central to the appraisal process because of his dealings with Graham Dillon. That was because he had the most dealings with Graham Dillon and the children and saw them regularly. BP was also very supportive of Graham Dillon.
1794. KE advised that her view of BP's role was managing supported accommodation as well as a family support caseworker. This was short and long-term, and once long-term had been achieved they were no longer involved.
1795. In respect to changes having occurred in CYPS post Bradyn's death, mentoring has become a formalised process. Policy and procedures around mentoring strategies have been updated. HP 1 is not given a caseload upon commencing work. They now have six weeks prior to been given the case and the caseload is low after that period. HP 3s are now given time to supervise and mentor workers.
1796. KE indicated that resourcing has always been a problem in child protection, and she is not aware of any discernible difference between the time of Bradyn's death and the present from her perspective.
1797. In respect to improvements to the system, a national database with information sharing that was fast and transparent would be very useful, better resourcing would be also useful and the mentoring program would be useful.
1798. As a result of the reduced workload of HP 1, HP 3 caseloads are now higher, resulting in more pressure because cases still need to be allocated. Training has been formalised.
1799. KE was unaware that SK had made complaints to care and protection as early as 30 July 2013 expressing concerns about the safety and well-being of her children. KE was taken to the care and protection report of that date. KE was asked whose role it was to gather information in respect to the report. KE advised that would be the case worker's role to collect all available information.
1800. KE had agreed that if she had known about that report it would have been something that should have been part of the risk assessment. KE advised she was unaware that there was a phone call from SK to NL on 9 December 2014. KE agreed that she had some recollection of a conversation about that call.
1801. It was suggested to KE that SK had contacted NL telling her of threats Graham Dillon had made to his ex-wife and to SK's eldest daughter and that there were also recordings of those threats having been made. KE agreed that would be something that should be followed up and be part of the assessment.³⁴⁶
1802. KE stated that it was usual in an appraisal to contact the parents separately from the children and ask them their views in respect to issues that arise, particularly in relation

³⁴⁶ Transcript of Proceedings, p 563

to safety of children, unless it is unsafe to do so. KE stated that in this case someone should have contacted SK to perceive her views.

1803. Given the circumstances of this case it may have been appropriate to also contact UN.

1804. KE stated that they did not take any photographs of the injuries that they observed on the children because it would not be common practice to do so.

1805. KE does now accept that the children made disclosures to them on the very first occasion CYPS became involved. KE also accepts that it was child abuse. Given that fact, KE was unable to explain why persons who had made notes in the system had indicated that the children had not made disclosures.

1806. KE accepts and understands the concept about 'hearing a child's voice', understanding that they may not necessarily make disclosures in a way an adult may make a disclosure. KE also accepted that it may be difficult to pick up those disclosures. KE advised that CYPS caseworkers are given training on that issue.

1807. KE accepted an interpretation could be identified that when a child does not want to talk about something that they have been asked about that may be a way of concealing abuse.³⁴⁷

1808. It was suggested that when caseworkers had made the comment that the interactions between the father and children were positive, that was after the father had an opportunity to speak with the children and perhaps threaten them or coach them as to what they should say.

1809. Whilst KE could not comment on that suggestion other than to speak of what she observed, she agreed that the children were compliant and that was after they had had the opportunity to speak with the father.

1810. KE accepted that compliant behaviour could potentially indicate fear and that was a possible indicator of what Graham Dillon had done. KE also accepted that behaviours attributed to Bradyn such as he freezes up, shuts down, is jumpy when the teacher raises her voice, as well as checking in, thinking that he is in trouble, asking if he is been a good boy are suggestive of him being abused.

1811. KE also accepted that given Graham Dillon spoke of his own experience in foster care and being taken from his family, as well as the fact that he had spoken to his children about those concerns, this would be a significant reason why the children were not willing to make disclosures to CYPS. This reasoning would similarly apply to the fact that Graham Dillon told his children that their mother was taking drugs.

1812. Given that JL spoke about her mother, it was suggested to KE that, if JL was concerned that she and Bradyn would be removed from their father, she thought it would be unlikely that they would be sent to their mother, so the reality for her was that they would be placed in foster care, which was a real consideration why JL may have not disclosed. KE said she was unable to comment in relation to this.

1813. It was suggested to KE that as Graham Dillon was allowed to contact the GP to make an appointment for the children, he was able to control the narrative. KE considered

³⁴⁷ Transcript of Proceedings, p 565

that could be the case in that circumstance. KE stated she was unaware of what information the GP knew and was not aware of any follow-up.

1814. KE agreed that best practice would be to use the CARHU and that was CYPS's preference, but the use of a GP was better than nothing. KE explained that if she was in that situation, she would give the GP some information about her concerns and wait for a report from the GP.
1815. KE agreed that the parent, in this case the mother and stepmother, can hold information vital to an appraisal assessment. KE also agreed that a history of family violence is also highly relevant to a risk assessment.
1816. KE also agreed with the proposition that violence toward a partner (particularly the mother of the man's children) does not stop when the relationship ends that the perpetrator can indeed use the system itself to perpetrate abuse.³⁴⁸
1817. KE further agreed that abuse can take the form of depriving contact, denigrating the mother, claiming to be a victim of domestic violence by their female partner, and use of the DVO system to prevent contact by the mother with the children. The perpetrators can use the child protection system to do that as well.³⁴⁹ KE agreed that it was fair to suggest that that is exactly what Graham Dillon was doing.
1818. KE agreed that she did have significant concerns about the children, even though the Child Protection Report was closed because there was insufficient evidence to do anything about that. KE stated she did not have a decision-making role.
1819. KE said that she was not aware that there were subsequent reports from another school in 2015 of bruising on the children. KE was not aware that those reports were not investigated or appraised. It was KE's view that any further reporting of bruising should have been investigated.
1820. KE stated that there is a chronology which forms part of the intake form. This chronology was manually entered, and reliance is placed on the worker regarding what is placed in the chronology. The new system will automatically populate information to be placed in the chronology.
1821. KE accepted the proposition that when a child discloses something to Child Protection and they are then returned to their abuser, it is unfair to expect the children to disclose anything to Child Protection ever again.
1822. In terms of how SACAT fits into the Child Protection System, KE stated that a call would come into the Intake Officer, who would then notify SACAT of the call and generate a report which is sent to SACAT for their consideration. A risk assessment would also be done by CYPS as to whether there needs to be an appraisal.³⁵⁰ Once a decision is made for an appraisal, the case would then go to a caseworker.
1823. KE agreed that the phone call to CYPS, which stated that the children disclosed significant physical abuse and were concerned about their father finding out and what

³⁴⁸ Transcript of Proceedings, p 570

³⁴⁹ Ibid

³⁵⁰ Transcript of Proceedings, p 575

he would do to them if he did, was of significance. KE stated that she would tell her mentee that she needed to escalate that information to the Team Leader.

1824. In relation to training since Bradyn's death there has been some in relation to forensic interviewing, domestic violence and family violence, motivational interviewing and interviewing young people. There has been a lot of training around trauma informed practice. KE agreed there is a focus now on how things should have been done but they didn't get done in this particular matter.

1825. In relation to the decision-making roles if there is consideration of statutory intervention it goes to the Operations Manager, but it goes from the caseworker to the Team Leader to the case manager and Operations Manager depending on the circumstances.

PG – CYPS Case Worker (HP3 Level)

Statement

1826. PG commenced working for CYPS in November 2014. PG was allocated the Dillon file on 4 December 2014. She was to be assisted by NL as her second. PG was aware of the reasons why it was allocated to her because of the threat made by Graham Dillon towards NL.

1827. PG was aware of the Child Concern Report from 20 November and that it would be elevated to an appraisal. PG's overall understanding of the case was that the children were living with their father Graham Dillon and that no disclosures had been made. However, disclosures were made when they were in Victoria just before they were to be returned to their father. PG was also aware of the SACATs involvement.

1828. PG reflected that her usual practice is to review any previous reports on a family to obtain background information. She believes she did so in this case. PG stated that an interview at the home with NL took place. This was for the purpose of developing a safety plan with Graham Dillon.

1829. PG and another caseworker attended Graham Dillon's residence on 19 December 2014. No one was home and she telephoned Graham Dillon who said he was interstate. PG then organised an appraisal to be undertaken in the New Year. PG also asked Graham Dillon for some further information and was advised by him that BP from CanFaCS would provide any documentation required.

1830. PG telephoned BP and she was provided with an email address. PG sent an email to BP in relation to the Victorian situation and advised that the children were to be returned to their father and that he considered Graham Dillon was being discriminated against by the Victorian Care and Protection service.

1831. PG sent a further email to BP on 22 December 2014 seeking written consent from Graham Dillon for the appraisal.

1832. During the Christmas period of 2014/2015, PG was on leave. She was aware that SK had contacted CYPS on two occasions on 30 December and 6 January. PG telephoned SK on 14 January. SK told her that the Victorians were to release documents about the children. PG also attempted to again make contact with BP.

1833. PG also telephoned BN from the Victorian Care and Protection service. This was a follow-up from the report that she made in respect to the children. PG wanted to understand the action that Victoria took in respect to the children once they had made the disclosures.
1834. BN said that she would return the call to PG later in the day, however there is no record that she ever did.
1835. On 14 January 2015 PG spoke with UN. UN advised that she had been asked by SK to contact PG. UN indicated that Graham Dillon was known to be violent and was a drug user. UN stated that she had photographic evidence of his drug use. PG asked UN to provide the photograph, but she did not receive it. UN also advised her that she was too scared to tell Police.
1836. PG emailed BP on 15 January stating that they were following up about what happened to the children's mother. It was anticipated that the CYPS should not be involved with this case for long. PG said that she emailed BP because she believed BP had been working closely with Graham Dillon for the prior 12 months and had not expressed any concerns about Graham Dillon's care of the children.
1837. PG also believe that there were other services involved with the children, such as the school, their doctors, and the Belconnen community service (Bungee Program/ counselling). Since these services were mandated reporters, PG believed that if there were any concerns, they would report them. PG also believed the children attended church with their father on Sundays and that CanFaCS was going to remain involved in the family.
1838. PG was advised by NP from CanFaCS about his version of events and PG assumed that Victorian Care and Protection had taken emergency action and the court had ordered the children be returned to their father.
1839. PG stated that it was not appropriate for her to express her view as to the appraisal result to BP and NP from CanFaCS and she now regrets doing so.
1840. After PG made a request for the safety plan from BP, she was advised there was no formal plan in place. PG then began to draft a safety plan. She relied again on BP to get Graham Dillon to sign that plan.
1841. On 19 January 2015 PG conducted a home visit at the Dillon residence. Both Graham Dillon and BP had been on notice of the visit. PG spoke with Graham Dillon, BP, FL and both Bradyn and JL.
1842. PG observed the children to be clean, well presented and appropriately dressed. Their rooms were clean and tidy as was the house. After speaking with FL, PG was under the impression that the children had been with their father by order of the court after they were relocated interstate without the father's consent. PG was also under the impression that their mother had not been entirely forthcoming with Victorian Care and Protection. Graham Dillon's duty lawyer FL told her that Victorian Care and Protection had withdrawn their application to the court with no further concerns. FL also advised that the Magistrate had taken the view that the mother's behaviour should not be rewarded and therefore ordered the children to return to their father. PG considered the information relevant to her appraisal.

1843. In a conversation with PG, Bradyn indicated that he was excited that school was starting soon, that he had fun on his holidays and loved his new house. He also indicated that his mother kidnapped them, and he doesn't like staying with her. Bradyn advised that 'dad found him', and he was 'happy to come back to dad because he likes going to the skate park and playing out the back of the house', and he also stated that his mother told him to make up stories, but his father said to tell PG what his mother did.
1844. When asked who would like to live with he said, "*my father as he's the best dad in universe*".
1845. When JL was asked about what happened in Victoria, she said that she was kidnapped. JL said she didn't like her mother's boyfriend and she was happy to leave because her mother does bad things including have Bongs and stuff.
1846. When JL was asked about what she had told the caseworkers, she said that '*mum told us to say those things. Mum said that that is bad and everything that he is a great dad*'. When asked about who she would prefer to live with, she said her father because he gives us "*the best life we can possibly have*".
1847. PG formed the view that each of them thought that they had been taken away by their mother and were happy to be found by their father and wished to stay with him. PG then told Graham Dillon and BP that she would recommend the case be closed.
1848. PG referred to her experience where parents often become competitive in custody disputes. She said that parents will try to influence what the children say and frequently children will repeat things said by a parent. In her view, it was not unusual for competing versions of events to be given by the children when they were with their mother in Victoria and when they were returned to their father.
1849. BP sent an email attaching his case notes which were then uploaded into the CYPS progress notes. PG noted that BP had a strong advocate role with Graham Dillon and was prepared to continue supporting him whether or not CYPS remained involved. BP reported that the abuse and future risks were not substantiated and recorded the analysis that led to the findings. Those findings were subsequently endorsed by BU in the appraisal process which was finalised on 23 January 2015.
1850. PG indicated that she did not receive any information from Victorian Care and Protection, and none has ever been provided to CYPS.
1851. PG made a supplementary statement confirming that when she first commenced work at CYPS, she had spent a significant amount of time training. From the time she was allocated the Dillon work she had 16 children/cases. PG was on leave over the Christmas period from 24 December until 12 January 2015.
1852. PG also expanded on her experience in New Zealand explaining that there is a difference between the New Zealand and Australian system.
1853. PG explained that her view was that NL's role was to assist her, because of her extensive experience with the family. PG said that she relied on NL for her knowledge and also for contacting various organisations.
1854. PG advised that in hindsight a designation of tasks would have been better so that all action followed through and it would prevent a safety check from being overlooked. PG

stated that she relied on NL for information particularly in relation to the history of the family.

1855. PG also explained her knowledge and gaining knowledge of the CHYPS system. PG advised that she would have reviewed the historical material on the system in relation to Bradyn and JL and also the physical file. PG admitted that she did not cross check for any other children with Graham Dillon's name in CHYPS. PG admitted that was an oversight because it is part of normal practice.
1856. In relation to the appraisal, PG stated that the purpose of the appraisal was determining the situation for the children at the present time and if there were any risks to them at the present time. PG was aware that no paperwork from Victoria was received by CYPS. PG accepted that in hindsight she should have made additional enquiries of Victorian caseworker BN when she failed to return her call. PG has also accepted that she did not contact ILO to request information because she had believe NL done so. PG was of the view that if disclosure in Victoria had been about current abuse, DHHS would have taken action in Victoria.
1857. PG said because she was inexperienced with the ACT legislation, she relied on both BU and NL to give her guidance about what thresholds were needed under the legislation to take emergency action.
1858. PG was also of the view that the preferred approach was to work collaboratively with the families and therefore she obtained Graham Dillon's written consent for the appraisal. It was PG's view that she should not question the findings of previous appraisals and decisions.
1859. PG said she re-read the notes of NL dated 30 July 2014 in which JL states that Graham Dillon expects them to do a lot of things quickly and if they don't get them done quickly he hits them on the head and kicks in the bum with his boot when they are not expecting it. The report then identifies that JL showed where she was hit in the three places. PG accepted this was a disclosure.
1860. PG agreed that the report from CAHRU raised a concern, particularly as the report stated;
- “the bruises are result of blunt trauma some of which are partially explained and others such as a bruise on the left cheek, left ear and red marks on his arms are of concern”.
1861. PG also accepts that the case consultation note signed by BU indicated that the appraisal which included cumulative harm, the current situation and the physical abuse was required. It was her view that the cumulative harm was “to take into account the past experiences of the children in the care of their parents, their life experiences and trauma”.
1862. PG also accept that she did not develop a formal written safety plan with the children. However she was satisfied as the children indicated that FQ was their favourite person, and they could go to her if they had concerns.
1863. PG said she was of the belief that the children were attending the Bungee Program and that they attended church with their father. She was also of the view that they would be returning to school shortly. In the safety plan with Graham Dillon, it was noted that he said he would seek counselling for the children as needed. It was those factors

together with the ongoing engagement of CanFaCS which meant that the children had sufficient community support and did not require further referrals.

1864. PG relied on mandatory reporters and BP's reassurance that he would remain involved with the family for three months and report any concerns. PG also suggested that when the children started school there would be more observations as they are under the supervision of mandatory reporters.
1865. Given that fact PG, now accepts that BP was an advocate for Graham Dillon. However, at the time she considered that given he was a mandatory reporter, he would report if he had any concerns. She accepted his word on that.
1866. PG said that she thought NL had contact with the Bungee Program and did not make any enquiries with the school because it was school holidays.
1867. PG said that CYPS was shocked by Bradyn's death and it has had a profound effect on the Department. PG was aware that there was a report known as the Glanfield Inquiry and that there have been changes since Bradyn's death. These include more fulsome appraisal and intake forms. Additionally, much more information to be considered in the forms in determining decision-making. It was her view that this has now improved the process.
1868. PG was asked to comment on the 'K' Review in respect to cumulative harm. She suggested that it was the Team Leader who has the ultimate decision, and they did not do so in this case.
1869. PG indicated that because they had been prior appraisals, that information would have been more concerned about what was happening at the time rather than in the past.

In Evidence before the Inquest³⁵¹

1870. PG stated that in November 2014 she was a HP 3. PG stated that she had worked in the sector since 1993 and has postgraduate qualifications in social work from New Zealand. PG stated that she commenced work in Australia in November 2014. PG agreed that the work she conducted in New Zealand was similar to that she was expected to conduct in the ACT.
1871. PG stated that she has worked in the area of Child Protection for many years and has had various roles, given her family had to relocate because of work. PG explained that she worked as a Family Group Conference Coordinator. This role involved conferencing in a gatekeeping role, examining the rights of the children, examining the rights of the family and the organisation. She stated that the balance needed to be struck in keeping with the organisational requirements.
1872. PG stated it is a different role to that of social worker because it was facilitating family groups and conferencing with them. That is something that is now new to the ACT. The role was essentially getting the families to agree to the requirements to ensure the care and protection of their children. It was an extended family-oriented conferencing where deliberations and issues would be determined throughout the family with the

³⁵¹ Transcript pp 1263 – 1314, 1344 – 1536.

assistance of a support person. Ultimately there would be recommendations and a decision plans would be put in place and then forwarded to the courts.

1873. PG stated that her role would be to have the social worker present the history of the family, the current situation, and any concerns. The social worker would also present the decision the family would need to consider so that recommendations and plans for moving forward could be put in place. This type of process was to allow the members of the family to have a voice and have the decision-making done by the family with the support of the facilitator. PG stated that she was a caseworker for part of the time, possibly for a total period of only five years because she was working part-time in both roles at one point.
1874. As part of her role as a caseworker she was involved in obtaining information from the files. However that system was upgraded to a centralised system for the whole of New Zealand. PG stated that the concept of family group conferencing was derived from Maori culture, but it was used for all families in New Zealand.
1875. PG stated that family members would be a source of information for her in her work because family in New Zealand is more than just the immediate family. PG recognised that credible sources of information included doctors, the schools and community organisations, particularly those who had worked with the family for long periods because they saw families regularly and there was an expectation that they would give relevant credible information.³⁵²
1876. Also PG stated that Child Protection in New Zealand works very closely with other organisations such as Barnardos and Maori organisations. There are monthly networking meetings with these organisations as well as meetings with police particularly in relation to family violence. It would depend on the risk as to which organisations would be allocated a case. An example is that the Domestic Violence Crisis Service will work with families with domestic violence. Whilst homelessness would be addressed by those who work with homeless people.
1877. PG expected that these organisations would be supporting the family as well as providing information to the service. There were meetings between those organisations called strengthening families meetings and that would be to get together to see how best to support the families and wrap services around them.³⁵³
1878. PG advised that she considered the information provided by the organisation were provided as a voice for the client but also the children.³⁵⁴ This was because in her view the organisations understood the role of Child Protection and that the children are paramount in decision making in relation to information provided by a parent. PG opined that it was not a different category of information, but it would be recorded and considered. PG stated that any information recorded and considered from a parent would be verified by contacting the source of the information.

³⁵² Transcript of Proceedings, p 1272

³⁵³ Transcript of Proceedings, p 1273

³⁵⁴ Ibid

1879. PG stated that she commenced working with CYPS on 3 November 2014. Upon her commencement she participated in a series of training modules and was also allocated casework. She then took leave between 24 December 2014 and 12 January 2015.
1880. PG was allocated the Dillon file and at the time her workload comprised of 16 cases including two for the Dillon file. These cases were allocated at different times when the cases came through for appraisals.
1881. PG accepted that she commenced work on 3 November 2014 and was at training on 12 November, 20 November, 24 November, 25 November, 27 November, and 28 November. Of those dates in November, there were 13 actual working days without training.
1882. PG also accepted that in December she undertook training on 3, 4, 5, and then 8, 9 and 11 December 2014.
1883. PG stated that she was allocated the Dillon file on 4 December 2014. On 12 December there was a case conference which she participated in. It appears that she had one day in December on which to work on this case. PG accepted that she worked on the case from 12 January until 23 January 2015 when the matter was closed.
1884. PG was aware about the type of work she was to undertake, although she said she was unaware of any duty statement or any such document in relation to her duties in the ACT. PG stated that there is a difference between the Australian and New Zealand's systems of care and protection. PG had not worked in Australia in care and protection prior to her commencement with CYPS on 4 December 2014.
1885. PG stated that there was less emphasis on the 28-day case closure and more emphasis on working with families to get a result, which may take time. PG was aware that it was a rule that you must complete within that time, although there was a process of extending, but you had to get leave from the Team Leader in order to do so.
1886. PG stated that the formal case consultation in respect to the Dillon files was on 12 December 2014. PG stated she could not recall whether she had access to, or had seen the file, but if she had, it would have been brief. PG was shown the case consultation note at page 1007 of C 123.
1887. PG stated that during that period she was allocated the Dillon file, BU was her Team Leader. In relation to the assumption as to the Team Leader's role she said that the Team Leader would have been working in the service for a number of years, would have a lot of knowledge around the working mechanisms of the organisation, and would be a kind of guru needed for guidance around processes, policies, and procedures as well as casework.³⁵⁵
1888. PG assumed that her role as a caseworker would be similar to what she did in New Zealand and that the secondary worker would work alongside her on a particular case, and if for example the caseworker was absent and tasks needed to be done, the secondary worker would pick up those tasks. Her experience in New Zealand was that

³⁵⁵ Transcript of Proceedings, p 1281

the worker and the co-worker would work together to make sure that all tasks and actions were covered and that nothing was left on its own.³⁵⁶

1889. PG assumed that that was the practice as she was unaware of any policy statements in that regard. Her view of that has not changed in 2020.³⁵⁷ PG suggested that having a designated task which differentiates between primary and secondary worker would be helpful to ensure that all tasks are acted upon and that having that clear understanding would have assisted in this case in 2014.³⁵⁸ PG stated that she has had no training in respect to the differentiation of the role of a primary worker or a secondary worker.
1890. The meeting held on 12 December 2014, involved herself, BU, and NL. PG was unable to recall the exact discussion however she understood that NL was to liaise with the Victorian Child Protection agency to get information from them. PG understood that it was referred to in the report written by NL.
1891. In relation to the supervisors (Team Leader) role, they were to ensure that tasks which had been allocated to caseworkers were followed through with, that the caseworker would keep them updated on the case, to give guidance when required, particularly when making recommendations about whether the case should be closed or not, and then to either endorse the recommendations or not.³⁵⁹
1892. The Team Leader and in this case BU, would also check the hard file to ensure that the paper file matched the electronic file. PG stated that BU was very diligent in ensuring the files were accurate prior to archiving them.
1893. PG stated that there were two ways of updating the case file, either working on it at the time or completing it and then uploading it to the file. PG stated that the physical file was sectioned into categories. PG stated that she had read the file and noted that there were intake forms, outcomes of appraisals, case notes as well as doctors' reports and the like.
1894. PG stated that she had looked at both the paper and electronic file in relation to Bradyn and JL. It was PG's understanding that the case file would have been updated by NL prior to being given to her.
1895. PG stated her understanding of the role of a caseworker when making a decision was that a recommendation in relation to whether a Child Concern Report would proceed to a Child Protection Report or to the case being closed. The Team Leader would either endorse or not endorsed that recommendation. That applies now as it did apply in 2014.³⁶⁰
1896. PG stated that there has been some training after Bradyn's death which involve the booklets in respect to risk frameworks. That training involved identifying abuse and neglect, protective factors, and strengths, and looking at who is vulnerable. There is

³⁵⁶ Ibid

³⁵⁷ Transcript of Proceedings, p 1286

³⁵⁸ Ibid

³⁵⁹ Transcript of Proceedings, p 1282

³⁶⁰ Transcript of Proceedings, p 1286

also a historical risk aspect, particularly for those parents who have mental health issues or if there has been domestic violence in the family.

1897. PG stated that they had a lot of training post Bradyn's death, some of which was mandatory, but they did have training prior to Bradyn's death as well.
1898. PG stated that cumulative harm is part of the training in risk assessment frameworks incorporated in the booklets.
1899. PG agreed that in the CYPs system one can review the documents by simply clicking on to either the Word or PDF file on the system. PG stated that in relation to the Dillon file she would have access from the database until she was provided with the paper file. The material which she was given in the witness box, was the material she had when she was given the case. It was PG's view that she would have looked at and read all of the documents.³⁶¹
1900. PG agreed that she had read the document entitled Case Consultation 30 July 2014. PG agreed that there was a request for a list of actions including liaising with CanFaCS, interviewing the father immediately, requesting interstate DOCS documentation relating to the father and liaise with school regarding the children's emotional and physical presentation, and to find out when previous absences occurred and whether those absences correlate to previous reports of bruises.³⁶² PG agreed that there was a list of actions to be performed but that was prior to her commencing with CYPs.
1901. PG stated that she would expect to find that information under the title, name, and description box and that is where those documents should have been placed. PG agreed that none of those documents were placed in that column. PG agreed that there was no documents of a third-party nature or enquiry on the file that she saw.
1902. PG stated that there was no request that she could see on either the paper file or the electronic file for mental health records to be obtained. Ordinarily there would be a request on file if one was to be obtained.
1903. PG accepted that she did not do anything to obtain the documents that had been provided in response to the earlier requests and accepted that it was clear that a case note by the Team Leader identified that they were to be obtained.
1904. PG said she had reviewed all of the files including the appraisals, but she would not have gone beyond any of the decisions, given they had been endorsed by the case manager. This included going behind them to the source material. PG stated that she would be dealing with the current material in front of her rather than going behind it because the previous reports had already been appraised and completed.³⁶³
1905. It was understood by PG that she would look at the background, historical risks, current risks as well as the current report allocated to her and weigh all of that information up in making a decision. She was now aware that there is a very clear expectation that all material will be thoroughly reviewed when conducting an appraisal.³⁶⁴ PG stated that in her view that expectation would have been there in the

³⁶¹ Transcript of Proceedings, p 1292

³⁶² Transcript of Proceedings, p 1293.15

³⁶³ Transcript of Proceedings, p 1295

³⁶⁴ Transcript of Proceedings, p 1296

past as well. PG said she understood now that the expectation was to look at all reports, all of the outcomes, any information for example the CARHU report, and reports in relation to actions taken, so that one can get a good grasp of what's previously occurred. There is an element of substantiating reports regarding allegations as well. That would require looking at decisions about information that was obtained and the material that was provided to substantiate it. It would also include looking at circumstances where material was not obtained.³⁶⁵

1906. PG stated that she understood at the time in 2014 that was what she was required to do, however accepted that she did not obtain any the records that had not been previously obtained but were requested.³⁶⁶ PG stated that it was also the responsibility of the Team Leader to ensure that the information was on file and if it wasn't, to find out why.

1907. PG stated that case consultation would involve the caseworker and the Team Leader but would not usually involve the secondary person.³⁶⁷

1908. PG accepted that page 1007 of C5 was a case note from the case consultation she attended on 12 December 2014. PG also accepted that there had been a telephone report from Victorian DHHS in respect to possible physical abuse being disclosed by the children. The notes were handwritten by BU who was PG's Team Leader.

1909. The note PG took stated

"concerns physical abuse historic and current. Appraisal required to be undertaken review cumulative harm, current situation and physical abuse".

1910. PG said that she understood from that comment that the report was about physical abuse and that it was a requirement that she investigate as to whether they had been physically abused. That is whether there was evidence of the abuse.

1911. PG stated that she would look at what was happening currently because there would have been appraisals if there was historical physical abuse.

1912. PG stated that she was looking at what was happening at the moment that is, as of 12 December 2014. She was considering the experiences the children had in relation to trauma and then she would make a decision around that information.

1913. PG accepted that there was a lack of clarity as to what she was to undertake and what NL was to undertake. Part of the plan was to visit the home and to seek approval of the father to appraise the situation. PG stated that it is normal practice to seek agreement from a parent to carry out an appraisal because the parents can then participate in it. PG stated that is still normal practice.³⁶⁸

1914. Despite the allegation being that it was Graham Dillon who had harmed the children it was normal practice to have the parents' consent. PG understood that because the court had given the children back to their father, the court had no concerns at that time about the abilities of the father to look after the children.³⁶⁹ PG also considered that

³⁶⁵ Ibid

³⁶⁶ Ibid

³⁶⁷ Transcript of Proceedings, p 1294

³⁶⁸ Transcript of Proceedings, p 1298

³⁶⁹ Transcript of Proceedings, p 1299

because the children had been allegedly kidnapped, that would have been a consideration.

1915. In respect to cumulative harm PG said

“it would have been looking at the children’s experience, any trauma experienced by the children, whether they had – looked at – whether they’d been exposed to, for example, domestic violence, those sorts of things, and it would be just sort of taking those into consideration when carrying out the appraisal”³⁷⁰

1916. PG also suggested that part of the consideration would be looking at previous outcomes of reports of physical abuse and the substance of those reports.

1917. Generally speaking a safety plan would be drawn up and that would require engaging with the children directly. However one was not drawn up because PG considered that there was no need for a safety plan because the children felt safe in the care of their father at the time and preferred living with their father, as they did not wish to live with their mother. PG also considered that FQ was their main support person. PG said that she did not speak with FQ, nor did she make any further enquiries as to whether FQ was a safe person to be relied upon.

1918. The behaviour of FQ did not raise any concerns for PG as she considered that her behaviour whilst the CARHU examination was taking place was something that should have been sorted out by either the doctor or the case worker at the time. PG suggested boundaries should have been put in place prior to the examination. Those boundaries could have been explained prior to the examination so that everyone knew their roles.

1919. PG was taken to the document, particularly the action plan where it spoke of speaking to the mother for her views. PG understood that NL had already contacted the ILO and requested documents from Victoria. There was no understanding as to who should complete which task, however, PG accepted that it was her responsibility to ensure that the tasks were completed.³⁷¹

1920. In respect to whether there was any difficulty in obtaining documents from interstate, PG opined that it was not unusual to receive information requested from other states. That applies at the present time as well as before she commenced work at CYPS.

1921. PG also accepted that it was expected that she would follow up because she was a caseworker. Both she and NL had requested information from Victoria but were unsuccessful in getting that information. PG also suggested that in relation to the physical abuse the report did not say when it happened and that makes a difference as to whether it’s historical or current.³⁷² PG stated that she was concerned with what was happening currently and that would inform her as to the outcome of her appraisal. PG did call BN from Victoria, as did NL, however BN did not reply to PG’s call.

1922. PG remained of the view that if the complaints were serious enough, Victoria would have taken action, such as putting orders in place or emergency action. It was a mystery to her as to why they did not take action around their concerns for the children’s safety in regard to the physical abuse. It was suggested to PG that the best course would have been to make contact through the ILO when no information was

³⁷⁰ Transcript of Proceedings, p 1299

³⁷¹ Transcript of Proceedings, p 1303

³⁷² Ibid

furnished by BN. PG still remained of the view that if Victoria had thought it serious enough, they would have taken action.

1923. PG agreed that a criminal history in relation to Graham Dillon would have been a significant piece of information. In respect to the report about domestic violence perpetrated by Graham Dillon upon his wife, UN agreed that failing to cross-reference that information was an oversight on her part and it would have been best practice to have done so.
1924. PG agreed that it would have been part of the appraisal consideration particularly given there were two partners with histories of firearm violence. PG stated that you must consider both historical and current circumstances and weigh up the difference in making a decision about it.
1925. PG opined that it is important to consider domestic violence, but there is a difference between domestic violence between the parents which don't necessarily involve the children being abused. PG understood that children being exposed to domestic violence is significant.
1926. In respect to the disclosures made by the children such as that '*dad hits and punches us*' and '*dad threw Bradyn on the couch*', it appears PG considered that the reference to throwing Bradyn on the couch was historical. When asked about the other information, PG considered that the disclosures happened in Victoria and she did not have any information about it. It was unclear whether Victorian authorities didn't take action or whether they did indeed take action because CYPS did not receive any information from Victoria to confirm what had occurred. This made it quite difficult for CYPS.
1927. In respect to the disclosures PG stated that you ask children questions which are open questions. When she interviewed them, the children revealed that they didn't want to live with their mother but wanted to live with their father. PG also advised that Bradyn had told her that his mother had told him what to say in Victoria.
1928. PG confirmed that prior to interviewing the children she would consider their appearances, whether they were comfortable in the presence of their father, how safe the home was and whether the children have proper sleeping arrangements and other similar things. They are factors which she also takes into account.
1929. PG accepted the proposition that where children have disclosed physical abuse and then have been returned to the person alleged to have been the abuser, those children may be reluctant to make further comment. She said that she took that into account.
1930. In respect to the allegation made by Graham Dillon's former partners, that he was still using ice, PG confirmed that she spoke with UN. PG suggested to UN that she provide evidence that Graham Dillon was using ice by way of photos or something of that nature. PG advised UN that the evidence should include a date stamp so that she could be satisfied it was current. PG confirmed that the allegation about drug use required substantiation and proof.
1931. PG confirmed that she spoke to SK and asked her to get further information from Victoria. SK confirmed that she would do so.

1932. PG was not aware of the information in respect to SK's older daughter who said that Graham Dillon continually sent her abusive of messages on Facebook and threatened to boil her mother's head and other similar threats.
1933. PG was referred to notes from a phone call entered by NL on the system in respect to significant and serious allegations of Graham Dillon's violent behaviour. Included in that reference was information disclosed by the children to their mother, including that Graham Dillon kicks her and her brother, he punches them, he strangles them, and he throws them around the room and that the children are too scared to talk. PG accepted that she had read that report.³⁷³
1934. PG also accepted that she had read the report from the ex-wife in relation to family violence and that there were recordings of Graham Dillon threatening his ex-wife UN. UN also revealed that SK's eldest daughter, BK was scared of Graham Dillon because he had made threats against her as well. PG stated she was aware that report of domestic violence had been known to the Department because of previous reports and appraisals. PG agreed that it would be very serious and would be considered as part of the appraisal process.
1935. In respect to the process of appraisal PG stated that she reads the files variously, takes notes or relies on her memory and also consulted NL and BU in respect to the file as they had better knowledge of it. PG stated that she did know the sources of the reports on the file. PG recalled that there were a lot from the school as well as the two ex-partners.
1936. Once the reports or allegations are made, the appraisal process essentially seeks to evidence the allegations or prove them. If that is unable to be satisfied, it will impact on the decision-making process.
1937. PG confirmed that her usual practice for a report that referenced other people would be to contact them. PG confirmed that she did not contact the school as it was the end of the year but did contact CanFaCS. When she returned from leave, she contacted both SK and UN in January 2015.
1938. In relation to discussions that she had with NL, she stated she had a clear recollection of those discussions including that NL stated that without disclosures from the children it would be very difficult for decision-making in regard to the outcomes of the appraisal.³⁷⁴ PG accepted that meant that UN had suggested there were no disclosures.³⁷⁵ PG also accepts that there were disclosures in July 2014 where the children said that Graham Dillon kicks them with his boots on.
1939. PG distinguished this from the disclosure information because of when it took place. This was because she had looked at historical risk, current risk, as well as considering how the children presented. It was also reported that UN took Bradyn to CARHU and there were no concerns around the bruising. In her view that was in relation to whether the bruising was accidental or not.³⁷⁶

³⁷³ Transcript of Proceedings, p 1345

³⁷⁴ Transcript of Proceedings, p 1351

³⁷⁵ Ibid

³⁷⁶ Transcript of Proceedings, p 1352

1940. In respect to the report where JL had said that her father kicks her and hits on the head at a time when there was bruising on her face, PG considered that she would have asked how JL got the bruise on the face and said that it is different from the disclosure that the father kicks them *'up the bum'*. PG consider that it was difficult because it wasn't her case note, she hadn't written it and she wasn't there at the time.
1941. PG considered that the disclosures made by JL were in respect to something that happened, rather than about the actual bruising on a face seen by NL. She thought that JL was speaking about something different because of the question that was asked, she further considered that there was no timeframe provided in relation to the disclosure.
1942. PG was asked about what she understood by cumulative harm and she said that that they received training in respect to risk assessments which includes cumulative harm. PG accepted that the issues raised in this proceeding would raise flags in respect to her assessment of cumulative harm.
1943. PG explained that;
- "around cumulative harm I would be looking at the [JL]'s experience not only while she is in her father's care, but also, you know, what her experiences – and also look at, you know, trauma – what trauma she may have experienced in her life."*³⁷⁷
1944. In relation to the events of 2014, PG considered that there was not a lot of focus on what could be determined as cumulative harm and was not significant in the considerations.
1945. PG was referred to her statement where she said that;
- "my overall understanding of the case was that CYPS had appraised previous reports while the children were in the ACT with their father, Graham Dillon, in which no disclosures had been made. They were then taken to Victoria by their mother, where general disclosures were reported to have been made against Mr Dillon. It was because of those disclosures and the subsequent return of the children to their father in the ACT that a further appraisal was to be conducted"*³⁷⁸
1946. PG confirmed that she had consulted BP extensively and that he emailed his notes about what had taken place in Victoria. When it was suggested that the notes were comprehensive, PG said there were only a couple of pages of notes and that BP had told her there was more that he could tell her, but he didn't have time to record it.
1947. PG agreed that she placed a lot of reliance on BP as he had been involved with the family since 2012 and had visited the family and the children regularly. PG agreed that BP had told her what he understood happened in Victoria.
1948. PG suggested that she spoke to Graham Dillon on the phone and met him when she conducted the first-time visit. She spoke to his lawyer FL when she was at that first home visit. FL advised her of what occurred in Victoria.
1949. PG accepted that she had written a note at the time she conducted a home visit with NL. BP was there with Graham Dillon at the time. PG was referred to the note she made in respect to that visit on 19 January and what she was told by FL.

³⁷⁷ Transcript of Proceedings, p 1355

³⁷⁸ Statement of PG, p 2

1950. PG accepted that she was aware of the court process and what happened in court but was not aware of what led up to the court process and what actual information was gathered by the Victorian DHHS and why they pulled out and said they had no further concerns. That's the question she would have liked to have been answered by Victoria. PG accepted that she should have made further enquiries as she was concerned to learn the detail.

1951. It was suggested to PG that there had been 12 reports in respect of Bradyn and JL. Five of those reports were allegations of physical abuse whilst in the care of their father. Two reports proceeded to appraisal but because there was no disclosure made by the children, the case did not meet the threshold of significant harm and was closed.³⁷⁹

1952. Having reviewed the file, PG did not believe there had been a disclosure made which had been placed on the file. PG explained that was because the disclosure was not about how the actual bruising occurred or what happened to her face. It was a general disclosure about what happened such as dad hits us and 'boot us up the bum' It was her view that the information must be taken into account with when it happened. Also, she considered that when the children were interviewed, they were happy to be in their father's care and they made no disclosures. They spoke of being kidnapped and they did not appear to be scared of their father.³⁸⁰

1953. PG was asked about this;

that even if there was no disclosure but the other history such as , the multiple reports and observations by teachers of bruising, the reports by SK and UN, the historical reports from other sources such as DVC's, AFP, a registered nurse, that would raise serious concerns would it not?

1954. PG said

"but if you will recall, yesterday I did say that with Ms when I spoke to [UN] I asked to- to send me evidence in the form of a photograph that was timestamped... so that I could use that information and consult with my supervisor around what action we would take. Also, when I spoke to SK she had given – she had said that she would ask Child Protection Victoria to send the documents that we were trying to get around what happened. So a lot of instances we do need to look at evidence. If people are saying things we need to have the evidence to back it up because at the end of the day if we going to take, for example, emergency action, or were going to seek orders in the court we do have to have information that is going to stand up in court. If we don't have that information that's going to stand up in court, there's not a lot that we can do. Plus were also guided by the legislation. That helps us determine" (The rest of her answer was cut off in comment by counsel).³⁸¹

1955. PG stated that it is not cut and dried nor is it black-and-white and one also takes into account the environment in which the children live. That includes whether the children appear healthy and how they interact with their parents. PG opined there is a lot to consider when carrying out an appraisal whether the report is substantiated or not.³⁸² PG stated that the other disclosure would also be considered in the appraisal process.

³⁷⁹ see Transcript of Proceedings, p 1365

³⁸⁰ Ibid

³⁸¹ Transcript of Proceedings, p 1366

³⁸² Transcript of Proceedings, p 1367

1956. PG accepted that whilst she did not consider the CARHU report to be substantiated in her supplementary statement, she now accepts that the report raised something of concern. PG understood the information and noted that there was bruising which could be explained and there was some which could not, and that was a concern.
1957. PG stated that the information she considered was historical. As it had already been appraised, the decisions had been made regarding the disclosure which might include consultation with the caseworker, manager, and supervisor regarding whether the matter had been substantiated and whether the matter should be closed with no further action taken. PG stated that because of that factor, she had taken at face value that the matter had already been weighed up and because the bruising was not present when she carried out her appraisal, her focus was what was happening in the present.
1958. It is patently clear to me, that PG did not have any proper understanding of what cumulative harm was at the time she gave her evidence.³⁸³
1959. PG accepted that she had significant contact with BP at CanFaCS but had no contact with the ACT Primary School 1. PG also accepted that she had no contact with Belconnen community services. In relation to the information that Graham Dillon was continuing to be supported by BP, ACT Primary School 1, and Belconnen community services she made no further enquiries as to whether that was accurate. In respect to the family and friends who Graham Dillon said could offer respite when things became too stressful, PG accepted she did not speak to any of those family members.
1960. PG was taken to page 1140 of exhibit C5. She was taken to a section which contained a box that asked to whether there was reasonable suspicion that the child may be need of care and protection. This box was checked.
1961. PG was asked what her understanding of her obligation was in respect to what material she must consider when deciding whether to act or not. PG said that if the children had disclosed something in their interview, that would have been one matter. She said if the children had bruising on them, that would have been another matter, she also said if the children had disclosed that their father punched them, booted them, bruised them, and told her that they were scared of their father and that they didn't want to live with him, those disclosures would have been evidence. PG reasoned that she would be looking at a physical injury which is not accidental and may denote abuse. Even if she observed an injury, she would need to consider whether it was accidental or reasonably explained. PG stated that in those circumstances they would take the children to a doctor for review.
1962. PG was taken to the analysis which documented that there had been five incidences of bruising to the children's face with no significant explanation as to how they occurred. When interviewed, the children did not want to talk about how it occurred. This was accompanied by the fact that the father had a history of family violence including reports of throwing infant JL against a wall, as well as reports that Graham Dillon had been abusive to the children in the past.

³⁸³ My emphasis

1963. PG also accepted that she did not have the PROMIS records, nor did she have the criminal history attributed to Graham Dillon. PG stated that it had been discussed previously but there was no criminal history on the file.³⁸⁴

1964. PG was taken to page 1141 of exhibit C5, which was an intake form and accepted that as part of the initial assessment, information was to be obtained by various individuals and services. PG also accepted that information was not obtained despite it being referenced as relevant to considerations to be made.³⁸⁵

1965. PG also understood that there were concerns as to Graham Dillon's behaviour and volatility as he had made threats to a caseworker and school staff, that resulted in the allocation of a new caseworker.³⁸⁶

1966. PG also accepted that the box which indicated whether there was a likelihood of past or current abuse and neglect box was ticked probable. PG was taken to that box, which reflected the following:

"history on this family indicates the children have been exposed to past abuse. At the current time, the report is in respect of physical abuse, family violence, which of the child has provided a clear disclosure, that requires further assessment in order to ensure their well-being and safety."³⁸⁷

1967. PG recognised that this document had been prepared by NL. PG stated that they had discussed NL's opinion and also that her view was that the children were at a probable future risk of abuse and neglect.

1968. PG accepted the comments regarding the disclosures, comment by the children about fear of telling their father about things, the fact that the children had witnessed abuse and family violence in the past, and that there had been six reports in the last four months. She also accepted the criminal history reflecting that Graham Dillon had spent six months in custody for family violence offences.³⁸⁸

1969. PG also accepted there were also other allegations made about Facebook messages being sent with threats to SK, UN, and BK. There was also a concern that Graham Dillon was using ice and it was recommended that Graham Dillon engaged with care and protection, undertake urinalysis, and engage with the appropriate support services.³⁸⁹

1970. PG accepted that she was aware of these matters as she had read them in the reports. There was also reference to the following:

*"CPS history indicates that the father has been able to demonstrate a level of willingness and ability to act protectively however further assessment is required in light of new concerns recorded. The new concerns provide new information that if known previously may have influenced upon previous case recommendations."*³⁹⁰

³⁸⁴ Transcript of Proceedings, p 1371

³⁸⁵ Transcript of Proceedings, p 1375

³⁸⁶ Ibid

³⁸⁷ Ibid

³⁸⁸ Transcript of Proceedings, p 1376

³⁸⁹ Ibid

³⁹⁰ Transcript of Proceedings, p 1377

1971. PG stated that she would have had a conversation with NL and BU about those matters. PG also stated she relied on receiving information from Victoria and also the former partners of Graham Dillon.
1972. PG also knew that there were concerns and therefore follow-up should have been actioned. PG stated that those actions were made in consultation with BU and NL. PG said she needed to complete the appraisal because time was running out and given that she did not receive any information in respect to Graham Dillon's use of ice from UN, she was unable to verify that assertion.
1973. PG agreed that it would have been a good idea to seek that information from other sources such as the AFP or PROMIS records.
1974. In respect to a record that Graham Dillon had not been involved with police for seven years, PG stated that she got that information from BP. PG accepted that there was a conflict, on the one hand the ex-partners stating there had been family violence issues and on the other, BP stating there was no police involvement for seven years.
1975. It was highlighted to PG that despite this conflicting information the information BP gave was ultimately inaccurate and would have been reflected on the police records at the time. PG agreed that the information BP provided was unreliable. PG also accepted that obtaining police records was fairly standard and straight forward and she does not know why it wasn't done in this instance.
1976. PG accepted that she did not follow up on all of the information to be sought.³⁹¹ PG also accepted that she did not follow up after she had read the document that she had been taken to.
1977. PG stated that
- “so what as in the case consultation would have been the actions that I would follow through on; those other actions as far as the mental health records and the police record that was with previous case managers that wasn't followed through.”³⁹²
1978. It was clarified that the previous records of what should have happened predated her employment with CYPs. PG agreed that by the time she took over the file it was clear to her that the record still had not been obtained. PG stated that she would have focused more on what BU had put down as the action plan.
1979. PG accepted that with her experience even in New Zealand obtaining source documents and materials would be necessary in order to review a matter accurately and thoroughly. PG also accepted that this did not occur in this instance as it was her view that it was not her role to take that action. Another factor was that because of her recent appointment to the position, she did not think about those things, and would have relied on the Team Leader to decide what particular tasks needed to be carried out.³⁹³
1980. PG accepted that there was material from Victorian notes, AFP records, and potentially the Domestic Violence Crisis Service (**DVCS**), all indicating allegations of family violence involving the children and information from Graham Dillon's ex-

³⁹¹ Transcript of Proceedings, p 1378

³⁹² Transcript of Proceedings, p 1378

³⁹³ Transcript of Proceedings, p 1379

partners. There was also possibly other information available to her which would assist. PG stated that it would be up to the case worker or case manager to follow up on that information.³⁹⁴ PG also accepted that the case worker would follow-up on community supports.

1981. PG also accepted that on page 1144 of exhibit C5, that threats following physical harm can have a cumulative emotional impact on the children. All previous Child Concern Reports, unsubstantiated and substantiated investigations, should be considered and reviewed. PG said she did consider that information and she reviewed it. In that regard PG said she accepted the conclusions reached by the other case workers from the previous report.³⁹⁵

1982. PG considered that any information that she took from those reports would need to stand up in court if she made a decision of that nature. She reiterated that the information she takes into consideration would also need to be able to stand up in court.³⁹⁶

1983. PG considered that there were other options for her to take if she felt the need, such as emergency action, however it was her view that was not required. In respect to extensions of time to complete the appraisal, PG stated that they have 28 days and may apply for an extension but there is a legislative compliance requirement in relation to the time it takes to complete. However, PG accepted that given the circumstances of it being over the Christmas period she expected that further time could have been granted if necessary.

1984. PG said that she contacted Graham Dillon directly to conduct the house visit and appraisal. Graham Dillon ultimately signed the agreement for the appraisal. PG formed the view that he was co-operative with the process.

1985. PG agreed that she prepared and signed a safety plan for the children.³⁹⁷ Part of the plan was for CanFaCS to remain involved with the family for at least 3 months. PG was to check that BP was to remain involved. PG also agreed that the case was closed before the 3-month period had expired but she relied on BP to maintain contact with the family for that period.

1986. PG was unaware that CanFaCS had ceased involvement with the family early in 2015 and was surprised that happened.

1987. PG agreed that she had utilised BP to assist with the appraisal agreement on 22 December 2014. PG agreed that she took leave between 24 December and 12 January 2015. PG recalled that she had received a voice message from DM whilst on leave. The message was from SK and referred to Facebook message of threats about guns and bullets. The report was assessed as having no urgency regarding any direct threat of harm to the children and therefore there was no urgency in response during the period of the shutdown.³⁹⁸

³⁹⁴ Transcript of Proceedings, p 1380

³⁹⁵ Transcript of Proceedings, p 1381

³⁹⁶ Ibid

³⁹⁷ See document no 1018-1019

³⁹⁸ Transcript of Proceedings, p 1385-6

1988. PG said she thought the message was of concern and would have asked for evidence of the threats. PG was referred to page 2640 exhibit C5 and said she had not seen that document and would have had definite concerns if she had. PG said that she rang SK and was shown the case note of the call.
1989. PG agreed that she uploaded the message to CYPS re the conversation of her concerns that she was unable to contact the children as per the order and that the father had moved, and she wanted to seek advice. There were 2 phone calls. one on 30 December about the guns and bullets and the other in relation to telephone access with the children.
1990. PG recalled the conversation and noted the concerns of PG and asked her to obtain the records from Victoria. PG agreed to speak to Graham Dillon regarding the request relating to contact with the children and SK agreed to contact Victoria DHHS to release their documents. PG told SK to let her do her job and that it was difficult without disclosures. PG could not recall the context of her comments.
1991. It was suggested to PG that SK felt she was not being listened to and was being mocked, PG said *"that's her privilege"*³⁹⁹ *"she has a right to feel that way"*. PG said she did not believe she was mocking her. PG said that SK agreed to contact Victoria and she said she would pass the message to Graham Dillon. She would use BP as an intermediary to contact Graham Dillon.
1992. PG was asked about whether she obtained further information about the Facebook message regarding the bullets and guns. PG accepted that she had received that message upon her return on 12 January 2015 and SK rang her on 14 January 2015. PG also accepted that she would have examined the file to catch up on what was happening over the break.
1993. PG also agreed that she rang and spoke to UN on 14 January 2015. PG agreed that UN had given her information about Graham Dillon's violent past and drug use and she believed that he was still using drugs. PG said that she asked her to furnish evidence to support her assertions.
1994. PG agreed those conversations evidenced that she had spoken to family members. It was suggested to her that she had said that it was an important feature of casework to involve all family members. PG agreed with that suggestion.
1995. PG said that she recorded the information but did nothing else with it because it had already been information known to the CYPS. It was suggested that she could have further investigated the information provided by the ex-partner. PG said that she did not cross-reference Graham Dillon's file to see reports of previous involvement.⁴⁰⁰
1996. PG agreed that the information already on the CYPS records of past involvement was important and it would be best practice to have all information available. PG agreed that she did not review the files in relation to Graham Dillon, UN, or their children, and in hindsight that is something that she should have done and would do now.

³⁹⁹ Transcript of Proceedings, p 1388

⁴⁰⁰ Transcript of Proceedings, p 1393

1997. PG was referred to an email sent by her to BP a day prior to visiting the house.⁴⁰¹
1998. As of 16 January, PG said that in her view she had insufficient information to warrant her involvement in the case. PG referred to the lack of information received such as photographic evidence of Graham Dillon's drug use and information from incidents in Victoria. She also had positive feedback from BP about Graham Dillon. She said her observations of the current situation formed her view that the service would not be involved for much longer.
1999. PG differentiated between first-hand knowledge and knowledge from third parties. She particularly focused on her ability to interrogate the third parties as to why they took the view that they did and why they did not take emergency action. PG also said that the children would need to disclose to her, and she could not to just rely on someone else's account. If the children had made those same disclosures to her, she would have discussed what action to take with her supervisor. They needed the children to disclose to them. That is her view and remains her view.⁴⁰² The information she received in relation to family violence would be weighed up against what she was seeing at the present time.⁴⁰³
2000. In relation to the source material PG relied upon to consider, for the purposes of risk assessment, PG said that they were snippets provided by BU. It was a collection of resources.
2001. In relation to updating the information PG had and the progress of her assessment and appraisal, PG said that she kept BU updated throughout the appraisal. PG said that she did not recall having a conversation with BU in relation to any further sources of information including police records, DVCS records and other similar things.⁴⁰⁴
2002. PG said that she understood that BP was employed by CanFaCS and that he worked with single men to provide accommodation and to support fathers and their children. PG agreed that she placed quite a degree of importance on the information received from BP, and upon reflection considered he was an advocate for Graham Dillon. PG also agreed that FL was Graham Dillon's lawyer and was an advocate for him as well. In relation to BP, she considered him to also be a mandated reporter.⁴⁰⁵
2003. PG said she placed a high degree of importance on BP's information because he had regular contact with Graham Dillon and the children, that he made regular home visits and had been involved with the family for approximately 12 months.
2004. In relation to the updated information as to whether there were concerns in relation to domestic violence and drug use in 2015, vis a vie the report by CanFaCS in 2014, it was PG's view that it related to Graham Dillon's ability to parent the children but accepts that she may have misinterpreted that.
2005. PG was shown a file note about Bradyn and JL in relation to a report from SK which is consistent with the information she gave to PG on 14 January 2015. PG recalls the

⁴⁰¹ Transcript of Proceedings, p 1394.30

⁴⁰² Transcript of Proceedings, p 1395

⁴⁰³ Transcript of Proceedings, p 1396

⁴⁰⁴ Transcript of Proceedings, p 1400

⁴⁰⁵ Ibid

note form 2014, and accepts the information is consistent with what SK told her in January 2015.

2006. In relation to information from BP about Graham Dillon having no incidents with police for the past 7 years, PG agreed that, in hindsight, it would have been helpful to have verified that fact. PG said that at the time of her involvement with BP she did appreciate that he was an advocate for Graham Dillon but also noted that he was a mandated reporter. BP was obliged to report any concerns to CYPS. PG said that she had no reason to believe he would have acted in bad faith.⁴⁰⁶
2007. PG said that she attended the house on 19 January 2015 with NL. Document no 996 in exhibit C5 contained the notes of the visit. BP was present as a support person. Graham Dillon was cooperative and in good spirits. PG spoke to FL on the telephone.
2008. In relation to the information given in respect to being on medication and being monitored by a GP, the name of the GP was not known to PG and she did not make inquiries. That was something that she would usually do, but she took BP's word for it. PG also agreed that the police records were to be obtained but were not.
2009. PG said that she interviewed Bradyn and explained her interviewing process. Her purpose was to ascertain what happened in Victoria and whether the children had made disclosures whilst they were in Victoria. PG said it was her view that if the children did not disclose to her there was not much she could do.⁴⁰⁷ That is still her view.
2010. PG said that her findings were written up in an outcome report,⁴⁰⁸ which had been endorsed by a Team Leader and in this case BU. The outcome was to close the case.
2011. PG confirmed that she took into account what Graham Dillon and BP had told her in her reasoning. She said that those accounts do not refer to historical information because the report is a current appraisal in relation to allegations of physical abuse and that is the purpose of the report.⁴⁰⁹
2012. PG agreed that she did not include in her report anything about the historical references given to her by SK and UN as they would be in the case notes. There was no evidence that supported the children were being physically abused.⁴¹⁰
2013. Despite being taken to evidence of the aggressive and volatile behaviour towards NL and the school staff which PG said she would have considered, PG maintained that it was the present she was concerned with, and Graham Dillon was cooperative and responsive to CYPS involvement. PG said that it was not unusual for parents to be aggressive towards CYPS.
2014. In respect to cumulative harm, PG understood that she was to as part of her appraisal observe the children, find out what had happened since they returned from Victoria, look at the children and their experiences, to observe the father's parenting skills, observe the children's demeanour, their appearance and whether they were anxious.

⁴⁰⁶ Transcript of Proceedings, p 1407

⁴⁰⁷ Transcript of Proceedings, p 1411

⁴⁰⁸ Page 1129 subpoena docs

⁴⁰⁹ Transcript of Proceedings, p 1414

⁴¹⁰ Transcript of Proceedings, p 1415

PG did not observe anything in the children's behaviour to suggest they were scared. They are some of the things she looked for.⁴¹¹

2015. In relation to cumulative harm, PG said there was not as much significance placed on it. She has had no specific training in "cumulative harm", but she gets risk assessment training. PG was aware of the Glanfield Inquiry but had not 'really 'looked' at it and had not read it in depth.⁴¹²

2016. PG does not recall having a conversation with CO when she commenced working at CYPS, nor can she recall speaking about CO's involvement with the children in Victoria. PG was advised that the evidence was they were standing near the photocopier and had a conversation along the lines of CO was glad the case was open. PG said she did not believe she did have the conversation with CO because she did not have anything to do with CO because they were in different teams.⁴¹³

2017. PG was advised that the conversation included PG saying that she was closing the case and CO said you need to contact Victoria, you need to contact Tasmania for his criminal history and she needs to speak with Victoria's view on SK being protective of the children. PG said she does not recall that conversation.

2018. PG said she was aware that the children had a high level of absenteeism but that was in previous reports.

2019. PG ultimately recalls seeing a report of results of drug screening regarding SK and that she was negative for ice.

2020. PG said she believed BP was a mandatory reporter because either BP or his brother NP had told her that this was the case.

2021. PG was taken to the report of NL in response to the report from Victoria where it said that in light of the new information it is recommended that Graham Dillon be subject to random urinalysis and to engage with appropriate services. PG accepted that she had received calls in relation to Graham Dillon's drug use in January 2015 as well. When asked why no urinalysis was sought, PG stated that it was not part of the action plan signed off by BU. PG suggested that it may not have been necessary at the time. PG stated that after the allegation, she did not order a drug screen because she did not receive the information from UN, and she would not have considered a random urinalysis.

2022. PG agreed that reports of facial bruising to both children would be concerning. PG was told that over a period of four months those reports were made, and they coincided with the time BP was involved with the family. PG did not ask BP if he had seen bruising but did ask if he had any concerns for the children's safety. PG made the assumption that BP visited the family regularly and would have seen signs of bruising.

2023. PG agreed that in relation to the phone call of 14 January 2015 from SK, the notes of the conversation do not reflect PG asking SK about her views on the safety and welfare

⁴¹¹ Transcript of Proceedings, p 1418

⁴¹² Transcript of Proceedings, p 1419

⁴¹³ Transcript of Proceedings, p 1420

of the children. PG suggested that might be because the conversation did not come up.⁴¹⁴

2024. PG agreed there is no case note of her ringing SK and asking her views in relation to the safety of the children in Graham Dillon's care in the appraisal process, yet PG agreed that was important for a parent to be asked.⁴¹⁵

2025. PG did not directly answer that question but explained her thinking that it was around what was happening at present time and what she could observe. Given SK was in Melbourne she would not be privy to the interview PG conducted.

2026. PG was referred to page 107 of exhibit C5 which set out the actions required to be taken out which included speaking to the mother of the children. PG accepted that action was ordered by BU, the Team Leader. However, it was her view that she had some information in respect to the mother and as she had not had contact, it was not current for her purposes.

2027. PG agreed that it was 60 days from the date of the report and when she interviewed the children. PG agreed that some parents coach their children on what to say. PG agreed that SK had advised on 19 December that Graham Dillon dictated what the children were allowed to say. The note from the appraisal on 19 January stated: Bradyn said, *"Daddy told me to say what my mother did"*. PG agreed that is what he said.

2028. It was suggested to PG that there was evidence that both the ex-partners and the children were too scared of Graham Dillon to talk. It was suggested that it is not uncommon for children to not make disclosures if they are scared of the parent. PG said

"if children don't disclose I can't force them to disclose. I can only base my decision making around what I do – what they do tell me"⁴¹⁶

2029. PG reiterated that she made her decision based on her observations and the children did not present as scared. There was nothing to indicate that what they said was as a result of fear of repercussions.

2030. In relation to PG's email to BP and whether she had already decided to close the case prior to interviewing the children, PG said her decision depended on the outcome of the interview with the children.

2031. PG stated that she would not speak to BN regarding the interview she had with the children and confide what they said as that is not normal practice. PG agreed that in order to get information from interstate, the ILO would be the appropriate person to do so.

2032. PG was unaware that no further request was made other than NL's first request on 4 December 2014. PG was unaware that no request was made by the ILO ACT to the ILO Victoria. PG agreed that with the benefit of hindsight she should have followed that up.

⁴¹⁴ Transcript of Proceedings, p 1429

⁴¹⁵ Transcript of Proceedings, p 1430

⁴¹⁶ Transcript of Proceedings, p 1435

2033. PG disagreed that she regarded the Victorian information as critical to her interviewing the children and suggested it would have been helpful. PG disagreed that the delay in interviewing the children was because of the lack of information from Victoria and said it was because of the Christmas break.
2034. PG was asked about the care and protection system used in New Zealand. The focus of their system was to be on family or Whanau which incorporates an extended family principle. It is different to the system in the ACT.
2035. PG was familiar with the supports and services available to aboriginal children. PG was unaware that both SK and the children identified as aboriginal. Generally, the Intake Team would ask the question about culture.
2036. PG said that if she required information from ACT Housing she would contact them by phone rather than using the legislative provisions but would use them if required. PG does not recall seeing a housing form which included information about Graham Dillon's mental health issues. PG agreed that would have been helpful information.⁴¹⁷
2037. PG agreed that mental health issues could be a red flag, if the person had something like bipolar and was not taking their medications or not continuing reviews with a psychiatrist. PG stated that she would take past drug use into her consideration with the caveat that if that was in the past and they were currently drug-free that would also factor into consideration.
2038. PG also agreed that early childhood trauma and abuse can result in risk of that person becoming a perpetrator of abuse. Likewise anger issues would be considered, along with whether the person was seeking counselling for it.
2039. PG advised that it is usual that they get criminal histories and DVCS records in relation to an alleged perpetrator, generally the victim parent. PG suggested that if there is domestic violence reported and there were children involved, CYPS are notified.
2040. PG explained that whilst they may consider historical reports of abuse or domestic violence, the current situation is what is focused on.⁴¹⁸
2041. PG agreed that if children make disclosures after being out of the alleged perpetrators care it would be unlikely to see bruising and that can be the difficulty in making assessments of abuse taking into account the historical abuse. PG said that you could take emergency action if there was current abuse and if there was evidence of it, evidence that would stand up in court.⁴¹⁹
2042. In my view, it seems that PG's focus was on the current situation when she conducted an appraisal and gave little weight to historical abuse or reports of bruising because she looked at the behaviours of the children at the time of appraisal. The question of cumulative harm was not part of her consideration.⁴²⁰
2043. In relation to the disclosures made in Victoria, PG had misunderstood when the disclosures were made and thought they had been made prior to the Court order

⁴¹⁷ Transcript of Proceedings, p 1447

⁴¹⁸ Transcript of Proceedings, p 1463

⁴¹⁹ Transcript of Proceedings, p 1473

⁴²⁰ My emphasis

returning the children. PG was also mistaken as to the power Victoria had to change the order and believed that if there was a concern, something could have been done.⁴²¹ PG also said that once the children had disclosed, they should have been interviewed as to the circumstances of what happened.

2044. PG opined that it would be considered appropriate to interview the children at a time when they were not distressed. The Court could have been advised that they required further time.

2045. PG gave her understanding of children's experiences of domestic violence which included witnessing it firsthand, hearing it and observing the parents body language. PG identified that it could have various impacts on the children.

2046. PG also accepted that controlling behaviour can occur even after separation of the parents. This could include using the children as pawns, which often happens. PG accepted that not allowing the mother of the children access to them is a form of family violence.

2047. PG also accepted that research shows that a high percentage of men who beat their partners also physically abuse their children.⁴²² PG accepted that the presence of family violence in a relationship by a man is a risk factor that the man may also perpetrate or threaten physical abuse to the children.⁴²³

2048. In relation to the safety plan, PG did not draw one up as she had not had an opportunity to meet with the family and was told by Graham Dillon that there was in fact a safety plan in place. Later it was ascertained that there was no safety plan, and she drew one up.

2049. PG agreed that a safety plan would be based on her investigation and whether there was substantiation of current abuse.⁴²⁴ PG stated that she needed to check what was currently happening with the children, assess their home environment and also to observe whether there were any physical injuries present at the time of the appraisal. PG stated that it may have been good to draw up a safety plan prior to the appraisal however at the "*end of the day you've actually got to assess what's going on for that safety plan to be relevant*".⁴²⁵ PG stated that what she had seen and heard when carrying out the appraisal was different to what the report had contained.

2050. PG agreed that she had spoken with Graham Dillon and he told her that he had a safety plan in place. She assumed that it was a safety plan which would include the children and that it had been written up by CanFaCS.

2051. PG was referred to an email from BP where he advised that he compressed the relevant files and have them to her by 19 January. PG was also referred to an email she sent where she spoke about brainstorming the safety plan and indicated one consideration was to protect children from their mother by having Graham Dillon's new

⁴²¹ Transcript of Proceedings, p 1478

⁴²² Transcript of Proceedings, p 1489

⁴²³ Transcript of Proceedings, p 1490

⁴²⁴ Transcript of Proceedings, p 1491

⁴²⁵ Transcript of Proceedings, p 1491

address remain confidential.⁴²⁶ PG stated that was because of the alleged kidnapping of the children by their mother.

2052. PG was taken to the safety plan she drew up which included matters which needed to be considered, matters which were unsafe and needed to change, what is to be done and who is to do it. PG stated that the address of the Dillon family was not to be disclosed and that was to ensure the safety of the children from being taken from their home.

2053. PG stated that was the only factor she considered after appraising the current situation. That was despite knowing the information that was received from CARHU and Victoria and the other information from previous reports.

2054. PG stated that she had no lingering concerns about the safety of the children based on the material that was in the Child Protection files because at the time of her appraisal she believed the children were safe in the care of their father and that their father was a willing parent who was able to care for them. PG stated she based that assessment on the historical risk and the current risk as well as her observations.⁴²⁷

2055. PG was taken to an email dated 5 February 2015 from ACT Primary School 1, advising NL that the school had been told by Graham Dillon that children were moving to New South Wales and would no longer be attending ACT Primary School 1. The school also advised that they were unable to get information regarding the new school placement. There was an email from NL to PG advising PG of the situation. PG was shown an email she sent to a teacher at the school to let her know that the case had been closed and that the family had moved to another area.

2056. When it was suggested that it would be appropriate to let the school know that the children may be at another local school, PG stated that was not their normal role. When it was suggested that it is normal for schools to pass on information in relation to children if the children are to go to another local school, PG stated

“yes, but for Child Protection to pass that information on, that would be a normal task for us to do and I had already closed the case, so I wasn’t working with the Dillon family at that time”.⁴²⁸

2057. PG knew at the time that the children were living in Jacka and at the time of interview it was school break and the children had not started at the school. PG also knew that the email stated they were going to New South Wales.

2058. Given that the ACT Primary School 1 had previously had eyes on the children, PG agreed it would have been appropriate to let ACT Primary School 1 know where the children were going to school so that ACT Primary School 1 could communicate their concerns about the children to the new school.⁴²⁹

2059. PG agreed that given she was closing the file, she left the safety plan management to BP who was to make contact with Belconnen Community Service and the school. PG

⁴²⁶ Transcript of Proceedings, p 1492

⁴²⁷ Transcript of Proceedings, p 1494

⁴²⁸ Transcript of Proceedings, p 1495

⁴²⁹ Transcript of Proceedings, p 1496

stated that BP advised he would have involvement for at least the next three months after she closed case.

2060. PG agreed that it was important when closing the case to ensure that the people tasked with continuing involvement with the children continue to have eyes upon them. PG stated she was assured by BP that if there were any concerns, he would report them to CYPS and she believed him, as she had no reason to doubt him.
2061. PG stated that she did not tell BP about the disclosures as she had considered that he knew more about the case because he had contact with Graham Dillon throughout. When it was suggested that Graham Dillon did not know about the disclosure's PG stated she was unsure about that, but she certainly did not tell him.⁴³⁰
2062. PG stated she relied on BP and the school as mandated reporters to continue to have eyes on the children after the case had been closed. PG formed the view that when a child is enrolled in a school, that school will then contact the last school to touch base around school records and other similar things.
2063. PG stated that although there is no record of her meeting with BP on 16 January, they did have a meeting. Arrangements were made for the home visit to Graham Dillon's home in Jacka. The records reflect that the home looked good, the bedrooms of the children looked good and did not raise any concerns. PG stated that was the only time she attended Graham Dillon's home.
2064. PG was asked questions in respect to a conversation she had with Bradyn where he told her that his mother told him to make stories up and that he his daddy told him to say to you what my mother did she was asked whether she considered that Graham Dillon may have also coached the children prior to that her arrival. PG said that that could be said of both parents.
2065. PG agreed that it was a possibility that Graham Dillon had coach Bradyn as to what to say to her. PG agreed she did not contact the children after that, and she did not attempt any further unannounced home visits. That was because the case was closed.
2066. PG stated that the case had been extended by 28 days but from what she had seen in her assessment and the fact she saw no evidence of physical abuse and that the interaction with the father was appropriate. In her view there was no need to consider it as 'new' and the case was closed.⁴³¹
2067. If a fresh report is made to CYPS, the old case is not reopened. Instead, a new report will be made, called a Child Concern Report. The Intake Officer would decide whether to transition the Child Concern Report to a Child Protection Report. If this occurs it may be sent to the appraisal team if that is recommended.
2068. PG stated that she had briefly seen the Glanfield Inquiry but did not read it in detail. PG was aware that there was an internal review but was unaware of an independent review. PG stated that there was no discussion or training about reflective practice

⁴³⁰ Transcript of Proceedings, p 1497 – 8

⁴³¹ Transcript of Proceedings, p 1504

about Bradyn's case as the case was sealed and she was not privy to that information. PG stated she had not had the opportunity to see the internal review.⁴³²

2069. PG stated that they have reflective practice, which is part of supervision. PG further stated that reflective practice is part of social work practice and social workers can reflect cases in that setting.

2070. PG stated that she had a period where she did not work in Child Protection such as organisations including Barnardos as a hospital social worker and working with young people with mental health issues. PG also stated she did some lecturing at a University in New Zealand.

2071. PG agreed that there was an 11-year break between being an active childcare protection worker and commencing work in the ACT.

2072. PG confirmed that in New Zealand there is a strong reliance on community organisations who provide feedback and information to the Department. PG expected that it would be similar in the ACT and relied on that fact. PG stated that she had spoken to FL and was aware that FL was a solicitor, she relied on the fact that FL would accurately reflect what had happened in court in Victoria.

2073. PG also confirmed that when she was allocated to the Bradyn Dillon file, she was new to CYPS and was still learning about the culture of the organisation. That included the unwritten rules of the organisation. PG also confirmed that because she did not know the culture and unwritten rules, she felt she was unable to look behind previous appraisals and reports that had been carried out.⁴³³

2074. PG stated that from her experience, Team Leaders were very experienced with a good working knowledge of the organisation. When she arrived in Australia, she looked to the Team Leader, BU as a person who would have that knowledge and experience including knowledge about the mechanisms of the organisation. PG stated she was aware that BU had extensive experience in the UK, and she had a lot of respect for her expertise. There was no reason why she would question BU's decision-making.⁴³⁴

2075. In relation to correlating the physical file and the electronic file, PG relied on BU because it was her experience that BU was very vigilant in ensuring that both files had been checked to ensure they matched up.⁴³⁵

2076. In respect to understanding the correlation between family violence and other forms of abuse and the risk of abuse to children, PG stated that in 2014 she opined that she and others were not as informed about domestic violence and cumulative harm because of the absence of research. PG opined there is a lot more training and information on domestic violence and cumulative harm now and her knowledge is better now than it was in 2014.

2077. PG was unaware how long NL had been working with CYPS but was aware she had worked with the Dillon family for 12 or 13 months. PG expressed that is a long time to

⁴³² Transcript of Proceedings, p 1505

⁴³³ Transcript of Proceedings, p 1508

⁴³⁴ Transcript of Proceedings, p 1509

⁴³⁵ Ibid

be working with a family. PG expected that because of that factor, NL would have a good knowledge of the family and that is why she relied on NL.⁴³⁶

2078. PG was aware of the process of obtaining material, particularly from the AFP and was aware that included the PROMIS notes. She opined that PROMIS notes should have contained relevant information including allegations of family violence which had not proceeded to criminal charges and incidents of family violence where police attended.⁴³⁷

2079. PG stated that in her experience, particularly when she first commenced work, police would often take considerable periods of time to furnish the material requested. She stated that it often took over a month, which meant material was being received after the 28-day period recommended for closure of the case.⁴³⁸

2080. PG also opined that if she had requested a large amount of material, that would impact greatly on her management of the caseload. PG stated that she would need to factor that into her workload whilst conducting appraisals, making her job much harder.⁴³⁹

2081. PG agreed that if the box on the case notes which indicated that the matter should proceed to care and protection appraisal within seven was ticked, it would mean that the initial appraisal period was seven days. PG stated that some work must be commenced in that period, but that the work must be completed in full within 28 days.

2082. PG was shown page 989 of exhibit C5. PG stated that information was uploaded to the CYPS database on 14 January 2015. PG stated that it is possible that when she was conducting her appraisal, she did not know that the case note was in there because of the date when it was uploaded to the system.⁴⁴⁰

2083. PG also stated that she needed to get up to speed with the other 14 cases that she had been allocated prior to her leave. PG also agreed that she would place more weight on what she was asked to do by the Team Leader than by the action plan on the intake form.⁴⁴¹ PG agreed that she had assumed that the action plan outlined in case consultation was what she was required to do.

2084. In relation to her experience with ex-partners making malicious complaints, she was aware that they can make malicious complaints or allegations to CYPS about their partners. That is why she asked for independent evidence in respect to the drug use allegation.

2085. PG agreed that that is perhaps one reason why she had said to UN “what do you and SK get out of this”.⁴⁴²

⁴³⁶ Transcript of Proceedings, p 1510

⁴³⁷ Transcript of Proceedings, p 1511

⁴³⁸ Ibid

⁴³⁹ Ibid

⁴⁴⁰ Transcript of Proceedings, p 1513

⁴⁴¹ Transcript of Proceedings, p 1514

⁴⁴² Transcript of Proceedings, p 1514

2086. PG also stated that in her experience, just because a person is aggressive to a teacher or a CYPs worker, does not automatically mean they are abusive to the children because some people get very heightened when dealing with CYPs.⁴⁴³
2087. In respect to her observations of Graham Dillon, she did not observe anything in relation to him suffering from mental health issues. Neither did she observe him to be under the influence of any substance when she carried out her appraisal. PG did not observe any indicia of drug use when she spoke to him on the phone on 19 December.
2088. PG was asked to comment on a hypothetical situation where her appraisal had found that physical abuse of the children had been substantiated. She was asked what recommendation she would have put forward to her Team Leader. PG stated she would take emergency action as well as perhaps a supervision order which could be granted by the court. Most of her recommendations would be court ordered action.
2089. PG stated that if a court had made an order, it would be likely that a family assessment would be conducted. This assessment would require that the parents must have psychological or psychiatric assessments, and extensive reports outlining the actions that the CPS has taken that include assessment of the safety and health welfare of the children, and their emotional and psychological well-being. It will also include an analysis of the risks to the children. PG stated that the assessment and chronology could take anywhere up to 6 or 8 weeks to carry out.⁴⁴⁴
2090. PG stated that she placed considerable weight on the fact that the mother had kidnapped the children in contravention of the order, there was a family violence order in place, Victoria determined that the children shall be returned to Graham Dillon's care and these factors weighed heavily on her appraisal.⁴⁴⁵
2091. PG stated that to this day she does not know what happened in Victoria. A chronology of events was read out by PG's counsel as to what occurred in Victoria.⁴⁴⁶
2092. PG was then referred to the file note written by the Victorian DHHS case worker which outlined the disclosures made by the children and the circumstances in which they arose. PG stated that would have been very useful and definitely would have assisted her and she questioned why she was not given that information.⁴⁴⁷
2093. PG was directed to two documents called working with families where an adult is violent and the other was a document about cumulative harm. PG stated she had not seen those documents before and did not believe she had any training in relation to family violence at that time. PG stated that BU had resources available, and she was given access to them.⁴⁴⁸ At the time when PG was allocated the Dillon file, she could not say whether she had access to those documents.
2094. PG confirmed that since Bradyn's death there is now access via the 'knowledge portal' about domestic violence and cumulative harm. PG confirmed that she has over time

⁴⁴³ Ibid

⁴⁴⁴ Transcript of Proceedings, p 1515

⁴⁴⁵ Transcript of Proceedings, p 1516

⁴⁴⁶ see Transcript of Proceedings, p 1517 – 1518

⁴⁴⁷ Transcript of Proceedings, p 1520

⁴⁴⁸ Transcript of Proceedings, p 1522

accessed 'knowledge portal' when she requires information about certain matters. She would also consult with colleagues.

2095. In respect to her knowledge that NL had been working with the Dillon family for 12 or 13 months, that was an assumption she made. She was unaware that NL had only been working with the family between July 2014 and December 2014.

2096. PG confirmed that her forensic approach to the material required to be examined was that she would read both the electronic and paper file.⁴⁴⁹

2097. When questioned about her forensic approach and how she digests all the information she must get across in the files, PG stated that she had no forensic approach other than to absorb it.⁴⁵⁰ After that, she would then consult with the Team Leader about what actions they would be looking at. PG stated that she would not do anything differently now than she did in 2014.⁴⁵¹

2098. PG explained what she considered to be historical. She considered the CARHU report to be historical because it had come out of another appraisal report that had been closed. This was her view despite the CAHRU report only being issued on 12 September 2014. PG explained that her view of 'historical' meant that the concerns had already been addressed and the CARHU report for example, was not something that she was looking at, at that particular time, regarding physical abuse.⁴⁵²

2099. In response to a question from me about the number of reports of physical abuse, PG stated:

"Yes, but also, you're looking at, as I said when I went out, did I - I was looking at physical abuse. Did I actually see any bruising on the children - - - Yes, I understand where you are coming from? ---Yes, so that would have been present or current. What happened previously was - that was - those concerns had already been addressed in those reports."⁴⁵³

2100. In relation to other options other than taking court action PG was aware that there were such things such as voluntary agreements.

2101. In relation to PG's understanding of the role of a second, she explained that that would have been discussed during the case consultation with BU and NL. It was suggested to her that NL had a different view in that she was to be taken from the case because the case was being transferred to PG and that to maintain continuity she would go with PG to the house and speak with Graham Dillon to let him know that PG was taking over the case. That it was protocol. PG stated that was quite different to what she expected NL as a second to do.

2102. PG agreed that the role she expected NL to undertake included following up on matters such as Victoria's notes. PG stated that the lack of clarity was significant and in her view the tasks and who was responsible for their completion should have been identified rather than assumptions being made.⁴⁵⁴

⁴⁴⁹ Transcript of Proceedings, p 1524

⁴⁵⁰ Transcript of Proceedings, p 1524

⁴⁵¹ Transcript of Proceedings, p 1525

⁴⁵² Transcript of Proceedings, p 1525

⁴⁵³ Transcript of Proceedings, p 1526

⁴⁵⁴ see Transcript of Proceedings, p 1530

2103. PG affirmed that the information from Victoria, as well as other information including records about family violence, Graham Dillon's criminal history and his drug, alcohol, and mental health, would have informed her appraisal process.⁴⁵⁵ PG confirmed that without that information, the forensic approach was limited.
2104. PG opined that information is very important, but the permission of the person is often required to get access to certain records. If they refuse, that can be difficult particularly given the Privacy Act and the Official Information Act. In respect to urinalysis, they would generally get consent from the parent to agree to undertake it.⁴⁵⁶
2105. PG was taken to some correspondence in respect to the date that she conducted the home visit with the children and Graham Dillon. The notes in respect of that were written up on 19 January and she assumed that the visit took place on that day but after correspondence from BP stating that it was 16 January it is possible that indeed it was 16 January that the visit took place.

BD –CYPS Caseworker (HP 3 Level), Working as an Acting Team Leader

Statement

2106. BD worked in the Child Protection field since 2010 and was a caseworker and Team Leader throughout the management of Bradyn and JL's case.
2107. She accepted that she understood the ILO process during her term as caseworker and Team Leader.
2108. In reference to exhibit C5 page 767, BD does not recall the report therein. She said that if she was aware of drug use by Graham Dillon, then that would have been the extent of the report, it would have not been confirmed, and would require further information from Victorian Child Protection.
2109. In respect to exhibit C5 page 1302, BD does not recall that conversation but stated that, in accordance with her standard practice, she would have directed them to family law proceedings or orders and advised that they seek legal representation.
2110. BD acknowledged that she signed off as a caseworker and recommended no further action on 5 August 2013.
2111. BD confirmed that she was a Team Leader at CYPS in July 2014.
2112. In relation to the case consultation convened on 30 July 2014,⁴⁵⁷ BD accepts that Bradyn did not want to talk about his bruises. She said that she noted that JL's description of fighting was inconsistent with Graham Dillon's description of fighting with the cousins. She said that the children were very compliant.
2113. BD does not accept as facts that Graham Dillon had Child Protection history in New South Wales, that he had recently separated, and that he had three children to his partner, UN. BD indicated that those matters would have been directed to New South Wales DOCS.

⁴⁵⁵ Transcript of Proceedings, p 1531

⁴⁵⁶ Ibid

⁴⁵⁷ Exhibit C5, p 1015.

2114. BD accepted that she recorded and directed, during that case consultation, that the following actions be undertaken pursuant to section 862: a request be made for Graham Dillon's mental health records; drug and alcohol history; criminal history and PROMIS records. Additionally, for Graham Dillon to be thoroughly interviewed, and for CYPS to liaise with the children's school in relation to their emotional and physical presentation, previous absences, and the correlation between absences and reports of bruising.
2115. BD does not remember writing the document located at page 1013 exhibit C5, where on 11 August 2014, she recommended no further action or consultation occur with NL. It was BD's standard practice not to close an appraisal prior to receiving the Section 862 information. However, in this case it would appear that she did.
2116. BD indicated that, as Team Leader, she endorsed recommendations of no further action on report 70088 as it was characterised as a duplicate of 70027, which was made the day before. As the allegations were of a similar nature and were being appraised by NL no additional appraisal was required.
2117. It was BD's view the recommendation of no further action regarding report 70627 was endorsed by BU on 13 October 2014.
2118. BD played no further role in Bradyn and JL's case.
2119. BD accepted that Team Leaders and caseworkers have access to all relevant CYPS material, which included the concerns of 23 November 2013. However, she does not recall working with the family.
2120. On 9 August 2014, BD endorsed the decision to take no further action on reports 70088 and 70027. She did so as they were further descriptions of previous injuries and, therefore, did not require a separate appraisal. BD does not recall endorsing that decision notice. She recalls the bruising detailed in report 70027.
2121. BD suggested that the words 'no further action' are not interpreted by CYPS workers in the same way that they would be by the general population.
2122. BD suggested that it was her intention that the injuries reported in 70088 be explored as part of the recently opened appraisal interventions with 70027, so as to ensure that all relevant information was recorded in the one easily located, and logically organised, place.

In Evidence before the Inquest⁴⁵⁸

2123. BD is a Family Group Meeting Convenor with Child Safety Queensland. She commenced work in 2020.
2124. BD was asked whether she was familiar with the CYPS Integrated Management System. She said that she may have once been, but that she does not recall the CYPS policy and procedures that were in place in 2014.
2125. BD stated that she was a CYPS HP 3 in 2014. Between June and August 2014 she was the acting Team Leader. The Team Leader was ordinarily BU.

⁴⁵⁸ Transcript 1559 – 1634, 1910 – 1920.

2126. BD stated that during the time she was Team Leader she assumed that she would access policies, protocols, and procedures through the intranet. BD was familiar with the 'knowledge portal' but was unsure whether, at that point in time, policies and procedures had been added to the portal.⁴⁵⁹
2127. BD said that, at some point throughout her employment at CYPS, those policies procedures and protocols were placed on the 'knowledge portal'.
2128. BD thought that there was access to those materials through the Community Services Directorate intranet or the D drive. She said that it was likely they were also available in hard copy.
2129. BD said that when a person commenced working at CYPS they were given a paper package of documents which contained policies and other similar things.
2130. She said that when she commenced working with CYPS in 2012, she accessed training through the training division, including policies, procedures, and information on the relevant role that was to be undertaken.⁴⁶⁰
2131. BD was referred to page 358 of the exhibit C5. She identified that document as relating to intake and appraisal procedures and confirmed that she was familiar with it. She agreed, in part, that the document was fairly comprehensive.⁴⁶¹
2132. BD confirmed that document (which contained several matters including the undertaking of an initial risk assessment, responding to a Child Protection Report, and undertaking a care and protection appraisal) would be relevant to her role and to the role of caseworker for CYPS. BD confirmed that it was a document which would be regularly referred to. She further confirmed that she was familiar with the nine key activities in relation to the intake and appraisal process.⁴⁶²
2133. BD stated that document was used where a question arose in relation to the direction or decision that one might take. This could occur either formally or informally with a colleague. BD believed that it was best practice to refer to that document when required.
2134. BD was directed to the flowcharts of the Integrated Management System. She agreed they were part of the practice tools available to case workers. BD confirmed that once you were in the 'knowledge portal' you can click on links which would include practice guidelines, policies, and procedures.⁴⁶³
2135. BD was uncertain whether the 'knowledge portal' referred to was like that in 2014 or when she recalled that when she last was there. BD stated that it was more of a resource because once you had undertaken multiple appraisals you would be familiar with the process and would only refer to it if required for guidance.
2136. BD outlined the usual steps in respect to what occurs after a Child Concern Report that is a Child Protection Report and then an appraisal. In relation to a section 862

⁴⁵⁹ Transcript of Proceedings, p 1561 – 2

⁴⁶⁰ Transcript of Proceedings, p 1562

⁴⁶¹ Transcript of Proceedings, p 1563

⁴⁶² Ibid

⁴⁶³ Transcript of Proceedings, p 1566

information gathering exercise the case manager would email the request to an administrative officer.

2137. BD recalled that she had seen practice tool documents, including those for abuse or neglect, head injuries multiple injuries and protective risk assessment guide. BD except was a very detailed practice guide available to her and her colleagues. BD recalls that she had seen the document, but she was unaware whether it was available. It was her view that it was not a current document for CYPS.

2138. BD was also taken to a heading 'making a recommendation whether a child is in need of care and protection' and agreed there was a guidance in completing that report, but she had not seen the document.

2139. BD said she was familiar with the document for the team later to finalise the appraisal and was referred to the following

"The Team Leader is to ensure that the AOR reflects a rigorous information gathering process, contains appropriate referral for medical examinations where required, analyses all relevant 35 information, reflects a professional safety and risk assessment and demonstrates evidence of the implementation of the appraisal actions, et cetera."⁴⁶⁴

2140. BD said that is what she understood the Team Leaders responsibility was.

2141. BD was taken to the next practice guideline in care and protection appraisals, gathering information. BD said that she was familiar at least with the headings and the basic tenants of forensic interviewing. BD does not recall that material being available on the 'knowledge portal' however she was familiar with the themes it referred to.⁴⁶⁵ BD agreed that she was familiar with the portal and would access the information if she required specific information arising out of the exercise of her duties.⁴⁶⁶

2142. BD agreed that there had been training but she was unable to recall specifically what training but understood that e-learning was not available initially. In 2014 she recalls that there was 'knowledge portal' training as it was in its infancy and she recalled they did have a large amount of training on the database. That training was in respect to how to navigate and use it.⁴⁶⁷

2143. BD accepted that the 'knowledge portal' was available for caseworkers to access if they required to refer to practice tools and guidelines. New employees were certainly able to access it.

2144. BD stated that she was acting Team Leader between June and August 2014 and her recollection was that it was only for a few weeks. It was her first time acting as a Team Leader. BD accepted that the time she was acting was from 28 July until 14 August.

⁴⁶⁴ Transcript of Proceedings, p 1572

⁴⁶⁵ Transcript of Proceedings, p 1574

⁴⁶⁶ Ibid

⁴⁶⁷ Transcript of Proceedings, p 1575

2145. BD stated that in order for her to understand her role she would have had a supervision session with BU. BD did recall some of the issues that arose during that time, such as checking to ensure that issues were acted upon and that reports came in in a timely manner.
2146. BD stated that whilst she was acting in the position in respect to her caseload, she was reallocating her cases because she was to go away on leave once BU returned.
2147. In respect to mentoring, BD did not specifically recall a practice of appointing one however the inexperienced caseworker would be paired with an experience caseworker. BD stated that she was supervised by BU. During that time, they would have formal supervision meetings and daily support meetings where matters could be discussed and deliberated on. These discussions could be informal and formal. The formal supervision was every two weeks where cases were discussed.⁴⁶⁸
2148. During the formal supervision case analysis was conducted and if certain tasks were to be undertaken that would be discussed. BD said the physical file as well were generally be used at that time and there were case consultation documents used for the formal consultation and also informal consultations.
2149. BD stated that she did not recall providing BU with a hand over of her files when she went on leave but that this would have been best practice and that she assumed that it did happen.
2150. BD agreed that her first involvement with the Dillon family was in 2013. BD agreed that she requested a child protection history from Victoria at this time and that it was usual practice to go through the Interstate Liaison Officer.
2151. BD was referred to a document showing that she had dealt with the Dillon family at that time. A report was generated as a result and ultimately no further action was taken. That report was signed off by a Team Leader.⁴⁶⁹
2152. BD was referred to an incident recorded by her in respect to bruising on Bradyn's face. The report was received on 29th of July 2014. The reporter had observed changes to the bruising on Bradyn's face in that he had faint black bruises under his eye. The reporter noted that JL had two small round bruises on her jawline which were faint and a bruise on her forehead. The reporter said they had not noticed those two bruises on Monday, 28 July when they first reported the bruising to the child's eyelid. BD had no recollection of the matter.⁴⁷⁰
2153. BD accepted that she was the Team Leader, and that NL was the caseworker. She did not recall reviewing the file but accepted that she may just not recall. It was her usual practice to review the files.
2154. BD stated that it was her usual practice to review the CHYPS file but not the physical file. BD accepted that, when looking at the CHYPS file, she would have potentially

⁴⁶⁸ Transcript of Proceedings, p 1577

⁴⁶⁹ Transcript of Proceedings, p 1584

⁴⁷⁰ Ibid

come across the fact that she had involvement with this family 12 months previously. She did not have any recall of the matter when giving evidence.⁴⁷¹

2155. BD could not recall there being a case consultation concerning this matter but assumed, with some confidence, that one had occurred. BD further had no recollection as to the discussion in respect to the interview with the children, however, having looked at Exhibit C1, she was confident that the information would have been considered concerning.

2156. BD stated that, looking back, the finger marks and surrounding injuries would have been concerning and would have warranted a case consult.⁴⁷²

2157. BD was referred to page 961 of the exhibit C5 where JL told an interviewer that Graham Dillon sometimes hits her and Bradyn on the head and kicks them up the bum with his boot. When JL was asked to show where it happened she pointed to both the left and right-hand side of her head, and the side of her face. When asked if it hurts, JL said no, and that the boot hurts more. BD was asked whether that comment would have warranted being recorded and she said she thought so as the child was providing a disclosure of being hit and kicked.⁴⁷³

2158. BD agreed that she had noted that several actions were required such as section the mental health records, drug and alcohol history, criminal history and PROMIS Notes. BD stated that she would have expected the caseworkers to have undertaken the requests and actions as required. Her expectation was that the HP 1 would have undertaken those tasks with the support of the HP 3.

2159. BD was only recently advised that those requests were never acted upon.⁴⁷⁴

2160. In relation to the direction to interview Graham Dillon thoroughly as soon as possible, BD would have meant that they should challenge him for an explanation. BD was unable to confirm if there was a policy and procedure providing guidance for the interviewing of parents, but it is likely that there was one.

2161. In relation to the direction to liaise with the school in respect to the emotional and physical presentation of the children, as well as previous absences and their relationship to reports of bruises, BD stated that she was not aware whether the correlation of that information had ever occurred.⁴⁷⁵

2162. BD was shown a document recognising abuse and neglect and felt that it was possible that she had seen it before. She was referred to risk indicators including where several explanations have been provided for an injury. She stated that it was difficult as you cannot have absolute certainty as to the weight it should be given. She said that it is very subjective.

2163. BD was taken to a record which indicated that there had been several incidences of bruising, that the behavioural issues of the children were unusual, and that there had been some disclosures and some absenteeism. It was suggested to BD that bruising

⁴⁷¹ Transcript of Proceedings, p 1585

⁴⁷² Transcript of Proceedings, p 1587

⁴⁷³ Transcript of Proceedings, p 1588

⁴⁷⁴ Transcript of Proceedings, p 1589

⁴⁷⁵ Ibid

around the face or grasp marks on small children are the sorts of bruising that must be considered nonaccidental. Having been taken to the report BD accepted that, in hindsight, it looked like the report of those bruises fall into that category.⁴⁷⁶

2164. BD agreed that there are certain sources of information which are credible such as schoolteachers, healthcare professionals, and other care and protection workers. BD further agreed that there are other sources which you would be inclined to seek verification of, such as information from parents who were involved with the children. BD also agreed with the proposition that, for other than information received from sources considered to be credible, verification of information is important.
2165. In relation to how Team Leaders would confirm that tasks and actions had been completed, BD said it could be checked via formal or informal supervision, examining the system, and at the point of review to consider the appraisal and whether closure is the outcome.
2166. BD stated that, as at 11 August 2014, with the case consultation, it would have been best practice to have a conversation about the things that hadn't been completed. BD had no knowledge of whether it had been at the time.
2167. In respect to the children having been taken to see a GP, BD said that it is not unusual and that while the preference is for children to see the Child Health Unit, parental consent is required for that to occur. BD was taken to the case note in respect of the phone call made by NL to the doctor on 11 August 2014. She confirmed that note would be available at the case consultation.⁴⁷⁷
2168. BD opined that the weight that could be given to the fact that the CanFaCS worker had advised that there were no concerns with the children was relative. She stated that particularly regarding how much intervention and access CanFaCS would have had to the family and the picture that the worker would have subsequently built regarding the dynamic between the children and the father.⁴⁷⁸
2169. BD confirmed this would not take away the necessity to verify the sources of information that had been requested and she said that she would not rely on what the CanFaCS worker had said. BD confirmed it would be just one more piece of the puzzle.⁴⁷⁹
2170. BD also confirmed that if historical family violence had been reported, but not progressed, this past report would remain relevant to her consideration.⁴⁸⁰
2171. BD was taken to a note, that says extensive support network were in place and lists; CanFaCS; Relationships Australia, Communities@Work; and the church. This note was authored by NL and discussed when updating the case. She would have been expressing that those supports were in place. That assumes that the information has either been verified, can be verified, or is known to be true.⁴⁸¹

⁴⁷⁶ Transcript of Proceedings, p 1592

⁴⁷⁷ Transcript of Proceedings, p 1594

⁴⁷⁸ Transcript of Proceedings, p 1595

⁴⁷⁹ Ibid

⁴⁸⁰ Transcript of Proceedings, p 1596

⁴⁸¹ Ibid

2172. BD said that where Graham Dillon has advised that he is supported by Relationships Australia and Communities at Work, as well as through a church group, how much involvement he has with those organisations should be verified.
2173. BD confirmed that when the case worker told her that she would check on the children once more before case is closed, she assumed that they would be assessing and reassessing the case right up until it was closed and depending on the information that is gathered, make a determination about closing the case.
2174. BD stated that if she had been given fresh information of further facial bruising, she would have consulted with her Operations Manager, the child would have been interviewed, and she would have concerns of the pattern of emerging behaviour. Further intervention would perhaps be required.
2175. BD agreed that when exercising discretion, care and protection workers must have a holistic viewpoint. That is, to identify risk factors and protective factors and to weigh them up. BD also agreed that part of the policies and procedures show how to identify those risk factors and protective factors.⁴⁸² BD agreed also that she would consider all of the information available to her.
2176. BD then went through the factors which she thought were protective, including supervision by BP, and relationship the children appeared to have with their father. Risk factors which BD identified were poor attendance, a reference to prior incidence of bruising, which BD agreed would be of concern. BD agreed that there are a large number of policy and procedure documents which deal with those factors.
2177. BD was familiar with the two assessment protocols 'Overview of The Process of Risk Assessment in Child Protection' and 'Recognising Abuse and Neglect' as well as 'Threshold Decision in Child Protection Work Practice Guides'.⁴⁸³ BD agreed that some of those guides, including 'Assessing Protective Factors and Risk Factors', emphasise the importance of record-keeping. BD agreed that this was important because of the impact of failure to keep accurate records matters.
2178. BD was asked to comment in respect to a failure to verify notes that have been placed on the record. She was provided with an example of where the record states that a person has extensive support networks, but no independent verification occurred. BD was asked whether in those circumstances would it be expected that the care and protection worker would rely upon that record, BD said
- “Not if it was - a different context perhaps would result in different exploration so if a new report was received, *generally* speaking we don't take things at face value, go back and assume that time has passed, and we would review and ensure whether those were current supports”⁴⁸⁴
2179. BD confirmed that it would be necessary when assessing cumulative harm to consider the risk factors of a particular file.
2180. BD was asked about the report of 28 July from ACT Primary School 1, reporting bruising to the children's face after they had been away for a week in Sydney, and the fact that this report was referred to as an extension of a previous report. BD stated that

⁴⁸² Transcript of Proceedings, p 1602

⁴⁸³ Transcript of Proceedings, p 1604

⁴⁸⁴ Ibid

the assessment of whether the cases were extensions of each other would be completed by a caseworker.

2181. It was suggested that the recommendation was to endorse closure of the case, as that report was simply a further description of previous injuries that had already been reported and therefore a separate appraisal is not required. BD explained

*"So I don't recall doing the report but like it's - to look at it, as you said, even if it doesn't appear as though we have extension and called it the same injury perhaps, bruise had, I believe, changed slightly, was the wording used in the report at the time the original concerns received in this report, is my understanding. So, we would have considered it appraisal-worthy, but not wanting to have two separate appraisal interventions opened for our client management system, sort of, no further action in this particular report, but that does not mean that the concerns are not included or investigated as part of the open appraisal for the previous day, with very similar concerns or injury."*⁴⁸⁵

2182. In relation to BD's observations of changes that have occurred since Bradyn's death, BD stated that there is a new client management system but could not be confident of any other changes that may have occurred given she was absent on maternity leave for a significant period of that time.

2183. In respect to the cumulative harm tick box, BD stated she was never directed not to tick the box when completing the document.⁴⁸⁶

2184. BD was asked to comment whether, looking back in hindsight, there was something that she would have done differently. BD said there were several areas where caseworkers and Team Leaders could do a better job in the space of child protection. These include structured decision-making tools, actuarial tools at different points on the child protection continuum or within an intervention.

2185. It was BD's belief that these improvements would go some way to provide a more consistent and regular assessment of the relevant risk and protective factors.⁴⁸⁷ BD considered that this part of the client management system, with those tools, ultimately would prevent caseworkers or Team Leaders from moving forward unless those tools had been utilised.⁴⁸⁸

2186. BD confirmed that those tools were not available within the practice at CYPS as part of the Client Management System.

2187. BD was asked about page 1015 of the report of 30 July 2014 contained in exhibit C5, where the case consultation note written by BD suggested *"no neglect. However, children very compliant"*. Whilst BD did not recall that meeting specifically, her understanding of the comment was that it was perhaps the children overall, in presentation, may not appear neglected or unclean or malnourished. However, another facet of the presentation may have been the children's manner in their manner was very compliant. BD's experience was that when children feel safe and secure with parents, they are not always compliant or overly compliant.⁴⁸⁹

⁴⁸⁵ Transcript of Proceedings, p 1606

⁴⁸⁶ Transcript of Proceedings, p 1607

⁴⁸⁷ Ibid

⁴⁸⁸ Ibid

⁴⁸⁹ Transcript of Proceedings, p 1608

2188. BD acknowledged that referring a junior member of staff to policies and guidelines would be best practice, but she had no recollection as to whether she referred NL to the policies. BD stated that she would have sought guidance for decisions in her role as Team Leader from her Operations Manager if she were felt that necessary. BD's Operations Manager at the time was LT.
2189. BD was asked about what BU was like as a Team Leader. BD agreed that BU was an experienced Team Leader and she felt that she could always speak with BU when she required assistance or advice.
2190. In relation to a Section 862 request, BD stated that there had to be relevant concerns reported for that section to be used, but there were no hard and fast rules.⁴⁹⁰ The reason for this was to ensure that your request was logical and reasonable, and the information gathered by that process was to ensure that you are targeting your investigation in some way.⁴⁹¹
2191. BD was asked questions about the intake process and how that occurred. BD stated that, generally speaking, it would depend how the report was received, either by telephone or email, and then whether the report was typed up either directly onto the system or in a Word document first and then then uploaded to the system. It was her understanding that this report would have been taken after hours and then placed in a tray for allocation.
2192. BD was taken to a request she had made to the Interstate Liaison Officer and the information in page 1303 of exhibit C5 suggests that the father contacted Protective Services prior to the mother making the report. BD could only explain that it was likely a typographical error and that the report was on the 31st not 30th. BD ultimately worked out that it was a communication event, that is a telephone call from Graham Dillon asking for advice about concerns he had that the children's mother was driving overnight to retrieve the children from Canberra.
2193. BD could not account for the reports and information. However, she accepted that it appears that she picked up the report and continued to complete it.
2194. BD also accepted that she had received a report from the mother which included violence towards her when she was pregnant and holding the baby, and that baby was essentially thrown against the wall.
2195. BD accepted the concerns raised by the mother were all significant concerns and said that she would regard some of the incidents described by the children's mother as family violence. BD accepted also that she made a request to Victoria through the ILO for information from them about the family. The Victorian ILO sent back an advice stating that the children were not known to child protection.
2196. BD stated that the reason she wanted to verify the information from the parties concerned was so that she could make a decision either way about that information. No information or verification was given. BD accepted she wrote that there was no need to proceed further, without verification of the information.

⁴⁹⁰ Transcript of Proceedings, p 1611

⁴⁹¹ Ibid

2197. In relation to National Criminal History Checks, it was BD's experience that it was difficult to obtain, particularly in relation to police in New South Wales. BD was not aware of anyone who was authorised to obtain National Criminal Records at CYPS.

2198. BD stated in respect to getting information from third parties at the intake stage that

"As a delegated case worker, you can make those section requests. However, the time in which it takes to do that and wait for the material to be received, I guess, will not then go beyond the time in which you are required to complete a Child Concern Report which is primarily seven days. So depending just - so I think that plays a factor in - and it's also about a least intrusive approach. So we'd always, with Child Protection, you're trying to balance the risk, safety of a child with, I guess, the impact or the appropriateness of the intervention of Child Protection".⁴⁹²

2199. BD stated that it's not that you can't get all the information you require but that it takes time, and this process would be best done in an appraisal setting because of the level of information gathering that's required. BD observed that there is also the factor of what is realistic and that is very subjective.

2200. BD stated that it appears that she did not contact UN. She stated that generally, she would contact DVCS if there were allegations involving family violence. It depended on the circumstances and whether there was a specific incident which would necessitate calling out DVCS.

2201. BD confirmed that it is the practice for workers to cut-and-paste documents from summaries of other documents/ reports, particularly if they were long. BD consider that one must be very cautious when that is being done.

2202. BD was referred to a report about Graham Dillon being rough with his toddler son. The report stated what had occurred and provided information from Graham Dillon as to what he said happened. BD was referred to the actual report which indicated a registered nurse, who is a mandated reporter, who made the observation. There was a lot more information contained in the actual report than what had been cut-and-pasted particularly in relation to who made the observation.⁴⁹³

2203. BD did not concede that she had cut-and-paste that information into the report she received. She stated that she did not write them, but she also may not have put them into the document either.⁴⁹⁴ BD accepted that the content detail was not the same as the original report.

2204. BD accepted that it would be unlikely that a registered nurse would make an allegation that was not true and the level of validity from the report would be higher as they generally have no personal agenda in making reports. BD also considered that they would have value base in applying description of what they saw.⁴⁹⁵

2205. When referred to the original report where BD recommended the report for closer, she stated that she was unable to explain her rationale.⁴⁹⁶

⁴⁹² Transcript of Proceedings, p 1621

⁴⁹³ Transcript of Proceedings, p 1623 – 4

⁴⁹⁴ Transcript of Proceedings, p 1624

⁴⁹⁵ Transcript of Proceedings, p 1625

⁴⁹⁶ Transcript of Proceedings, p 1627

2206. BD confirmed that it was her expectation that material, such as the case consultation, would get scanned onto the CHYPS system around the time she wrote it. BD confirmed that that would also allow the Team Leader to have access to the material.⁴⁹⁷
2207. BD agreed that research shows that results consistently finds that children who have been abused often become abusers themselves.⁴⁹⁸
2208. In respect to guidelines, procedures, and policies, as well as directions, BD stated that they are not necessarily a one size fits all kind of document. These document also reflects the experience of caseworkers over time. This would include the development of thought processes in respect to cumulative harm.⁴⁹⁹
2209. BD also agreed that she would hope child protection agencies would bring in training for their workers to keep them up to date.
2210. BD also agreed that guidelines are not the only information a caseworker may rely on, and that conversations with colleagues would be another resource. That is also true with regard to personal experience that comes as one develops their own expertise.⁵⁰⁰ BD also agreed that an individual's own experience informs their casework.
2211. BD also agreed that, when considering evidence of things such as accidental or nonaccidental bruising, one's own experience and training is important as that experience can assist in the recognition of differences between the two. It can also assist in determining whether to accept explanations that are provided.
2212. BD also accepted that, when examining and assessing certain circumstances of a case, a holistic approach is appropriate. She stated that's the approach that is taken when making decisions about children's safety. The example given in respect to 30 July 2014 case consultation reflects that⁵⁰¹
2213. BD accepted that, in the circumstances, the asterisk points read together would reflect a lesser degree of urgency and taking the children safety into account it was not necessary to take emergency action at that point.
2214. It was suggested that even though there had been disclosures made by JL about being hit and kicked, BD did not consider that this would necessarily indicate that it was unsafe for the children to be with the father overnight.⁵⁰²
2215. Regarding the note written by NL in relation to the interview on 30 July 2014, BD agreed with the conclusions drawn in the case conference with respect to the confidence of the children's safety overnight. BD agreed that she would have expected that further enquiries such as those which were listed under the asterisk points.
2216. BD explained that the phrase 'close appraisal intervention' also means that the appraisal will not be completed until there are no other concerns received or assessments received. She stated that there will be assessing and reassessing

⁴⁹⁷ see Transcript of Proceedings, p 1627.41 – 1628.10

⁴⁹⁸ Transcript of Proceedings, p 1629

⁴⁹⁹ Transcript of Proceedings, p 1911

⁵⁰⁰ Ibid

⁵⁰¹ see Transcript of Proceedings, p 1913

⁵⁰² Transcript of Proceedings, p 1916

throughout the period and this continues until the assessment is cross checked by the Team Leader.⁵⁰³

2217. In respect to having the information about the disclosures, BD suggested that the right process and best practice would be to contact SACAT or the AFP.⁵⁰⁴

2218. BD was referred to the document which referenced the children of Graham Dillon and UN on 11 November 2013. BD confirmed that either an Intake Worker, caseworker or Team Leader would have sat down and written an action plan to be undertaken as part of the appraisal. BD stated that she would have expected any information, such as interviews with the children, to be on the CHYPS system and it was her practice to write this information in the intervention which ultimately ends up as a progress note as well.⁵⁰⁵

2219. In order to investigate the matter at a later time, BD suggested that she was only able to easily access the note if the intervention had their names on it.⁵⁰⁶

EJ – Intake Team Leader

Statement

2220. EJ has worked as an Intake Officer for CYPS since 2008. She has also worked on the joint investigation and response team with New South Wales Family and Community Services on the Central Coast. In June 2015 EJ was an Intake Team Leader for CYPS.

2221. EJ adopted processes in line with the Children and Young Persons Act 2008 and CYPS policy. Broadly, as a Team Leader, she would review the intake form for assessment and endorsement as soon as applicable. EJ reads the form in close detail, assessing whether there is any abuse or neglect present as part of the reported concerns.

2222. EJ may research the files depending on the nature of the assessment and form her view of any historic interventions. This is to understand the family dynamic the child's lived experience and the consequences of any previous interventions by CYPS.

2223. EJ will then review the intake form and check to see whether investigations have been conducted and whether any further investigation is required. If there is a need for further investigation, EJ would contact the Intake Officer and discuss what further information is required.

2224. In doing so EJ would discuss the history and vulnerabilities of the children, as well as suggesting whether there is any experienced cumulative harm.

2225. Once EJ has satisfied herself that the relevant information has been obtained, a determination will be made as to whether the outcome recommended by the Intake Officer is appropriate. If a recommendation that there is a reasonable suspicion of abuse or neglect is endorsed then a Child Protection Report must be escalated.

⁵⁰³ Transcript of Proceedings, p 1915

⁵⁰⁴ Transcript of Proceedings, p 1916

⁵⁰⁵ Transcript of Proceedings, p 1918

⁵⁰⁶ Transcript of Proceedings, p 1920

2226. If EJ considers that there is no information supporting such a conclusion, then she may take no further action if it is considered that the issues raised could be managed by the current casework or if the matter could be referred to the AFP if the report involves the commission of a criminal offence, or if appropriate the family could be engaged with on a voluntary basis or a case conference be conducted with the family to address specific issues.
2227. Once EJ is satisfied that a sufficient initial assessment has been undertaken, and the recommendations are appropriate, she will then endorse the recommendation. Generally, she will record a brief summary of her reasons as to why she has endorsed the recommendation.
2228. In respect to the intake report received in relation to JL and Bradyn Dillon on 26 June 2015, EJ received an intake form from TN between 6 and 8 July 2015. EJ had no recollection of this report but believed she would have followed her general endorsement process.
2229. It was EJ's view that following the content of the report she concluded that the issues were mainly related to a dispute regarding family or custody arrangements between the parents; potential relationship difficulties between the children's father and his new partner, as well as the children's uncles belief the children were malnourished being in the context of the difficult relationship between the children's uncle and the father. There were also reports of the father driving erratically with the children in the car, poor attendance at school for both children, the fact that the father looked like he was using methamphetamine, the father's violent relationship towards the mother when they are in a relationship, and the mother had seen the children five months earlier. However, all of this information was not firsthand.
2230. It was EJ's view that only certain of these matters were relevant for Child Protection and matters such as relationships and Family Court proceedings were not normally within CYPS's area to intervene unless there is related issues that pose risks to the safety of the children.
2231. It was EJ's view that the only the allegation was the one relating to the physical abuse of the children whilst in the father's care. There was no assertion that the father physically harm the children.
2232. EJ concluded that the Intake Form showed that TN had contacted the children's school and that was appropriate. TN obtained information that indicated the school were concerned at the level of attendance. It was suggested in the Intake Form that the school was dealing with the non-attendance but there was some explanation given by the father. The Form disclosed that Bradyn was well behaved, presented well, and attended school appropriately clothed with adequate food. This would tend to suggest that the children were not malnourished. There was no suggestion that the father had ever been observed to be drug affected.
2233. EJ concluded from the conversation that the father had with TN showed that he was honest about his difficulties and that he was receiving help from community groups for his mental health.
2234. It was suggested that much of TN's information came from the father. It was also noted the father had friends who could support him if he felt overwhelmed. It was EJ's view

that TN's analysis and the conclusions drawn from that analysis were appropriate and based on the contents of the report, and on the information gathered by TN.

2235. EJ said that she placed great weight on the protective factors in place such as the children being at school and the family receiving community-based services support.
2236. It was EJ's view that the recommendation was appropriate, particularly given that the school did not indicate any cause for concern regarding the well-being of the children only that they had an erratic attendance.
2237. EJ endorsed TN's recommendation and stated that she believed that the endorsement and those reasons were still appropriate.
2238. EJ suggested that given there were reports of drug use but no further information it was difficult to assess whether Graham Dillon was using drugs which may harm the children.
2239. I note that nobody considered whether Graham Dillon should take a drug test to ensure that he was not taking methamphetamine.⁵⁰⁷
2240. EJ considered that from a holistic view, nothing in the report suggested that anything further should have been done.
2241. In respect to calls to CYPS, there is only one record that SK contacted CYPS and that was on 26 June 2015 which matches with the Intake Form.
2242. EJ stated that since Bradyn's death there has been greater collaboration and information sharing, as well as updating of reports and examples of best practice.
2243. There was also mandatory training in family and domestic violence, which now responds to reports of domestic and family violence holistically.

In Evidence before the Inquest⁵⁰⁸

2244. EJ stated that she was an Operations Manager of Intake and After Hours at CYPS.
2245. In 2015 she was a Team Leader at CYPS. In July 2015, CYPS was in the process of completing a restructure of the organisation. At that point EJ went into an intake role from a Family Work team. This was a transfer to a completely different area. EJ went into that area as the Team Leader but did not have any specific training in relation to the new position.⁵⁰⁹
2246. EJ's work consisted of allocating work, triaging the child protection inbox, and allocating work according to the ability and experience of staff members. Her role was also to oversee the caseworkers work and endorsed that work.
2247. EJ described that once information is received, she considered that information, assess it in terms of immediate response, in accordance with whether it's medium risk or low risk or high response, then allocated accordingly.

⁵⁰⁷ My emphasis

⁵⁰⁸ Transcript p 1993 – 2043.

⁵⁰⁹ Transcript of Proceedings, p 1994

2248. EJ considered that was not possible to examine all of the reports, given the large volume. However, that is something that can be done if required. EJ stated that she would definitely look at the report information to see what the concerns were about and then look at the Intake Worker's completed report.
2249. EJ agreed that there were risk assessment framework policies at the time in 2015 and outlined them.
2250. When asked whether she was Team Leader for TN, EJ stated that she could not recall as EJ was only there for four weeks. Despite not having any training in the area, TN had very many years of experience in child protection and was aware of the basic steps she needed to take to inform herself of the presenting information given by the Intake Worker.⁵¹⁰ That also included verification of the information received by the Intake Worker.
2251. EJ suggested that at that time supervisors were dealing with between 1200 and 1800 cases a month. There were three supervisors.
2252. EJ agreed that number of cases equated to each Team Leader having approximately 600 cases per month to review, which was an extremely busy case load. EJ stated that does not include all of the other work that needs to be done, including supervision, meetings, and other similar activities.⁵¹¹
2253. EJ stated that the new system, CYRIS is a lot more sophisticated, quicker, and less cumbersome than the previous data base. The system now makes the levels of risk or amount of risk are more visible than when they had the old system. That is because of the triage system is now within the new database and the database can be utilised that way.
2254. In respect to the endorsement of the Intake Concerned Report, if EJ was not satisfied with the investigation of the sources of information, she would discuss that with the Intake Officer.
2255. In respect to the issues of cumulative harm the criteria, EJ suggested she would consider was
- “I think if children are subject of neglect for a considerable period of time and we have continued reporting that there is a pattern developing and there is no change, then you can assume that it is likely that the children will be experiencing or have cumulative harm at some point.”⁵¹²
2256. Regarding the 14 reports about Bradyn and JL, and the question of cumulative harm, EJ opined that seven reports were received in relation to family violence and the mother's substance misuse, and five were in relation to allegations of physical abuse.
2257. EJ opined that 14 reports may seem a lot of reports but in relation to the families that they work with it is quite a low number.⁵¹³ EJ clarified that position by stating that one

⁵¹⁰ Transcript of Proceedings, p 2000

⁵¹¹ Transcript of Proceedings, p 2043

⁵¹² Transcript of Proceedings, p 2003

⁵¹³ Transcript of Proceedings, p 2004

report is too many on any family, but in terms of some of the families that are reported to CYPS, that's quite a low number.⁵¹⁴

2258. EJ stated that, given the information on this case that they had to hand at the time, she would probably endorse the case as 'no further action' which she considered hard to say given the outcome.⁵¹⁵

2259. In respect to the source of the information that was relied upon in this referral, EJ stated that would not happen today as CYPS would not contact the father to get that information.⁵¹⁶

2260. EJ stated that at the time there was no policy in relation to contacting the possible perpetrator of the alleged abuse as a resource.

2261. EJ stated that she would expect that the report writer would contact the sources to verify the accuracy. However, that is not possible because of the lack of capacity of staff and the volume of cases at that time. Given the system was being rolled out it was difficult to fully analyse reports such as this.⁵¹⁷

2262. EJ agreed that the Intake Officer could have spoken to the actual source of the report and that would been best practice.⁵¹⁸

2263. EJ stated that the new system guides Intake Workers and Team Leaders through a process in which it is difficult to move on to the next step if you haven't completed step previous to it. The new system provides consistency and uniformity.

2264. EJ stated that there is now a multi-agency, weekly meeting with DVCS, CYPS and Police to discuss particular cases which come to the attention of Police so that they can be cross-referenced with the DVCS and CYPS. Canberra Rape Crisis Centre and SACAT attend the CYPS office a half day per week.

2265. The Department now runs mandatory training in domestic violence, which is held off-site and provided by external providers. EJ confirmed that she was not given sufficient time to examine policy documents in relation to the new role in 2015 and that this affected her ability to complete the role to the highest possible standard. EJ said

"it would have been helpful to have some breathing space to have a look at what the legislation said in relation to reporting and some of the policy and procedure documents".⁵¹⁹

2266. In respect to recommendations that the Coroner might make, EJ opined that there is a need for a resource capacity strategy to be put in place relating to the lack of resource capacity.⁵²⁰

2267. It was suggested to EJ that there had been 14 previous reports, five of them being allegations of physical abuse whilst in the care of the father, together with some recent information about police attendance, given those pieces of information it was her view

⁵¹⁴ Ibid

⁵¹⁵ Transcript of Proceedings, p 2005

⁵¹⁶ Transcript of Proceedings, p 2007

⁵¹⁷ Transcript of Proceedings, p 2010

⁵¹⁸ Transcript of Proceedings, p 2023

⁵¹⁹ Transcript of Proceedings, p 2023

⁵²⁰ Transcript of Proceedings, p 2015

that because a number of historical appraisals had not been substantiated, this would have influenced her analysis of the case.⁵²¹

2268. In respect of the previous reports, including that the children had previously disclosed abuse, EJ stated that this information would certainly have changed her view when assessing the matter. This was the same about the fact that the children had been assessed by CARHU, who had found that bruising was of concern.

2269. EJ confirmed that it would have been possible, and quick for the intake offers to make a phone call to some organisations such as CanFaCS and the Salvation Army as well as fairly quickly making a request to Police.⁵²² However, a caveat was placed in that whilst it is best practice to do so, there is uncertainty as to the capacity for the worker to be able to do that.

2270. In respect to questions about whether the children's mother, who was the reporter, would have access to the results of the assessment, EJ stated only mandated reporters are made aware of an outcome of a report.⁵²³

2271. EJ was referred to page 1118 of exhibit C5, the intake report, EJ stated that the Intake Officer would consider the prominent feature of the report which applies to CYPS issues. The other issue, which may be for other agencies to deal with, are not factors which they would take into account.

2272. EJ stated that the main feature of the report was the malnutrition issue. The Intake Officer contacted the school in that regard, and was advised that the children wear warm clothes, come to school with food, and are well behaved and well presented. Those issues were prominent for CYPS and they were addressed by contacting the school. In relation to absenteeism that could be a CYPS issue, but the school would need to exhaust its legislative remit.

2273. In terms of past history and the relevance of previous disclosures, together the CARHU report, given that this report about malnourishment, rather than injury, the focus would be on questions in regard to malnourishment rather than anything that is historical.⁵²⁴

2274. EJ agreed that in relation to information received that the police have been involved with the family at some stage, does not necessarily require demands of police to produce documents on every occasion otherwise they would inundate police.⁵²⁵

2275. EJ agreed in respect to a report of a disturbance involving Graham Dillon, that having read the narrative it was clear that there were two versions of events and the Police had made some enquiries. EJ agreed that the version of events given by Graham Dillon to TN was not the same as the version in the police report.

2276. EJ stated that having considered the documentation overall and having been made aware of that incident, she may have asked for further information to be gathered. That

⁵²¹ Transcript of Proceedings, p 2019

⁵²² Transcript of Proceedings, p 2026

⁵²³ Transcript of Proceedings, p 2027

⁵²⁴ Transcript of Proceedings, p 2032

⁵²⁵ Transcript of Proceedings, p 2034

is because the Police gather evidence on the basis of being able to prove beyond reasonable doubt whereas the test for CYPS is probability.

2277. EJ opined that something was going on that night and in her experience victims of violent relationships often do not want to provide statements to police nor engage with the DVCS.⁵²⁶

2278. EJ opined that she would have wanted some further information as to what occurred that evening. EJ said that if TN had incorporated that additional information into her analysis and information gathering she may have asked further questions. Although she also accepted that the matter was complex because there are two versions of events and it is often difficult to understand the complexities as things can change and ultimately the outcome would or could have been the same.⁵²⁷

2279. EJ considered that the Intake Worker had been presented with no evidence which could established what factually occurred. However, EJ accepted that there was no further examination of that matter and that it would have been beneficial to make more enquiries.⁵²⁸

2280. EJ accepted that had CYPS had access to the police files relating to reports of disturbances, as well as the use of jerry cans and threats of the use of fire, it was highly likely that the reports would have been of interest as to whether further action would be taken in the matter.⁵²⁹

2281. EJ accepted that as a Team Leader, there was not enough time to review all the material available, nor was there enough time to review the policies and procedures.

2282. EJ stated that the case workers did not have enough time to review all of the information on the CYPS files in order to respond to the task at hand.⁵³⁰ EJ further stated, that the case workers did not have enough time to thoroughly assess and examine the case history and that this is still the case for all matters above level 1.⁵³¹

2283. EJ stated that if the matter is triaged at level 3, it is physically impossible to undertake a process of review of all historical matters on the system. Where that level 3 matter results in no further action being taken, there is no further involvement with the Department other than perhaps referrals to non-government organisations.⁵³²

2284. EJ stated that in terms of referrals there was and still is a gap for children aged 7+, however, for under-fives there are a number of services available.

2285. In relation to practice and policies, it was EJ's view that caseworkers did not have enough time to become familiar with them and the greater priority would be to review the CHYPS files.

2286. EJ opined that the Child Concern Reports are an initial assessment and given the volume of cases, considering up to 19,000 reports coming through, they would not

⁵²⁶ Transcript of Proceedings, p 2036

⁵²⁷ Transcript of Proceedings, p 2037

⁵²⁸ Ibid

⁵²⁹ Transcript of Proceedings, p 2040

⁵³⁰ Transcript of Proceedings, p 2040

⁵³¹ Ibid

⁵³² Ibid

have capacity in any of the Departments to do a comprehensive investigation on each and every one of them.

2287. EJ stated that the legislation is 'caller defined' rather than 'Department defined'.⁵³³

2288. EJ said that if the information which had been provided by Graham Dillon had been further investigated and found to be false and that he wasn't engaging with those services it is highly likely that the matter would have been sent for a Child Protection Report.⁵³⁴

2289. EJ agreed that when looking at each report a holistic approach would be appropriate and that prior reports would fall into that category.

HC – Intake Officer (HP 3 Level)

Statement

2290. HC was an Intake Officer with CYPS in August 2015. She was a level HP 3. She had worked with the CYPS since 2006 as an Intake Officer.

2291. HC set out the requirements for an initial risk assessment and what is required to determine the risk to children. These included obtaining relevant documentation and information about the children and the report, gathering information about the child's circumstances and history, addressing safety and risk factors and potential needs. Then you had to determine whether a suspicion has been formed on reasonable grounds that the child may be in need of care and protection. It also had to be decided whether the matter should proceed to a protection report.

2292. HC also explained the statutory requirements she must adhere to. HC explained the requirement to classify the type of harm alleged. In order to make such a classification a review of past involvement was necessary to determine any patterns of behaviour. Insights about current concerns include opinions of managers as well as themes evident throughout reports made about their living circumstances, relationship dynamics and other similar matters.

2293. HC also suggested she would sometimes review records for other siblings or family members to obtain a picture. There is also a necessity to examine presenting risks including previous allegations, parental drug use, parental mental health challenges, housing instability, criminal activity, and relationship breakdowns.

2294. HC included that the assessment includes gathering information from relevant entities such as the Police, housing, and other similar entities. Having examined the risk factors she determines what the family needs by way of home support, mental health support, parent education and referral to advocacy services and community supports.

2295. HC stated that her assessment and information gathering must be and was assessed by a Team Leader and if insufficient information is gathered or analysis is insufficient, the form will be returned for a resubmission.

2296. HC was responsible for receiving a Child Concern Report via email on 12 August 2015 in relation to Bradyn Dillon. HC explained that she classified the report as a 'neglect',

⁵³³ Transcript of Proceedings, p 2041

⁵³⁴ Transcript of Proceedings, p 2042

because from her experience there are many causes of bruising on a child, and it cannot be automatically assumed to be physical abuse (particularly given that Bradyn had reported the bruises were as a result of falling off his bike).

2297. Although HC does not recall the intake, considering her usual practice she would have determined whether he was at risk of immediate harm. She did not believe that he was because there was no allegation of physical abuse and (at face value) there was a reasonable explanation for the injury and there was no information to suggest Bradyn was fearful of his parents or caregiver. HC also did not consider it necessary to contact SACAT because, from her viewpoint, there were no allegations of abuse or disclosures of such.
2298. HC may have reviewed JL's file but cannot recall whether she did so. HC included that she would have reviewed the recent appraisal of Bradyn and noted the similar observations made and that the father was willing to engage and protect children. HC also noted that there was a CARHU report as well which indicated there were no concerns about bruising to Bradyn's face but the bruise to his ear was of concern. HC noted that there was positive interaction between the children and their father noted in the report.
2299. HC also said that she considered contacting the parents but declined to contact the mother given there was an alert on CHYPS advising not to disclose the children's address to the mother. Therefore she opined that the mother could not provide any assistance.
2300. HC said she contacted the father to ascertain the level of knowledge about the bruising and to see whether there was a reasonable explanation for it. HC explained that the father did provide a plausible explanation for the bruises to his face. That included that he had a new bike which was slightly too big for him and he kept falling off and hit his head on the handlebars. That was consistent with the advice from Bradyn, and HC came to the conclusion that it was credible that a handlebar could leave a small bruise on the child's face if he fell awkwardly.
2301. The father also told HC that he was receiving support from CanFaCS which indicated an objective person was attending the home and had eyes on the child. Further, the children were attending school and would be exposed to mandated reporters on a daily basis.
2302. On that basis, given the information available, the assessment was no further action. The assessment was endorsed.
2303. I note that there is no one who actually looked at the bruising, if they had it would have been clear that the bruising was not consistent with the alleged bike excuse.⁵³⁵
2304. HC recognises that she made the decision not to refer the report of bruising, the case was closed and six months later he was violently killed by his father. Whilst HC wishes that she had made a different decision, she explained that on a typical day she had between four and eight reports to investigate and complete. Those reports varied in urgency and priority.

⁵³⁵ My emphasis

2305. I would not that it seems as though HC's investigation and that of the other caseworkers was basically on the papers rather than obtaining any actual verifiable evidence.⁵³⁶
2306. HC went on to explain the process of receiving reports in relation to Child Protection and that the system depends on the reporter, the quality of the records available and a decision taken by the individual officer. HC acknowledged that others may have made a different decision, but in her view there was an explanation for the bruising, and it was corroborated by Graham Dillon. Despite the fact there were previous reports of face bruising, it was her view that the reports of those were not substantiated.
2307. HC reflected that she has since Bradyn's death undertaken in-depth training in respect of family violence and trauma informed practice. Clearly she recognises that it can be difficult to identify if a parent is being truthful and not coming clean to Child Protection.
2308. HC indicated that she had been deeply affected and saddened by Bradyn's death, and opined that it is a constant reminder of our important Child Protection work is but also the enormous consequences if the system doesn't work as it should.
2309. In relation to what she would do now if he had the same situation presented to her as it did in August 2015, HC indicated that she would conduct the same analysis but would also contact the reporter to provide any additional information which might require further investigation.

In Evidence before the Inquest⁵³⁷

2310. HC commenced work at CYPS in 2003 as an Intake Officer on the after-hours service. At the time of giving her evidence her level was HP 3. HC stated that at the time of her commencement she did not recall having training or induction and that she learned on the job,⁵³⁸ however she had been working as a Child Protection worker in South Australia before she came to Canberra.
2311. HC stated that at some point she did have access to policy and procedure documents in relation to carrying out her duties. This would have been after an enquiry which occurred around 2004 – 2005. The policies and procedures were located in folders which were available to the workers.
2312. HC stated said that the 'knowledge portal' is now where policy and procedures are and that is accessible online.
2313. HC was taken to exhibit C129 which is the policy and procedure folder. HC said she was familiar with this document. In respect to the intake and appraisal procedure HC would have had one in a hard copy which was on her desk.
2314. HC stated that the policies and procedures in her view have been updated. In the 2014 – 2015 period, HC stated that all the workloads were very high, and they did not

⁵³⁶ My emphasis.

⁵³⁷ Transcript pp 2051 – 2117.

⁵³⁸ Transcript of Proceedings, p 2053

get to every single report that they received. There was also a lot of pressure to get the work done, so access to policy and procedure would have been of less priority.⁵³⁹

2315. During the period 2014 – 2015, the workload was extremely busy, and they had a number of Team Leaders during that time, particularly around July 2015.⁵⁴⁰ HC said that there was a lot of sick leave at the time and that added to the busyness of the teams. Depending on the shift that HC worked she would also have different Team Leaders.⁵⁴¹

2316. HC was taken to the seven-page practice guideline in relation to threshold decisions which she said she believed she had seen. HC was also taken to a six-page practice guideline recognising abuse and neglect which she was familiar with, and also one in respect to initial risk assessment. These documents guided her work.⁵⁴²

2317. HC accepted that intake is effectively triaging information, assessing that information and making determinations in recommendations. Given the enormous workload when a report came in, the review of the CHYPS file was quite minimal and would often only be for the 12 months prior to the report. If there was not a lot of reports for the 12 months, they would often delve deeper into the history. How far would be a judgement call.⁵⁴³

2318. In respect to the process undertaken when a report comes in, HC stated that she would first of all enter into the client details screen and then probably the events screen and depending on the length of that, may also look at the family viewscreen as well.

2319. HC said that she considered that she was highly experienced given she had been working in the field for 9 years. Generally, she would, as an Intake Officer, refer to the policy practice guidelines that are current, however on a day-to-day basis she doesn't have time to do so.⁵⁴⁴

2320. In respect to how she undertakes her tasks, HC said that she would particularly pay attention to the recent information because of the time constraints and because the recent information may provide insight into the issues. HC said that in times of high volumes of reports she would not have time to go back more than two years.

2321. HC said the time it takes to typically undertake a review depended on the severity of the information and allegation received. It could take anywhere from an hour to 4 hours depending on the information. In 2014/2015 there was no triage system that she recalled.⁵⁴⁵

2322. HC said that she would not go deeply into the CHYPS system other than the initial areas she has already described. For example, she would not look at the progress notes, generally speaking.

⁵³⁹ Transcript of Proceedings, p 2056

⁵⁴⁰ Transcript of Proceedings, p 2057

⁵⁴¹ Transcript of Proceedings, p 2058

⁵⁴² Transcript of Proceedings, p 2059

⁵⁴³ Transcript of Proceedings, p 2060

⁵⁴⁴ Transcript of Proceedings, p 2062

⁵⁴⁵ Transcript of Proceedings, p 2064

2323. HC stated that if she had any issues that needed to be resolved, or any advice she needed to discuss she was able to contact a Team Leader providing one was available. During July 2015 it was a very busy with the amalgamation and often Team Leaders were not available (particularly in the afternoon).
2324. HC stated that after completing the analysis and submitting it to the Team Leader it was not uncommon for her recommendations to be endorsed.⁵⁴⁶
2325. HC stated that she was aware there was a review to be completed and was not aware of the Muir Review, was aware of the Glanfield Inquiry but has not read it.
2326. In respect to a report from October 2013 when she was the Intake Officer, HC said that it's likely that she could have reviewed at least 12 months but unlikely it went more than that. HC has no independent knowledge of entering the report. HC stated that she would like to think that she would have considered the material in relation to the siblings that was on the file as it is best practice.
2327. In respect to the October 2013 report HC said she started that report on 10 October 2013 but did not complete it. That is not unusual and still occurs presently. When that occurred, there was no exchange of information it was just handed over to be completed.⁵⁴⁷
2328. Generally, the system is now as it was then, that the matter was entered into the system, triaged, and another worker would come to complete. There was no particular hand over.
2329. In relation to the 12 August 2015 report, she was the Intake Worker. That report was from a teacher who indicated that Bradyn had presented at school with 4 small bruises to his left cheek and some seven days later had bruises on his right cheek. The first week the explanation was that he fell and hit his cheek on the handlebars of his bike and the second explanation was that he didn't know. HC said she could not recall the report so did not recall what her understanding was of what the report meant.
2330. HC understood that that meant that there were two separate incidents one week apart. HC was asked why she placed on the report that she had written that it did not contain any specific allegations of nonaccidental injury. In her statement she recorded that
- "as a consequence, bruising, marks or injuries on a child often cannot automatically be assumed to indicate physical abuse".⁵⁴⁸*
2331. HC stated at the time she could not recall the particular policies; however, she now understands bruising to the face is an unusual occurrence. HC was referred to the policy on accidental bruising which states that repeated or multiple bruising on the head or on sites unlikely to be injured accidentally, bruising around the face, handprint belt marks, hairbrush grasp marks on small children must be considered nonaccidental unless there is evidence, or an adequate explanation provided. HC agreed that the policy is that they are to be considered nonaccidental unless otherwise explained.⁵⁴⁹

⁵⁴⁶ Transcript of Proceedings, p 2066

⁵⁴⁷ Transcript of Proceedings, p 2069

⁵⁴⁸ Transcript of Proceedings, p 2072

⁵⁴⁹ Transcript of Proceedings, p 2073

2332. HC stated that if she had been given that information now, she would have made further enquiries about those bruises
2333. I would note that the question is why she did not do so at the time given the policy on bruising to the face.⁵⁵⁰
2334. HC stated that if the information presented to her now, she would consult a Team Leader and potentially CARHU.
2335. HC was taken to the outline of the history that she provided in her report which included a reference to the children being returned to their father and describing being physically abused by him. HC said that she obtained that from the CHYPS. HC also recorded that the father had been in prison for violent crimes and there was a pattern of violence within his relationships. The history also revealed that there had been previous reports of bruising to the children with no explanation. That occurred over a five-month period. HC had that information together with the report that she was examining and yet, ultimately, recommended no further action.⁵⁵¹
2336. HC said if she had the same information today, she would ask the police to assess the situation, contact CARHU and consult with others about the possible causes of the bruising and consider whether an appraisal should proceed.⁵⁵²
2337. In respect to cumulative harm, HC said she now understands what it means but does not recall whether she had the same degree of understanding in 2015.⁵⁵³ Since that time she has done her own education in respect to various matters as well as receiving training in respect of family violence, trauma informed care and sexual abuse.⁵⁵⁴
2338. In respect to the schoolteacher making the report which would normally come in via email, today she would contact the reporter to make further enquiries as to the nature of the information.
2339. In respect to the actual report, HC agreed that she contacted Graham Dillon and he gave a different story to that of the teacher. Generally speaking, she would not contact the alleged perpetrator unless she had consulted with her Team Leader. However, HC indicated that there was no perpetrator. This was despite the history on the system, and she cannot recall whether she had considered that he may well be perpetrator.⁵⁵⁵
2340. HC opined that even today workers would need some form of allegation or direction as to what they are investigating.
2341. HC also agreed that it would appear that she accepted what Graham Dillon had told her despite the teacher having a different viewpoint and she did not, it would appear, contact the schoolteacher to clarify or investigate the matter further.⁵⁵⁶
2342. In relation to the report at page 1109 of exhibit C5, HC stated that she could not recall the specific file and had ticked the box 'no identified safety concerns'. HC stated they

⁵⁵⁰ My emphasis

⁵⁵¹ Transcript of Proceedings, p 2075

⁵⁵² Ibid

⁵⁵³ Transcript of Proceedings, p 2076

⁵⁵⁴ Ibid

⁵⁵⁵ Transcript of Proceedings, p 2079

⁵⁵⁶ Transcript of Proceedings, p 2080 and my comments at 2082.35

rely on the reporters and the files to indicate whether there are safety concerns or not, but that is specifically related to the workers going to the home.⁵⁵⁷

2343. In relation to whether there are alerts on the system, HC stated that there are, and you basically see them when you go into the client file.

2344. In relation to the criteria for the analysis of future abuse or neglect, HC stated that they would usually examine the file to predict on the balance of probabilities whether there is a risk. HC stated that now what she would do is look for patterns and now with the benefit of hindsight she would have had a completely different view of the report. Having been given the time to actually reflect on it, she would have gone in a completely different direction.⁵⁵⁸

2345. HC agreed that she did accept the father's denial about the bruising being on both sides of the face and that it occurred because he fell from his bike. However, disagreed that she rejected the teachers report stating that it was not that black and white.⁵⁵⁹

2346. HC stated that it is not a question of rejecting the allegations, it's a question of whether she had enough information to proceed to an appraisal and that needed a determination of whether the child needed care and protection.⁵⁶⁰

2347. Following from that, HC agreed that if a determination is made for no further action and there are no further options offered to assist family that is the end of CYPS involvement.⁵⁶¹

2348. HC agreed that the role of intake is a triage role and is a very critical role and would require experience of the highest level. HC opined that over the last few years they had lost most of their experienced workers and are now dealing with a lot of graduates who do not have that experience. HC stated that is of extreme concern.⁵⁶² HC was of the view that it required the level of HP 3 or above.

2349. In relation to areas for change, staffing was a significant issue. The issues were quantity of staff and experience of staff. HC opined that not only would staffing numbers need to be increased in intake but also at the appraisal area.

2350. In relation to the system that is used, HC agreed that might be useful to have a pop-up tool to remind the worker of the policy underlying the issue that they are trying to determine.⁵⁶³

2351. HC stated that she is aware of what reflective practice is, although they never have time to engage in it and there has been no formal reflective practice in respect to Bradyn's death, although HC has engaged in her own personal reflection.⁵⁶⁴

⁵⁵⁷ Transcript of Proceedings, p 2085

⁵⁵⁸ Transcript of Proceedings, p 2080

⁵⁵⁹ Transcript of Proceedings, p 2086

⁵⁶⁰ Ibid

⁵⁶¹ Transcript of Proceedings, p 2087

⁵⁶² Ibid.

⁵⁶³ see Transcript of Proceedings, p 2088.30

⁵⁶⁴ Transcript of Proceedings, p 2089

2352. In respect to considering the risk assessment, HC stated that the workers use a risk assessment framework together with the information at hand and the allegations and current information.
2353. In relation to whether a parent is protective or not it is a difficult assessment because parents are not contacted immediately, whereas the previous practice was that they would be contacted right away. HC stated that if it were a parent who was making a report that would be easy. However, if it was someone else then they would need to look at the information on the file and consider whether or not the case should go to an appraisal. The process would be to consult with the Team Leader as to whether direct contact with a parent would be appropriate.⁵⁶⁵
2354. In respect to whether she would act differently knowing what she now knows, that was a difficult question to answer as she was looking at it from a different viewpoint and with a completely different set of tools to what she had back then.
2355. HC stated that in considering her approach she would look at the most recent intakes, the appraisals and what occurred and rely on that information. HC also stated that when she assesses intake reports they look at the specific reports (had there been any disclosures previously) and they would be considered but are not necessarily heavily weighted, particularly if those reports had not been substantiated.⁵⁶⁶
2356. HC stated that had she known of the disclosures made by the children about their father hitting them on the head and kicking them up the bum (whilst she does not recall seeing that document), if she had known those facts she would have taken them into account, and this may have given rise to a reasonable suspicion potentially.⁵⁶⁷
2357. HC stated that there is now a triage system identified as a traffic light system and considers age, vulnerability, and allegation.⁵⁶⁸ In relation to the report that she dealt with, in hindsight HC accepted it could potentially be nonaccidental injury.
2358. It was suggested that if there has been an allegation of nonaccidental injury by school, part of the intake role could be to attend the school. HC stated that in this particular matter she would not be going to the school as that would be the role of a caseworker.⁵⁶⁹ She stated that it could potentially take up to 5 days for a caseworker to attend.⁵⁷⁰
2359. HC agreed that a mandatory reporter such as a teacher would generally be an independent and reliable source of information.⁵⁷¹
2360. HC stated that the information from the intake source is generally copied from the email received onto the system.
2361. HC was taken to the various reports which she had included in her report which she had some knowledge of. She was unable to explain why the only person she contacted

⁵⁶⁵ Transcript of Proceedings, p 2091

⁵⁶⁶ Transcript of Proceedings, p 2096

⁵⁶⁷ Transcript of Proceedings, p 2099

⁵⁶⁸ Transcript of Proceedings, p 2108

⁵⁶⁹ Transcript of Proceedings, p 2110

⁵⁷⁰ Ibid

⁵⁷¹ Transcript of Proceedings, p 2111

in her preliminary investigation was the child's father. HC accepted that in hindsight she should not have relied on the information from the father as the sole source of information in her investigation.⁵⁷²

2362. HC also accepted that given there was a discrepancy between the mandated reporter and Graham Dillon, in hindsight it would have been appropriate to contact the mandated reporter to confirm the information she gave.⁵⁷³

2363. HC accepted that a narrative had evolved which reflected adversely upon the mother and that the family situation overall was complicated. It was HC's experience that the family had become extremely convoluted and complicated.

2364. HC accepted that the job undertaken by her was high-pressure with high-volume and lacking resources and accepted that she could have been suffering from it.⁵⁷⁴

2365. HC said the following

"Over my time as an Intake Officer I have had sleepless nights thinking about my risk assessments, if a particular decision I have made is safe and if there was something I missed, or if I have made a different decision I wondered how' - 'I have wondered about this decision I made about the Child Concern Report received on Bradyn in August 2015 and what I could have done differently to change the outcome for Bradyn. Overall, this has been a deeply confronting experience and it is difficult to articulate how Bradyn's death has personally impacted on me as an individual and how it has impacted on my work'. 'Bradyn's death has deeply saddened me and it is a constant reminder of how important Child Protection work is, but also ... (inaudible) ... consequences if the system doesn't work as it should. I am acutely aware of how important the decisions are that I make on a daily basis and the potential impact on a child's life, and I extend my deepest sympathies to his family'.⁵⁷⁵

TN – Intake Officer (HP 3 Level)

Statement

2366. TN commenced work with CYPS in March 2003. Between 2008 and May 2014 she held various positions in other employment. When TN returned to CYPS in June 2014, she was a HP three level worker and worked in the Intake Team as an Intake Officer.

2367. TN, in her statement, outlined how she would process her intake reports and stepped through the provisions of the *Children and Young Persons Act* and the CYPS policy. TN said that she broadly adopted the same process of assessing information and considered whether there was an immediate risk of harm and if the escalation of a report to a Team Leader for urgent action was required.

2368. TN said she would undertake a review of the children's relevant information on the database and gather information in relation to the allegations made in the report including from community members; school or day-care providers; medical professionals; and family members.

2369. TN outlined that she made her assessment based on background and contemporary information and subsequently formed an opinion on the probability of risk of abuse or

⁵⁷² Transcript of Proceedings, p 2112

⁵⁷³ Transcript of Proceedings, p 2113

⁵⁷⁴ Transcript of Proceedings, p 2115

⁵⁷⁵ Transcript of Proceedings, p 2116

neglect. She also made an assessment on whether a parent is willing and able to protect their child/children.

2370. TN indicated she follows the process outlined in the CYPS risk assessment framework and that when doing so she formed a reasonable suspicion the child may be need of care and that the report must proceed to a Child Protection Report.
2371. On 26 June 2015, TN was the Intake Officer who received the call at 2:13pm in relation to JL and Bradyn Dillon. The call was from Bradyn and JL's mother, SK. The intake form – exhibit C5 pages 117 to 128 - is, in her view, an accurate record of the information from the intake source.
2372. The information, in summary, provided by SK was that the children were living with their father, Graham Dillon, that they were malnourished, were not attending school, that the father was misusing illicit drugs, that he had been seen erratically driving the children in a car, and that he had, in the past, been a perpetrator of domestic violence towards SK.
2373. There was some further information provided by SK that TN did not consider to directly impact on the immediate safety of the children. TN characterised the concerns raised by SK as abuse/neglect and that the majority of the allegations were in relation to different types of neglect.
2374. TN opined that if the children were malnourished that would appear to be a clear case of neglect, and if the children were not attending school that could also be characterised as neglect. Illicit substance use may further pose risks to the children. However, it was her view that SK did not make any allegations of physical abuse towards the children that was connected to any drug use.
2375. TN said that, in response to the report, she reviewed the history of JL and Bradyn's involvement with CYPS and recorded a summary of that history on the intake form. TN noted that CanFaCS and the Salvation Army were supporting the father. She noted that the children were attending ACT Primary School 2 and called and left a message with the principal and deputy. She had not received a reply by 3 July 2015 and sent an email to the teacher at the ACT Primary School 2 asking for a return call.
2376. There was a conversation with the school in respect to the children's unexplained absences and what processes would be adopted to address this. What was provided by the schoolteacher, SU, did not cause TN to believe that any urgent action was required. However, SU was not able to give detail about the factors leading to the report and that later she was advised that the teachers observed Bradyn in appropriate clothing and adequate food and had previously spoken to the children's father and nothing of concern was raised.
2377. TN phoned Graham Dillon on 6 July 2015. Graham Dillon believed the children were fine. He said that he had a car license, was taking prescription drugs, and did not use amphetamines. He said that he remained link with CanFaCS and the Salvation Army.
2378. TN said that she analysed the information that she had gathered from the children's records, the school, and Graham Dillon. She concluded that the children were supported by professionals, that the family's needs were being addressed, that there were no concerns from the school about the father providing basic needs, that there was no other information to suggest that he was not acting protectively towards the

children, and that some of the reports were received thirdhand and were not directly observed by the reporter.

2379. Subsequently, TN was of the view that there was no immediate risk of harm to the children, and that no further intervention was warranted.

In Evidence before the Inquest⁵⁷⁶

2380. TN stated that her role at CYPS in 2015 was as an Intake Officer. This role required her to receive information from the public by telephone email or from mandatory reporters.

2381. TN explained that once a report has been made, the Intake Officers would check the system called CHYPS (an online database) which keeps all information in relation to children and young people known to the Department.⁵⁷⁷

2382. TN explained that the system contains section that contains reports and the other documents which comprises case note. There are other components where CYPS workers can click to see whether a case is open, and whether any family members are associated with the reported person.

2383. TN stated that the new system CYRIS works differently to the system of the CHYPS. CYRIS has a different format and at the time of giving evidence TN was reasonably good at operating it but not particularly proficient.

2384. In terms of training TN stated that she had mandatory training in the new CYRIS database, domestic violence, training in risk assessment, and training in sexual abuse.⁵⁷⁸

2385. TN agreed that in some situations if the case had been recently closed, she would contact the caseworker and discuss the report because that person may be able to assist in the provision of further information.

2386. When TN was working with the CHYPS database, she was able to press the 'view button' which would tell her how many reports and how many assessments had been conducted. They were able to be accessed quite easily and that is what she would do as part of her assessment.

2387. TN stated that she would not generally examine the case notes.⁵⁷⁹

2388. TN indicated that there were also separate areas for documents such as criminal histories, and mental health, drug, and alcohol history. This would also include CARHU reports. These reports are easily accessible by the search engine function.

2389. In respect to the intake report that she completed on 26 June 2015, TN stated that the date is something that they would import into the report, whereas other matters are generated automatically.⁵⁸⁰

⁵⁷⁶ Transcript pp 943 – 991, 2155 – 2163.

⁵⁷⁷ Transcript of Proceedings, p 945

⁵⁷⁸ Transcript of Proceedings, p 949

⁵⁷⁹ Transcript of Proceedings, p 953

⁵⁸⁰ Transcript of Proceedings, p 955

2390. TN stated that once the information from a call is received, she would make further enquiries if she had been told certain things.
2391. If there had been reports of malnutrition or something of that nature she would make an enquiry of the school to ensure that the children had been sighted and that was no malnutrition.
2392. TN stated that she had been told by the father, Graham Dillon, that he was involved with CanFaCS and the Salvation Army. In the report it is clear that TN had spoken with the school and spoken with Graham Dillon. TN stated that she did not make any enquiry from Graham Dillon's brother Michael. TN also would contact family members if in the history there were was a degree of involvement.
2393. In respect to the report in which it was asserted the children were not going to school and the father was on drugs, TN agreed that the report relates to the children's safety.
2394. TN agreed that there were 14 report in respect to Bradyn and JL, for intervention, and seven reports in relation to family violence and the mother's alleged substance misuse.⁵⁸¹
2395. It was TN's practice to look at the last few reports to initially inform herself of the history. After she had reviewed that information and the concerns or themes suggested in the reports, TN would consider whether there was a need for separate case analysis in relation to cumulative harm.
2396. TN stated that she would not only look at the conclusions reached by the authors of the reports but would also enquire in relation to the source material relied upon if that was relevant. However, she conceded a conclusion drawn by another caseworker would be something that she would rely upon.
2397. One of the conclusions she relied upon was that the children and father continue to be supported by CanFaCS. That conclusion was drawn from a report she that had read.
2398. TN stated that generally speaking she would get the contact details of the caseworker at that community organisation. However, she did not do so in this instance. Nor did she contact CanFaCS for any information, instead it appears, she relied on information from the caseworker.⁵⁸²
2399. TN stated that her understanding of what she needs to be satisfied is set out in the threshold test. This test is whether a child is at risk, or likely to be at risk of harm, if the child has been physically abused, whether bruises been sighted, or the child has made a disclosure of abuse or assault. Those factors would require further enquiries. TN confirmed that disclosure plays a more significant role to that consideration.⁵⁸³
2400. TN agreed that she relied on the case notes and assessment from previous reports, together with what Graham Dillon had told her, and the information she received from the school.

⁵⁸¹ Transcript of Proceedings, p 960

⁵⁸² Transcript of Proceedings, p 964

⁵⁸³ Transcript of Proceedings, p 964

2401. TN agreed that she possibly should have contacted the community supports that Graham had referred to and perhaps even considered looking at any police history.
2402. Ultimately TN agreed that she had assessed that there was not probable risk of future abuse, that the family were serviced by a collective of professionals, which she noted as CanFaCS and the Salvation Army, as well as a GP and possibly the school.⁵⁸⁴ TN also relied heavily on the school, and also what Graham Dillon had told her, but she said this reliance was not 100%.⁵⁸⁵
2403. TN considered that the school was following up on the absences with Graham Dillon and that engagement was part of the information she considered. TN agreed that she wrote the letter of 7 August because she had considered that the father remain committed to engaging with professionals as that is what he told her, and she had also relied on some earlier case notes. However, she accepted that the school were having difficulty getting Graham Dillon to engage with them.
2404. Having considered those matters TN consider that no further action should be taken.⁵⁸⁶
2405. In reference to sources used, TN agreed that the best practice would be to obtain information from the director source.
2406. TN was unable to assist the Court in relation to the report from the teachers on 13 August 2015 about the issues that she had dealt with in July 2015. That report was dealt with by another Intake Worker, SC, in report 78231.
2407. TN stated that since Bradyn's death there have been several changes, including systems and processes such as the CHYPS to the CHIPS database, and new reporting forms and a clear risk assessment framework. TN stated that this appears to be a much clearer framework for the assessment of risks and possible risks.
2408. TN stated that DVCS now come into the office and there is free sharing of information. SACAT also attend the office and them being on-site is very helpful and handy. In respect to DVCS, if there was information in respect to domestic violence, they would be able to assist them in obtaining details.
2409. TN also said there has been a restructure where both child protection and youth justice matters are dealt with at a central intake point, and the child protection area is now streamlined with two separate teams.
2410. In relation to the forms, TN stated that they are much easier to read, and they have narrowed the document so that it is more efficient to use.
2411. It was TN's view that the new form considers parental capacity and what the risks are.⁵⁸⁷

⁵⁸⁴ Transcript of Proceedings, p 971

⁵⁸⁵ Transcript of Proceedings, p 971

⁵⁸⁶ Transcript of Proceedings, p 973

⁵⁸⁷ Transcript of Proceedings, p 980

2412. In relation to training, TN said she has had considerable training since the Glanfield Inquiry. This includes domestic violence training to assist with understanding domestic violence and triggers.
2413. TN was also aware of the specialist team within CYPS that investigates cumulative harm.
2414. TN stated that there is a new system in respect to intake, so that if a child report comes in of physical abuse, sexual abuse, or something of that nature there is now in place a Memorandum of Understanding with the police. Under the MOU Police are informed by CYPS of the information within two hours.⁵⁸⁸
2415. TN agreed that the role of Intake Officer is to filter out the complaints so that those that need to be referred for investigation are referred. The grounds upon which the threshold test is reached is whether there is a reasonable suspicion that the child may need care and protection.⁵⁸⁹
2416. TN agreed that 14 reports within two years was a fair few reports, but she was unable to recall whether she knew that they were from numerous teachers, a worker at the hospital who observed abusive behaviour by Graham Dillon toward the child, as well as neighbours.
2417. TN stated that now, if intake had received more than five reports within a year, a discussion must be had with the Team Leader.⁵⁹⁰
2418. TN agreed that the policy adopted by Victoria in respect to consecutive reports within a certain timeframe and also the cumulative harm factor would be useful policies for CYPS.⁵⁹¹
2419. TN stated that she is aware that abuse impacts children in different ways, and that in her experience, a child might not report abuse due to fear of the person causing the abuse.⁵⁹²
2420. TN stated, in respect to the report that she dealt with, that it was a low-level neglect report and there was an allegation that the children were malnourished, that their father driving erratically, and there was some issue about the children's attendance at school. Her enquiries involved a school who informed her that the children presented well, and they came with food and that there was no concerns about nutrition. Whilst the school attendance was an issue; they were going to address it with the father, and therefore that was the extent of her role.⁵⁹³
2421. TN indicated that she has utilised the case analysis team since its introduction following the Glanfield Inquiry and that she was part of that team for six months. TN stated that the team has the luxury of reading all the documents when coming up with recommendations for caseworkers.⁵⁹⁴ TN said that, if the case analysis team was

⁵⁸⁸ Transcript of Proceedings, p 983

⁵⁸⁹ Ibid

⁵⁹⁰ Transcript of Proceedings, p 985

⁵⁹¹ Transcript of Proceedings, p 986

⁵⁹² Transcript of Proceedings, p 987

⁵⁹³ Transcript of Proceedings, p 2156

⁵⁹⁴ Transcript of Proceedings, p 2157

available at the time, she received the report, she would have used them for this case.⁵⁹⁵

2422. In respect to receiving the report and the fact that it was a thirdhand account, TN agreed that she may not have contacted SK for the details of the reporter who observed the abuse. TN could not recall whether she did but agreed that best practice would have been to have done so.⁵⁹⁶

2423. Regarding resources, TN stated that she would from time to time refer to policy and procedure, but not often.⁵⁹⁷

TG – CYPS After-Hours Intake Team Leader

Statement

2424. TG worked at CYPS in the After-Hours Intake Team. This work is shift work and after-hours work. Senior managers are available for urgent matters if required during these times.

2425. The Intake Team takes reports in accordance with the same CYPS policy which operates for the day staff. That means that they required to make enquiries and appraisals as necessary to determine whether a child is in need of care and protection. They can also conduct announced and unannounced home visits upon request of managers. The Intake Team will also assist managing Child Concern Reports that have come in earlier in the day.

2426. After hours staff also record a daily log of calls which come in and the action taken by the after-hours team. The log serves a number of purposes, which include providing a summary of the number of matters coming through each evening, providing data regarding reporting patterns, and any developments in matters which day staff have responsibility for so that a follow-up can occur.

2427. As a Team Leader TG was responsible for ensuring team members perform their roles appropriately. She was also responsible for reviewing recommendations made in the intake forms and deciding whether they should be endorsed. In order to do so, she reviews content of the reports and the investigations undertaken by the after-hours staff.

2428. TG endorsed the description of the process given by EJ in her statement.

2429. TG has no independent recollection of two reports numbered 78147 and 78152 which were made in relation to Bradyn Dillon on 13 August 2015 by SC. Both of those reports came from teachers at ACT Primary School 2.

2430. Report 78147 set out the teachers' observations of bruising to Bradyn's face and the explanation Bradyn gave as to how the bruising occurred. In that report SC had set out a summary of previous involvement with Bradyn. TG's assessment was that the parents were separated but there were allegations of family violence, there been an alleged kidnapping attempt by the mother, after which the children claimed the father

⁵⁹⁵ Transcript of Proceedings, p 2157

⁵⁹⁶ Transcript of Proceedings, p 2159

⁵⁹⁷ Transcript of Proceedings, p 2161

had physically abused them when they were to be returned to him. The children later told CYPS that their mother told them to say that their father hits them. There had been previous Child Concern Reports received regarding bruising which had been appraised, these included a CARHU visit. The father was assessed as willing and able to protect the children and the case was closed.

2431. The CARHU report said that the bruising to Bradyn's face was not unusual but the bruising to his ear was of concern and that the explanation was that the bruising was as a result of play fighting.
2432. The report 78094 logged the previous day related to similar circumstances, in that a teacher had reported seeing bruising on Bradyn's face. As a result of that report, the father was contacted about the bruising and no further action was taken as the bruising was considered to be accidental.
2433. TG stated that SC had formed the view that the two reports were multiple reports. It was asserted it is common that multiple reports are received and regarded as the same incident if occurring within 28 days. So whilst the reports are logged individually and allocated as separate reports, if they are deemed to be multiples of the first report they do not require separate investigation.
2434. TG considered that the matter did not warrant further investigation. This was because the reports were similar in nature, there was no nonaccidental injury alleged, no one was alleged to have caused the bruising, there were no concerns raised about Bradyn's health or well-being, there was no disclosure, and only the bruising to Bradyn's ear was described as a concern and an injury that may have been nonaccidental injury. In addition, the father had been contacted.
2435. However, TG was aware that there was a further report 78152 which had not been analysed. This was not deemed to be a multiple report as it raised concerns of a different nature. TG indicated that she would have endorsed no further action on the multiples but knowing that 78152 was to be followed up further, she noted that in the endorsement recorded recommendations.
2436. The report 78152 was in relation to Bradyn not having anything to eat whilst at school. Bradyn also asked not to have his father called because he would get angry with him. SC attempted to call Graham Dillon but was unable to contact him. SC advised that a call should be made to the father discussing the anxiety Bradyn displayed about telling his father he had not adequate food at school.
2437. TG advised that an Intake Officer from the day team attempted to contact Graham Dillon but was unsuccessful.
2438. TG also identified an email from SU from the ACT Primary School 2 in which the author stressed that she wanted to ensure the family were getting the support they need. It was reported that the email did not raise any additional concerns about the well-being of the children and appeared to validate the excuses provided by the children's father regarding their poor school attendance.
2439. TG said SC failed to mark one of the boxes in relation to his recommendations. She inferred that no further action should be taken from those recommendations.

In Evidence before the Inquest⁵⁹⁸

2440. TG commenced work at CYPS in 2004 as an appraisal worker. She had experience previously working in Scotland and England.

2441. When TG commence with CYPS, her training consisted of one week of induction, after which she immediately commenced work. TG described the existence of what she called as a “slight mentor program” because CYPS were recruiting workers from abroad. TG was provided with the CYPS policies and procedures as part of her induction.⁵⁹⁹

2442. TG agreed the policies and procedures were uploaded onto the ‘knowledge portal’ in about 2014. TG opined that she did not consider that there was any substantial change to the policy and procedure when it was uploaded to the ‘knowledge portal’. However, she stated that there were updated and received by the workers via email.

2443. TG stated that between 2013 and 2015, she was a Team Leader. It was her view that some new staff completed the induction, and some didn’t, depending on overall staffing availability. TG agreed that if a new starter commenced in the team they would be shadowed by more experienced staff member. She stated that the induction would be part of the Team Leader’s responsibility.⁶⁰⁰

2444. TG agreed that between 2013 and 2015 she was in the After-Hours Intake Team. This team comprised of part-time workers who often did not access the required training. Work in the team was part-time, with the shifts been structured as seven nights on, seven nights off, totalling 24 hours a week.

2445. TG stated that there was no specific training that was required in order for a staff member to be promoted to a Team Leader position. She further stated that there was no specific training in respect to how to ‘*go about*’ endorsing recommendations, the training that was provided was on the job-training.⁶⁰¹

2446. TG was asked how she would be satisfied that she could endorsed a file as ‘no further action’. TG stated that in making her decision she would consider the nature of the abuse reported, the history, the relationships, the child, and any previous involvement with CYPS.⁶⁰²

2447. TG explained that at the end of each shift every worker would hand in a running sheet with the completed work to their Team Leader. The Team Leader would then examine the work and sign off in a timely manner. If there were any questions arising from the running sheet, she would speak to the caseworker who wrote the report.

2448. TG explained that she would not necessarily go through the case history herself because the case history was dependent on the worker providing a report. TG said that if she had worked with the particular case worker for a long time and had an understanding of their ‘risk lens’, and their level of experience, those factors would

⁵⁹⁸ Transcript of Proceedings, p 2117 - 2150

⁵⁹⁹ Transcript of Proceedings, p 2119

⁶⁰⁰ Transcript of Proceedings, p 2120

⁶⁰¹ Transcript of Proceedings, p 2122

⁶⁰² Ibid

reduce the need to look into the file further. If on the other hand the case worker was new to the job, TG stated that there were definitely checks and balances.⁶⁰³

2449. In relation to her practice in 2015, TG explained that she would get an overview of a particular case from reading the material, including the family history. TG opined that the 'family view' on the history would probably be priority. That included relationships.⁶⁰⁴

2450. TG explained she would expect that case workers would have a good understanding of their roles and that she relied upon them having such understanding of their roles.

2451. TG confirmed that she was familiar with exhibit C129, the policy and procedure document current in 2015. TG also confirmed that she was familiar with the practice guide in respect to intake and appraisal procedures.

2452. TG further confirmed that she was familiar with the practice guidelines in relation to threshold decision making and that she was aware of these guidelines in 2015. TG was also aware of the practice guideline in recognising abuse and neglect. TG confirmed that these documents would guide her through that risk lens.⁶⁰⁵

2453. TG confirmed that she endorsed two reports in relation to Bradyn Dillon, although at the time of giving evidence she had no independent recollection of them.

2454. TG confirmed that the two reports were numbered 78152, and 71847 and these reports were taken by a senior caseworker, SC. TG confirmed that SC was a senior caseworker with significant experience and knowledge, and that she had confidence in his assessment ability.⁶⁰⁶

2455. TG confirmed that she had considered the two reports as a multiple of each other, one of which had been dealt with by another case worker, HC, the day before. TG also confirmed that she endorsed the recommendation by SC that no further action be taken.

2456. TG was asked about the information available as part of the assessment, such as an analysis of the CPS history, which included current and previous CPS contact with the child, siblings, or parents. Information in the history included that several reports had been made concerning the children, particularly reports of unexplained facial bruising. The reports of the bruising occurred over a five-month period. Appraisals were conducted, and the cases were closed after case workers had analysed the reasons for the report. TG confirmed this was something that was at the front of her mind as the ultimate decision-maker in this case.

2457. Regarding the report of 12 August TG agreed that information received by SC was more specific than the previous reports, because the bruises were described as five finger marks. TG agreed that the teacher making the report questioned the truthfulness of the explanation provided that the injury was due to the child falling off a bike. TG also agreed that the teacher indicated that the bruises were new.⁶⁰⁷

⁶⁰³ Transcript of Proceedings, p 2123

⁶⁰⁴ Ibid

⁶⁰⁵ Transcript of Proceedings, p 2124

⁶⁰⁶ Transcript of Proceedings, p 2126

⁶⁰⁷ Transcript of Proceedings, p 2128

2458. TG was asked why this report was considered to be a multiple of the first report, a decision which meant no action would be taken. TG stated that she suspected it had likely been assumed that this was the same information as what had been previously reported. The initial report had resulted in a recommended that no further action be taken. Therefore, this new report was considered a multiple of the first report.⁶⁰⁸ TG explained that SC must have considered it to be the same report but being reported by different reporters.
2459. TG also explained that if the report contained different information it would not have been categorised as a multiple. However, the fact that there was different information was not identified. TG agreed that this report included a broader level of information.
2460. TG also accepted that the information from the intake source received by SC on 13 August suggests that the bruising was non-accidental.⁶⁰⁹
2461. TG opined that in order to fix this situation, a better review of the first or 'lead' report should have been conducted. With a review of the history and a referral to SACAT also occurring and the report being forwarded to the daytime staff.⁶¹⁰
2462. TG also agreed that it was inappropriate, considering CYPS policies and procedures, to contact the father, who was a possible source for the bruising in this report.⁶¹¹ TG explained that she thought SC did not tick the box indicating that there was a reasonable suspicion the child may be in need of care, because SC considered this report to be a multiple report.⁶¹²
2463. TG agreed the report was not entirely accurate in suggesting that there was an explanation of the bruising. This is because the allegation was that the bruising was in the shape of finger marks, which would be caused by a person rather than an object.⁶¹³
2464. TG was asked about a report received 13 August 2015 where Bradyn had come to school with inadequate food and that was reported to CYPS. It was also reported that Bradyn had concerns that his father might be called and would get angry. It appeared on that report that a box had been ticked that indicated that the child has access to support from another family member or from the community, TG agreed that it was essentially confirming that there were 'eyes on the children'. TG confirmed that ordinarily this box being ticked would give CYPS an opportunity to contact others in the community who have eyes on the children to verify information about them. TG agreed that she would ordinarily verify what she had been told.⁶¹⁴
2465. Regarding the threshold necessary to determine whether there is abuse or neglect of a child, or whether a child is in need of care and protection in circumstances where there is no parent willing and able to do so, TG opined that the level of suspicion required is quite low, and one can form a reasonable suspicion at any level.

⁶⁰⁸ Transcript of Proceedings, p 2129

⁶⁰⁹ Transcript of Proceedings, p 2130

⁶¹⁰ Transcript of Proceedings, p 2131

⁶¹¹ Ibid

⁶¹² Ibid

⁶¹³ Transcript of Proceedings, p 2133

⁶¹⁴ Transcript of Proceedings, p 2135

2466. TG explained that a case worker can form a reasonable suspicion if there is a disclosure, accompanied by an injury, where there is a definite time and date for an incident.⁶¹⁵ TG agreed that report 78147 may have been enough to form a reasonable suspicion, if it had not been recorded as a multiple report.⁶¹⁶
2467. TG opined that it is not always straightforward however, emerging from the three reports it was clear that something was happening.⁶¹⁷
2468. TG accepted that CYPS would usually rely on the teachers as credible sources of information and assumed that they would report accurately. Graham Dillon had indicated to the worker, when phoned, that the bruises were all the same side of the face and had nearly gone. This explanation clearly warranted further investigation given the difference between what the father stated and what was in the report from the teacher.⁶¹⁸
2469. In paragraph 26 of her statement, regarding her assessment of the report, TG said she would not now stand by her answer because of the detail she had now been taken to. It was now TG's view that the report should have proceeded to an appraisal.⁶¹⁹
2470. According to TG, the fact that there were several reports over a short period of time led to the conclusion that this was a multiple report, which was the cause of this report being handled in the manner it was.
2471. Further, the extreme workload of CYPS in 2015, when the organisation was under restructure, was another factor. The third factor was that CYPS were very much focused on incident-based reporting, rather than considering reports through a lens of history and overall story. The fact there was little time to reflect also had a bearing on the matter.⁶²⁰ TG stated that there has been some improvement but in respect to multiple reports has been no substantive change.⁶²¹
2472. TG accepted that at the time of the 2015 bruising reports, there was a policy that bruising around the face or grasp marks on small children should be considered nonaccidental unless proven otherwise.
2473. TG also explained that there is now a focus on 'cumulative harm' and an analysis team is now in place for high-risk families. However, just because the box is ticked yes does not necessarily trigger a separate case analysis. The current process following the box being ticked is that the caseworker assessing the risk conducts a more substantial investigation to determine whether the threshold test has been met.
2474. TG also accepted that it is important that when creating a history that it be accurate because any errors can pollute future analysis.⁶²²
2475. In relation to training, TG stated that there has not been specific training in relation to cumulative harm. However, there has been training in domestic violence and sexual

⁶¹⁵ Transcript of Proceedings, p 2135

⁶¹⁶ Ibid

⁶¹⁷ Transcript of Proceedings, p 2136

⁶¹⁸ Transcript of Proceedings, p 2139

⁶¹⁹ Transcript of Proceedings, p 2139

⁶²⁰ Transcript of Proceedings, p 2139

⁶²¹ Transcript of Proceedings, p 2140

⁶²² Transcript of Proceedings, p 2142

assault. TG stated that the new CYRIS system has a better recording and accountability facility. There has also been a restructure of the intake and after-hours process within CYPS.

2476. TG opined that there are still some struggles, such as inexperienced staff, lack of staff and overreporting, inappropriate reporting, lack of quality assurance, lack of connectivity to the community. TG opined that care and protection continue to be flooded with information and concerns that probably don't fit that department. There is a lack of streamlining and evolution to move forward.⁶²³

2477. Regarding possible recommendations, TG suggested that child protection does not work in that 9 to 5 space. TG suggested that CYPS are trying to operate a call centre in the sense that they are receiving information in that manner but without the call centre resources. TG opined that CYPS had worked hard but not smart and given the changing population it does not fit what is happening within the community.⁶²⁴

2478. TG further stated that the workers try to conduct too many tasks at the same time, such as taking phone calls, prioritising assessments, and analysing comprehensive histories to embark on a risk assessment. The timeframes are quite small to sign off on the documents. There is also the difficulty of conducting enquiries at the times when the night intake staff are working. That is generally not 9am to 3pm. TG's opinion was that the Department has not evolved sufficiently to spread the workload and do things differently for the better.

2479. TG opined that better training in respect to uniformity of approach, particularly in relation to gathering information, is important to the determination of whether there is a risk.⁶²⁵

2480. TG also stated that there is a high attrition rate of workers at CYPS. TG also opined that the Intake Officer should be given more importance as they are the interface between reporters and care and protection.⁶²⁶

ST – Interstate Liaison Officer, CYPS

Statement

2481. ST was the Interstate Liaison Officer (**ILO**) in December 2012. She remained in that position until mid-2015.

2482. As the ILO it was common for her to receive requests for information regarding children in the Child Protection arena. Upon receiving a request she would go into the CRIS database and look for any assessments that had been completed by CYPS staff regarding that particular family. This information was useful because it contained a history of involvement of the family with Child Protection agencies.

2483. ST stated she would send the completed Family Assessments, Child Concern Report, and the Appraisal Reports to the ILO of the requesting state. These documents were

⁶²³ Transcript of Proceedings, p 2143

⁶²⁴ Transcript of Proceedings, p 2144

⁶²⁵ Transcript of Proceedings, p 2146

⁶²⁶ Ibid

sent in their complete form and were never redacted. Once sent, the request for information and record of details would be stored in the ILO database.

2484. ST said she received a request for information from CF, a Child Protection worker from Victoria, on 4 November 2014. At that time, information would usually come from the ILO of the State requesting the information. However, given the urgency of the request ST felt she needed to reply.

2485. ST indicated that she replied on 5 November 2014 and provided protection reports, appraisals, and supplementary notes. ST also provided a copy of the same documents to the Victorian ILO after speaking with CYPS.

2486. ST outlined how she searched for information on the CRIS system, identifying the correct family and checking the list of documents relating to them. It appears that not every Child Protection Report referable to the children was in fact sent by her to Victoria.

2487. ST was surprised and shocked by this. She said that the only explanation is that she was doing the check quickly and did not follow the usual process. She said this may have been as a result of not going through the ILO of each state because when requests go through the ILO there are templates and forms which request various information.

2488. ST does not recall dealing with the Dillon family at all but accepts that she had received the email and sent the information. She also does not recall making the request recorded at pages 764 – 766 of exhibit C5 about speaking with NL or receiving any request from NL to seek information from Victoria in respect to the Dillon children.

2489. ST was of the view that if she had received a request she would have been expected to have generated a form similar to the one generated at page 766.

2490. ST could not account for why she did not contact the Victorian Care and Protection services in relation to such a request.

In Evidence before the Inquest⁶²⁷

2491. ST was the ILO between 2012 and 2015. ST was an HP3 and transferred to front-line work in 2015. ST left CYPS and transferred to a consortium which involves providing support to children in need of care and protection.

2492. ST gave evidence in respect to the protocol in place in respect to the sharing of information. The process was, upon request, to forward a request for information to other care and protection agencies in various states.

2493. ST stated that there is also a role to provide information to the Family Court as well. In order for her to be able to garner that information she had a good working knowledge of the two databases that she used CHYPS was the most recent.

2494. ST stated that her first point of investigation was the family assessment document. This was a document generated with a history of concerns and also a child's development and an assessment of the parents capacity.

⁶²⁷ Transcript pp 755 – 780.

2495. That document is generated when there is a court process either in progress or to commence. This document is generated because of care and protection proceedings. ST would also consider any Child Concern Reports, and the appraisal connected with the report. These would be on the CHYPS system.
2496. ST stated that it would be her expectation that any information such as a criminal history which had been requested would be uploaded onto the system. Document such as DVO, toxicology reports, report from CARHU and other similar reports would also be uploaded. Each report would contain documents that are separated but on the same file.
2497. ST opined that those type of documents wouldn't normally be part of the appraisal assessment and the documents would not be on the appraisal document.
2498. In relation to her part in this matter ST, said that she received a request from BE from Victoria on 4 November 2014. ST uploaded the documents pertaining to the request and sent them on 5 November 2014.
2499. ST stated that generally it would be the ILO from each state which consults with each other however in this case it was a direct request and because of the urgency, material was sent directly to the person requesting information. However, the Victorian ILO was also advised.
2500. Generally, the process is ILO to ILO so that there is consistency with documentation being uploaded and sent and received. There is also a legislative requirement as well.
2501. ST thought that she sent to BT all of the information that she had available to her. ST was shocked to be told that that some of the information was not attached. There were two reports missing. ST identified that may well have been the case that those two-report had not been uploaded to the system and that is why she didn't send them. ST explained that a new report must be uploaded to the system it doesn't do so automatically.
2502. ST advised that generally in order to prepare the information she would crosscheck all historical material or a summary of that material, she would then consider that to be part of the information she would send.
2503. ST advised that her general practice was that she would go through the most recent reports and crosscheck the other appraisal reports. If there were summaries of those reports that is what she would send rather than the whole document. If there was no summary she would send the whole document.
2504. ST stated that there is a hard file as well as the CHYPS system and her experience is in theory it should mirror out that system however it is not always the case. That was because the material had to be put into the system and then also printed and placed on the file.
2505. ST stated that she did not always look into all of the documents because that material should be in the family assessment and summary part of the document. It was not generally practised to look at other documents, beyond care and protection reports, appraisals, and assessments.⁶²⁸ ST stated that the information she would

⁶²⁸ Transcript of Proceedings, p 764

predominantly exchange was the Child Protection Reports and appraisal outcome reports.

2506. ST was asked in relation to a request she sent in August 2013 to Victoria seeking particular information. ST advised that there is generally a standard form which is generated to provide the information. That form differs between states.

2507. ST was taken to a document number 1157 of exhibit C5 material and was asked about the content of the information which included

“care and protection services Interstate Liaison Officer of both Victoria and ACT are working together to ascertain the whereabouts of the children and mother as well as determine concerns and safety issues in relation to the children’s well-being”

2508. ST stated that she did not understand that information and did not write it. Her role is limited to sharing of information in response to a request. ST had no role in appraisal or assessment or anything of that nature.⁶²⁹

2509. ST was also referred to an email sent by BD in respect to information requested from Victoria through her in July 2013. The request was provided by Victoria and ST provided the information to BD. That was a typical response to a request. ST stated that she did not have any recollection of receiving a request from NL in late November 2014.

2510. ST set out the usual way the request is received and that is either through the ILO email box or via a verbal exchange. ST said it was not uncommon for a caseworker to come to the legal area and speak directly with the ILO. ST stated that nine times out of 10 there would be a written request or an email. If a request had been received it would have been in writing.⁶³⁰

2511. ST stated that once she received a written request, she would collate all of the information and place it into the template and send it to the ILO of the state where the request is being made. Depending on the urgency of the request sometimes they would also have a phone conversation to get a quick turnaround or perhaps give information by the phone.

2512. ST has no recollection of ever receiving a request for information from Victoria at around 20 November 2014. ST stated that if she had received one, she would have actioned it in the usual way. ST stated that in her experience it was not possible to have an interstate agency give information without a request seeking that information.

2513. ST stated that if there were some concerns about children, an interstate alert could be issued. That alert would go to the interstate alert inbox and be check and actioned on. ST stated that when she receives an alert, she would forward it by email to the Intake Team, and they would have a record.

2514. ST stated that she did not receive any requests in December 2014 or January 2015 for any information that she could recall.⁶³¹

⁶²⁹ Transcript of Proceedings, p 767

⁶³⁰ Transcript of Proceedings, p 771

⁶³¹ Transcript of Proceedings, p 774

2515. ST was shown a document which indicated that on 4 December 2014 a request was made via phone call to CPS ILO requesting information in respect to involvement in DOCS (NSW). ST said that after the phone call she would request an email be sent to her with information on it and then she will get that information.⁶³²
2516. ST stated that emails were not automatically placed on the CHYPS database it had to be uploaded onto it manually.
2517. In relation to an explanation as to why the two reports were not sent to the Victorian ILO, ST opined that one explanation could be that if the report had not been uploaded to the CHYPS database when she examined the database, that could be the reason why she didn't send the information.
2518. ST advise that there is no alert on the system to indicate that there are any pending assessments or reports in the pipeline other than having an open document on the system which the case worker was working on. ST explained that there are two ways of working on a case, one is to have it on the system working on the system which will be open and the other is to have it on a separate Word document which would then be uploaded onto the system when it was finalised.

SC – CYPS Team Leader

2519. SC commenced work with the CYPS on 4 January 2016.
2520. SC was asked to search the ILO database to locate a request made or received from an Interstate Child Protection agency regarding Bradyn and/or JL Dillon.
2521. SC searched the ILO database which showed that an outgoing request from the ACT to Victoria was made on 1 August 2013, requesting any Child Protection history held by Victorian Child Protection in relation to JL and Bradyn Dillon and their parents SK and Graham Dillon. Victoria responded advising they had no records in relation to JL and Bradyn.
2522. On 4 November 2014 a request was received from Victoria questing details of Child Protection history held in the ACT in relation to JL and Bradyn Dillon. A response was provided to Victoria on 5 November 2014. That response attached Child Protection Reports received by CYPS up until that date in respect to those children.

BU – CYPS Team Leader

Statements

First Statement

2523. BU was employed by CYPS from February 2009. She was employed as a level HP 4. BU was an experienced social worker, working in the field of Child Protection.
2524. In February 2016, BU was employed as the Team Leader at CYPS.
2525. In 2014 she was the Team Leader in the North 0-12 team within CYPS. BU was responsible for managing seven full-time health professionals' levels 1 to 3 and two part-time student social workers. Caseworkers typically held between seven and ten

⁶³² Transcript of Proceedings, p 775

family cases and sometimes more. Those cases would include multiple children with each child having its own Care and Protection file.

2526. In relation to 28 July 2014 mandatory report 70027, BU became aware of the Dillon family around 12 August 2014 after returning from annual leave. BD had been handling her role while she was on leave. NL was allocated an appraisal in relation to that Child Concern Report.
2527. BU also advised that she would have conducted a demand management check of all open cases to advise her Operation Manager as to the status of the cases in her team.
2528. BU does not recall having any personal communication with Bradyn JL or Graham Dillon.
2529. BU noted that NL had appraised the report and recommended no further action.
2530. In relation to the knowledge she had, she was advised by NL that NL had seen JL and Bradyn with bruises to their face, that they were small and faint. She had spoken with CARHU but had been informed that as the bruising was faint, CARHU would not accept a referral. It was her understanding that after discussion with the Team Leader, recommendations were made that the children attend a medical with the family GP.
2531. NL advised Graham Dillon to take children to the GP and, despite his reluctance, he agreed, and an appointment was made. NL confirmed that she spoken to the GP who advises nothing of significance. BU then endorsed the recommendations of no further action.
2532. BU indicated that she endorsed that recommendation on 13 October 2014 and would have reviewed the information available to her at the time including previous reports, progress notes and any records on the paper file. She would have taken that into account.
2533. In relation to the appraisal 28 August 2014 mandatory report 70621, BU indicated that she was out of the office between 5 to 29 August but understood from the file that NL had received a call from the Deputy Principal of ACT Primary School 1 concerning a report that Bradyn had attended school with bruising to the bridge of his nose and a purple-black ear. BU was also advised that Bradyn could not account for the bruising to his ear but said he had been fighting with his father who had thrown him up in the air and that he had hit his nose on the couch.
2534. BU became aware that NL had contacted SACAT, and they informed that there was no disclosure and handed the case back to CYPs for investigation. If there had been any disclosures, they could then be contacted.
2535. In relation to her endorsement of this action taken by NL, it was completed after a demand management check report had been made. BU indicated that NL had discussed with her the appraisal and advised that the children did not provide any further information about the bruising. BU was advised that OQ from CARHU examined the child and felt the bruising was accidental but could not ascertain or be specific as to whether the other bruising was accidental or non-incident.
2536. BU also advised that NL had told her the interaction with the children was noted and there was nothing of significant concern. NL considered the children not in need of

care and protection. A discussion was had in respect to the threats made by Graham Dillon toward NL and KE and an alert was placed on the CYPs system.

2537. At some point BU became aware that the CARHU report conflicted with what she was told by NL. NL advised that she raised her concerns with the doctor at the time because she was concerned at the frequency of the bruising and the reason provided by the children and the father. NL advised that the verbal feedback from OQ was that the bruising was not significant enough to be regarded as suspicious.
2538. BU recalled that both NL and KE interviewed the children separately and it appeared that they were not afraid of the father. The children did not elaborate or change the story they had told their teachers in relation to the bruising. BU indicated that she asked both NL and KE whether Bradyn was in need of care and protection and both of them said they were not of that view.
2539. BU endorsed the recommendation for no further action given the protective measures that included school, the family home able to meet basic needs, and the support of CanFaCS for the father who met regularly with him and did not hold concerns for the children. Also the children did not appear to have any fear of the father.
2540. In relation to risk assessment 14 October mandatory report number 71439: BU was aware of this report and believed NL spoke with the teacher who indicated there were five small circular bruises on the side of Bradyn's cheek and that they appeared to be fading. Bradyn advised that he fell at the shops.
2541. BU outlined the Child Concern Report created by NL and her conclusions, it appears NL recommended that there was a probable risk of future abuse/neglect and BU took that to mean that CYPs may continue to receive concerns about Bradyn having sustained bruising. NL recommended no further action given the protective measures in place as discussed. BU endorsed a recommendation based on the risk assessment that NL had undertaken and her knowledge of the case the date.
2542. BU was also aware of the risk assessment report 71846 in relation to the suspected kidnapping of the children by their mother. BU requested NL to complete the report if the case was still open at that point. Given that the children were now in Victoria, BU endorsed NL's recommendation of no further action.
2543. In relation to the mandatory report 72483 on 4 December 2014: BU was present when NL had a conversation with BN. On 27 November 2014 BU undertook a demand management check and noted that the report remained incomplete. BU emailed NL asking that she complete the report by close of business that day or the by the following Monday morning.
2544. BU advised NL that she was to proceed to a Child Protection Report and appraisal because of the reasonable suspicion that Bradyn and JL were in need of care and protection. This was because they had disclosed to Victoria DHHS they did not want to live with the father and that he hits and punches them. BU identified that these were new concerns in relation to Graham Dillon.
2545. On 3 December 2014 NL completed the report and recommended an appraisal be undertaken. NL identified protective factors that included support from CanFaCS and that the children were returning to ACT Primary School 1, but that further information

was required to determine whether there was someone with parental responsibility willing and able to protect the children.

2546. BU endorsed her recommendation. The reasons were that Graham Dillon had made verbal threats towards NL, both children have disclosed suffering from physical abuse by their father, they were observed by a Victoria DHHS to be distressed when leaving their mother, and that the father's eldest daughter does not have contact with him and reported that he continually sent abusive messages on Facebook. Further, there were concerns that Graham Dillon may be misusing illegal substances such as ice.

2547. BU then, given the complexity of the case, allocated it to PG. It was agreed NL would continue to be involved as a secondary worker.

2548. The appraisal intervention outcome report indicates that it was BU who was undertaking the appraisal but that was incorrect- it was PG who did so. PG advised BU that she had met for a case consultation and had gained the consent of Graham Dillon to conduct an appraisal. BP was also emailed.

2549. BU was away from 24 December 2014 until 5 January 2015. An email was sent to her dated 30 December 2014 informing her that SK had contacted CYPS stating that Graham Dillon had been threatening her with Facebook messages involving guns and bullets. DM advised that there was no urgency in respect to the direct threat to the children and therefore no urgent response was required. BU did not see this until she returned from leave.

2550. On 6 January 2015 she received another email informing her that SK had rung in requesting to speak with PG and raised concerns regarding the fact she had not received contact from her children in accordance with court orders. BU advised that records indicate PG returned SK call on 14 January 2015.

2551. BU met with PG in relation to the appraisal being unable to be completed because the family was interstate. PG informed the children were conditionally safe and the father indicated that he would engage with the appraisal on his return to the ACT. The Operation Manager supported the recommendation.

2552. PG undertook their appraisal and found that there was no physical abuse and neglect, and BU endorsed that decision. BU advised that over the previous six months there had been numerous home visits and consultation with the supporting agencies, various telephone conversations and face-to-face meetings as well as examining the home environment and the school environment. It was her view the caseworkers had held discussions with Graham Dillon, SK, and other key parties in the children's lives. Regular consultations had occurred with Team Leaders where appropriate and the conclusions drawn were that the children were not in need of care and protection.

Second Statement

2553. BU provided a supplementary statement where she highlighted the structure of CYPS and the role of the Team Leader as well as training of caseworkers. In relation to her role as Team Leader she provided direct line management and supervised the caseworkers and their cases. BU indicated she would not necessarily be involved in the cases on a day-to-day basis. However, she indicated that if she received a report, she expected that the topic should be covered appropriately.

2554. BU identified she had an open-door policy and caseworkers in her team were free to come and speak to her as they wished.
2555. BU indicated that given the caseload for her team, she was unable to consider each and every document and relied on the competence and ability of her caseworkers. In particular, the competence and ability of both NL and PG to perform their work.
2556. It was her view that her role was quality assurance and to review what had been done, the recommendations made, and agree to endorse the recommendations made and provide reasons for the endorsement.
2557. BU indicated that all caseworkers would receive particular instructions in relation to their work which included undertaking appraisals.
2558. BU identified the between 2010 and 2015, CYPS underwent about seven changes of management. There were often restructures under those changes. This provided a difficult work situation which BU described as, at times, chaotic and unmanageable.
2559. It made it more difficult when advised by management that certain boxes in the report should not be ticked this included cumulative harm because the case analysis team for assessing cumulative harm had not been set up at the time.
2560. BU identified that a specialist group, the Case Analysis Team, was developed to assess cumulative harm. Prior to 2014, the assessments were based on physical abuse, sexual abuse, emotional abuse, or neglect. In was her view, there was an awareness of cumulative harm, but a specific assessment group was being developed for cases that particularly involved cumulative harm. It was BU's view that that is the reason why the box 'no cumulative harm' was ticked in relation to the form she was shown that was contained in exhibit C5 on page 1165.
2561. There was also a lot of pressure from senior management to close cases within 28 calendar days. There was also a situation where not all policy documents and guidelines were on the intranet, some were in hard copy, and some were in development.
2562. BU also identified that the staffing situation in 2014 was significantly under resourced with staffing levels at only about half the level required.
2563. In respect to referrals to CARHU it was her view that where a child is injured it would be examined and a determination made as to how the injuries were inflicted, if they were suspicious, if they were significant, and if they were inconsistent with the information provided as to how they were sustained, in that case, emergency action would have been taken by CYPS.
2564. BU identified that NL advised her that OQ had told her that the bruising on Bradyn's face was not suspicious. BU also advised that it was her experience that the CARHU doctors would not send a child back home if they thought there was suspicious injuries and certainly wouldn't delay the provision of a report for several weeks.
2565. In respect to SACAT, BU suggested that it was her view that they should have taken the lead in the investigation after being provided with the two reports in relation to Bradyn and JL, however they chose not to do so.

2566. BU then identified what she recommends changes need to be made. They include various agencies were operating as silos rather than as a multi-agency operating together for the protection and welfare of children.
2567. It was BU' view that Child Protection appraisals ought to be only undertaken by skilled and experienced caseworkers at a minimum of HP level 3 and above. BU also considered that the intake forms need to be revised and simplified.
2568. In relation to the federal system where there is separate territory and state legislation separate systems, separate forms, and separate assessment methods, it was her view that there should be a coordinated and uniform approach to Child Protection.
2569. BU also identified that she was provided with the 'K' Review but was not permitted to access the files of JL or Bradyn or access the documents which underpinned the report. BU identified that she was asked to write a response to the report and did so however she did not have access to any documents and had to base her response on her memory.
2570. BU identified that in her view the 'K' Review referred to systems in place in 2016 not 2014 and 2015. And that was a shortcoming in her view.

In Evidence before the Inquest⁶³³

2571. BU described her position in 2014 and 2015 as an HP4 and she was a Team Leader. BU agreed that the position description document accurately reflects her duties and responsibilities.
2572. BU described her day-to-day responsibilities as managing the care and protection team of health professionals responsible to her. In 2013 her team were mainly concerned with appraisal work. The system then began to progress to a single case management team where a team was allocated appraisals and they would conduct those appraisals through to the conclusion of the case.⁶³⁴
2573. In addition to managing the cases, the Team Leader would respond to duty phone calls; assist the Intake Team respond to the appraisal process; allocating and rating appraisals; attending court; attending various meetings; training; and attending and organising team meetings. It also consisted of organising training for staff and attending leadership meetings. The role was various and was centred around child protection.
2574. In relation to her duties to assist in the development and implementation of policies and procedures, BU said that they trialled changes to policy, including documentation and then provide feedback to the Operation Manager which in turn went back to the IMS project team.⁶³⁵
2575. BU agreed that quite significant development and changes occurred which included development of policy and procedures. BU suggested that not all documents were on the 'knowledge portal' and that prior to the IMS system. policy and procedures were found in folders. The purpose of the 'knowledge portal' was it was there for reference

⁶³³ Transcript p 1640 – 1693, 1729 - 1975

⁶³⁴ Transcript of Proceedings, p 1642

⁶³⁵ Transcript of Proceedings, p 1643

and would also be updated on a daily basis. BU suggested that the 'knowledge portal' went live in September 2014.

2576. BU stated that there was training in relation to the 'knowledge portal' which was available over a period in 2014 and 2015. BU attended training in August 2014. The 'knowledge portal' was available to everyone. BU was unaware whether policy and procedures were available on the 'knowledge portal' at the beginning. BU stated that prior to the policy and procedures being placed on the 'knowledge portal' it would have been in Team Leaders or managers offices contained in folders.

2577. BU explained that she would conduct a weekly team meeting, where information would be passed on to the members of the team. There were also workshops for completing intake and how to complete reports. Indeed, in some instances it was the caseworkers who showed her how to complete the reports because they were more familiar with using the system. BU would also have meetings where she discussed with the case workers their understanding of physical abuse and sexual abuse thresholds and any complexities with their case that they're struggling with. Team Leaders would be a sounding board for the team.⁶³⁶

2578. There was also a sense of responsibility instilled in each individual member of the team to find out the information on the system themselves, particularly given the system was updating the information regularly.⁶³⁷ That occurred as soon as the integrated management system went live in September 2014.

2579. BU agreed that she was involved with the Dillon family from 14 August 2014 until 24 January 2015. In relation to the policy and procedure available to NL, who was allocated the case, she would have had access to folders which contained the policy documents.

2580. BU stated that NL would have attended an induction and been enrolled in the pathway group which was spread over a 12-month period. This group was intended to introduce workers to the role of a caseworker which included what they needed to know to do their job.⁶³⁸ BU stated that there was a lot of compulsory training that new workers must attend prior to being allocated a case load. New workers would also have a mentor who shadowed them, giving them guidance on their case work.⁶³⁹

2581. BU confirmed that NL was given a starter pack containing policies, procedures, and other relevant documents, and sent an email advising her to familiarise herself with those documents.⁶⁴⁰ BU stated she was also familiar with the documents. BU also confirmed that the second bundle of documents she was shown consisted of information gathered by caseworkers with examples of how to write using terminology within the format of a report. The purpose was to familiarise the workers with the role of care and protection.

⁶³⁶ Transcript of Proceedings, p 1644

⁶³⁷ Transcript of Proceedings, p 1645

⁶³⁸ Transcript of Proceedings, p 1647

⁶³⁹ Transcript of Proceedings, p 1647

⁶⁴⁰ Transcript of Proceedings, p 1814 – 1815

2582. BU also confirmed that it would be useful for her to send a starter pack similar to that shown to her to PG when she commenced work, however she was not sure that when PG commence that it would have been on the IMS and the 'knowledge portal'.⁶⁴¹
2583. BU allocated KE to be the role of mentor to NL. However, she did not discuss the role of mentoring NL with her because she already knew the work and was a skilled care and protection worker.⁶⁴²
2584. BU described NL as having a level of experience from previous work with children and families and despite her being new to the role she had other qualities which BU felt would sit very well with working at the front line of case management.⁶⁴³ BU did not discuss the role of KE being NL's mentor because it was informal buddying up system, over the first couple of weeks.⁶⁴⁴
2585. In respect to her response to the 'K' Review, she recorded that two HP3 workers required further supervision because of some issues with their work.⁶⁴⁵
2586. BU recalls discussing with NL relevant policies and procedures in respect to the Dillon family. These included intake and appraisal policy parts of the legislation as well as a lot of other information, including compulsory training that NL must attend. BU also compiled a new starters pack which included policy documents in a series of emails.⁶⁴⁶
2587. BU did not specifically recall discussion around actual policy insofar as it was more applied to the work that they were doing so that guidance can be given for example in completing reports. It was her expectation that the workers would have a good understanding of what the policies and guides are because it's a core part of their business, the policy underpins that, and that it would also apply to all levels⁶⁴⁷
2588. BU stated that ideally you would try and protect the HP 1 however that didn't occur because of the increased capacity of the caseloads. Therefore, allocating fewer complex matters to the lower-level caseworkers was what was attempted.
2589. BU stated that to her knowledge, NL understood the policies and procedures because it was part of her induction. Also, NL was not allocated anything for the first two weeks because it would take them weeks to become admitted to the online system to get a pass and login for the computer system. In that two weeks they would be sitting down reading policy and procedure as well as having discussions with their supervisor.⁶⁴⁸
2590. BU agreed with the policy document referring to HP 1 duty statement where, within a short period of time, they were undertaking work rather than assisting. It was her recollection that NL was working actively on cases when she went on leave on 14 August 2014.

⁶⁴¹ Transcript of Proceedings, p 1816

⁶⁴² Transcript of Proceedings, p 1648

⁶⁴³ Transcript of Proceedings, p 1648

⁶⁴⁴ Ibid

⁶⁴⁵ Transcript of Proceedings, p 1650

⁶⁴⁶ Transcript of Proceedings, p 1651

⁶⁴⁷ Transcript of Proceedings, p 1652

⁶⁴⁸ Transcript of Proceedings, p 1653

2591. BU stated that she had a hand over with BD which was generic, not specifically in relation to the Dillon file. BU noted that on her whiteboard in the office the case was marked for closure and she had a conversation with both BD and NL as part of handover.⁶⁴⁹
2592. BU stated that the handover conversation would usually cover whether there is anything that she needs to be aware of, any active appraisals or emergency action to be taken, and any care plans due to anything that has been identified, including training.⁶⁵⁰ BU confirmed that she did not have any specific discussion with BD in respect to the Dillon matter.
2593. BU stated that there is no particular system to trigger outstanding matters it's just a matter of familiarising oneself with the file. However, the system is designed to show outstanding reports after running a domain management check.⁶⁵¹
2594. In respect to case consultation, the documents would generally be on the CHYPS database. A copy would also be held by the caseworker and the Team Leader should also have a copy. It would also at some point be placed on the paper file.⁶⁵² BU considered that NL was a very organised worker and would usually bring everything, including the paper file, with her to the meeting. BU said that there could be a delay in respect to scanning of documents onto the CHYPS database.
2595. It was the caseworker's role to undertake actions highlighted. However, there also could be several reasons why actions weren't undertaken; BU stated that at the beginning of the appraisal, often a case consultation would be held and there were standard matters which would be subpoenaed, such as mental health records, drug and alcohol history, criminal history and PROMIS notes.⁶⁵³ If during the course of the appraisal, it becomes apparent that the information is not required, then it doesn't need to be actioned. It was not designed to be a fishing exercise on the family.
2596. BU stated that in the old system there were memory joggers for caseworkers in respect to actions to be completed however in the new system they were not necessarily there, and things could get lost.⁶⁵⁴
2597. BU said she was aware that Bradyn and JL had half siblings on the system and that there had been previous Child Concern Reports. BU stated that she had access those files but cannot recall why and she certainly would not have read them unless there was a reason for her to do so. In respect to the other children's file, she would have been aware that there was a criminal history on one of them and that she was aware of the case.⁶⁵⁵
2598. BU agreed that she was aware of the Dillon file and the specifics came from NL through day-to-day conversations and weekly meetings with her. BU also had access to the CHYPS database as well.

⁶⁴⁹ Transcript of Proceedings, p 1655

⁶⁵⁰ Transcript of Proceedings, p 1655

⁶⁵¹ Transcript of Proceedings, p 1656

⁶⁵² Transcript of Proceedings, p 1657

⁶⁵³ Transcript of Proceedings, p 1659

⁶⁵⁴ Transcript of Proceedings, p 1660

⁶⁵⁵ Transcript of Proceedings, p 1661

2599. BU was questioned about the process of examining files when it was evident that the father of the two children to whom the report was made also has three other children known to the CYPS. The issue raised was whether it was appropriate to look at the other case file to see whether similar reports were made in relation to Graham Dillon. BU stated that it may not necessarily be looking for the nature of the reports but looking to check something out such as a criminal history. In this case, there was an open case; therefore, one area would be to check with the caseworker to see whether there was any information that they needed to be aware of.⁶⁵⁶
2600. BU agreed that in cases where there is a report made about children who have other siblings, including half siblings, that the CYPS worker would also look to see whether similar reports had been made in relation to the other siblings.
2601. BU stated that provided the children are linked on the system, the system should automatically link those to families, and that information could be obtained. The system relies on somebody making the connection and updating that system. BU agreed that that information would be important.⁶⁵⁷
2602. BU was furnished with policy documents which she stated, she had seen in some shape or format. BU advised that the information was available on the 'knowledge portal' and that needed to be continually checked because of the updating of the practice and guidelines, given it was a live system. They also had discussions at team meetings about what was now on the 'knowledge portal' in respect to practice and guidelines. Encouragement was given for the workers to review them online.⁶⁵⁸
2603. BU could not recall what was actually on the 'knowledge portal' in September 2014. BU was shown an intake and appraisal procedures document which was available in July 2014. Reference was made to 9 key activities in the intake and appraisal process and particularly dot point 4 of the document. BU was familiar with this document and stated this was available to staff in respect to the objectives of risk assessment. The guidelines explain and dictate the required steps and how to respond to those requirements.
2604. BU confirmed that the process is as follows: an intake is received, a Child Concern Report is generated, if further assessment is needed it becomes a Child Protection Report, and if that requires further action, becomes a child protection appraisal.⁶⁵⁹
2605. BU also confirmed that the recommendations on the Child Concern Report actions must be endorsed by the Team Leader.⁶⁶⁰ BU agreed that in endorsing the report there are these steps to take which reflects a rigorous information gathering process.⁶⁶¹ BU agrees that all of this information was available to her in her role as a Team Leader.⁶⁶²
2606. BU stated that the policy documents were a work in progress, and they did change throughout the period she was the Team Leader in respect of the Dillon family. BU

⁶⁵⁶ Transcript of Proceedings, p 1663

⁶⁵⁷ Transcript of Proceedings, p 1663

⁶⁵⁸ Transcript of Proceedings, p 1730

⁶⁵⁹ Transcript of Proceedings, p 1733

⁶⁶⁰ Transcript of Proceedings, p 1734

⁶⁶¹ Transcript of Proceedings, p 1735

⁶⁶² Ibid

stated that the intake and appraisal policy was the first module because that is the core business and that was rolled out in the middle of January 2014.

2607. BU stated that prior to the policy documents going online, the policy documents used to have clear differences in them about how to respond to a Child Concern Report. This included how the report should be completed. The revised policy on the 'knowledge portal' was far more comprehensive than the previous policy.⁶⁶³

2608. BU stated that basically caseworkers and other workers are trained and received information and training from University. They also received training from their employment, and it was her view that anything that was in the practice tools and guidelines would be known to the workers through their tertiary qualifications and learned experience, and they would be able to undertake those practices.⁶⁶⁴

2609. BU stated that she is familiar with the subject matter of recognising physical abuse particular in reference to bruising. BU also recognised the practice guide recognising abuse and neglect, stating it was familiar to her throughout the period 2014-2015.

2610. In respect to the 'knowledge portal', BU said the Department made it clear to all workers that they should check the 'knowledge portal' regularly, to the point where they could check to see if workers were not checking the portal and they would then have to explain themselves.⁶⁶⁵

2611. BU stated that it was very difficult in the court setting to explain all the tools that caseworkers use to gain information and to assess situations, but primarily they should demonstrate that they have been complied with in undertaking the assessment and that the children were safe.

2612. In respect to the Dillon children, BU said that NL came to her citing concerns in respect to the number of bruises on Bradyn's face. They both discussed what action should take place and what information was required in order to determine that action. There would have been discussion in respect to what had actually been undertaken.

2613. BU stated that both NL and KE had concerns and they came to her to discuss them. Even though Graham Dillon was difficult at the school, they felt they could manage him because, whilst he was volatile, he was not to the point where they couldn't manage him.

2614. BU also opined that the discussion would have been along the lines of are the children in need, do we need to take emergency action, both NL and KE considered that the children were not in need of care and protection because, despite their concerns, there seemed to be a plausible explanation for some of the bruising. BU stated that she went to see Graham Dillon and spoke to him about his use of physical chastisement, what punishment he used, and discussed the use of rough play, because those things could

⁶⁶³ Transcript of Proceedings, p 1739

⁶⁶⁴ Transcript of Proceedings, p 1739

⁶⁶⁵ Transcript of Proceedings, p 1741

be inappropriate if they are causing bruising to the children and he needed to change what he was doing at home to prevent it.⁶⁶⁶

2615. BU advised that, whilst the case was open, NL would discuss with her who she had spoken to, what information she sought, including from the school, and information in relation to the various supports Graham Dillon had in place, including from BP, FQ, the church, and the Bungee Program.

2616. BU stated that they always independently double check what the parents have told them

“unless you can see for yourself that and you know they’re attending something or they can produce a certificate of attendance, we always try to verify that from another source.”⁶⁶⁷

2617. BU confirmed that that would be in accordance with the policies that were expected to be implemented.

2618. BU was aware of the role of BP and considered that his support and information would carry a lot of weight because he was the ‘eyes and ears’ in the community.

2619. In relation to the Dillon file when BU returned from leave, she informed herself of the file by speaking with NL, reading the reports, and cross-referencing them with Child Concern Reports and information that was required by her. It would have been her practice to check this information on the CHYPS database.⁶⁶⁸

2620. BU stated there is also a component of looking at the harm factors. She stated that she endorsed the recommendation contained in report,. She stated that the matters she took into account when signing off on the recommendation were that the child was not at risk, that was noted from examining the analysis and conclusions reached by the caseworker. She stated that this is the usual process for satisfying oneself that there are no issues requiring further investigation and that it is therefore the right recommendation.

2621. The Team Leader is also required to look at the harm factors to determine whether further action care and protection should be taken. Those include whether you should take no action, remove the child from the family or whether there needs to be community referral support. There is also a component of whether the child is in need of further care and protection involvement.⁶⁶⁹

2622. BU recalled that when meeting with NL for supervision she was very organised and always had paperwork and notebooks. BU was shown the notes from NL and agreed that she recalled having discussions reflecting on that note.

2623. BU was aware of the reports from the schoolteachers in respect of finger marks on Bradyn’s face and grab marks on JL’s face. In relation to the factors she took into account when endorsing NL’s recommendations, she accepted the account of positives articulated in the safety and protective factor analysis.

⁶⁶⁶ Transcript of Proceedings, p 1746

⁶⁶⁷ Transcript of Proceedings, p 1746

⁶⁶⁸ Transcript of Proceedings, p 1749

⁶⁶⁹ Transcript of Proceedings, p 1750

2624. In regard to gathering information, BU stated that it is not always appropriate to speak to the parent who does not have primary care of the children. It would depend on the situation. BU was aware that there was a dispute in respect to the custody of the children, and that NL's report had stated that the children were in the full-time care of their father.
2625. BU was asked whether it was usual practice to obtain documents to ascertain the actual care arrangements and she replied that it would depend again on the situation and if approaching the Family Court was required, they would need to have a very specific reason to do so.
2626. BU stated that in relation to reviewing the whole case file, it would be impossible for the Team Leader to do so, given there would be not enough hours in the day, however her expectation was that the caseworker would have reviewed all the material including from 2013.⁶⁷⁰
2627. BU was aware that UN had made an allegation involving Graham Dillon which included aspects of family violence but only insofar as it had been reported by the caseworker.
2628. BU stated that various information that may well be on the system, whilst may be available to her, would not be something that she would be aware of unless she went specifically into the report. Her knowledge would come from the report created by NL.
2629. There appears to be a difficulty in respect to the documentation because the new IMS system, which went live in 2014, had a different layout to those used previously. That would include the 2013 report. BU agreed that she had raised in her response to the 'K' Review that there was less ability for free-flowing dialogue in the boxes than there is in the new format, and that has created a difficulty.⁶⁷¹
2630. BU confirmed that in her view the files of this family should have been linked. However, someone would need to create that link, and to do so they would need to be aware of the other family connection. There are gaps in the system, and it requires case workers to ask questions when allocated a case to cross-reference the children as best as they can.⁶⁷²
2631. BU confirmed that it in this case the Child Concern Report from 29 July 2014 identified UN and the three children. It also provided a contact number and address for UN. BU was asked whether there would be an expectation that the caseworker should contact an ex-partner given the file was open and she replied that it was not necessarily appropriate at that stage of the appraisal. It may be possible or appropriate if there was to be a care and protection assessment report but that all depends on the circumstances and the information that is required.⁶⁷³

⁶⁷⁰ Transcript of Proceedings, p 1755

⁶⁷¹ Transcript of Proceedings, p 1760

⁶⁷² Transcript of Proceedings, p 1760

⁶⁷³ Transcript of Proceedings, p 1761

2632. BU stated that if there was an open case linked to the case that either she or the caseworker was working on, it was her practice to have a conversation with the other Team Leader and or caseworker about their knowledge of their case.⁶⁷⁴
2633. BU identified that when recommendation is made for no further action, it does not mean that they have just dismissed the report. It means that, after the assessment, the threshold test has not been met. Generally, a caseworker would go back and familiarise themselves with the chronology of the matter. However, it can be difficult because there may be hundreds of reports depending on the child being reported on.⁶⁷⁵ Importantly, it is whether the system is linked at the intake stage.
2634. BU set out the role of the Intake Officer which included being at the front line, taking calls and emails from multiple sources having considered the information reported to them, and determining whether it meets the threshold in terms of policy and procedures, If the case doesn't require generating a particular report, they also consider if the child is known to the CYPS and generate a Child Concern Report on their record.⁶⁷⁶
2635. BU stated that there are clear guidelines if there is a mandated reporter providing information and there is also issues as to the activity their undertaking, and whether it is more of an appraisal activity than an intake activity.⁶⁷⁷
2636. BU stated that she was aware at the time she received the appraisal report from NL on 20 August 2014 that there had been previous reports of bruising to the face of Bradyn and JL. BU confirmed that she did have a conversation with either NL or KE about that fact. BU opined that they would have discussed and made comments such as it is not appropriate and that, if it is a form of discipline, a conversation will be had with the parents about finding more appropriate ways of disciplining their children.⁶⁷⁸
2637. BU confirmed that the disclosure made by JL was a disclosure of physical abuse and that would have been understood by even the lowest HP 1.
2638. BU stated that her practice when endorsing such disclosures is that the children's views are considered, and they are taken into account when considering whether being subjected to physical abuse with reference to policy and procedure. She further stated that whether the parents are engaging with Care and Protection and how they are responding to the questions are factors that are taken into account.⁶⁷⁹
2639. Once those factors are taken into account and the risks are weighed up, recommendations are then made, and those recommendations are required to be endorsed by a Team Leader.
2640. BU was asked about her response to the 'K' Review, and she stated that both she and NL composed the response together. In respect to that response BU made the following comment;

⁶⁷⁴ Transcript of Proceedings, p 1762

⁶⁷⁵ Transcript of Proceedings, p 1762

⁶⁷⁶ Transcript of Proceedings, p 1763

⁶⁷⁷ Transcript of Proceedings, p 1763

⁶⁷⁸ Transcript of Proceedings, p 1766

⁶⁷⁹ Transcript of Proceedings, p 1767

"This report was handed - this report was handed back to me. The director hadn't read the report but somebody in the what he said is that somebody in the executive team had read the report and were concerned at the responses that Mary-Anne and I had made, because we were accepting if somebody else has read - and if our reporting and our paperwork hadn't been clear to a reader, we were accepting - I think at several points we agreed with what the reader was saying, agreed with their - sorry. It was said to us that the way - it was said to me that the way we had reported, we were accepting liability for Bradyn's death, for what happened to Bradyn, and there was a suggestion that I could go through the report and address it in more of a forensic - a forensic response going by appraisal, by appraisal, by appraisal, stating what we did, how we did it and the - how we arrived at our conclusion. But at that time I became very unwell"⁶⁸⁰

2641. BU stated that neither she nor NL had access to the children's file as they were not allowed to access those files and their response was purely from memory. This response occurred over two very long full days. Both BU and NL went through the report providing responses where appropriate. It was BU's evidence that she and NL looked at the report from the lens of a front-line worker and it was her view that the 'K' Review looked at it from the lens of an executive member with a focus on a systemic response about practice in place and what policies and procedures were in place at the time. This was from a very different perspective to both her and NL.⁶⁸¹

2642. BU accepted that going through the process meant identifying gaps that were not identified during the time that would be beneficial. However, it was made clear that both NL and BU believed they were diligent in their assessment of the case. BU made the case that the working environment was difficult, they were very short-staffed, and there was a lot of things going on for staff at the time in terms of policy changes, practice changes, continual meetings, and uncertainty about their jobs.⁶⁸²

2643. There were also issues in respect to the terminology the reviewer had used in the paperwork because those forms hadn't even been developed at the time of the incident. There was also comment in respect to the sexual abuse forensic interview training, which was an excellent training course on how to interview children however it was pitched at a very high level not at the HP1 level. Priority was given to more senior workers, which was not allowing for the fact that the junior workers were undertaking the work which would require them to have that level of knowledge.

2644. BU also reported that between 2014 and 2015 there was a priority order in relation to training. She stated that everyone was trying to enrol their team members and it was difficult.⁶⁸³

2645. BU was asked whether it was appropriate that NL relied on the information provided by BP about concerns in relation to Graham Dillon such as no domestic violence concerns, no drug and alcohol issues, or any issues identified with the children. BU stated that it is difficult because her answer would be given in hindsight, but she does not consider that it was best practice. Best practice would be to contact the police or request PROMIS notes, providing there is a good reason to do so, and it relates to a child concern reason.⁶⁸⁴

⁶⁸⁰ Transcript of Proceedings, p 1773

⁶⁸¹ Transcript of Proceedings, p 1774

⁶⁸² Transcript of Proceedings, p 1774

⁶⁸³ Transcript of Proceedings, p 1775

⁶⁸⁴ Transcript of Proceedings, p 1778

2646. In relation to whether it would have been best practice to examine the previous case note recorded on CYPS if there was an issue involving the police, BU stated that if police had concerns, they would have contacted CYPS themselves.⁶⁸⁵
2647. In relation to the endorsement of the appraisal dated 20 August 2014, BU said that she would have considered the intake and appraisal policy as well as the legislation. BU confirmed that she would need to be satisfied of the activities conducted by the caseworker, how they arrived at their conclusion, and their analysis of their assessment. BU stated she needed to be satisfied that the children were not left in an environment where they could be experiencing harm.⁶⁸⁶
2648. BU confirmed that she would review the records including Child Concern Report, appraisal outcome reports, and any other material or information that had been gathered during that period. BU confirmed that she was satisfied that the relevant legislative requirements had been addressed.
2649. If BU had been given a case with the same set of circumstances, in hindsight and on reflection, she would have contacted a parent or had those conversations with her workers in respect to why they hadn't contacted the parent as there may be reasons why they did not.⁶⁸⁷
2650. BU stated that it is difficult for her to reflect as to whether she would have done more in the case where JL had disclosed that she got hit and kicked by her father. Every day she has reflected on whether she teased out enough information from the caseworker at the time or whether the team did enough, knowing the outcome.⁶⁸⁸
2651. BU stated that, whilst the practice guidelines are very robust, there needs to be a commitment to ensure that the most appropriate person undertakes the statutory investigation. That includes the level and experience of that caseworker.⁶⁸⁹
2652. BU was taken to the case supervision document in respect to Bradyn's bruised ear, nose, and face from the school. BU had ordered a section 862 request for a criminal history for the father. There also needed to be an incident report completed regarding threats by him to staff and a CARHU report. BU was informed by NL that Bradyn had been taken to CARHU for assessment but cannot recall any conversation she had about it. However, she would have had access to the case notes on the CHYPS database.
2653. BU confirmed that in her statement she said that NL had advised her that the bruises were not significant enough to be suspicious and, in the second statement provided, that NL told her that OQ had told her that the bruising on Bradyn's ear was not suspicious.⁶⁹⁰ BU opined that she did discuss it with NL and expects that every bruise is of concern, however she was informed that the assessment didn't identify that bruising was suspicious enough to warrant removing the child from their carer.

⁶⁸⁵ Transcript of Proceedings, p 1778

⁶⁸⁶ Transcript of Proceedings, p 1780

⁶⁸⁷ Ibid

⁶⁸⁸ Transcript of Proceedings, p 1781

⁶⁸⁹ Ibid

⁶⁹⁰ Transcript of Proceedings, p 1784 -85

2654. BU confirmed that she did read the CARHU report but could not recall when in September that was. BU could not recall whether it was a hard copy or uploaded onto the system. When she read the opinion, she consulted with NL and queried the opinion about the blunt trauma, the red marks on the arms, and if they were of concern. BU said she queried the discrepancy with NL because she believed she had been told there was no concern regarding those marks. NL told her that OQ was very clear to her that there were no concerns in relation to the bruising. NL was concerned about the bruising but given the report outcome, that meant that they were not of sufficient concern or suspicious enough for them to take emergency action.⁶⁹¹
2655. Generally, if there was some uncertainty about a report such as a CARHU report, contacting the writer or author of the report would be the appropriate action to take. BU thought that NL had spoken to or attempted to speak to OQ about the uncertainty in the report.
2656. BU said it would generally take two weeks for the written report to be generated and if there were any further information to be provided to the CARHU Doctor that would be a new referral.⁶⁹²
2657. BU was referred to a document (page 1008 of exhibit C5) and asked whether it would surprise her if no independent contact was made by the caseworker in relation to the services, referred to in the document, being said to have been involved with the family. BU said she would be surprised.
2658. Despite the assertion by BP that he had no concerns in respect of Graham Dillon, both NL and BU had concerns about the bruising.⁶⁹³ BU said that her gut instincts were telling her and also NL that there was something wrong given the reports of bruising coming through. However, those concerns did not match up to the information they received throughout the assessment and also through the observations by both caseworkers and the secondary worker which indicated that the children were not experiencing physical abuse.⁶⁹⁴
2659. BU agreed that there had been a number of schoolteachers who had reported concerns about the bruising that they had observed. BU also agreed that the teachers had concerns over the high level of absenteeism. There were also reports of the behaviours observed by the teachers of Bradyn freezing up and not talking and shutting down as well as other teachers observing JL with bruises to her face at various points. It was also identified that there was a positive information coming from the school as well. BU agreed there were positive and negatives coming from the school which were of concern. BU also agreed that the note in respect to a phone call on 1 August with an opinion from NL that the children did not inflict this upon each other, would indicate there was some concern by the caseworker about the explanation given.
2660. BU agreed that there should have been independent checking of assertions, particularly made by Graham Dillon, and if there was no verification and was just accepted at face value, then that would continue with everyone assuming that there

⁶⁹¹ Transcript of Proceedings, p 1785

⁶⁹² Transcript of Proceedings, p 1788

⁶⁹³ Transcript of Proceedings, p 1789

⁶⁹⁴ Transcript of Proceedings, p 1789

was community service providing support, when there wasn't.⁶⁹⁵ BU agreed that it would be best practice not to rely on statements provided by a parent and it was the caseworker's responsibility to verify the information.⁶⁹⁶

2661. BU stated that is a common area of training and encouragement is given to ensure that they do confirm the veracity of the reports. BU stated that NL was very clear, and BP was very clear, that Graham Dillon was attending those services when he was not. BU said she would have no reason to disbelieve BP as he was in a professional role.⁶⁹⁷ BU agreed that BP was an advocate for Graham Dillon and said that was not uncommon.

2662. In relation to the tick box about cumulative harm, BU said that where cumulative harm was identified that was something they wanted to undertake a separate case analysis on. BU confirmed that it was her view that cumulative harm is assessed in case work, however what they were not good at doing was capturing that analysis on the form in respect to cumulative harm. It is not to say that the caseworkers were not doing assessment, it was just not captured well on the format.⁶⁹⁸

2663. BU was asked to look at the document where she endorsed the appraisal in the report on 13 October. That document outlines NL's views as to the protective factors in place for the family. BU said she was not aware of any Protection Orders from Victoria but would expect a caseworker to obtain that information.

2664. BU was taken to the further information in the document about the mother's role and the children's wishes. BU stated that it is not necessarily expected that the caseworker would contact the mother.

2665. BU was taken to the endorsement where she recommended that appropriate protective measures were identified, and the case can be closed. In reaching that conclusion, she stated that she considered the following factors;

- 1.1 The threshold definition of physical abuse and what constitutes significant harm;
- 1.2 whether the children are in need of care and protection at that point in time;
- 1.3 whether the children are being abused or neglected or are they at risk of abuse and neglect; and
- 1.4 other protective measures in place to mitigate the risks.

2666. BU stated that, on the basis of the assessment, Graham Dillon was willing and able to provide appropriate care for his children and therefore no further CYPS role was recommended.⁶⁹⁹

2667. BU stated that she had concerns still at that point, as did NL. The reason why those concerns did not elevate the recommendation was because they had not reached a

⁶⁹⁵ Transcript of Proceedings, p 1791

⁶⁹⁶ Ibid

⁶⁹⁷ Transcript of Proceedings, p 1792

⁶⁹⁸ Transcript of Proceedings, p 1793

⁶⁹⁹ Transcript of Proceedings, p 1795

threshold for them to take emergency action. A letter was sent to Graham Dillon on 14 October 2014 advising him of that fact.

2668. BU was shown a report dated 14 October 2014 at 13:30 hours from the school reporting that Bradyn had returned from school holidays with bruises down the left side of his face.

2669. An email was generated by another case worker, DM, about the report and whether there was any indication of how Bradyn sustained those bruises.

2670. DM forwarded on another email to NL and BU suggesting that if further information is obtained, a report can be generated, or a report of physical abuse could be generated.⁷⁰⁰ BU thought that she may have received that email.

2671. It was apparent that on the same day the letter advising Graham Dillon that the report of abuse was not substantiated, a report was forwarded by the school in relation to more bruising to Bradyn's face.

2672. BU said she would have had a conversation with NL about that report, but that she could not recall the conversation.⁷⁰¹

2673. BU recalled that NL generated a Child Concern Report about that report from the school with the information about the observations the schoolteacher made on both Bradyn's face and Graham Dillon's behaviour.⁷⁰²

2674. The initial risk document said the following;

"There have been 12 reports in respect of Bradyn and [JL], seven reports in relation to family violence and the mother's substance misuse in 2013. Currently there is a domestic violence Protection Order against Bradyn and [JL]'s mother. There have been five reports in relation to both the children presenting with several bruises to the face since June 2014. All reports received in 2014 are in relation to allegations of physical abuse'⁷⁰³

2675. The box that asks, '*is there a need for separate case analysis in relation to cumulative harm*' was marked 'no'. Another box which asks whether there '*is a reasonable suspicion that the child may be need of care*' was also marked 'no'. At page 1166 of exhibit C5, it states at this time there is no evidence to suggest Graham is not meeting Bradyn's day-to-day needs.

2676. Concerns remain in respect to allegations concerning physical abuse, however a CARHU medical assessment has been conducted and there were no suspicious concerns regarding the bruising on Bradyn's face. There has also been no disclosure from the child to indicate physical abuse. BU confirmed that there was no CARHU assessment in relation to this report.⁷⁰⁴

2677. BU, upon considering the report, stated that the caseworker had looked at the information and there was an explanation which was plausible in respect to the bruising.

⁷⁰⁰ Transcript of Proceedings, p 1796

⁷⁰¹ Transcript of Proceedings, p 1796

⁷⁰² see Transcript of Proceedings, p 1797.15

⁷⁰³ Transcript of Proceedings, p 1797.29

⁷⁰⁴ Transcript of Proceedings, p 1798

2678. BU was also of the view that it was appropriate to generate a Child Concern Report so that would be placed onto the file, however the assessment of it resulted in the threshold for a care and protection assessment or referral to either SACAT or CARHU was not warranted.⁷⁰⁵
2679. It was BU's view that they had already had experience of the previous CARHU referral, the bruises were faint, there was nothing which would ordinarily mean that child should be seen by the GP, the bruises were old and fading and the child was not distressed.⁷⁰⁶
2680. BU stated that even though the previous report had indicated there were finger marks and grab marks on the jaw line she would not necessarily have responded differently because the report is only one part of what a caseworker looks out when completing a report.
2681. BU stated the critical issue is whether the information they have meets the threshold test for care and protection report and all the caseworkers had to go on at that point in time was the one email. It was suggested to BU that the other part of the report was that the teachers had concern because there was similar facial bruising identified previously. It was suggested to BU that the information had been received, together with other information such as Bradyn's explanation of how he got the injuries as well as the suspicious behaviour of Graham Dillon that would be additional information to take into account. BU agreed that that would be something she would consider.
2682. It was suggested to BU that in hindsight with that information would that be assessed or considered for cumulative harm. BU said;
- "I'm not sure about the cumulative harm, because that was very separate. That was in respect of the case analysis team. So, the guidance we would be given, the information and the advice we were receiving at that time – we weren't able to consider that. In respect of cumulative harm in – during casework – this was another reason as to why we – we weren't readily closing the case as quickly as what we should – should have been doing. We were trying to keep the case open as long as possible. It just did not meet the threshold for us to take it through to the next – the next stage. I can't remember, without seeing all of the – the activities, what NL (sic) did – on this report"⁷⁰⁷
2683. It was suggested to BU, who agreed, that NL was the case worker for the whole of the time of these reports between June and October 2014. BU also agreed that NL would be aware of all of the reports which had been made. BU stated that NL would have considered the cumulative harm aspect automatically through her casework.⁷⁰⁸
2684. BU stated that this was not a case where cumulative harm had been identified as being needed to be forward to a principal practitioner, because there was no clear role for what she was undertaking. CYPS had at the time cases of cumulative harm or worrying cases that were thought to require more senior analysis and that principal practitioner was available for that purpose definitely by November 2014, but she may not have been taking cases on until January 2015.
2685. BU agreed that given the number of reports in this case that by themselves do not meet threshold for ongoing care and protection but because they were received in such

⁷⁰⁵ Ibid

⁷⁰⁶ Ibid

⁷⁰⁷ Transcript of Proceedings, p 1800

⁷⁰⁸ Transcript of Proceedings, p 1800

a short period it would have been beneficial for different eyes to do the analysis of the history and chronology and that is what the purpose of the case analysis team was. Their role was to very thoroughly examine every report and every decision made to determine whether there was a pattern and that the threshold for cumulative harm was sufficient to take further action.

2686. In relation to options other than taking emergency action or closing the file, BU opined that at the time the direction was that is the child or children in need of care and protection and if not they had to close the case, they were not able to keep the case file open.

2687. BU advised that they used to keep the case file open for 3 to 6 months, but it was determined that that was not appropriate because there was no legal basis to do so.⁷⁰⁹

2688. BU stated that an appraisal is like a snapshot and there was a very short window of opportunity to assess the risk or concerns being reported. The appraisal was meant to be completed within 28 days. If you needed further time, you needed to request an extension. For that to happen she would have to present to the Operation Manager about why that file should be kept open longer than that.⁷¹⁰

2689. It was pointed out to BU that this report was received on 14 October and closed on 14 October. BU agreed with that proposition.⁷¹¹

2690. BU was taken to a report received on 3 November by NL. The report identified that the children's mother had taken them to Victoria and had drugged the father in order to do so.

2691. In relation to the report of the schoolteacher on 14 October, BU stated that because of the gaps the coronial inquest had identified what she would do differently because she would not wish any family to go through this nor would she wish any caseworker to go through this. BU stated that it would be impossible not to make different decisions or inquiries looking at it in hindsight and she would not trust caseworker's decision-making again.⁷¹²

2692. BU stated that she would doublecheck everything and she would ensure that every practice guideline was followed by the caseworkers. BU stated that

"and I know they have followed it, but we have not captured – in our decision-making we have not captured – nowhere near captured as good as what we – what we should have been able to present in a written format"⁷¹³

2693. BU was taken to the recommendation by NL that the case should proceed to a Child Protection Report which was endorsed by BU. This recommendation was as a result of report received from Victorian DHHS Care and Protection worker in respect to the alleged kidnapping.

2694. BU does not recall receiving any request for information on 17 November 2014 from Victorian DHHS. At that time, both NL and BU were on training and were not in the

⁷⁰⁹ Transcript of Proceedings, p 1801

⁷¹⁰ Transcript of Proceedings, p 1802

⁷¹¹ Transcript of Proceedings, p 1802

⁷¹² Transcript of Proceedings, p 1804

⁷¹³ Ibid

office.⁷¹⁴ That training was in relation to the Integrated Management System being rolled out at the time.

2695. BU explained that when case workers were away from the office at training, there would be a board which indicated where they were so another Team Leader could contact them if it was urgent. There was the option of also emailing a caseworker or Team Leader who was on the training if it was urgent. Failing that, there were Operation Managers and other managers on the floor who could have assisted in the request, given it was urgent.⁷¹⁵

2696. In relation to allocation of case load, BU said that Team Leaders allocated files to team members. This would occur in the morning, after a discussion about any new referrals or reports from the intake department which had been recommended for appraisal. There would be discussion as to who had capacity to take on the new work, as well as the nature of the work, and who in the team would be most suitable to do that work.⁷¹⁶ Another consideration would be the urgency rating of the referral.

2697. BU confirmed that ultimately, it was the Team Leader's decision to allocate the Dillon file. The Team Leader responsible for allocating that file was BD. BU stated that it wasn't necessarily BD but that it may have also been the Team Leader from the Intake Area who would also come along to present the case and be there during the discussion following. That was one way of allocating a file.

2698. Another way of allocating files, particularly if one worker was leaving, was to allocate it into the same team, which would be best option. However, if that was not possible it would be taken to a Team Leader meeting with an Operation Manager and a decision would be made as to who was best place to take on the existing file.⁷¹⁷

2699. In relation to qualifications for new starters, BU expected that those with qualifications could start their case work very soon after commencing and that they would "*hit the ground running*".⁷¹⁸ BU also qualified that proposition but suggesting that she had spoken to both newly qualified students at University and was surprised that despite having work placement experience they hadn't actually specialised in the role of children and families.⁷¹⁹

2700. BU stated that she had a different training which identified various strands such as mental health in adults, or child protection. It was her experience that workers who came to CYPS were often overwhelmed with what they were faced with in the field, essentially the reality of the work they were engaged in.⁷²⁰

2701. BU confirmed that she relied upon the information given to CYPS by BP. The reason she did so was because he was a professional employee in a professional organisation. BU was unaware of his qualifications

⁷¹⁴ Transcript of Proceedings, p 1805

⁷¹⁵ Transcript of Proceedings, p 1806

⁷¹⁶ Transcript of Proceedings, p 1818

⁷¹⁷ Transcript of Proceedings, p 1819

⁷¹⁸ Ibid

⁷¹⁹ Ibid

⁷²⁰ Ibid

2702. BU accepted that BP advocated on behalf of Graham Dillon, particularly after the CARHU assessment where he expressed concerns on behalf of Graham Dillon. BU also accepted that he was a spokesperson for Graham Dillon and was certainly in Graham Dillon's camp.⁷²¹
2703. BU was taken to policy documents in relation to the recognition of physical abuse. Particularly, the policy which stated that facial bruising is to be considered nonaccidental unless there is evidence or an adequate explanation. BU confirmed that that was one of the policies applied when determining matters in the first appraisal. BU was taken to several reports of facial bruising and agreed that the policy to be applied was that policies in respect to facial bruising.⁷²²
2704. In respect to the classification of urgency BU opined that she would have assessed that urgency, in line with policy and procedure at the time.⁷²³ She stated that you also considered a number of factors that would be taken into account and the urgency rating was in relation to the urgency of commencing the appraisal.
2705. In respect to the allocation of the Dillon file to PG in December 2014, BU stated that the allocation was for PG, that allocation would generate an Appraisal Outcome Report (AOR) by the system. BU was unable to say why she was named as a caseworker by the system.
2706. She agreed that if an allocation was made to a caseworker and they were unable to work on the case because of leave that would be unfair, therefore the case would be allocated to the Team Leader for a short period of time until handover could be conducted.⁷²⁴
2707. BU confirmed that NL had reported concerns she had about Graham Dillon and the threats he made to her and her family. That was the reason she requested to have the matter reallocated to someone else.⁷²⁵ BU agreed that after receiving the request she allocated it to herself until PG was available to take on the case.⁷²⁶
2708. BU agreed she had a hand over and case consultation with both NL and PG on 12 December 2014.
2709. In relation to what knowledge she had at the time of the contact from Victoria on 1 December 2014, BU was unable to assist as she could not recall, and she did not want to mislead the court.
2710. BU could recall that when NL received a call she was present, as was the Operation Manager. However, she could not recall the context of the conversation, other than that it was concerning. BU stated that she knew that the actions that were taken at that time were appropriate.
2711. BU agreed that LT was the Operation Manager on 20 November 2014.

⁷²¹ Transcript of Proceedings, p 1820

⁷²² Transcript of Proceedings, p 1823

⁷²³ parental page 1824

⁷²⁴ Transcript of Proceedings, p 1826

⁷²⁵ Transcript of Proceedings, p 1826

⁷²⁶ Ibid

2712. BU was asked about the actions required in light of the document completed by NL on December 1. BU stated that, in her view, the recommendation was an indication that the father may be still using ice and she would expect that the caseworker would pick up on that report and act upon it.⁷²⁷
2713. BU confirmed she did not become aware of or see any urinalysis results following from the report.
2714. BU confirmed that the usual practice in relation to obtaining interstate information was through the court liaison officer.⁷²⁸ I note that BU later referred to this position as the Interstate Liaison Officer.⁷²⁹
2715. BU confirmed that at the time of this request there was some issue in respect to the number of referrals via the ILO. Therefore, it was a requirement to check the 'knowledge portal' to check to see what was required in the situation. BU was aware that NL contacted the ILO and discussed the process of obtaining what she required which would include the Victorian documents.⁷³⁰
2716. BU referred to a conversation she had with NL regarding the process, and recalled NL telling her that they will seek them, but they may not be able receive them, which, BU stated was not unusual as she cannot force another agency to hand over records.⁷³¹
2717. BU was referred to a note written by NL on 9 January 2015 and entered on 14 January 2015, in respect to a phone call from SK. The note identified that SK wanted to know how the children were because she was unable to contact them without their father listening in. There was an allegation that Graham Dillon dictates when the children were allowed to talk and what they're allowed to say.
2718. There was also a disclosure in Victoria that the children were scared of their father and were scared of what he would do if he found out that they had spoken about his behaviour to other people. There was other information in respect to domestic violence with his ex-partner and threats he had made via Facebook.
2719. BU said she was aware of the phone call from SK however could not recall when she became aware of it.⁷³²
2720. BU was referred to the case consultation which contained a number of things which needed to be attended to. One of those was to speak with the mother for her views. BU stated she would be extremely surprised if NL had not told PG about the phone call given that she was aware of it.
2721. BU explained the role of secondary worker, particularly that the role was not always the same it depended on the circumstances. BU was clear that NL would have understood her role as the secondary worker.⁷³³

⁷²⁷ Transcript of Proceedings, p 1829

⁷²⁸ Transcript of Proceedings, p 1829.38

⁷²⁹ My emphasis

⁷³⁰ Transcript of Proceedings, p 1830

⁷³¹ Transcript of Proceedings, p 1830

⁷³² Transcript of Proceedings, p 1832

⁷³³ Transcript of Proceedings, p 1834

2722. BU was referred to the case note she wrote, which stated “*consider decision and rationale, consider a care protection case conference to develop an action plan.*”⁷³⁴ BU stated that she was considering the use of this multi-agency response to be held with the family to develop an action plan. BU stated that it was the caseworker who needed to consider whether that was to be the case. At the time the caseworker was PG.⁷³⁵
2723. BU agreed that PG was new and still learning the ropes however she was also experienced and particularly in relation to facilitating family group conferencing within difficult cases.
2724. BU explained that there were two options in relation to a child protection case conference, one through the court proceedings, and the other through the case management team holding a case conference themselves.⁷³⁶
2725. BU was satisfied that PG was aware of that option because of the various practice guidelines available for her to access. However, she could not be certain whether the practice guideline was available at the time. If there was no practice direction, the expectation would be to seek guidance from a Team Leader. BU stated that getting onto the ‘knowledge portal’ was a daily frustration because it was sometimes difficult to manoeuvre.⁷³⁷
2726. In relation to chasing up the Victorian records, BU opined that it was PG’s task to chase them up.⁷³⁸ In respect to the issue of conflict, which appears to have arisen between NL and BU as to whether NL was a secondary worker to PG, BU opined that ‘secondary worker’ means different things to different people. At that particular time when NL was the second she would be ‘the go to person’ if PG was not there. This does not necessarily confirm that there was a formal arrangement where NL would be co-working the case.⁷³⁹ Specifically, BU explained that, in relation to NL, she was to make herself available as a secondary for PG to assist with home visits for consistency and also for the family to have a familiar face to assist and particularly for the purposes of interviewing the children.⁷⁴⁰
2727. BU was taken to the letter sent by her to Graham Dillon on 23 January 2015. BU confirmed that she endorsed the recommendations of PG, after considering the risk analysis that had been conducted and the assessment of the caseworker.
2728. BU also stated that she had discussions with the Operation Manager and had all the information that had been gathered by care and protection in respect of the report. BU agreed that she endorsed the report knowing that the Victorian Care and Protection file had not yet been received.⁷⁴¹

⁷³⁴ Ibid

⁷³⁵ Ibid

⁷³⁶ Transcript of Proceedings, p 1385

⁷³⁷ Transcript of Proceedings, p 1836

⁷³⁸ Transcript of Proceedings, p 1837

⁷³⁹ Transcript of Proceedings, p 1838

⁷⁴⁰ Ibid

⁷⁴¹ Transcript of Proceedings, p 1840

2729. BU stated that she did so because they could not keep a file open that was waiting for that information. That was particularly the case given that Victoria had outlined their concerns to NL. Those concerns had been addressed in the report created by NL.
2730. BU also stated that there was guidance from senior management, and that given they were at full capacity, case appraisals needed to be completed so they could close the case, providing they were satisfied as to the assessment and report.
2731. The other consideration was that there was a home visit which would have given information as to whether the case was closed or not.
2732. Another factor was that there was community services supporting the family which would be the eyes and ears in terms of Care and Protection. A further factor was that the children were going to school.⁷⁴²
2733. BU said that she didn't have concerns after endorsing the recommendation because PG was a worker who had extensive experience in the field and with making reports. BU was also satisfied with the rationale underpinning PG's recommendation.⁷⁴³
2734. BU was referred to a note created by PG regarding a telephone call she had with SK. It was highlighted that the words appear to suggest that PG has articulated a threshold question had to be satisfied to be able to take further action beyond the appraisal of a need for disclosure.
2735. BU suggested that that is not the case, because if they believe the child needs to be removed, they don't rely on a disclosure. BU gave an example of a child with a broken arm attending the CARHU. Clearly children would be removed without disclosure if it was deemed that it was a nonaccidental injury.⁷⁴⁴
2736. BU stated that PG would need to be satisfied of the threshold which is stipulated in the legislation that is that the children are at imminent risk of harm in the care of their father.⁷⁴⁵
2737. In respect to recording progress notes, BU suggested that there was inconsistency around that practice. Her own experiences was that she takes copious notes and records them. Other caseworkers may just give a synopsis in their notes.⁷⁴⁶
2738. BU was referred to the telephone call from SK, where she stated that Graham Dillon had been sending her threatening messages via Facebook, with guns and bullets, at the time when the appraisal process was still on foot.
2739. BU was asked to comment on whether she would expect the caseworker to follow up on SK's report and she said yes it should be followed up with the father. In answer to a question from me, she also said that it should be followed up with the mother as well.⁷⁴⁷

⁷⁴² Transcript of Proceedings, p 1840

⁷⁴³ Ibid

⁷⁴⁴ Transcript of Proceedings, p 1842

⁷⁴⁵ Ibid

⁷⁴⁶ Ibid

⁷⁴⁷ Transcript of Proceedings, p 1844

2740. BU clarified her position and stated that she would certainly advise the mother to contact police to seek their advice.
2741. When she referred to following up with the father BU said she meant that at some point there should be follow-up but perhaps not specifically about the communication the subject of the report.⁷⁴⁸
2742. In respect to both of the phone calls received from SK, BU expected that the caseworker would follow those up, and if the caseworker was away the case would have been re-allocated to someone else undertake that task.⁷⁴⁹
2743. BU was shown the case note created by PG, where she told UN, after she had reported her concerns and some information, that *“unless there was evidence to substantiate the abuse such as disclosures or photos there’s not a lot that they could do”*.⁷⁵⁰
2744. BU opined that that was not the way it should have been written because it gives mixed messages because there are things that can be done by CYPS in those circumstances.
2745. In respect to the endorsement made by BU to close the case, BU said she was not as involved with PG because of her experience. However, she said that in her analysis in making the decision to endorse the recommendation she reviewed the file, reviewed the appraisal outcome report and progress notes written by PG. She reviewed the rationale for the decision and assessment that was made.
2746. BU also stated that she would have had discussions with PG about the conversation she had during the course of the case assessment.⁷⁵¹
2747. Looking through the lens of hindsight in respect to the number of Child Concern Reports and protection reports, together with the Final Appraisal Reports she was involved with, BU believes she would definitely do things differently.
2748. BU said she was a strong advocate for allocating appraisals to the most experienced caseworkers because they are a creature of statute. BU stated that previously there were two appraisal teams, and they were staffed by the most competent HP numbers and that it was a daily role to undertake appraisals.⁷⁵²
2749. BU said there was no requirement to instruct workers to section information as it would automatically be done, because they would know what to do and they would know how to follow a case through.
2750. BU explained there were very big changes in respect to the workload and the work type done by the caseworkers.⁷⁵³ BU opined that now that it is a centralised system, caseworkers have varying and competing demands, such as completing care plans,

⁷⁴⁸ Ibid

⁷⁴⁹ Transcript of Proceedings, p 1845

⁷⁵⁰ Ibid

⁷⁵¹ Transcript of Proceedings, p 1846

⁷⁵² Ibid

⁷⁵³ Transcript of Proceedings, p 1847

completing annual reviews, completing child protection assessments, and attending case conferences.

2751. BU stated that this makes it difficult, and the pressures placed on the caseworker are huge. BU opined that there are two separate areas in respect of case management and appraisals with two separate skill sets.⁷⁵⁴ BU opined that experience and common sense are two things that you need when it comes to appraisals.

2752. BU opined that in hindsight, she would have done things differently, specifically, she would have asked different questions, and she would have teased out more information to satisfy herself of the circumstances. In relation to the report of 14 October 2014, she stated she would definitely have done things differently. Those things included having a conversation in respect to who was the most appropriate person to appraise these reports, and whether this case was appropriate to go for a separate case analysis.

2753. BU stated that that pathway is now well and truly embedded thorough Principal Practitioners and Senior Practitioners.⁷⁵⁵

2754. In reference to questions posited about cases where children have suspicious bruising or injury and deny anything untoward happened to cause those injuries, it was her experience that if those children lived in fear of the perpetrator they would not disclose because of concerns of retaliation. That should also be known to caseworkers who are appraising the situation, because they attend training on sexual abuse and the forensic interviewing of children.⁷⁵⁶

2755. A further question was posited directed towards behaviours observed by schoolteachers such as telling the teacher *'don't tell dad'*, giving teacher's hugs or asking whether they were in trouble. BU agreed that those sorts of behaviours would be part of the consideration. However, she stated that it could also be that they children are concerned that their parents will find out something and they might get into trouble and that this applies to abusing and not abusing parents alike.⁷⁵⁷

2756. Similarly, if a partner indicated that they suffered from domestic violence and abuse but was too scared to report it because of the consequences that will also be an important piece of information.⁷⁵⁸

2757. BU stated that it was her normal practice to review material on the CHYPS database and that would include whether there was siblings given the case was still open. BU also agreed that information of prior domestic violence would also be matters to feed into the assessment.⁷⁵⁹

2758. BU did not agree with the proposition that neither caseworker considered the material in respect to the prior domestic violence with the ex-partners because she said she could clearly remember conversations between NL and UN in relation to concerns

⁷⁵⁴ Ibid

⁷⁵⁵ Transcript of Proceedings, p 1849

⁷⁵⁶ Transcript of Proceedings, p 1849

⁷⁵⁷ Transcript of Proceedings, p 1850

⁷⁵⁸ Ibid

⁷⁵⁹ Transcript of Proceedings, p 1853

about whether Graham Dillon was an appropriate person to provide care for the children.⁷⁶⁰

2759. It was suggested to BU that on 8 July 2014 there was some advice from UN that Graham Dillon had been aggressive with the children in the past and had wanted to throw one of the twins into a wall to stop the twin child crying.

2760. This suggests that Graham Dillon had a history of aggression with children. BU stated that she was not the Team Leader at the time, and that this was inconsistent with the information that was provided to her.⁷⁶¹ It was BU's view that it was inconsistent that she could have been advised by the same person that they did not have any concerns for Graham Dillon's parenting skills.⁷⁶²

2761. BU stated that it is not uncommon to receive these types of reports about abuse, that it is one of the complexities and challenges that caseworkers face on a day-to-day basis. She stated that therefore, caseworkers are very aware of any history and what that means for the future concerns for the children. They would then follow up what are the immediate risks, and future risks and what are the immediate protective measures that could be put in place

2762. Another question to be asked is whether there are any other gaps in the delivery and what protective measures can be resourced from other areas.⁷⁶³ BU opined that it would be her expectation that caseworkers would review the records in determining what they consider for their assessment because a Team Leader would not be able to undertake the review of all of that material.

2763. BU confirmed that during this period her team grew from three people to nine people because she had to take two extra students for supervision. This increase certainly changed the way she did her job as a supervisor and Team Leader.

2764. The changes were as a result of dividing her time between each of the person she was to supervise or lead, as well as recruitment of HP1 & HP 2 caseworkers. Another limiting factor was that they were trying to bed down significant changes in practice, and it was incre3

2765. 334+65dibly busy.⁷⁶⁴

2766. BU confirmed that there is a relationships tab on a child's record, and it is hoped that

2767. 3265 this would record siblings or half siblings. However, that is not always the case.⁷⁶⁵ BU agreed that if it had been linked there would be an expectation on the care worker to identify those children and examine the system in relation to them as well.

2768. In respect to the process once a report is made, it would appear that there is some overlapping activities. For example, at what point does an Intake Worker conducting an activity become an appraisal activity and so on. If an Intake Worker was considering

⁷⁶⁰ Ibid

⁷⁶¹ Transcript of Proceedings, p 1854

⁷⁶² see Transcript of Proceedings, p 1857.5

⁷⁶³ Transcript of Proceedings, p 1859

⁷⁶⁴ Transcript of Proceedings, p 1861

⁷⁶⁵ Transcript of Proceedings, p 1864

a recommendation of an appraisal, then they would not undertake a thorough activity such as requesting information.⁷⁶⁶

2769. BU agreed that the Intake Worker is expected to provide a brief analysis of current and previous contact by CYPS and the children or their siblings.

2770. BU also agreed that the appraisal does not just rely on the brief analysis but that there is a requirement to look at the whole history and conduct a thorough analysis. BU agreed that at the appraisal stage there is still a requirement of rigour in terms of looking at previous material.⁷⁶⁷

2771. In respect to the appraisal form, seen at page 1203 of exhibit C5, BU agreed it did not reflect a history of concerns in relation to emotional abuse but that it did confirm that emotional abuse would be part of domestic violence or family violence and an automatic connection should be made.⁷⁶⁸

2772. In respect to that report from a neighbour that Graham Dillon was being particularly hard on Bradyn and that there they were concerned as to his level of care for the children, BU was referred to the answer by NL (contained on transcript page 1873.20 – 45). NL was asked whether a family which has 40 or 50 reports was of significant concern to the Department and to which she answered yes it was. It was then suggested to her that she should look carefully at each and every one of those reports and the cumulative effect rather than glossing over them and NL answered yes. When it was suggested that she may have glossed over some of them in this case she said she *"I don't know, probably, I don't know."*⁷⁶⁹

2773. BU was asked whether she expected that NL would look at the full child protection history and every single report, BU replied it's a difficult question and that they do expect caseworkers to have a thorough understanding of the case and part of that will be going back through the children's history.

2774. Having said that, BU stated that one does not expect caseworkers to go back to every single intervention or every single appraisal which had been undertaken and reassess the situation. The expectation is that the caseworkers go back, familiarise themselves with the history and be aware of key incidents to formulate a picture around the cumulative harm and the pattern of reporting to care and protection.

2775. If those reports are not substantiated, then there is no reason to go back and review them, particularly if there were protective measures and the risks were assessed.

2776. In relation to the urgency rating, it appears that in the material there were two sets of urgency ratings, with the same underlying principles and criteria. One set having an urgency rating of 24-hour's and one of 72 hours. BU described it as being rather confusing for everyone using the system.

2777. Given that the assessment for the Child Concern Report at page 2666, exhibit C5 provided seven days, was it usual to depart from the urgency rating. BU stated that it was quite common practice at the time if there were certain circumstances surrounding

⁷⁶⁶ Transcript of Proceedings, p 1865

⁷⁶⁷ Transcript of Proceedings, p 1866

⁷⁶⁸ Transcript of Proceedings, p 1871

⁷⁶⁹ Transcript of Proceedings, p 1873 – 1874

the report and the enquiries have already been made.⁷⁷⁰ BU opined that it is essentially a guide and it is not set in stone.⁷⁷¹

2778. , BU said that the seven days generally commences when the Team Leader endorses the file to proceed to an appraisal.

2779. In answer to questions from Counsel for DHHS in relation to the ILO, BU agreed that there most likely would be a practice guideline for the ILO,⁷⁷² the practice generally is that the caseworker would contact the ILO in their state with a referral to another statement requesting information. The ILO would then contact their counterpart in that state and liaise with that counterpart for the exchange of information. The information would then be furnished to CYPs.

2780. BU stated that there is a number of ways to request the information, either by speaking to the ILO face-to-face, by email, or telephone call.

2781. It was suggested to BU that there was no request made by the ACT ILO to the Victorian ILO for the material from Victoria. BU said she was not aware that that was the case.⁷⁷³ BU does clearly remember having a conversation with NL about obtaining the information via the ILO.

2782. BU stated that it was her view that NL had contacted the caseworker in Victoria and there was a conversation about Victoria providing the material to the ACT. Given the notes were not obtained they did not chase it up, BU was of the view that the ILO was also chasing the material up and that the ILO had told her that it may not be successful.⁷⁷⁴

2783. BU was asked whether there was anything preventing NL from confiding in the Victorian caseworker that she spoke to about her concerns in respect to the children in the care of their father. BU stated that there is no reason why she could not do so, and it was her understanding that NL had made it very clear to them the concerns about the report they had received.

2784. It was her view that NL would have advised that their assessment was that the case did not reach the threshold for the children to be removed from Graham Dillon's care, and that was because there were supports in place which were protective of the children.⁷⁷⁵

2785. BU was provided with an outline of the system in Victoria where they have an Intake Team, a separate Investigation and Response Team, and a Case Management Team. BU said the system described was similar to the one they had in 2012 /2013. BU said there were significant changes in the way they dealt with their core business during that period and there was a lot of stress on the staff, but she had no concerns in respect to NL's practice.⁷⁷⁶

⁷⁷⁰ Transcript of Proceedings, p 1894

⁷⁷¹ Transcript of Proceedings, p 1895

⁷⁷² Transcript of Proceedings, p 1897

⁷⁷³ Transcript of Proceedings, p 1899

⁷⁷⁴ Transcript of Proceedings, p 1900

⁷⁷⁵ Transcript of Proceedings, p 1927

⁷⁷⁶ Transcript of Proceedings, p 1937

2786. BU stated that if a case had been closed and within three months there was a new appraisal coming through, she would expect that the initial case management team looking at the case would be best placed to continue to reappraise the situation if they had capacity to do so.⁷⁷⁷ In terms of the November report from DHHS, they had capacity to re-appraise the case.⁷⁷⁸
2787. The appraisal was completed on 3 December and endorsed on 4 December.
2788. In respect to the issue of Graham Dillon seeking counselling for both himself and the children, it was thought that he was being resourceful and showing initiative to get these supports in place. It was because of the counselling and support Graham Dillon had in place that the appraisal was endorsed, and closure and recommendation was made by BU.
2789. Had she known that Graham Dillon had indeed not done any of those things she would not have endorsed it. BU stated that this knowledge would have given the caseworker another option and they would have commenced a further assessment in that regard.⁷⁷⁹
2790. In regard to the toxicology results, BU said that whilst it is difficult to say what they would do if they had had that information, it would have been included in the assessment by the caseworker.⁷⁸⁰
2791. BU stated that even if they had known that there was amphetamine or methamphetamine in Graham Dillon's system, they would need to have a context surrounding that information and that the information would be assessed in that context.⁷⁸¹
2792. BU stated that she was unaware at the time PG commenced work with CYPS, that PG had not worked in the area of Care and Protection since 2003.
2793. BU agreed that she had not discussed with PG her experience or expectations in relation to a caseworker and a second. BU said that she aware that PG did undertake quite a lot of training when she commenced working with CYPS. BU agreed that it was a lot of training which would have taken a considerable amount of time to absorb all the information.
2794. BU also agreed that PG's understanding of the role of a secondary worker was different to the role occupied by CYPS secondary worker.
2795. It was suggested that PG's understanding when she was allocated the Dillon file was that if she was away or unable to action or complete a task that the secondary worker would take over those tasks. BU was unaware of what PG's expectations were but stated that if there was another person expected to carry out the task, then the task would have been attributed to that person's name on the action plan.⁷⁸²

⁷⁷⁷ Transcript of Proceedings, p 1938

⁷⁷⁸ Transcript of Proceedings, p 1939

⁷⁷⁹ Transcript of Proceedings, p 1946

⁷⁸⁰ Ibid

⁷⁸¹ Transcript of Proceedings, p 1947

⁷⁸² Transcript of Proceedings, p 1950

2796. It was also suggested that PG was of the view that specific tasks should have been allocated to a specific worker, BU agreed that in hindsight that would have been appropriate.⁷⁸³
2797. BU agreed that if an action had not been completed and it was the Team Leaders view that it should have been, it is open to the Team Leader to not endorse the recommendation.⁷⁸⁴
2798. It was further suggested that, regarding the Child Protection Case Conference, if that had not been considered then it was again open to the Team Leader to reject the recommendation and not endorse it. That was also the case for an appraisal outcome report. BU agreed that she did endorse PG's recommendations in relation to the Dillon case.⁷⁸⁵
2799. BU agreed that she would be better assisted by the contents of Care and Protection Services Appraisal Outcome Report which records the actual process of the appraisal and investigation of what occurred in those reports.⁷⁸⁶
2800. BU agreed that reading through the outcome report that was shown to her was consistent with the handover she was given by both NL and PG. Stating
- “there's nothing from what [NL] and [PG] have said throughout their assessment of the situation that would make me think they've not gone through and familiarise themselves with the case history. “.⁷⁸⁷
2801. BU agreed that the actual appraisal outcome report is of more forensic value to her than just the report as it provides context.⁷⁸⁸
2802. BU agreed that when she returned from leave in August 2014, she conducted a demand management check of all open files. This report consists of the system completing a run of reports allocated for each worker within the team, as well as allocated cases. This is to ensure that the Team Leaders are aware of the current status of work allocated to their team.
2803. BU stated that Child Concern Reports had been entered on her whiteboard in the office and had 'NFA' which meant no further action.
2804. In relation to a doctor's report on an assessment of a child, BU was of the view that a doctor would not countenance a child being returned to an abusive parent.
2805. BU also stated that she would not have thought that a doctor would wait two weeks to provide a written report if they were of that view.⁷⁸⁹
2806. In relation to her contact with SACAT, BU stated that the reports received indicated physical abuse. The normal course of action would be to contact SACAT and advise

⁷⁸³ Transcript of Proceedings, p 1951

⁷⁸⁴ Ibid

⁷⁸⁵ Transcript of Proceedings, p 1952

⁷⁸⁶ Transcript of Proceedings, p 1955

⁷⁸⁷ transfer page 1956

⁷⁸⁸ Ibid

⁷⁸⁹ Transcript of Proceedings, p 1959

of the situation, giving them an opportunity to either take the lead or ask CYPS to do so.

2807. In relation to the relationship with SACAT, BU agreed with recommendation seven of the Muir Review as something that should be contemplated, having considered these matters through the prism of hindsight.⁷⁹⁰

2808. In respect to cumulative harm, BU suggested that at the time of the reports in 2014 and 2015, the reference to cumulative harm on the outcome reports was about new reforms which were taking place for a separate case analysis team which was being set up at that time.

2809. BU stated that cumulative harm was something that was being assessed throughout the case assessment by the caseworker at that time.⁷⁹¹

2810. In respect to the caseload at the time of these reports, BU stated that she found the situation unmanageable and that there were demands and expectations placed upon her which were difficult to meet.⁷⁹² BU also stated that the development of the IMS and the 'knowledge portal', added to the difficulty.

2811. In relation to the report which she endorsed, BU opined that there was nothing in those reports which had included analysis and reasoning as to why the decisions were made which concerned her to such an extent that she would not endorse the recommendation.⁷⁹³

2812. In relation to the understanding of both NL and PG, BU was never advised by them that they did not understand their roles.⁷⁹⁴

2813. BU address the court and SK. BU wanted to assure SK that she was certain that the coronial inquest would identify the gaps that occurred in this case and that the agencies have, and will, take the inquest very seriously and will implement recommendations that are made, and she apologised to SK for the loss of her son.⁷⁹⁵

2814. BU confirmed that it was her expectation that NL would have verified information given by Graham Dillon about his participation with various organisations.⁷⁹⁶

⁷⁹⁰ Transcript of Proceedings, p 1961

⁷⁹¹ Transcript of Proceedings, p 1966

⁷⁹² Transcript of Proceedings, p 1967

⁷⁹³ Transcript of Proceedings, p 1968 – 1969

⁷⁹⁴ Transcript of Proceedings, p 1971

⁷⁹⁵ Transcript of Proceedings, p 1972

⁷⁹⁶ Transcript of Proceedings, p 1973

Policy and Procedure Witnesses

Victoria

UC – Chief Practitioner Human Services, Director, Office of Professional Practice, Community Services Operations.

Statements

2815. Associate Professor UC outlined the functions of the Office of Professional Practice (OPP) which include;

- 1.5 supporting frontline practitioners and programs through direct involvement with casework,
- 1.6 monitoring and reviewing practice;
- 1.7 providing practice research and evaluation;
- 1.8 promoting professional development and training;
- 1.9 being the expert spokesperson on professional development;
- 1.10 influencing policy and program design; and
- 1.11 functions to assist information exchange regarding vulnerable children.

2816. Associate Professor UC had no direct involvement with Bradyn Dillon's case. Associate Professor UC familiarised herself by reviewing the Victorian Child Protection files. Her evidence was based on her understanding of the handling of the case by Victoria.

2817. Associate Professor UC then set out her understanding of the case and the circumstances surrounding it. Associate Professor UC also sets out her understanding of the reports made to the ACT CYPS.

2818. Having undertaken a review of the material provided to Child Protection Victoria, it was UC's view that the actions taken by Child Protection Victoria were appropriate in the circumstances, given the urgency of the situation. She came to this conclusion particularly regarding the disclosures made by the children after Magistrate 2 had ordered that they be returned to their father.

2819. Having considered all of the factors, including that the Magistrate had already made the order, UC opined that Child Protection Victoria had done all that they could. This included Child Protection Victoria advising the children's mother to make a report to CYPS, to make an application to the Family Court and other similar actions.

2820. Upon further review, particularly noting CYPS's failure to advise of the recent reports of bruising in August and October 2014, Child Protection Victoria were unable to present such material to the Magistrate which may have allowed him to consider the assessment in greater depth.

2821. Associate Professor UC opined that

“there are significant challenges in Child Protection practice where there are allegations of violence from both parties and where parents are embroiled in disputes over custody”.⁷⁹⁷

2822. Associate Professor UC also opined that

“Child Protection Victoria’s assessment of the complexity in Bradyn’s family led to a practitioner contact in the ACT and making a verbal report. The missed opportunity was not using the interstate liaison process rather than an assumption that verbally reported information is the effective solution”⁷⁹⁸

2823. Associate Professor UC suggested that a number of issues arose in relation to information sharing in this particular case. One of those issues was that information received from CYPS was incomplete and in some cases inaccurate.

2824. Despite the information from the ACT ILO being incomplete, it did reveal historical concerns about Graham Dillon’s capacity to care for the children.

2825. Secondly, despite the confusion as to what information was requested by CYPS it was acknowledged that Child Protection Victoria should have sent the information that they said they would send.

2826. Associate Professor UC also noted that CYPS did not use the ILO process to seek information from Child Protection Victoria in 2014 and 2015 either before or after the relevant worker failed to send information or respond to request.

2827. The only requests made by CYPS to the Victorian ILO was on 1 August 2013 and they were provided with the answer that there was no history of the children in Victoria. They further made a request on 16 February 2016, after Bradyn’s death.

2828. Associate Professor UC also acknowledged that SK had given a report to Child Protection Victoria in June 2015, raising concerns in relation to the children. Whilst it was acknowledged that that same report was also made to CYPS, Victoria acknowledges that it would have been best practice for Child Protection Victoria not to have relied on SK to make the report to CYPS. It would have been best practice for Victoria to do so by the ILO process.

2829. Associate Professor UC referred to the Victorian Coroner’s findings in relation to the death of Luke Batty in 2015 and also the Royal Commission into Family Violence in Victoria which was finalised in March 2016. The Victorian government accepted all 227 recommendations from the Royal Commission.

2830. As a result of those proceedings, Victoria has significantly changed the way practitioners respond where there is family violence present. Studies have been conducted in respect to understanding perpetrator behaviour in family violence settings and how women and children are impacted by violence, particular focusing on the impact on their behaviour and capabilities.

2831. Associate Professor UC concluded that

“regardless of where Bradyn and his family were, greater assessment and information sharing was essential. The assessment required included further risk assessment and information gathering to determine the risk posed by either parent to both children.”⁷⁹⁹

⁷⁹⁷ statement No 1 - exhibit C145 paragraph 20

⁷⁹⁸ Ibid paragraph 22

⁷⁹⁹ Ibid paragraph 28

2832. Associate Professor UC also referred to the Royal Commission which identified that the reason for the lack of information sharing is complex and overlapping, but three important themes emerge;

1.12 the fact that legislation and policy governing information sharing are complex, confusing, and restrictive;

1.13 the lack of an information sharing culture and leadership;

1.14 reliance on outdated IT systems, which impedes information sharing

2833. The Royal Commission recommended that there been amendments to specific family violence information sharing regimes particularly through the Family Violence Protection Act.

2834. However, Associate Professor UC identified that none of the new policies and legislation impact information sharing with other states and territories. She stated that the new policies will be available to Child Protection Victoria who can then use that information in the interstate sharing arrangements.

2835. Associate Professor UC set out the Interstate Liaison role and function and noted that it was first established in October 1999. Eventually all Australian states and territories as well as New Zealand became parties to the scheme.

2836. There was a review of the 2009 protocols which was finalised and approved in April 2016. Clause 26 of Schedule 1 of the Operating Procedures provides;

“despite anything to the contrary in this act, the Sec may disclose to an interstate officer any information that has come to his or her notice in the performance of duties or exercise of powers under this act if the Sec considers that it is necessary to do so to enable the interstate officer to perform duties or exercise powers under a child welfare law or an interstate law”⁸⁰⁰

2837. There have been a number of changes to the ILO role, including providing for dedicated interstate liaison positions.

2838. Associate Professor UC opined that there are a number of reasons why the ILO should be the first contact in relation to sharing formation. Firstly, because of the provisions of Clause 26 of Schedule 1. Secondly, because of the nature of the work and the caseload including difficulty in responding in a timely way. Thirdly, because many requests may involve historical reports which may be closed.

2839. In respect to training recommendation 29 of the Commission Report, which requires child practitioners to participate in professional development and training, particularly in relation to the nature and dynamics of family violence, and training related to the Departments practice guidelines for dealing with Family Violence.

2840. In Associate Professor UC's second statement, she identifies the policies and procedures relevant to intake investigations across various Child Protection operating models.

2841. In particular UC was asked to comment on several matters including:

⁸⁰⁰ Ibid paragraph 42

- 1.15 the failure of BN to open an email sent to her which provided information from ACT CYPS;
- 1.16 the disclosures made on 17 November 2014 in the presence of the mother and to practitioners, and what decision was made in relation to actions taken before the children were returned to their father;
- 1.17 the lack of immediate notification to CYPS in relation to those disclosures;
- 1.18 the timeliness of notification of the disclosures by DHHS to CYPS;
- 1.19 the failure to send documents to the ACT when asked; and
- 1.20 the inaction when SK attended the office in July 2015 raising concerns in relation to the children.

2842. In order to answer these questions, Associate Professor UC provide an overview of Victoria's Child Protection operating model at paragraph 6-9 of her second statement.

2843. Associate Professor UC also provided an overview of the intake procedure in paragraphs 11 – 19 of her statement.

2844. UC considered the circumstances of the Dillon children being in Victoria and what was done in respect to the notifications in paragraphs 20 – 32 of her statement.

2845. Associate Professor UC's opinion, having considered all these factors, that the procedures adopted by the practitioners in the intake phase and assessment of risk phase were in accordance with best practice and consistent with policies and procedures applicable at the time.

2846. Having said that, Associate Professor UC identified a number of administrative areas where procedures were not followed. She identifies those in paragraph 36.

2847. Associate Professor UC identified that "critically, the practitioners have kept an open mind during this part of the investigation as required by the first visit procedures. They did not prejudge the mother, notwithstanding they had received information from three credible sources, the AFP, CYPS and Victoria Police. Equally, though, they did not simply accept SK's account and considered further information was necessary"⁸⁰¹

2848. Associate Professor UC also set out the enquiries the case workers made including contacting BP, obtaining a drug test from SK, and obtaining information from UN . They also made an assessment that Graham Dillon was responsible for harm and as failing to protect from and including emotional and psychological harm.

2849. In respect to the unusual circumstances facing the practitioners on 17 November 2014 Associate Professor UC opined that there was nothing in the policy and procedures which covered this matter. It would appear from her investigation that legal advice would need to have been sought and the options were an appeal to the Supreme Court or the application for a new intervention order.

2850. The complexity of the situation also involve the intervention order granted in the ACT which involved the children. Time also played a factor in the situation as well.

⁸⁰¹ statement – exhibit C148 paragraph 42

2851. Associate Professor UC also referred to a national online software solution for interjurisdictional Child Protection information sharing called 'Connect for Safety'. This software allows jurisdictions to search and match Child Protection information in real time. This software will be used in conjunction with interstate liaison protocols and procedures within each jurisdiction.

2852. Associate Professor UC advised that Queensland, Western Australia, New South Wales, and Victoria are currently using this software for a small cohort of staff. Associate Professor UC advised that this software will be available for rollout across all states and territories by June 2022.

In Evidence Before the Inquest

2853. UC was the Chief Practitioner and Executive Director of the Office of Professional Practice for the Department of Health and Human Services Victoria.

2854. UC has qualifications as a Registered Nurse, holding a Bachelor of Nursing Training, a Postgraduate Diploma in Professional Practice and a Master of Arts and a Master of Business Administration.

2855. UC prepared a statement which addressed issues arising out of the Department in Victoria's involvement with Bradyn Dillon.

2856. UC explained that as the Chief Practitioner she is the most senior practitioner in the Care and Protection space. UC explained that she is in the top role and there are a range of Principal Practitioners some specifically for child protection matters. There are others practitioners with varying roles and functions.⁸⁰²

2857. There is also the role of Client Safety Practice Leader, which sits outside the operational division of the office and is available when practitioners are concerned about decisions made by their management. The role serves a review and intervention function.⁸⁰³

2858. UC then set out the roles and levels in respect to child protection work.⁸⁰⁴ This also included the Child Safety Commissioner who was responsible for reviewing all deaths of children known to child protection in the previous 12 months. UC set out the role of the Child Death Review as well.⁸⁰⁵ UC explained their functionality across their state.⁸⁰⁶

2859. UC explained that Victorian Child Protection have a central intake area which was developed to create consistency around decision-making.⁸⁰⁷

2860. UC explained that there is now a central portal for reports of family violence to child protection by police. It is known as the L 17 Portal. This eliminates the need for faxes or emails and other mechanisms for reporting. Care and Protection can access that portal. The portal is specific to family violence incidents. If there is a report through intake, the portal allows for the worker to check the history.

⁸⁰² Transcript of Proceedings, p 2383

⁸⁰³ Ibid

⁸⁰⁴ see Transcript of Proceedings, p 2384.1 – 20

⁸⁰⁵ see Transcript of Proceedings, p 2384.30

⁸⁰⁶ see Transcript of Proceedings, p 2385 – 6

⁸⁰⁷ Transcript of Proceedings, p 2386.25

2861. UC explained that intake is a very difficult role because often there is rich but ambiguous information and therefore other sources of information are required to confirm what you're looking at, and to effectively plan and investigate.

2862. There are 6 areas of exploration.

- 1.21 The first is in relation to an email from CF, which BN accepted she received but did not open.
- 1.22 The second issue is the disclosures on 17 November 2014 made by the children in the presence of their mother to workers BN and CO.
- 1.23 The third issue was that, after the disclosures were made and the children were returned to their father, there was no immediate notification of those disclosures by DHHS to CYPS, despite DHHS knowing that the children were returning to the ACT.
- 1.24 The fourth issues was a question about the timeliness of the provision of the information to CYPS in any event. The evidence was that the notification was made on 17th November and the notification with details of that conversation did not occur until 20 November 3 days after disclosure.
- 1.25 The fifth issue is a failure to send the documents that were asked for by CYPS.
- 1.26 The sixth issue is the communications and interactions between SK and the office in July 2015 where she raised concerns in relation to the children.

2863. In relation to the first matter in which the Department conceded the email was not opened, the email was received by CF, forwarded to AC, the records then show that the email was forwarded to BN, but she had no record or recollection of receiving such an email. UC agreed that the failure to open the email and to upload the information to CRIS was a shortcoming.⁸⁰⁸

2864. UC was asked whether there would have been any practical difference to the conduct of the proceedings before the court if the email had been opened.

2865. It was UC's view that the information contained in the email would have helped the caseworkers think about how they might want to present the information to the court. However, the ACT had not substantiated any harm. It was also UC's understanding that ACT had not sent through the last two reports in respect to the children.⁸⁰⁹

2866. UC opined that her expectation would have been that the information or emails would have been opened and reviewed by somebody. However, there were significant challenges in that office around workload.⁸¹⁰

2867. In relation to when a request had been made and nothing had been received, UC agreed it would be best practice to follow-up the request for that information. That is

⁸⁰⁸ Transcript of Proceedings, p 2479

⁸⁰⁹ Transcript of Proceedings, p 2394

⁸¹⁰ Transcript of Proceedings, p 2395

why they have an ILO and have a protocol in place. That protocol would have been considered to be best practice at the time.⁸¹¹

2868. In respect to the evidence from KO that communication between caseworkers can be very fulsome and helpful, UC advised that this is particularly important in emergency situations, when there is a need to communicate things quickly. KO identified that when BN made a report to the ACT CYPS that was about making a report rather than seeking information.⁸¹²

2869. UC agreed that SK had provided a history of severe family violence from Tasmania. UC agreed that given that circumstance, the recent interaction with CYPS would have been crucial and that DHHS should have followed up that information. UC stated that this was a severe form of family violence with a high level of lethality. The correlation between intimate partner violence and the possibility of that been perpetrated against children is a factor in itself which creates alarm.⁸¹³

2870. In relation to the evidence of disclosures made by the children prior to being returned to Graham Dillon, UC stated that given the children made those disclosures in front of their mother there needs to be some assessment of the situation. KO considered it to be very significant circumstance and it would need to be progressed to an investigation into the circumstances of the disclosures.

2871. UC described the difficulties faced by the caseworkers in that scenario where the court had made an order, and the children's father was on his way and very close to arriving to take the children. In terms of court options and appealing the Supreme Court that would have been an unlikely option.

2872. In relation to other options, given there were new facts and circumstances the case workers could have applied to a bail justice for a new Interim Accommodation Order. That order would have meant that the children would be away from both parents. That would have had a significant impact upon the children. That option was made more difficult because it was out of hours as well.⁸¹⁴ UC accepted that this was an option to get a new interim order. UC also accepted that the disclosures had not been known to the Magistrate who made the earlier decision.

2873. It was suggested to UC that CO, a reasonably experience Care and Protection worker expressed her concerns about doing something given the new information. UC said there was that option open however, there were confounding issues of time and a whole range of other things. The other option would have been to contact police. However, at that time of the day it would have been difficult to get police officers who were particularly experienced in dealing with these types of matters.⁸¹⁵

2874. UC opined that there were a range of issues to consider, and the issues were tricky, particularly when looking at them in hindsight, actions are always obvious. However, at the time the Magistrate made the finding in respect to SK's behaviour, and with clear evidence of support around Graham Dillon's ability to care for the children it would

⁸¹¹ Transcript of Proceedings, p 2395.17

⁸¹² Transcript of Proceedings, p 2395.30

⁸¹³ Transcript of Proceedings, p 2396

⁸¹⁴ Transcript of Proceedings, p 2398

⁸¹⁵ Transcript of Proceedings, p 2399.20

have been extremely difficult in the circumstances for there to have been a different outcome.⁸¹⁶

2875. UC opined that there were other options available, with one being to report the concerns they held for children, including the disclosures, to the ACT. However, there were many barriers in Victoria for protective workers to have their matters heard or returned to court.⁸¹⁷

2876. UC further stated that it was a very difficult situation and there were some other options, such as asking Graham Dillon to stay overnight. However, generally it would be the workers asking advice of the supervisor which BN did.⁸¹⁸ UC also agreed that there were other options, such as seeking legal advice or contacting the Australian Federal Police. Another option also available would be to contact the ILO and share the information with the ACT.⁸¹⁹

2877. In relation to reporting the disclosures to the ACT, UC agreed that it would be preferable and best practice to contact the ACT immediately after the children leaving their jurisdiction. UC reflected that there were eyes on the children in the ACT, such as BP, and that was another factor.⁸²⁰ It was UC's view that everyone could have acted more promptly.

2878. UC also agreed that information sharing by way of a written document would have been the best practice way to share the information.⁸²¹

2879. UC reflected that with the knowledge that the workers had, one would look at patterns of history. Given there were reports of bruising which were not substantiated, and some which didn't include suspicious bruising, provided a lot of different information to take into account for that analysis.⁸²²

2880. Regarding the ACT CYPS email to BN requesting a report, UC opined that best practice would have been for this information to have been requested through the ILO because it appears that a judgement had been made that ACT CYPS required further comprehensive assessment and therefore needed information.

2881. UC also stated that BN had already given a report over the phone to NL. UC opined that there was confusion as a request was made for a report, but BN considered that she had already made that report over the phone.⁸²³ UC opined that best practice would have been to go through the ILO.⁸²⁴ UC also agreed that the ILO policy was not followed.⁸²⁵

2882. In relation to the Form B used in the application for the children in November 2014, UC accepted that it contained limited information. UC said that the Form B was

⁸¹⁶ Transcript of Proceedings, p 2399.45

⁸¹⁷ Transcript of Proceedings, p 2400.17

⁸¹⁸ Transcript of Proceedings, p 2400.37

⁸¹⁹ Transcript of Proceedings, p 2480

⁸²⁰ Transcript of Proceedings, p 2402.15

⁸²¹ Transcript of Proceedings, p 2480.40

⁸²² Transcript of Proceedings, p 2406

⁸²³ Transcript of Proceedings, p 2408 –09

⁸²⁴ Transcript of Proceedings, p 2409

⁸²⁵ Transcript of Proceedings, p 2481.5

relatively new at the time, and the purpose was to provide the parties and the Magistrate with information so that they could determine the immediate risks that the Department wanted the Magistrate to consider.

2883. In relation to implementation of policy, at the time there would have been dissemination of the information by team managers. Information in relation to policies was also available on the electronic system. UC stated that now she conducts briefing sessions twice a week and staff can attend those sessions in relation to any changes to practice.⁸²⁶ There is also a daily briefing with teams which goes through information which may be relevant to practice at the time.

2884. In relation to the evidence about SK's request that the Shepparton office, and BN in particular, send the file to the ACT, as well as BN's response that she would get back to SK in respect to the phone number, UC agreed that this was not an appropriate response to the query SK made. UC agreed that her expectation would be to follow the query up.⁸²⁷ That was particularly so given both workers expressed concerns for the children given the Tasmanian history of family violence.⁸²⁸

2885. UC outlined a referral system where, when the threshold for child protection intervention is not met, a referral can be made to Child First. This service provides support for people and links them with community services prior to statutory response.⁸²⁹ These organisations are federally funded and provide a range of programs to support children and families.

2886. UC outlined the procedures available in Victoria in November 2014. If there had been two consecutive reports in 12 months by Child Protection, and neither had been investigated, any further report should be sent for investigation unless an area manager or their delegate reviewed the case and assessed that the investigation was not warranted. That remains as current procedure.⁸³⁰

2887. UC outlined that the procedure is that if there is three reports in 12 months or five in a lifetime, the report would not be closed until further assessment and a senior practitioner would assist to determine the outcome of the case.⁸³¹ That would also include multiple reports of the same issue.⁸³²

2888. In relation to matters for recommendation, UC opined that they have done significant reflection around the practices at the time of Bradyn's death, and constantly change practice based on perceptions of shortcoming or opportunities that may arise. That is particularly so around cumulative harm policy. Ensuring that staff understand and continue to develop their understanding of cumulative harm is important.

2889. In Victoria there is also an information sharing scheme which creates greater opportunity for better information sharing across services. This has resulted in better

⁸²⁶ Transcript of Proceedings, p 2481

⁸²⁷ Transcript of Proceedings, p 2482.25

⁸²⁸ Ibid

⁸²⁹ Transcript of Proceedings, p 2483

⁸³⁰ Transcript of Proceedings, p 2483

⁸³¹ Transcript of Proceedings, p 2484

⁸³² Transcript of Proceedings, p 2484

cohesion across the Child and Family Services System so that services are aware of the risks for children and families at the right time.⁸³³

2890. Professional development has been given greater significance, there are now capability frameworks which include all levels of practice. Victoria has also developed a new risk assessment framework to support practitioners' understanding around children as victims and survivors. Training levels have been increased throughout the system as well. There has also been an increase in the number of practitioners after the Government injected significant funding in this area. Victoria has also introduced a wellbeing program for staff.

2891. There has been a review of the ILO process around protocols and implementation. UC considered that in terms of recommendations, information sharing is one of the most important matters to consider.⁸³⁴

2892. In relation to organisations which are required under statute to report matters to Care and Protection, and issue of what was described by KO as 'white noise', UC indicated that there are now online policies available for organisations as well as Memorandums of Understanding between those organisations in relation to policy and procedures for mandatory reporting. Victoria also conducts training with those organisations particularly in relation to mandated and non-mandated reporting.⁸³⁵ UC agreed that having those policies online could assist people to educate themselves.

2893. Victoria also provides training and learning as well as development to the community service organisations in respect to various issues such as Care and Protection, exploitation, and other similar issues.⁸³⁶

2894. UC stated that Care and Protection workers utilised a number of people with varying degrees and experiences in various roles not just in social work. UC stated that the Department had significant difficulty recruiting workers. A strategy was developed which opened up the work to a range of different disciplines including nursing, police, psychology and psychologists, teachers, and a range of other professionals.

2895. These candidates are psychologically tested before they are accepted into the program after three months of work. UC stated they have had difficulty at the senior practitioner level, and they have now developed a career advancement program for those who are working in the field. The program is over a period of 12 months and it assists workers to develop skills and practices across the system. It is a skills-based system.⁸³⁷

2896. Victoria also has a Specialist Intervention Unit Team which assists people in practice and business processing. They have also developed a mentoring program particularly for rural areas. There have also been strategies enacted around retention of staff.⁸³⁸

2897. They have recently been funded for not only positions but also professional development and well-being programs. There is now a separate allocation of money

⁸³³ Transcript of Proceedings, p 2484

⁸³⁴ Transcript of Proceedings, p 2486

⁸³⁵ Transcript of Proceedings, p 2487

⁸³⁶ Transcript of Proceedings, p 2488

⁸³⁷ Transcript of Proceedings, p 2493

⁸³⁸ Transcript of Proceedings, p 2493

for these programs. There has also been funding for the Safer program, which is a framework for five key practice areas including seeking information, analysis of the information, formulating a plan, enacting that plan, and then reviewing the plan.⁸³⁹ The framework itself is a professional judgement model.

Australian Capital Territory

LT – CYPS Operations Manager

Statement

2898. LT has been in the Child Protection arena since 1988 and was employed by CYPS until January 2020.

2899. During the period Bradyn and JL were case managed she was the Operations Manager. LT stated that her role and those of other members of the team were detailed in a duty statement. Those roles included staff safety and well-being, prioritising work and resources which were in addition to the position descriptions.

2900. LT stated that Operations Managers were responsible for overseeing the allocated line area, the allocation of resources, team building, compliance, mentoring, supervision of Team Leaders, identification of systemic issues and problem-solving, project work, recruitment, community education and liaison to build and strengthen networks across the system, training, and leadership.

2901. Operations Managers were also responsible for meeting organisational objectives and answering ministerial requests.

2902. LT stated that Team Leaders were more 'hands on' when it came to responsibilities for their staff members. Team Leaders supervise their staff through regular supervision and review of their work.

2903. LT stated that whilst they tried to allocate work based on skill, capacity, and interest that was not always the case given the urgency some matters required.

2904. LT identified that a Team Leader could supervise three Teams and up to seven in some circumstances. The number of staff under supervision depended upon the Team Leader's capacity, skills, and experience. LT identified that there was "*considerable emphasis in CYPS on building capacity through coaching and mentoring*".⁸⁴⁰

2905. LT stated that the number of teams managed by Operations Managers would vary, but in 2014 she had approximately seven teams. In relation to workload, LT identified that she was busy and mostly manageable until staff levels dropped due to sickness or retention issues or when there was compulsory training for all staff to attend. This left a gap in the capacity for staff to respond and complete work.⁸⁴¹

⁸³⁹ Transcript of Proceedings, p 2495

⁸⁴⁰ exhibit C142 paragraph 7

⁸⁴¹ Ibid paragraph 10

2906. It was LT's opinion that staff numbers on paper do not reflect staff competency and capacity. It was her view that there are also issues with universities regarding the quality of students seeking placements at CYPS.
2907. LT was able to identify some of the changes following the Glanfield Inquiry including how training around family violence has changed the way CYPS works with families experiencing family violence and how the Organisation views and responds to cumulative harm. CYPS have also introduced various other community commitments and also the development of senior and principal practitioner roles within CYPS to provide support training and management of complex casework across the CYPS teams.⁸⁴²
2908. LT also identified the establishment of a Case Analysis Team which conducts reviews of entire cases from a family's first involvement with CYPS through to the present day.
2909. LT also identified development of online training modules, the establishment of the role of Coordinator General for Family Violence, review of work with other agencies clarifying roles, responsibilities, and expectations, as well as the implementation of a new computer system with increased capacity and capabilities to access and store information.
2910. Interestingly, LT stated that
- "most of the recommendations in the Glanfield Inquiry were not surprising or new to experienced managers but validated what we had been struggling with for years. I felt finally there would be more hope for collaboration and a joint vision across the sector".⁸⁴³
2911. In relation to training at the time of CYPS' involvement with Bradyn Dillon, LT recalled that the procedures and policy were tedious and not always up-to-date. They also had multiple sources of information and were difficult to access. There were difficulties with knowing which documents were current.
2912. LT stated that the new IT system, introduced in 2018, has corrected those difficulties as the information is all in one place with all staff having access to the system. LT also stated that there was a review at the time in relation to intake and appraisal procedures to determine what matters required statutory intervention and what matters should be considered to be community responsibility. There was also discussions and meetings in relation to what constitutes abuse and neglect and what is 'good enough parenting'.⁸⁴⁴
2913. In relation to the forensic approach taken to appraisals, LT identified that the risk assessment tool was based on the child's age and stage development, and the type of neglect and abuse that was suspected. It included considerations of protective factors to help determine if a child was considered to be at risk of harm or abuse.
2914. LT identified that around this time there were ongoing conversations about cumulative harm and the effect of ongoing abuse and neglect on a brain. LT stated that

⁸⁴² Ibid paragraph 13

⁸⁴³ Ibid

⁸⁴⁴ Ibid paragraph 14

“risk assessment is not a one-off task; it is an ongoing reflective practice that is updated as more information is gathered and hypotheses are explored, plans developed and reviewed to identify and manage risk”.

2915. Supervision and case discussions are part of the process from the first report to case closure. Directions and discussions within the case management team are supposed to be recorded and placed on client’s files.⁸⁴⁵

2916. In relation to complex matters, LT stated that the complexity of the case can come from a range of sources such as the personality traits of the alleged abuser, the parents own trauma history, which may impact their capacity to protect and parent, the way the abuser uses the system to push blame towards others (which I note Graham Dillon did⁸⁴⁶), the age and developmental stages of the child, and the way information is reported, interpreted, and recorded all impact the weight the information is given and the response by the system.

2917. LT also stated

“ongoing communication and reflective practices between staff should help support staff through the assessment process with the use of risk assessment tools, in conjunction with knowledge about child development, trauma, how parenting capacity can be impacted by mental health, disability, drug or alcohol misuse, poverty, domestic and family violence and a plethora of other possible scenarios that affect how people interact with each other”.⁸⁴⁷

2918. LT also stated that what is critical is that one must always be *curious and reflective and check information through multiple sources*,⁸⁴⁸ in order to have the best understanding possible which will influence your decision and reasoning.

2919. In relation to whether the Dillon case was ever classified as complex, LT said she could not find any record that a discussion of that kind was ever had about the Dillon case.

2920. LT identified that there is, and had been, training in respect to what are complex matters, issues of family violence and cumulative harm, as well as the responsibilities caseworkers have under the legislation.

2921. In respect to the responsibility for Section 862 requests, LT outlined some of those requests were present in the material provided to her. She also opined that the responsibility for following up the Section 862 requests, as listed on page 1011 and 1015 of exhibit C5, would rest with the caseworker (NL) as directed by her Team Leader.

2922. LT indicated there have been multiple changes prior to and after the Glanfield Inquiry. One issue is the turnover of staff across the workforce, which does not always allow for consistency for children and their families when working with CYPS.

2923. In her view as an Operations Manager, there were multiple demands and expectations placed on her and her staff by the Organisation that were not always realistic or practical. An example of this is case numbers and allocation. Even when staff have been assessed as not having the capacity to take on more work and the Team

⁸⁴⁵ Ibid paragraph 14

⁸⁴⁶ My emphasis

⁸⁴⁷ Ibid paragraph 14(v)

⁸⁴⁸ My emphasis

Leaders try to support them through this phase, they are told to start a performance management process, which means the People Management Branch of the Directorate become involved which is not always helpful or compassionate.⁸⁴⁹

2924. LT was the Operations Manager who supervised the Team Leader on the Dillon file. LT believed that she was consulted by the Team Leader and that she had reflective discussions with them and stated that any record of such conversations would be on the file.

2925. LT was not made aware of the threat made by Graham Dillon toward caseworkers. However, she opined that it is not uncommon for threat to be made against the CYPS staff by clients. It was her view that this was critical information to assess the risk of the threat and develop a safety plan. Generally, the Team Leader would brief the Operations Manager and look to provide support for the staff member involved. There are other matters which would also be considered.

2926. LT stated that she has reflected on Bradyn's case and made the following comment, "the death of Bradyn was tragic and terribly sad for everyone as he was a beautiful boy who never had the chance to live and achieve the future he deserved. I know that the workers I debriefed and supported after his death are still deeply affected by his death and will never be the same."⁸⁵⁰

2927. It was LT's view that with the knowledge of hindsight and power of community anger, we now have a focus on knowledge about the complex nature of family violence and systemic manipulation by perpetrators who have learned how to play the complex systems so that they are seen as victims. However, we still do not have enough options and professional services to support victims to feel safe and secure enough to leave their homes

In Evidence before the Inquest⁸⁵¹

2928. LT confirmed that she has worked with CYPS since 1988 and commenced as an Administration Officer Level 2.

2929. When LT commenced with CYPS, she participated in a 12-week training course for new starters, where experts were called upon to teach the required training subjects. During her 30 years of practice, LT had regular ongoing training and in 2009 commenced a social work degree.

2930. LT confirmed that the role of the Operations Manager was to ensure staff had regular supervision and support in their work, as well is an opportunity to reflect on the business, as it is very hands-on. LT stated that regardless of training and experience, reflective practice is important.⁸⁵²

2931. LT stated that part of the practice was to ensure goals that set by Government legislation were achieved. There was also the 'building of relationships across the community initiative' to ensure that people are confident in speaking with CYPS. LT stated that part of her work was to speak with organisations, such as new recruits at

⁸⁴⁹ Ibid paragraph 15

⁸⁵⁰ Ibid paragraph 18

⁸⁵¹ Transcript pp 2164 – 2244.

⁸⁵² Transcript of Proceedings, p 2165

the AFP, Barnardos, and other community services. This was to assist in the community organisations knowing what they should and shouldn't report and explaining that CYPS expectations may not always meet their community expectations regarding what is possible.⁸⁵³

2932. LT confirmed that in 2014/ 2015 one of the Team Leaders was TG and that she was TG's Operations Manager.

2933. LT explained what the After-Hours Team is and how they worked one week on one week off. Most of the workers in the After-Hours Team were level HP 3 because staff in that team needed to have experience so they could work independently with less supervision.⁸⁵⁴

2934. In relation to the roles of the different levels, LT explained that HP 1's are at the initial stages of their career and would assist in performing Care and Protection work rather than undertake it themselves,⁸⁵⁵ when HP 1s work in the field they would always be sent out with a more experienced worker.⁸⁵⁶

2935. LT explained that one would not necessarily give a new HP 1 a caseload, but they may be given some work to conduct independently particularly if they show aptitude and skills in those areas. LT gave an example of an HP 1 who may have been with CYPS for 5 weeks would be asked to perhaps make some phone calls and set up some appointments. She said it depended on the skills and learning ability.⁸⁵⁷

2936. LT agreed that, in terms of capacity, there were times where the capacity to have everyone working appropriately at their levels was not feasible.⁸⁵⁸ This would mean potentially giving an HP 1 a caseload within weeks of starting.

2937. In terms of training, there was a difference between training and induction, because it was more appropriate to have groups of people commencing a training course together rather than just groups of 1 or 2.⁸⁵⁹

2938. In terms of experience and roles, LT stated that there are some people who are very pragmatic and prefer rules-based thinking and won't change their plan. This may be particularly so because often they are on contract and want to be seen to be confident despite the fact that they may not be so. Other workers are quite confident in seeking assistance and discussing matters to ensure they are on the right track. LT agreed that common sense is one of the most important characteristics for a child protection worker.⁸⁶⁰

2939. LT also said that;

"over the years we've got more and more qualified people who, on paper, look brilliant but in our line of work and in the field who aren't a good fit and that's tricky to manage because they're overconfident and they're not always able to take advice in the light that it is given in

⁸⁵³ Transcript of Proceedings, p 2166

⁸⁵⁴ Transcript of Proceedings, p 2167

⁸⁵⁵ Transcript of Proceedings, p 2167.18

⁸⁵⁶ Ibid

⁸⁵⁷ Transcript of Proceedings, p 2167.30

⁸⁵⁸ Transcript of Proceedings, p 2167.45

⁸⁵⁹ Transcript of Proceedings, p 2168

⁸⁶⁰ Transcript of Proceedings, p 2168.20

terms of building their skill and their craft and some people come in believing that they're entitled to just, you know, give me my desk and off I go."⁸⁶¹

2940. LT stated that this is tricky to manage.

2941. LT further opined that where employees are highly theoretically qualified they tend to lack common sense and are often overconfident, the policies, procedures and training are often not helpful to overcome those problems. However, she stated sometimes they can be helpful if seen as a guide.

2942. LT said that some workers take the policies literally and assume, they have no flexibility which makes it more challenging because they're hanging onto the legislation so tightly that they misinterpret the intention.⁸⁶²

2943. LT considered that adaptability, experience, and common sense were essential tools for caseworkers.

2944. In 2014/2015 consideration was given to engaging specialist Senior Practitioners who could hone the practical skills of the new staff coming in and also for tertiary level students at the universities.⁸⁶³

2945. LT agreed that new starters would be given a set of materials to assist them in their work. This would also include supervision from the Team Leader, who would make time available for that purpose. It was also expected that the new starter would be given time to read and get across the material.⁸⁶⁴

2946. LT agreed that team building was very important, and she would assist the Team Leaders in that regard. LT advised that they often have a morning tea and invite someone from one of the other organisations CYPS works with in an effort to break down barriers and build relationships.⁸⁶⁵

2947. LT stated that she was very hands-on and would speak with the team regularly. There was always difficulty with managing people and relationships, particularly assessing their level and standard of work and the expectations of the workers.

2948. LT also agreed that there was an informal buddy/mentor system. Team Leaders would allocate staff on based on who had capacity, and who was a good match for that particular report. It was a way of honing people's skills and experiences. Buddies would not be allocated for the duration of the work because it was important for staff to build their own style.⁸⁶⁶ However, there was an expectation that the two workers would go together to complete the initial phases of the assessments so that there was continuity with the families.

2949. LT stated that it was both her personal and professional view that the responsibility to ensure new workers were appraised of the policy, practice and procedures was a shared responsibility between the worker, the Team Leader, colleagues on the floor

⁸⁶¹ Transcript of Proceedings, p 2169

⁸⁶² Transcript of Proceedings, p 2169.15

⁸⁶³ Transcript of Proceedings, p 2170

⁸⁶⁴ Transcript of Proceedings, p 2171

⁸⁶⁵ Transcript of Proceedings, p 2172

⁸⁶⁶ Transcript of Proceedings, p 2174

and the Operations Manager.⁸⁶⁷ The responsibility would also include senior managers and the Director because everyone has a responsibility to ensure that resources are accessible and available to everyone, and that they understand them.⁸⁶⁸

2950. LT stated that the recommendations process, whereby they are made by a caseworker and endorsed by a Team Leader, is meant to be a safeguard as well as a learning opportunity for staff to develop and hone skills.

2951. LT stated that in her experience some people are focused on factors such as the presentation of their house and whereas she believes that does not have anything to do with Child Protection. It was her view that it is the relationships in the family and not what is on the surface which is important. Observations of the children themselves in relation to the family is more important.

2952. LT stated that the Team Leader has the most difficult job in Child Protection because they have to balance their workers well-being and safety, the agency's expectation, and the community expectation. She stated that they ask a lot of Team Leaders.⁸⁶⁹

2953. In relation to her expectations as to what an assessment for recommendation would look like, LT said that she would expect the Team Leader to oversee the report, read the information, ensure it makes sense and is recorded in a factual way. She would expect this to ensure that the assessment has provided reasons and rationale behind the decision. A Team Leader's job is to ensure that they examine the report including the rationale, the conclusions, and the recommendations, to ensure that that the recommendations are correct given that information.

2954. LT expected that the Team Leader might also go into the database to see whether there were any other reports that have been made or whether the family is known to CYPS. However, LT agreed that generally the Team Leader relies solely on what is written in the report because there is no capacity to examine all of the records. Having said that, LT stated that with new workers there would be an expectation that the information referred to would be double checked.⁸⁷⁰

2955. In relation to training of Team Leaders, LT said

'essentially there is some training but because of the nature of the work and the high turnover of staff they often do not get that formal training. However, there are conversations in respect to their career paths and what skills they wish to build up and knowledge they wish to enhance'.⁸⁷¹

2956. Having said that, LT agreed that often people were given too much responsibility too soon, when they didn't have the appropriate skills for that much responsibility.⁸⁷²

2957. LT stated that the Organisation was not good at supporting people through in relation to that issue in a more structured way and that can have some significant consequences.

⁸⁶⁷ Transcript of Proceedings, p 2175

⁸⁶⁸ Ibid

⁸⁶⁹ Transcript of Proceedings, p 2176

⁸⁷⁰ Transcript of Proceedings, p 2177

⁸⁷¹ 20 pages 2178

⁸⁷² Ibid

2958. LT formed the view that the new system created too much confusion because there was so much to try and consider rather than just doing the job.⁸⁷³
2959. LT opined that, in her experience, the practice of CYPS was about safety and well-being of children and families in the community and that it was for the senior managers and the Director-General to manage the Minister and the media.⁸⁷⁴
2960. LT considered that the workers are so caught up in the system, ticking each box, that they lose sight of the real purpose and become overwhelmed.⁸⁷⁵
2961. LT also opined that there are many reports to child protection that are not appropriate and would be better assisted by other Directorates, such as housing where there is homelessness. These reports clog up the system.
2962. LT opined that the system is overwhelmed with reports and that the expectations are at times, in her view, stupid.⁸⁷⁶ LT opined that community education around expectations of the role of care and protection is required, as well as education on the role of the community as a whole.⁸⁷⁷
2963. LT agreed that if a child tells a teacher or a care and protection worker that they have been hit on the head or kicked up the bum that is a disclosure unreservedly. However, it is necessary to also understand the context in which these actions were said to have occurred.⁸⁷⁸
2964. LT also agreed that hitting a child, particularly a young child, in the head would be physical abuse. LT agreed that in 2014/2015 there was training in respect to this issue. It was on the cusp of knowledge that is now well understood, and community values were changing at that point.⁸⁷⁹
2965. LT was shown the report by the schoolteachers in 2015, as well as reports of previous bruising and the report by CARHU that expressed concern about bruising 12 months prior. LT was then asked about what expectation would be, knowing that history.
2966. LT opined that she would want to know whether the family had been recently visited by caseworkers, but she would want to follow this particular information up further.⁸⁸⁰
2967. Having been told that there had been no further appraisal or contact, since the last appraisal which close the case in early 2015, and with the report being August 2015, LT stated she would probably get back to the reporter and asked whether there were any other matters that they had observed, such as how the children presented at school and whether there was anything which raised a flag for the school in relation to the children.⁸⁸¹

⁸⁷³ Transcript of Proceedings, p 2181

⁸⁷⁴ Transcript of Proceedings, p 2181.21

⁸⁷⁵ Transcript of Proceedings, p 2181.22

⁸⁷⁶ Transcript of Proceedings, p 2182

⁸⁷⁷ Transcript of Proceedings, p 2182 – 3

⁸⁷⁸ Transcript of Proceedings, p 2183

⁸⁷⁹ Transcript of Proceedings, p 2185 – 86

⁸⁸⁰ Transcript of Proceedings, p 2189

⁸⁸¹ Transcript of Proceedings, p 2189

2968. LT opined that most of the time, she considers teachers credible sources but often they get upset and over-involved, particularly when CYPS do not remove the children when they think they should. LT stated that the teachers sometimes have unrealistic expectations.⁸⁸²
2969. However, in this case she said she would want to find out more information about the bruising, where it was, how it occurred and things like that.
2970. In relation to policy on whether CYPS should contact the primary caretaker, who may be potentially the perpetrator of the nonaccidental injury, LT opined that they should never be contacted however that policy has changed somewhat. Different people have different opinions on the policy.⁸⁸³
2971. In relation to how she would approach this particular case, LT said she would not limit her options and investigate with some curiosity and open-mindedness. Given that the hypothesis is that it could be the father who inflicted the nonaccidental bruising, in her view he should not have been the person to seek information from.⁸⁸⁴
2972. LT also opined that from memory the father was involved with a community service agency and it would be her practice to contact that agency and ask them whether they had worked with the family recently and what the family presented like.
2973. LT was also advised that the father had given a contradictory statement to that of the schoolteacher, whereby the father reported that the bruising was on the same side and was disappearing, but the schoolteacher said that one week the bruising was on one side and the next week it was on the other side, and the child could not explain how he got it. LT stated that in that situation she would definitely follow that up with the reporter.⁸⁸⁵
2974. LT commented that CanFaCS were very unhappy with CYPS and threatened to sue them on behalf of the father for harassment. LT stated that this was something that people threaten CYPS with often, and it is used as a ploy. LT said she reassured her staff to get back to their core business.⁸⁸⁶
2975. LT stated that on occasions, CYPS have been directed to give the community more credit for their skills and work, and CYPS has been directed to close matters because the community has eyes on the family and are supporting the family. Those directions are contained in legislation and policies and procedures, particularly in relation to closing matters because the capacity to keep them open is not there.
2976. LT stated that if the children have the eyes of the community upon them, that is; they are linked to community agencies and are tentatively safe because of that supervision, CYPS are encouraged to close the case.⁸⁸⁷

⁸⁸² Transcript of Proceedings, p 2190

⁸⁸³ Transcript of Proceedings, p 2191

⁸⁸⁴ Transcript of Proceedings, p 2191

⁸⁸⁵ Transcript of Proceedings, p 2193

⁸⁸⁶ Transcript of Proceedings, p 2193.19

⁸⁸⁷ Transcript of Proceedings, p 2193.38

2977. LT agreed that in those circumstance it is very important to confirm that the community organisation does have eyes on the family.⁸⁸⁸
2978. LT confirmed that the caseworker and the Team Leader were concerned about the activities of the community organisation who was supporting Graham Dillon and the children. It appears that there was some focus on the organisation insisting that the case be closed, rather than the case being closed on the merits of the information received.⁸⁸⁹
2979. In relation to reports written by the caseworkers, LT opined that just because information is not in the report it doesn't mean that it hasn't been considered or acted upon. Given the extraordinary caseload, it may well be that things that were done weren't referred to in the report.⁸⁹⁰
2980. In relation to the report of 13 August 2015, LT explained that for a report to be multiple it had to have the same information, with no new information, so that you would be "*checking apples are the same apples and not checking apples with oranges*"⁸⁹¹. her view was it could well be considered a multiple report.⁸⁹² LT agreed that it had been assessed as a multiple report and therefore no risk assessment had taken place and she would not consider it to be necessary to do a follow-up.⁸⁹³
2981. LT opined that it is important to speak with the teacher and clarify their concerns and tease out why they are reporting matters.
2982. LT agreed that she had specifically stated that the workload was busy but manageable however there were peaks and troughs. LT stated that it was all a question of management, particularly when people felt overwhelmed by the workload.
2983. LT also agreed that the extraordinary pressure was from the bottom-up as well because of the sheer volume of reports to the Intake Team and the lack of capacity in terms of staff numbers to deal with that volume.⁸⁹⁴
2984. LT further agreed that accuracy of recording in the histories is of vital importance. However, the volume of work could distract when writing those reports and the record system presented challenges because it kept crashing and one would have to rewrite the same thing they had written a number of times.
2985. LT agreed that if there is inaccurate information it can be perpetuated throughout the rest of the reports going forward. LT agreed this causes difficulty in the narrative of the history of the child. LT stated that that was known and there was an introduction, to have random reviews of information and also the development of the review team who could take on some of the load.

⁸⁸⁸ Transcript of Proceedings, p 2194

⁸⁸⁹ Transcript of Proceedings, p 2194 all

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⁸⁹¹ Transcript of Proceedings, p 2199.44

⁸⁹² Transcript of Proceedings, p 2201

⁸⁹³ Transcript of Proceedings, p 2202

⁸⁹⁴ Transcript of Proceedings, p 2203

2986. LT agreed that CYPS workers must exercise extreme caution when contacting families or parents directly because of the risk that they may be the perpetrators of the harm.⁸⁹⁵
2987. LT also agreed that on the face of the three reports that she reviewed there was no indication that anyone had exercised extreme caution prior to contacting Graham Dillon about the bruises and the lack of food.⁸⁹⁶
2988. It was suggested to LT that she had discussed a telephone call with NL on 20 November 2014 regarding the Victorian DHHS. LT stated that she had no actual recollection of the conversation but said she would accept that there was a conversation.
2989. LT recalled that there were conversations regarding the children being in Victoria and that there was some scrambling regarding information as the matters were going to court.
2990. In respect to staff being threatened by parents, LT stated that was not unusual and did not always inform CYPS of a parent's potential to be violent to their children. There are procedures in place as to whether police should be called, or a restraining order taken out or an upgrade of security after a threat is made. However, if there is a pattern of threatening behaviour, that may well be something to consider in an assessment.⁸⁹⁷
2991. LT was shown reports in respect to JL at page 961 of exhibit C5, LT considered these reports to be a disclosure of physical abuse.⁸⁹⁸ LT opined that it could also be a disclosure of inappropriate discipline but under the legislation this was clearly abuse.⁸⁹⁹
2992. LT stated that she was aware that the 'K' Review existed but had not reviewed it herself. LT was also aware that there was a training scheme happening at around that time which required compulsory attendance. LT stated
- "... We did some reviews and we found that some peoples supervision methods weren't up to the standard that we expected and so they brought in professional trainers who were experts in that field to help Team Leaders and ops managers understand the roles and responsibilities of the supervisee and supervisor."⁹⁰⁰
2993. LT was also aware that both BU and NL were taken to a room to make a statement. LT was not involved and was concerned that she had not been told because, in her view, it would not have been helpful for their mental well-being to have them there without support.⁹⁰¹ That decision was taken by the Director at the time.
2994. LT advised that she has received briefings in respect to the Glanfield Inquiry and she had received a copy of it. LT cannot recall whether she saw the Muir Review or not.
2995. LT opined that given her years of experience one thing she has observed is,

⁸⁹⁵ Transcript of Proceedings, p 2206

⁸⁹⁶ Transcript of Proceedings, p 2206

⁸⁹⁷ Transcript of Proceedings, p 2207

⁸⁹⁸ Transcript of Proceedings, p 2211

⁸⁹⁹ Ibid

⁹⁰⁰ Transcript of Proceedings, p 2212.20

⁹⁰¹ Ibid

“with technology comes more responsibility but less relationships and social work in child protection is about relationships and understanding people and being with people and you can’t do that if you’re making referrals electronically because the information just isn’t there”⁹⁰².

2996. In respect to changes that would be beneficial, LT opined that information sharing and working with the different agencies to build relationships would be beneficial. LT stated that “*we need to focus on people because people are our biggest resource*”.⁹⁰³

2997. LT opined that the expectations on staff have increased significantly and that the system has become difficult to navigate. That includes workload timeframes and pressure from above.

2998. LT opined that she believes the system works best where there is trust in senior managers and those directly above her, when she feels that her boss has her back and to have trust that the senior management has got the ministers ear and that they are all telling the same story.⁹⁰⁴ LT stated that sugar-coating the truth doesn’t work.

2999. Time management is a significant issue, particularly where there is training allocated and then there needs to be reprioritisation because of other urgent needs for staff to attend.

3000. LT opined that, in respect to BU, at the time she worked with her she had no concerns about the way she performed her duty. She said that BU took her responsibilities very seriously and was diligent in doing her job⁹⁰⁵

3001. LT also accepted that BU was allocated social work students because of her capacity and positive attributes. BU also wanted to give something back and thought it would be a good experience for her to take on the students. LT estimated that this additional responsibility would have taken at a minimum 4 to 5 hours of extra work per week.

KO – Principal Practitioner, CYPS

Statement

3002. KO was a Principal Practitioner in North Operations of CYPS. He said that the focus of the role of a principal practitioner is to promote excellence in service delivery. This is achieved through a variety of methods, including co-working with case management, improving practice, and directly case managing complex and/or sensitive cases.

3003. KO said that he also takes the lead in training development and delivery and consultation on practice issues.

3004. KO had been employed in Child Protection since 2003 and was hired by the Community Services Directorate in 2008. In his role at the Directorate, KO has worked as a Team Leader, case manager, assistant manager for youth justice case management, and as a principal practitioner.

⁹⁰² Transcript of Proceedings, p 2216

⁹⁰³ Transcript of Proceedings, p 2217.25

⁹⁰⁴ Transcript of Proceedings, p 2218

⁹⁰⁵ Transcript of Proceedings, p 2237

3005. KO's first involvement with Bradyn Dillon's family was after Bradyn's death on 15 February 2016.
3006. KO set out the various information management systems that have been used by CYPS.⁹⁰⁶ KO reported there have been several iterations of the information recording system over the years.
3007. In relation to guidance for decision-makers, KO identified a portal on the intranet called the CYPS 'knowledge portal'. This portal covers all areas of client related and case management work including policies; procedures; practice guides; links to templates; flowcharts; and other research reference material.⁹⁰⁷
3008. I note that at subparagraph H of KO' statement the cumulative harm practice guide has been developed and approved but has not been loaded onto the system yet.
3009. KO identified that guidance is embedded into key sections of the forms and assessment templates to promote consideration of meaningful assessment and analysis.
3010. KO outlined the differences between the 2014 and 2019 intake forms, indicating that they had been reviewed and updated to better suit their purpose.
3011. In relation to inter-agency liaison, KO identified that Education, Health, and the AFP are the primary agencies that CYPS deals with, however, there are a number of other non-government agencies with which CYPS also liaises. Most of that liaison is done via telephone, email, face-to-face case conferencing, or team meetings.⁹⁰⁸ There are also formal requests for information sharing.
3012. KO opined that inter-agency information sharing and collaboration is a fundamental aspect of Child Protection work.⁹⁰⁹
3013. KO identified that there had been interagency liaison positions within SACAT, AFP, ACT Health, and said, interagency information sharing, and collaboration is a fundamental aspect of child protection work. Since 2016, an additional position with the Education Directorate has also been created.
3014. There has been additional funding for two part-time community protection positions with One Link, as well as the co-location of liaison officers with services including Health, SACAT, Education, Restorative Justice, Domestic Violence Crisis Service (DVCS) and Canberra Rape Crisis Centre.
3015. KO identified that while there are formal protocols in place for interstate collaboration and information sharing this typically occurs at the individual worker level. However, the nature of Child Protection work means that individual workers are not always immediately available when required. In those circumstances, administration staff, Team Leaders, managers and other team members are available via the general administration telephone lines to ensure that urgent enquiries are responded to.⁹¹⁰

⁹⁰⁶ Exhibit C144 paragraph 11-23

⁹⁰⁷ Ibid 24.

⁹⁰⁸ Ibid 33.

⁹⁰⁹ Ibid.

⁹¹⁰ Ibid 49.

3016. KO set out the assessment and decision-making process at CYPS. While the decisions are made at the caseworker level they must be reviewed with any recommendations requiring the endorsement of a Team Leader.
3017. KO outlined the responsibilities of an Intake Officer as recording information, discussing it with case management, and ultimately deciding whether further assessment or action is required. The focus is on whether there is a reasonable suspicion that a child may be in need of care and protection in accordance with the Act.
3018. Interestingly enough, KO explained that CYPS workers should exercise extreme caution when contacting families and parents as they may be the source of the risk of harm. KO was of the view that
- “making contact with families can jeopardise criminal and child protection investigations and can significantly increase the risk to the child, who may then be coerced, threatened, taken or hidden from the reach of CYPS. This is equally applicable in the context of family and domestic violence, where both child and adult victims can be placed at great risk if contact is not able to be made with them safely.”⁹¹¹
3019. In relation to safety plans, KO suggested that a worker must decide whether such safety plans are realistic and credible, with information often taken at face value where there is an absence of evidence to the contrary.⁹¹²
3020. KO identified that it was difficult to decide whether to continue with an appraisal or to close a case. Closing a matter comes with a degree of risk and it was KO’s practice to arrange further feedback where possible - particularly with agencies such as the school who can monitor a situation and re-report if necessary. It was his view that this type of work always carries some level of risk and that people may be influenced, coerced, or make errors in respect to information given. He said that it may not always be possible to eliminate that risk, but that it is a case of; *“making the best possible decision based on the information available at the time.”*⁹¹³
3021. KO outlined the triage system of allocating work according to risk. This system can be affected by volume and staff availability as well and may require cases to be re-triaged throughout the course of the day.
3022. In relation to the number of cases that a case manager may have under their management, it was KO’s experience that managers could have up to 30 children - sometimes more. The Team Leader would have between five and seven case managers under supervision at any one time. Supervision includes a number of responsibilities in respect to training, policy, quality assurance. Team Leaders may, in some circumstances, have responsibility for individual cases.
3023. KO identified that CYPS processed 16,068 Child Concern Reports between 2017 and 2018.⁹¹⁴
3024. KO identified in relation to appraisal decisions that substantiation may lead to the case being closed where, in accordance with the Act, the source of harm has been

⁹¹¹ Ibid 59.

⁹¹² Ibid 62.

⁹¹³ Ibid 63.

⁹¹⁴ Ibid 70.

removed, or where there is a person who can act protectively. KO identified that decisions are made on the balance of probabilities and are based on the evidence available.

3025. KO stated that

“it is usual for decisions to be reached by balancing multiple (and sometimes competing) factors, applying professional judgement, and drawing from legislation, policy, research, ethics and a value base.”⁹¹⁵

3026. KO set out the options available where parents either refuse to engage or relocate interstate. These include applications to the court.

3027. In relation to risk management, KO identified that children who have experienced abuse and neglect often do not make clear and consistent disclosures. He said that they often feel guilt and shame, fear being removed, fear potential reprisal from their parents, and are frequently conflicted by feelings of loyalty to their family members.⁹¹⁶

3028. Having said that, KO explained that the principles enshrined in the Act required that children should be cared for and should remain in the care of their family if safe to do so. This means there is a greater emphasis on supporting families rather than utilising statutory interventions.

3029. KO, in paragraphs 80 – 86 of his statement, outlines the process that occurs after the finalisation of an appraisal report. This differs depending on the decision that was made.

3030. In relation to training, KO identified that the training available to staff has evolved - particularly since 2016. There is now a team at CYPS known as the Training and Workforce Development team which facilitates and coordinates training.

3031. Now, when new workers start at CYPS, they are given an extensive introduction package and career pathway which continues as the worker progresses through their career. There is also access to e-learning and face-to-face training as well as informal training such as ‘lunch and learn’ sessions - a conversational style of learning where topics are selected over the course of a school term.

In Evidence Before the Inquest⁹¹⁷

3032. KO gave evidence that he had gained a diploma in social work from the United Kingdom and had experience in that arena. He worked for 11 years as a Care and Protection Worker in Australia and reached the level of principal practitioner prior to leaving.

3033. KO gave evidence that the integrated management system (IMS) commenced in 2015 and was the result of input from workers and the systems management team.

3034. In relation to training, KO advised that all new starters were given induction training. He said this training is now more intense.

⁹¹⁵ Ibid 74.

⁹¹⁶ Ibid 77. [It would appear that this was a well-known risk factor and is applicable to this case.]

⁹¹⁷ Exhibit C144 and pp 2265 - 2381

3035. In relation to workload, he said it was his experience that the office was busy, but manageable.

3036. KO spoke of the information system used in 2016. He said the information system was called CHYPS and was used until October 2019. When asked whether it was a good system, KO said that the new system, CYRIS, was superior due to increased functionality. He said, however, that the CYRIS system was only as good as the information placed in it. The new system is much better to ascertain the whole family picture.⁹¹⁸

3037. For example, KO stated that with CHYPS each sibling would have their own file and if a caseworker did not make the connection between siblings, and relay it on the file, a connection may never be known.⁹¹⁹

3038. KO was unable to explain why, despite a report made in 2013 in relation to Bradyn and JL being on the CHYPS system, that connection was not made when the 2014 reports about Bradyn and JL came in to CYPS.

3039. In relation to the interstate communication issue, and in respect to his statement, KO explained that he was not being critical of the Victorian DHHS being resistant to information sharing. He said that it was not an effective mechanism of sharing information.⁹²⁰

3040. KO opined that the usual course should have been followed, that is, the use of an Interstate Liaison Officer (ILO). He did state, however, that in some circumstances caseworker-to-caseworker communication can be an effective mechanism of sharing information.⁹²¹ KO said

“I mean I think you can’t understate the importance of that ability to call somebody that you can have that conversation with because generally what comes through an ILO is a document and it is not the context, is not the ability to ask those questions and that’s the same whether it’s interstate or it’s in the ACT. It’s a fundamental part of assessment work in child protection is talking to somebody, asking them the questions, the things that you’re not clear about, asking for clarification, all that kind of stuff. It’s really, really important piece of work.”⁹²²

3041. KO further stated

“that it was just misfortune in a lot of it; it was somebody wasn’t there at the time and then somebody was trying to phone them back and they weren’t there at the time, nor were their Team Leader, nor was the, it seems like it was just – it was real misfortune in terms of that communication... From what I read of the notes, I could see the information was being shared and respective workers were aware of various things and that there were concerns.”⁹²³

3042. KO said that, in his experience, when a report is made through intake it is triaged, a process is agreed upon, and, at that point, a decision is made whether intake

⁹¹⁸ Transcript of Proceedings, p 2272.37

⁹¹⁹ Transcript of Proceedings, p 2276.27

⁹²⁰ Transcript of Proceedings, p 2279.25

⁹²¹ Transcript of Proceedings, p 2279

⁹²² Transcript of Proceedings, p 2280.10

⁹²³ Transcript of Proceedings, p 2280.40

recommends no further action. If no further action is recommended the report will be sent to the Team Leader for endorsement.

3043. KO said that an efficient Intake Worker might complete 12 reports a day, including the taking of the report, the making of enquiries, phoning people where needed, and completing an assessment and recommendation. KO stated that a Team Leader has approximately 50, or more, reports to sign off per day.⁹²⁴
3044. KO stated that the time it takes for a worker to process a report depends on both the report type and the worker themselves. A report may only take 5 minutes, or it may be a matter that is required to be referred on. KO stated there are approximately 18,000 reports completed per year.⁹²⁵
3045. Following this, the Team Leader will endorse the recommendation. KO said that a Team Leader would not necessarily make their own enquiries, unless they felt that the enquiries made by the caseworker were not robust enough. They would then direct further activity.⁹²⁶
3046. In relation to the assessments and information regarding family support, KO stated
- “you know, the family might give you an indication that they get going to get some support, that everything suggests that that’s looking likely. You know, an appraisal is not required because you’ve got to give them the opportunity.”⁹²⁷
3047. He agreed that in that case the matter may not get looked at again until somebody made a further report.
3048. In relation to the accessing of information, KO stated that sometimes information from family members is better than information from credible sources such as teachers and police officers. KO said this was because family members have the most information. However, he also said that there may be complexity in the motives of family members as well.⁹²⁸
3049. KO opined that the use of proper judgement, and an analysis of patterns, as opposed to training or risk measurement tools, are required when conducting an assessment - particularly where there are experienced caseworkers. Ticking boxes does not always work when assessing risk. When dealing with human beings, the infinite variety of humanity and all that’s inherent in it can mean, that using such tools doesn’t necessarily tell you what to do.⁹²⁹
3050. Ultimately, KO said, responsibility sits with the Team Leader particularly where junior caseworkers are conducting an assessment.
3051. In relation to the making of reports, and the quantity of reporting, KO theorised about ‘white noise’ reports, particularly coming from schoolteachers... It was his view that this

⁹²⁴ Transcript of Proceedings, p 2281.43

⁹²⁵ Transcript of Proceedings, p 2284.10

⁹²⁶ Transcript of Proceedings, p 2284.40

⁹²⁷ Transcript of Proceedings, p 2285.5

⁹²⁸ Transcript of Proceedings, p 2285.15

⁹²⁹ Transcript of Proceedings, p 2286.27

increased the volume at intake and that organisations who are required to make mandatory reports need training and what it is that they should report.⁹³⁰

3052. KO was asked about the practice guideline in relation to bruising to the head of children. The guideline indicates that “children can have accidental bruising, but the following must be considered as nonaccidental unless there is evidence, or an adequate explanation provided”.

3053. KO accepted that he is familiar with that document and said that it has now been improved.⁹³¹ He accepted that, at the time, it was a clear guideline practice.

3054. It was suggested to KO that the process of endorsing recommendations relied on the information in the report from the case worker, for example, if bruising had not been considered nonaccidental, the Team Leader would only have the recommendations referred to in the document to consider. KO stated they could look on the system but accepted that it depends on the capacity of the Team Leader to do so, given the volume of matters at any one time this is difficult.⁹³²

3055. KO stated that he did not want to give the impression that it was a struggling system with inadequate resources. He said this was not always the case, and that it is the volume of reporting which takes away the resources.⁹³³

3056. KO said that, in 2015 and 2016, as a safety net for complex cases emerging from intake and assessment, a case analysis team was introduced to CYPS.

3057. KO stated that he was familiar with the Muir and Glanfield Inquiries and had read them. He was aware of the ‘K’ Review but had not read it.⁹³⁴

3058. As a principal practitioner at the time of Bradyn’s death, KO opined that what happened to Bradyn was an extreme situation, and this was not the usual case outcome. KO said that, having reflected on the case, it was his view that things were missed, and that the organisation should learn from its mistakes.

3059. KO reflected that he did not want to answer questions with the hindsight bias that comes with knowing the outcome.

3060. In relation to a policy about contacting parents, who are the potential perpetrators, KO opined that workers must exercise extreme caution so that more harm is not caused. KO was unsure whether that policy came into effect prior to, or post, Bradyn’s death.

3061. KO said there were lots of different views on the policy of whether to contact the parents or not. He said it is something one must think about and, since Bradyn’s death the view has been strengthened that caution should be applied before contacting anyone who could be the source of harm.⁹³⁵

3062. Counsel assisting asked KO, in relation to the scenario put to him in respect of the disclosure made by JL to the schoolteachers:

⁹³⁰ Transcript of Proceedings, p 2284.10

⁹³¹ Transcript of Proceedings, p 2288.18

⁹³² Transcript of Proceedings, p 2288.35

⁹³³ Transcript of Proceedings, p 2289.20

⁹³⁴ Transcript of Proceedings, p 2292

⁹³⁵ Transcript of Proceedings, p 2295 .35

"My question in relation to that aspect, in the whole of the context, is would you consider that to be a disclosure of physical abuse?"

3063. KO responded:

"It's really hard to say. And, again, I've got massive hindsight bias. I can see a lot of the other things in there which would really confuse me and would detract from that. Asking a kid how they feel about a person – and look, they may – I've had so many disclosures in statements and interviews from kids that – it's really tricky. It's really tricky. That could be abusive, it could be a little tap, could be a little – it's really difficult to say. It's really – what I've noted from there is we've got an explanation about the bruising, which was the kids fighting, which is obvious he not correct but is plausible. And we've got 2 kids that both identified dad a real safe person, he is a protective person, and then we've got that photograph in there that raises some questions."⁹³⁶

3064. KO clarified the following paragraph of his statement where he said

"children who have experienced abuse and neglect often do not make clear and consistent disclosures and are frequently conflicted by loyalty to family members, fear of removal and reprisals for themselves or their parents and feelings of guilt and shame"⁹³⁷

3065. KO explained that one needs to read between the lines as it is a difficult situation. He said that he understands parents can become frustrated, scared, and confused. He also noted that sometimes there are other issues such as mental health, drugs, and alcohol issues, where parents can lose control and things don't go well. KO said that CYPS workers are trained to work with that as the alternative is bringing the children into care. He said that children can also be abused in care as well and that is another matter to take into account.⁹³⁸

3066. In relation to the view formed by one of the workers that the matters raised by the children were not disclosures, KO opined that it was ambiguous and that with hindsight bias we know that they were. When KO was referred to the fact that the child had reported being hit on the head and kicked up the bum with a boot, he stated that the report required looking into and that is what happened - CYPS went to find further information by conducting an appraisal.

3067. When asked whether, in his opinion, it was a disclosure, he stated

"Now obviously, but at the time I don't know. It would depend very much on – parents give their kids little taps, and you know, it's playful. And in the context of bruising and history then it is more concerning but, you know, playing – could be different. It's not clear, it's not – she is talking about how he's protective and in the context of that I can see why it wasn't viewed that way. I'm not saying it's right because it wasn't right because I'm looking at it now and I know what I know. But in the context of being there and being that that could have been me. That could have been me. I could have wrote that."⁹³⁹

3068. KO recognised that Graham Dillon was manipulative, and that the caseworkers relied on another professional saying that Graham Dillon was doing the best he could, and he is a good dad. KO also recognised that Graham Dillon also manipulated the case workers into believing that as well.⁹⁴⁰

⁹³⁶ Transcript of Proceedings, p 2296.27

⁹³⁷ Transcript of Proceedings, p 2297.10

⁹³⁸ Transcript of Proceedings, p 2297.10 – 25

⁹³⁹ Transcript of Proceedings, p 2298.17

⁹⁴⁰ Transcript of Proceedings, p 2299.28

3069. KO was taken to the Child Concern Report made in August 2015 as well as the report of July 2014. KO was asked about the fact that after the schoolteachers' reports, the first contact was with the father, and whether he thought that was appropriate. In response KO stated:

"I can see what happened. In my head I can picture how we came about this. We have fallen into a trap of – Bradyn had obviously been to CARHU previously and had explanations and that kind of – I think that's had more weight on it than it should have done because each new time could be a different set of circumstances, but I can see how that's kind of progressed is that we have already spoken to the father about bruising, he's already been responsive, he is a person we can talk to, doesn't get angry with us when we call, we don't make it worse, this is a valuable source of information."⁹⁴¹

3070. KO suspected that there would not have been a significant amount of weight put on the past, and the conclusions and recommendations that were reached at that point.

3071. In relation to the nonaccidental bruising and the report from the teachers, KO stated that factors such as the bruises being explained as being the result of a bike fall and because previous explorations into bruising had resulted in no concerns being raised, could have influenced the caseworker's decision-making.⁹⁴²

3072. In relation to the 2015 report, it was pointed out to KO that the caseworker did not contact the school to gather further information. In response, KO stated that it was best practice to ring the school to make further enquiries.⁹⁴³ KO agreed that given there were two reports a week apart about different bruising they should have been explored.⁹⁴⁴

3073. KO opined that in terms of intake, things could have been done better but he stated that he was looking at it in hindsight.⁹⁴⁵

3074. It was suggested to KO that there was a history of multiple bruises over a period of time as well as a history of facial bruises impacting on two children who continued to have the eyes of agencies or schools on them. KO stated that if you have multiple bruising multiple times on children who are repeatedly coming back to you, the reports need to be looked at more deeply.

3075. In relation to information about family Court Proceedings or Domestic Violence Orders, KO opined that these are good pieces of information. He further stated that if parents give information that there may be those orders in place, it would be good practice for CYPS to see if they could get information to either prove or disprove whether those orders are in place.⁹⁴⁶

3076. In respect to training, KO stated there has been a step up in training and he spent two weeks in Victoria learning about their training system to enhance ACT's system. KO stated that there has been a greater focus on training since Bradyn's death.

3077. In respect to schools, KO opined that there were some good relationships with schools, while some relationships were not so good. He stated that there is now an

⁹⁴¹ Transcript of Proceedings, p 2301.9

⁹⁴² Transcript of Proceedings, p 2303.30

⁹⁴³ Transcript of Proceedings, p 2304

⁹⁴⁴ Transcript of Proceedings, p 2304

⁹⁴⁵ Transcript of Proceedings, p 2306.43

⁹⁴⁶ Transcript of Proceedings, p 2315.40

Education Liaison Officer which has assisted greatly in the relationship between the Department of Education and CYPs.

3078. In relation to the reports made by the teachers about Bradyn and his sister, KO agreed that none of those reports were 'white noise' reports and that those reports should have been made.⁹⁴⁷

3079. In relation to cumulative harm, it was pointed out to KO, that there was a considerable and fairly comprehensive summary in respect to allegations of family violence in the relationship between Graham Dillon and his wife while the children, Bradyn and JL, were with them.

3080. It was also pointed out to KO that there was an assessment and consideration of cumulative harm in that context. That was contained in page 636 of exhibit C5. When it was suggested to KO that the cumulative harm information should have been carried over when dealing with Bradyn and JL, KO accepted that it should have been as it was relevant.⁹⁴⁸

3081. KO opined that cumulative harm is a complex area and said it is one of the most difficult concepts in Child Protection in a number of ways. Those ways ought to be identified so that something appropriate can be done about it. KO also identified there are thresholds which need to be met for various interventions.

3082. When asked what his definition of cumulative harm was, KO stated:

"it's either harm that continues again and again and again and again, or it's – sometimes it can be described as low-level incidents that as they kind of build and build and build and build – so something that – an event that in isolation wouldn't necessarily cause significant harm or be particularly problematic, something that people can recover from, if that continues for weeks, months, years, the impact becomes greater and greater and greater."⁹⁴⁹

3083. KO agreed that the information indicative of cumulative harm having been suffered by Bradyn and JL would have been important information for the caseworkers who were looking at the case in June and July 2014. KO also agreed that it would have been important information 12 months later when the August 2015 reports were made.⁹⁵⁰

3084. In relation to training caseworkers and Intake Workers to recognise cumulative harm, KO identified that he was unsure what training look like in the cumulative harm space. KO was of the view that he did not know how you can get to a point where you fully understand it because it is a difficult concept to get your head around.

3085. In answer to a question from me about whether the so called 'white noise' reports could also be an indicator of harm, KO agreed that they could.

3086. KO also agreed that harm should be part of the record-keeping of an organisation so that whoever looks at the case files 12 months down the track or later can recognise any potential cumulative harm.⁹⁵¹

⁹⁴⁷ Transcript of Proceedings, p 2328.1

⁹⁴⁸ Transcript of Proceedings, p 2329.25

⁹⁴⁹ Transcript of Proceedings, p 2329.37

⁹⁵⁰ Transcript of Proceedings, p 2331.37

⁹⁵¹ Transcript of Proceedings, p 2332.15

3087. KO agreed that you cannot intervene if you do not recognise what cumulative harm is but said that it is noted and recorded in the document as it evolves, and the case history is where it's found.⁹⁵²
3088. In relation to recruitment, KO stated that it was very difficult because it is a hard job and internationally there are shortages of caseworkers of all levels. Whilst Australia has better pay and conditions than other countries, the job is difficult. KO stated that the job entails threats, abuse, living with decisions you have made, and trying to reconcile when things go wrong. There are much better paid, less stressful, less consequential jobs for those with social working or psychology background.⁹⁵³
3089. In relation to recommendations, KO opined that more time is needed to look at and reflect upon cases, and that time is often a luxury that caseworkers do not have.⁹⁵⁴ KO stated that one can only look at some cases more deeply at the expense of others.
3090. KO opined that the workload is always high, and it peaks at different times. KO also stated that it would be better to have more Intake Workers, but that it would also be appropriate to have more community responsibility for appropriate reporting so that the 'white noise' reports are reduced.⁹⁵⁵
3091. KO opined that other organisations should be willing to intervene because some families need referral to support agencies not statutory, intrusive intervention. For example, they may need a playgroup, to go out to child and family centres, financial assistance, or be in need of housing.⁹⁵⁶
3092. KO opined that the reporting figures are going up and up and community expectations are getting higher. He stated that with greater understanding of family violence comes greater frequency of reporting.
3093. Therefore, triage is more and more important and places Intake Workers under more and more pressure. That pressure increased exponentially after Bradyn's death.⁹⁵⁷ As a result, there are many more reports and not really the time to consider them all.
3094. In relation to how to embed sound policy into practice, KO opined that in relation to physical abuse he would look at the practice guides to bring that into his assessment of the information, in order to consider the matter and progress it. However, he stated it was easier for him because he had less matters.⁹⁵⁸
3095. In relation to other caseworkers accessing and referring to policy, KO said it is inherent within the practice. However, it's got to be fitted in to everything else that is going on and that is harder the more work you have. If, for example, a report was in relation to physical abuse, one would go to that particular document but there is something in the

⁹⁵² Ibid

⁹⁵³ Transcript of Proceedings, p 2333

⁹⁵⁴ Transcript of Proceedings, p 2334

⁹⁵⁵ Transcript of Proceedings, p 2334

⁹⁵⁶ Transcript of Proceedings, p 2335.10

⁹⁵⁷ Transcript of Proceedings, p 2336.5

⁹⁵⁸ Transcript of Proceedings, p 2340

order of 2000-pages of policy documents so it would be impossible for a worker to be cognisant of every single policy that was applicable.⁹⁵⁹

3096. KO stated that there is a learning management system in place, as well as mandatory training with more specialised training. KO agreed that it is possible that an urgent influx of work would outrank training days in terms of importance and the work would take priority.⁹⁶⁰ KO opined that since 2015, training has improved significantly but could be further improved.⁹⁶¹

3097. KO stated that after Bradyn's death, he went to the police station to speak with SK. He was to advise SK that they would take emergency action in respect to JL. At the time he had limited knowledge of the history of the case but made himself familiar with it in due course. KO explained the negotiations he undertook with the family and also the hospital in managing the situation that arose.

3098. KO stated that his impression of Graham Dillon was that he was manipulative. He formed that view from speaking with SK and also considering all the factors that were known to the Department, including that she had put sleeping tablets in his drink to take this the children.

3099. KO also said he learned subsequently that SK taking this action made perfect sense to him because Graham Dillon had painted a picture of SK which was not true. Graham Dillon said that he was supporting SK and doing the best he could, giving off the impression that he had cared for SK.

3100. KO stated it was crafted, it was abuse and it was manipulative. KO said everything that SK had going for her was in spite of him.⁹⁶²

3101. In relation to material for practitioners to be more user-friendly or accessible, KO said that the recent material is more useful and gave an example of the Family Violence Guide for practitioners which is easy to read, relevant and purposeful and could be easily accessed anytime.

3102. Further, KO said that he did not believe you could encapsulate everything that the job entails in policy, there is no manual for the job, because despite the legislation, there is always something different that comes in, that requires you to think about things differently. KO opined that guides for practitioners, rather than rigid policies, are more in his style. However, he stated that he understands that some people prefer the structured approach.⁹⁶³

3103. KO also observed that since he has done the family violence training, he would have been able to understand the context of abuse and the power imbalance better. KO stated that it would make him think more deeply about situation. However, he was unsure whether it would have changed his response in this case.⁹⁶⁴

⁹⁵⁹ Transcript of Proceedings, p 2339

⁹⁶⁰ Transcript of Proceedings, p 2340

⁹⁶¹ Transcript of Proceedings, p 2340.40

⁹⁶² Transcript of Proceedings, p 2345

⁹⁶³ Transcript of Proceedings, p 2347 – 48

⁹⁶⁴ Transcript of Proceedings, p 2347.25

3104. In relation to how the care and protection system could be improved, KO stated it would be through a combination of things including, having enough staff, having enough time, having staff with experience, having enough staff with experience that have enough time to mentor junior staff. There are many other facets including systems of work, accuracy, and practice elements.⁹⁶⁵
3105. In terms of recommendations, KO said it was a broader issue and that a place to start would be understanding what the role of caseworkers and CYPS is and the challenges that they faced daily.
3106. KO also opined that negative publicity is very challenging for staff. KO also expressed that they need more experienced staff, as well as a system where the work is attractive to employees.
3107. In respect to errors that were made, including the policies and best practice that were not followed, KO opined that this problem wouldn't be solved through training in isolation, or an increased volume of staff. He stated that greater salaries and greater resources may help, as well as better reporting awareness and understanding in the community. He further stated that greater collective responsibility would help, among other things.
3108. In respect to information sharing, KO opined that the culture in Australia is different from that in the UK and posited the example of police don't ask for an agreement to investigate a crime. He stated that there is a focus on human rights and those sorts of issues.
3109. KO suggested that CYPS are not reckless in relation to protecting information and they do not fish for information and that when they seek information, they take a targeted approach with a good rationale behind it. KO agreed that unlike the ACT, Victoria has a system which does not have that issue of seeking consent to investigate.⁹⁶⁶
3110. KO opined that the main impact of getting that consent is that it is an extra step which can get in the way. In terms of interviewing children there is a provision in legislation which allows case workers to interview without consent or agreement.⁹⁶⁷
3111. It was suggested that an example of the failure to maintain integrity of information received in Child Protection Reports over time, was the reporting that SK attempted to kidnap JL, as well as the report she kidnapped both children and took them to Victoria, contravening a Protection Order. KO agreed that information was not accurate because at the time there was no order preventing SK from having contact with the children. The accurate information was contrary to the CYPS information, and KO learned this when he spoke with SK.⁹⁶⁸
3112. KO agreed that the report which identified and analysed the cumulative harm suffered by the children at the hands of Graham Dillon was good work. KO said the report stated

⁹⁶⁵ Transcript of Proceedings, p 2349

⁹⁶⁶ Transcript of Proceedings, p 2354

⁹⁶⁷ Transcript of Proceedings, p 2354.27

⁹⁶⁸ Transcript of Proceedings, p 2357.35

there were multiple factors, but Graham Dillon was partly responsible for that cumulative harm.

3113. KO accepted that there is a connection between intimate partner violence and abuse of children.⁹⁶⁹ KO opined that the impact of nonphysical aspects of family violence had not been always talked about, and that caseworkers are now much better at understanding the impact of those factors.⁹⁷⁰
3114. KO was taken to the reports at pages 697 – 701 of exhibit C 5, described as a brief analysis of current or previous report. KO opined that the reports could have been expanded somewhat but they were intended to prompt and provoke thought. In a further question about the fact that there were only 8 reports, KO agreed it was not an onerous task to go back and examine them all.⁹⁷¹
3115. KO was referred to the 'K' Review, where the number of matters reported and the evidence of the type of bruising, particularly on the face, and the number and frequency of those reports, should have led to a reasonable suspicion being formed and an appraisal assessment should have taken place. However, KO expressed that looking without knowing what he does now, it does not appear to be one of the most serious cases. Having read it, it was his view that *"no it's not even remotely on the high-end of things"*.⁹⁷²
3116. KO was asked about whether an interrogation of Graham Dillon's criminal history would have been important. Particularly given that history can be a good predictor of future behaviour and therefore it may have made a difference to the assessments made by the caseworkers. KO stated that it should be considered as important information and had he been doing the appraisal, he would have investigated whether there this was a criminal history.⁹⁷³
3117. In relation to the volume of intakes and the consequence for the appraisals team, KO stated that it fluctuates and if one team is busy the other one can be as well. KO explained that if there is a reasonable suspicion by the worker then, rather than not dealing with it because of the workload, it would be better that it was identified as risky but not able to be 'worked'. He stated that it does not mean that the team ignores it. He further stated that in his experience some Intake Workers go above and beyond what is *"the best fit for intake... because the appraisal would not take priority over others."*⁹⁷⁴
3118. KO stated that if there is a substantiated finding of abuse or neglect that will not necessarily always lead to emergency action being taken for the child.
3119. KO said that 'substantiated' is not part of the legislative requirements that CYPS need to be satisfied of. The question required to the ask is, was the person the responsible source of harm following assessment of the report. KO explained that potentially you

⁹⁶⁹ Transcript of Proceedings, p 2359.15

⁹⁷⁰ Transcript of Proceedings, p 2361

⁹⁷¹ Transcript of Proceedings, p 2363

⁹⁷² Transcript of Proceedings, p 2365.34

⁹⁷³ Transcript of Proceedings, p 2366

⁹⁷⁴ Transcript of Proceedings, p 2376

may be substantiating that somebody is presenting as a risk of something that they might do but it hasn't happened yet.⁹⁷⁵

3120. In relation to whether a child suffering from cumulative harm that meets the threshold test would be classified as being in need of care and protection immediately, KO said

"in my opinion they meet the threshold of in need of care and protection. I would say it's highly unlikely that they would meet the threshold of immediate need of care and protection, hence the perpetuation and the ongoing – the next little bit, the next little bit, the next little bit."⁹⁷⁶

3121. In relation to whether it would be likely that the court would make an order for that child KO stated:

"that they may make an order, but it would possibly be a less intrusive order. it might be an order for supervision where the child is at home, which has a purpose, but you've got a legal requirement to do the type of thing were trying to do through negotiation anyway. You've not got eyes on the child every day. You've not got eyes on the child every week necessarily it's extremely problematic."⁹⁷⁷

IQ – Executive Group Manager of CYPS

Statement

3122. IQ was the Executive Group Manager CYPS. IQ has been with the Community Services Directorate since February 1999 and has held many roles including Case Manager, Team Leader, Operations Manager, senior managerial roles, and Director.

3123. In August 2020 KS resigned from her position and IQ replaced her.

3124. KS provided a statement dated 21 August 2019. IQ has provided a statement to update matters which were covered in KS's statement, these updates have occurred since 21 August 2019.

3125. In relation to paragraph 25 of KS's statement, IQ indicated that given the research on trends regarding family and domestic violence are never settled and are always changing, CYPS have engaged in updating their response in that area of Child Protection by continually monitoring and analysing operational policy and practice.

3126. CYPS has committed to fund significant training packages for CYPS staff in relation to family and domestic violence. IQ identified the training packages that are to be delivered at paragraph 9 of her statement.

3127. IQ also identifies that there are now staff co-located within CYPS from other agencies and vice- versa with those agencies.

3128. Those include AFP, ACT Education, Canberra Health Services, Canberra Rape Crisis Centre, And Domestic Violence Crisis Service.

3129. IQ also identifies that CYPS continues to engage One Link with recent review and extension of arrangements being finalised.

⁹⁷⁵ Transcript of Proceedings, p 2377.20

⁹⁷⁶ Transcript of Proceedings, p 2378.40

⁹⁷⁷ Transcript of Proceedings, p 2379.5

3130. In respect to training of CYPS staff, a significant number have attended a five-day training course, which was referred to in KS's statement at paragraph 38.
3131. Further training in relation to working with families affected by family and domestic violence courses have also been provided to workers.
3132. There is also now a program, referred to by KS and presented by the Family Safety Team, which will provide whole of government training in relation to family domestic violence.
3133. IQ also sets out a range of training that existed for a number of government staff across various departments in paragraph 15.
3134. In relation to mandated reporters CYPS, Health Liaison Officers provide education sessions to various units within health, alcohol and drug services, women and children's health, Calvary Maternity Unit, The Canberra Hospital, The Emergency Department and Paediatric Services.
3135. The Community Engagement and Client Services Team continue to operate as described by KS. The team is currently progressing a redesign of the CYPS complaints processes emphasising a restorative and resolution focused approach to complaint management. In light of that focus, further training by the ACT Human Rights Commission will be available for members of that the team.
3136. In terms of the difficulties of recruiting workers at CYPS, new enterprise agreements have been structured to encourage workers into the area, along with the employment of Aboriginal and Torres Strait Islander people with relevant experience and culture and knowledge, which will be sufficient in lieu of tertiary qualifications.
3137. There has also been the appointment of a permanent Aboriginal and Torres Strait Islander Training Officer.
3138. The Community Services Directorate has participated actively in establishing the national child protection information sharing system called Connect for Safety (C4S) which went live in September 2020. All jurisdictions, including the Commonwealth, have committed to using this as part of standard child protection practices.
3139. This information sharing portal allows CYPS staff to check if a child is known to other Child Protection jurisdictions at the point of intake. If a match is found on the system the jurisdiction holding that information will be contacted for further details.
3140. It is hoped that this system will provide information about children at risk faster and more efficiently than the current system. This system has already been put to use in establishing involvement with a child protection authority that was not otherwise available.
3141. Further work is being done in relation to recommendation 12 from the Glanfield Inquiry. See paragraphs 30.
3142. A new system named CYRIS was introduced in October 2019. The next phase of CYRIS will be an integrated online reporting portal for the public to make reports. This will increase administrative efficiencies.

3143. More portals are being planned so that children, young people, and their carers can access their case managers to share relevant information.
3144. IQ also identified that the pilot program to integrate Child Protection practitioners and policing officials within the Family Law Courts has commenced with all states and territories having implemented the system. This is ongoing.
3145. It is hoped that once the pilot is established and operating regularly, CYPS hopes that it will assist in strengthening relationships with key stakeholders such as Legal Aid and the family law court system.

In Evidence Before the Inquest⁹⁷⁸

3146. IQ is the Executive Group Manager for Division of Child Abuse and Families which is a Division of the Community Services Directorate. IQ is a social worker by qualification.
3147. IQ addressed SK and made the following statement;

“on behalf of CYPS, we are truly sorry for the loss of your son Bradyn and I’m truly sorry for the loss of your son, Bradyn, and to JL for the loss of her brother.... What I can say to you SK is that the death of your son has demanded that we do something differently; that we change the way we do our business and think about how we can do it better. We have taken this responsibility very seriously and we continue to take very seriously. Unfortunately, the work that we’re doing now won’t change the reality of what happened to your son and your family. However, it is my hope that it will contribute to reducing the likelihood that it’ll ever happen again. sincere apologies”⁹⁷⁹

3148. IQ explained the structure of CYPS in that there are 2 areas, one is an operational focused area, and one is a practice and performance area, which goes to policy and training. At the time of Bradyn’s death Ms K worked to her and IQ explained that she made Ms K available to do the review on behalf the operational area.
3149. IQ was involved in the development of the terms of reference, that was the extent of her involvement with the report.⁹⁸⁰
3150. In relation to the Glanfield Inquiry, IQ contributed to that report in that she was interviewed by Mr Glanfield and provided a response on behalf of CYPS, but only the area concerned with child and youth protection. IQ stated that the review was triggered specifically by Bradyn’s death, but it was a Whole of Government Review in respect to people who have experienced family violence and deaths that had occurred as a result of family violence.⁹⁸¹
3151. In relation to the Muir report, IQ agreed that it was an external report which was predominantly in relation to a review of the documents. IQ was aware that 17 recommendations were made. IQ was also aware that CYPS accepted 16 of the recommendations and noted the 17th. The 17th recommendation proposed that a structured decision-making model rather than a professional judgement model be considered and adopted.⁹⁸²

⁹⁷⁸ Transcript pp 2425 – 2473, Exhibit C147

⁹⁷⁹ Transcript of Proceedings, p 2425

⁹⁸⁰ Transcript of Proceedings, p 2428

⁹⁸¹ Transcript of Proceedings, p 2428.35

⁹⁸² Transcript of Proceedings, p 249 point and

3152. IQ stated that she has considered the structured decision-making model for the ACT but noted that it also would require a practice framework set within it. IQ stated that they have considered the WA model, which is a signs of safety model and there has been some discussion in regard to that model.⁹⁸³
3153. In relation to the 'K' Review, where she referred to a workshop for managers and Team Leaders in relation to the discussion of themes, that workshop occurred in March, with Ms K running them through the findings of the report. IQ stated that there were 13 recommendations and they have been adopted by CYPS.⁹⁸⁴
3154. IQ agreed that the 'K' Review was a general analysis of the Bradyn and JL files. IQ agreed that if the report stated that there was a minimal application of risk assessment she would agree with that analysis. IQ agreed that there was nothing in the report that she took issue with.⁹⁸⁵
3155. IQ agreed that one of the issues identified by the 'K' Review was a lack of consideration of cumulative harm in decision-making and a lack of understanding of thresholds applicable by care and protection workers.⁹⁸⁶
3156. IQ also agreed that Ms K identified a consistent theme in how caseworkers looked at the issue of whether a child had made a disclosure and the evidence they relied upon as part of the threshold issue.⁹⁸⁷
3157. IQ also agreed that the 'K' Review identified specific themes in relation to questions around the interviewing of children and their parents.⁹⁸⁸
3158. IQ agreed that 'K' Review also dealt with the delay in interviewing Bradyn and JL following the disclosures in Victoria on 17 November 2014. IQ also agreed that another theme identified in the report was in relation to information gathering and exchange.⁹⁸⁹
3159. IQ agreed that another theme identified was the lack of useful information gathering in this particular case.⁹⁹⁰ IQ agreed that there were criticisms in respect to the accuracy of record-keeping, as an example, it was identified that the CARHU report in respect of Bradyn was found on JL's file not his file and not on the CHYPS system.⁹⁹¹
3160. IQ also agreed that the 'K' Review also identified that there were shortcomings in supervision and lack of scrutiny over cases.⁹⁹² IQ agreed that a major conclusion reached by Ms K was;

“the major conclusion reached is that had more detailed analysis of information, history and risks by the application of a risk assessment, consideration to the impact of cumulative harm, the application of thresholds to inform decision-making, coupled with forensic interviewing of the children and a professional judgement based on sound assessment, then it is likely

⁹⁸³ Transcript of Proceedings, p 2429.25

⁹⁸⁴ Transcript of Proceedings, p 2430.21

⁹⁸⁵ Transcript of Proceedings, p 2430.36

⁹⁸⁶ Transcript of Proceedings, p 2430.40

⁹⁸⁷ Ibid

⁹⁸⁸ Transcript of Proceedings, p 2431.10

⁹⁸⁹ Transcript of Proceedings, p 2431.20

⁹⁹⁰ Transcript of Proceedings, p 2431.27

⁹⁹¹ Transcript of Proceedings, p 2431.35

⁹⁹² Transcript of Proceedings, p 2431.40

that the intervention pathway for this family's involvement with child and youth protection services would have been different"⁹⁹³

3161. IQ agreed that there were 4 themes identified that require immediate and ongoing work, they were;

- (a) understanding and application of risk assessment including cumulative harm in informing decision-making
- (b) understanding and application of legislative thresholds and informing decision-making
- (c) skills in relation to interviewing children and parents and information gathering and exchange
- (d) record-keeping and supervision

3162. IQ explained that the new system called CYRIS was to enable real-time information sharing with other agencies, and that the implementation has been conducted in phases:

- (a) The first phase was implementation of the child protection services case management system;
- (b) the second was an implementation in respect to Bimberi Youth Justice Centre; and
- (c) the third stage goes to portals which will allow reporters to access into the system and provide information directly into the system.

3163. IQ explained that just recently the portal, which is web-based, was refreshed which allowed greater capability. The system is much more flexible in terms of how it can be adapted and adjusted for use.⁹⁹⁴

3164. IQ also explained that the intention of real-time access is to push information to key parts of the support system around child protection. Delays will be reduced and the information which comes in can be used multiple times rather than having to be re-entered time and time again.

3165. IQ stated that the information can be loaded from a case record into an enduring chronology, so that the next person who deals with a case gets a sense of what happened before without having to go into each individual record. That information can then be downloaded into a document for use, such as annual reports or providing it to an external provider and is much easier to use in the old system.⁹⁹⁵

3166. Regarding the changes that have been implemented, such as co-location of DVCS and the SACAT team with CYPS, IQ opined that in her experience a child protection system in isolation is not a good system. IQ stated that you cannot expect CYPS to be the only people responsible to respond to child safety in the community. This has been recognised over time and there are now partners in the safety of children including police, education, health, community organisations partnered with CYPS in that arena.

⁹⁹³ Transcript of Proceedings, p 2432 – 2433

⁹⁹⁴ Transcript of Proceedings, p 2439

⁹⁹⁵ Transcript of Proceedings, p 2439

These organisations need to be imbedded into CYPS in order for there to be a continuation of service and availability of response, there also needs to be a visible partnership with those organisations.

3167. IQ opined that there needs to be relationship building and information sharing, with mechanisms to facilitate and maintain the relationship between these organisations. Feedback is an important aspect to improve relationships. Improved information and information sharing will do so in understanding each other's business.⁹⁹⁶
3168. IQ also opined that an integrated service rather than an embedded co-located service would be the ideal. This is because agencies would understand what the information that they might exchange is used for. Building relationships over time will engender trust between the organisations.⁹⁹⁷ IQ opined that it would take a sustained cultural shift to do so.
3169. IQ stated that her preference for the system would be that a family could go to an organisation, for example a maternal or child health nurse, and ask for support without escalating to a Child Protection Report because the Child Protection system is designed to respond to abuse, neglect and risk. However, currently CYPS is spending a lot of time responding to other needs rather than abuse, neglect, and risk.⁹⁹⁸
3170. IQ also described the 'reimagining child safety project', which involved think tanks who are leading the project for the Department. It will engage with Education, Health, and other organisations who are concerned with children's safety. IQ stated that this project is still in the early stages, with a timeframe of completion in 2021 anticipated.⁹⁹⁹
3171. IQ also outlined that CYPS, and the Public Advocate's Office would set up a joint shared facility. This will assist in receiving information faster, with only one upload required and the information then being received with no delay. This system sits outside of the CYRIS system, but it is hoped that it will be brought on board and embedded within CYRIS.¹⁰⁰⁰
3172. In relation to the CYPS Case Analysis Team, IQ stated that it was based on the New South Wales model and was in place in 2016. However, the Government ceased funding that initiative progressively with the full cessation of funding occurring in 2021. IQ stated that she was committed to the team as she felt it was excellent initiative and the function of the team will continue despite the lack of funding.¹⁰⁰¹
3173. The initiative will be funded within the existing budget because it allows transparency across the service. It also provides an opportunity for reflective practice, which allows the teams to look at practice, from which they can then consider where they could do better. IQ stated that this process is refreshing, and you get better 'buy in' from staff as well, which leads to better outcomes in terms of culture.¹⁰⁰²

⁹⁹⁶ Transcript of Proceedings, p 2440 – 41

⁹⁹⁷ Transcript of Proceedings, p 2441.15

⁹⁹⁸ Transcript of Proceedings, p 2442

⁹⁹⁹ Transcript of Proceedings, p 2445

¹⁰⁰⁰ Transcript of Proceedings, p 2445.17

¹⁰⁰¹ Transcript of Proceedings, p 2446.3

¹⁰⁰² Transcript of Proceedings, p 2446.15

3174. IQ stated that the Case Analysis Team is utilised as an independent review of the case.
3175. IQ stated she uses the team quite heavily in her work. Anyone can use the team if they are concerned and would like an independent review of what is happening in their case.¹⁰⁰³
3176. Whilst it is preferable to have a Team Leader and staff discuss it and triaged the matter there is no formal approval for the analysis team to review the case.¹⁰⁰⁴
3177. In relation to the 'Strengthening Practice Committee', which was a recommendation from the Glanfield Inquiry, IQ stated that this committee allows an external expert to talk with staff about how they could do things differently in relation to their practice.
3178. IQ agreed that what she is discussing in relation to the Strengthening Practice Committee is;
- "currently underpinning the implementation of the internal review process will be a program of practice development to strengthen decision-making practice with a focus on restorative principles, documentation, collaboration and relationship management."¹⁰⁰⁵
3179. IQ also stated that in terms of measurements, they are developing competency-based progression in the staffing system rather than using the standard public service recruitment process. The new system is a skills-based process where the staff are able to demonstrate their abilities.¹⁰⁰⁶
3180. IQ stated CYPS are also working actively with the University of Canberra and the Australian Catholic University in respect to student placement. IQ stated that it is necessary to sell the work in order to entice the best recruits, bearing in mind that the work is not for everyone.
3181. IQ also outlined that 'Connect 4 Safety' is a Commonwealth led initiative IT system for sharing information across jurisdictions. IQ understood that all jurisdictions have now signed up to the system, which will be able to identify involvement with families in other jurisdictions.
3182. IQ opined that you may not get all the information through the Connect 4 Safety system, but you will get some information about the child/ children or their siblings, as well as a contact to establish whether the family you are enquiring about is the same as the one on the system. The system has been utilised by ACT and they are very happy with the way it works. It would appear that the system will benefit everyone.
3183. IQ stated that the system is not currently live, but she understands it will go live imminently.¹⁰⁰⁷ IQ stated that there will be a need to adjust the ILO system to encompass the new system.
3184. In respect to the policies and procedures available in 2014/2015, these were transferred to the 'knowledge portal' in 2015.

¹⁰⁰³ Transcript of Proceedings, p 446.40

¹⁰⁰⁴ Transcript of Proceedings, p 2447

¹⁰⁰⁵ Transcript of Proceedings, p 2448.7

¹⁰⁰⁶ Transcript of Proceedings, p 2448 – 9

¹⁰⁰⁷ Transcript of Proceedings, p 2451.10

3185. IQ was asked about the ability for caseworkers to access that system given the high workload, and the prioritisation of both practical and professional development of staff during the period. IQ said that this is becoming easier with the implementation of the 'knowledge portal' and staff are encouraged to use that as the one source of truth.¹⁰⁰⁸
3186. IQ stated that work is being done in relation to the IT system to make them more proactive such that a user can ask a question and the legislation would pop up with the answer. There are currently investigations being undertaken to see whether this is possible.¹⁰⁰⁹
3187. In respect to workload, the Intake Area experiences the greatest demand because they are the front door of the service. That can change with things like school holidays, and there are peaks and troughs throughout the year.
3188. IQ stated that the ACT is experiencing growth in the service and has continued to experience this growth over years.
3189. IQ stated that in the last financial year there were 18,600 report which is very large, of those reports approximately 3000 were actually appraised.
3190. In the ACT there is a two-step process. IQ stated that it is a complex system in that if a report comes in it must be documented with a Child Concern Report. If the report meets the threshold test then it will go to a Child Protection Report.
3191. IQ opined that the reporter defined process is a cumbersome process and, in her view, a more contemporary piece of legislation will simplify that fact. In relation to the work undertaken with Health and Education, IQ stated that it will help the organisations better understand the reporting obligations. That will also assist in the response from CYPS. IQ opined that the front door of every child protection system in Australia is under pressure.¹⁰¹⁰
3192. In respect to the mandated reporters, IQ said there is a new publication Called 'Keeping Children and Young People Safe'. That publication is educating mandated reporters as to what is and is not a mandatory report.
3193. IQ indicated that CYPS will really get traction when Health, Education and others realign and refresh their own policies, making it clear to their staff how to interact with the system'.
3194. At the moment the number of reports indicate that it is being ineffective because despite having the e-learning out there, the number of reports is going up.¹⁰¹¹
3195. IQ also stated that when there is media coverage in the child protection space, they also have a spike in reports.
3196. IQ stated she was working in the child protection space when the mandatory reporting was introduced. She stated that at that point in time there was sufficient time to have the opportunity for in-depth discussion around the concerns of the reporter. However,

¹⁰⁰⁸ Transcript of Proceedings, p 2453

¹⁰⁰⁹ Transcript of Proceedings, p 2453.25

¹⁰¹⁰ Transcript of Proceedings, p 2455.35

¹⁰¹¹ Transcript of Proceedings, p 2459

as demand grew, they suffered from the legacy of that initial increase. That is reflected in the 18,600 reports in the last financial year.¹⁰¹²

3197. IQ stated that, in respect to mandatory reporting, she would like a system such as a 'consultation function system', whereby the reporter had some support to be able to engage with the family in their own service.
3198. IQ stated that they want to put a safety net around families, but the child protection system cannot do that, rather it is the community that needs to do that. The gaps need to be closed in respect to support required by families.
3199. IQ also observed that, in order to achieve this, those other organisations would need to think differently about how they do their business because their demands may have increased.¹⁰¹³
3200. IQ agreed that at present if intake is not going to progress the matter further, there are other services which the family can be referred to. That is particularly the case where parents are not considered to be responsible or possibly responsible for the abuse.¹⁰¹⁴
3201. IQ agreed that where there is high workload, accessing information is problematic.¹⁰¹⁵ However, there is flexibility in the workforce, and staff can be accessed from non-operational areas to assist and help manage the demand.
3202. In terms of the level of experience for Intake Workers, IQ opined that her sense was that experience should be a matter of balance and there is a need for newer workers to be given the opportunity to learn how the system fits together and intake is the first part of that system.
3203. In relation to cumulative harm, IQ said that it is a really complex construct and there is this expectation that child protection workers have knowledge about everything and that's not the case. She stated that there is work being done for staff to have a foundational knowledge to be able to identify and be curious about what they are observing.¹⁰¹⁶
3204. In relation to the cumulative harm aspect, it was posited that if it is a complex construct how can people then understand what they are assessing if they don't understand it? IQ agreed with this and said that there is more that they could do to help people apply it to their practice.¹⁰¹⁷
3205. IQ agreed that there are drivers in relation to cumulative harm and certainly family violence, mental illness, or drug and alcohol addiction are part of those drivers. Homelessness is also a factor that is recognised.
3206. In relation to whether the number of reports should trigger an assessment, IQ opined that it is not necessarily the number but rather whether the reports are about abuse or neglect and that's what should trigger a review or analysis or assessment.

¹⁰¹² Transcript of Proceedings, p 2460.10 – 37

¹⁰¹³ Transcript of Proceedings, p 2463.1

¹⁰¹⁴ Transcript of Proceedings, p 2462.30

¹⁰¹⁵ Transcript of Proceedings, p 2463.10

¹⁰¹⁶ Transcript of Proceedings, p 2464.40 with

¹⁰¹⁷ Transcript of Proceedings, p 2466

3207. IQ stated that at the present time there is no number of reports which trigger a review. In the past there has been a number set, however, in the ACT because they often get multiple reports about the same incident from various people it would inflate the number and affect the resourcing.¹⁰¹⁸
3208. IQ stated that in 2013/2014 a two-year audit occurred in relation to the whole of the Department's policies, procedure and management. However, there has been no further internal comprehensive audits of a similar nature to the one conducted in that period.
3209. IQ stated that they had been in consultation with the Safety Together Institute in the United States to audit the policies and procedures as to whether the settings are right for example, family violence. It could not be the whole system because it is too large, but they are doing segments and that's what is being worked on at present.
3210. IQ stated...
- "So, an organisational review will tell us, are the instructions clear? Have we got the right narrative? Have got the right training program? What do we need to revise, and it's a way for us to keep continual learn (sic) and to continue to reflect about how we provided the guidance for staff to help them do their work?"¹⁰¹⁹
3211. In respect to workload, IQ said there are ongoing challenges because the demand for the system is significantly high and that in itself presents challenges around managing work. There is also a need for balancing of people's workload so that training can be prioritised as well.¹⁰²⁰
3212. Identification of risk and understanding how to apply that through a risk lens is a challenge. That is particularly so given the "*relatively regular turnover*," of staff.¹⁰²¹ It is always going to be a challenge to ensure staff understand the risk, analyse that risk, and then document the risk.¹⁰²²
3213. IQ identified that community expectation around child protection is an issue and it is critical that only the most serious incidents are reported because the system cannot sustain the ongoing response and workload.
3214. Community partners are an important factor in child protection as well because child protection seems to be only ever at the crisis point and it is expected to be everything to everybody,¹⁰²³ and that needs to change.
3215. IQ agreed with the proposition that there needs to be a form of filtration at the initial intake where someone very senior can identify whether there is a risk that the case is one of abuse and if so, refer it on or a needs case then have an automatic referral system to community organisations to assist the families and to keep eyes on the children.

¹⁰¹⁸ Transcript of Proceedings, p 2468.10

¹⁰¹⁹ Transcript of Proceedings, p 2469.46

¹⁰²⁰ Transcript of Proceedings, p 2470

¹⁰²¹ Transcript of Proceedings, p 2471.1

¹⁰²² Ibid

¹⁰²³ Transcript of Proceedings, p 2471.20

3216. IQ described it as an active triage system that responds to families and can engage with families about what the issues are. IQ stated that sometimes it should be the child protection system that deals with the report but that it is not always the child protection system that needs to deal with it. There needs to be active management of that at the front door (intake) so that means families aren't reported and then fall into gaps in the service system.

3217. IQ opined that care and protection is not about welfare concerns which can properly be dealt with in the community. It would take some acceptance and understanding of the risks and challenges for the community organisations to engage with families. The child protection system is the safety net around families where that risk cannot be managed in the community.¹⁰²⁴ That, however, is in an ideal world where all the resources needed are available to these organisations.¹⁰²⁵

KX – Coordinator-General for Family Safety within the ACT

Statement

3218. KX was appointed as Coordinator-General for Family Safety within the ACT in 2016. This role was commissioned after the Government made commitments across various themes as set out in her statement at paragraph 8.

3219. The Government response addressed the following reports: The Glanfield Inquiry 2016, the Review into Domestic and Family Violence Deaths in the ACT from May 2016, and the ACT Domestic Violence Service System Final Gap Analysis Report from May 2016.

3220. As part of the response, the Government was focused on establishing a New Family Violence Act, improving sharing of information between agencies through legislative provisions. They also established a case analysis team within CYPS to provide independent advice in individual cases at key decision-making points, training courses for caseworkers in CYPS. They further removed legislative barriers so that CYPS workers can undertake appraisals effectively and added the Family Violence Screening Program in perinatal mental health across all child and adolescent mental health services.

3221. KX indicated that the Coordinator-General has a commitment to ensuring Government responses are delivered by key strategic and service development initiatives such as the ACT's family safety hub.

Reports and Reviews in Response to Bradyn's Death

The Glanfield Inquiry

3222. Laurie Glanfield was asked to hold a board of enquiry and report to the government. The Report's terms of reference included a review of the current legislative framework, policy, practices and operations of ACT Directorates and service providers who respond to family violence with a focus on systemic issues.

¹⁰²⁴ Transcript of Proceedings, p 2472.1 – 35

¹⁰²⁵ Ibid

3223. Specifically, the enquiry was asked to review the effectiveness of interactions and responses of government directorates/agencies and service providers in relation to mandatory reporting, family violence (particularly where children are involved) and the sharing of information on at-risk family.
3224. The enquiry came about as a result of the death of Bradyn Dillon one week prior to the appointment of Mr Glanfield.
3225. Mr Glanfield found that in the ACT there was no one single integrated family violence sector but a number of sectors which operate independently of each other.
3226. There was identified, four key outcomes for achievement. They are.
- (a) the creation of a collaborative and informative culture sharing within the sector focusing on whole of family safety and early intervention
 - (b) improved assessment referral and case management processes for bundle families and children
 - (c) improved quality of, and transparency in CYPS decision-making and practices; and
 - (d) improved oversight of the system responses and ensuring recommendations are implemented
3227. collaboration was identified as significantly important with a need for better collaboration and integration of services. Despite privacy issues, a recommendation was made for legislation to be implemented to achieve that collaboration and integration of services.
3228. Improved governance and coordination within the system was also recommended for reform. That includes better information and feedback to mandatory reporters. This would improve better collaboration between the agencies.
3229. As an example of proper feedback, the report identified 'at risk' children who have been reported by mandated reporters and identified as being at risk, and who continue to be at risk, particularly when they are moved to another jurisdiction or another school.
3230. Schools could advise CYPS of the unenrolment and CYPS could then notify child protection agencies in that state. The recommendation was made to ensure that the child is not lost from the sight of protective agencies.
3231. A recommendation was made in respect to ICT systems to support integrated sharing.
3232. Establishment of an early intervention sector such as a family safety hub which would initially assess low risk children and link them with other appropriate services, leaving the more serious cases to the attention of the CYPS.
3233. It was noted that the main entry point for children or families experiencing family violence is CYPS. The consultation process engaged by the reviewers found that there was 'significant concerns about CYPS processes and decision making'.¹⁰²⁶

¹⁰²⁶ Glanfield p 6

3234. An important finding for my purposes¹⁰²⁷, was the finding that the CYPS has been facing increasing numbers of Child Concern Report over the past 10 years but very few, in fact, proceed to appraisal, substantiation or intervention. Many of the reports that do not meet the thresholds for further appraisal are not resulting in referral of cases to services. When referral is made it is rarely followed up. This is consistent with CYPS seeing its statutory role as dealing with high-risk children, not providing human services to vulnerable families generally.
3235. There is a need for cultural change to ensure greater collaboration and transparency in decision-making area. There is also a need for a dedicated quality assurance mechanism to be in place to review the decision making.
3236. One of the issues that arose in respect to the constraints on CYPS to investigate child concerned was identified as requiring parental consent or a court order. The enquiry opined that this requirement allows an opportunity for a perpetrator parent to delay the appraisal while a court order was obtained, 'or to negotiate their presence" when the children are interviewed. This significantly decreases the possibility of a child disclosing abuse which in turn is likely to reduce the priority attached by Police, to matters they may investigate. Subsequently a recommendation for a change in the legislation to facilitate a different alternative to consent or court order be considered.¹⁰²⁸
3237. The report also recommended that the government create a Coordinator - General for Family Safety role with a small support team included, designed to provide high level coordination oversight and drive. It also recommended that resources of the public advocate and child and young people commissioner be properly resourced to ensure oversight is being provided by the statutory officer and is working effectively.
3238. In relation to mandatory reporting, one of the recommendations identified that CYPS must ensure appropriate feedback is given to notifiers who report child concerns and where matters do not proceed, referral to support services for the family must be considered. The report also recommended that the legislation should be changed so that parental consent is not necessary, nor notification to the Children's Court.¹⁰²⁹
3239. Importantly, in this case, ACT policing policy regarding not undertaking investigations unless children have disclosed abuse, should be modified to ensure this policy is not rigidly applied and that the circumstances in individual cases are considered and discussed with CYPS.
3240. Further, CYPS must adopt a culture of transparency and engagement with clients, agencies, and service providers to inform improved decision-making and to engage more effectively with those who provide services to families come to the notice of CYPS.
3241. It was also recommended there should be a merits review in respect to decisions made by CYPS.

¹⁰²⁷ My emphasis

¹⁰²⁸ Glanfield p 7

¹⁰²⁹ Glanfield p 9

3242. Glanfield further recommended that CYPS should use case conferencing more frequently, using a collaborative approach with other government and non-government agencies as well as families.

3243. The report asserted that adoption of the public health model in child protection and human services more broadly, aims to shift the attention away from the statutory end of the service system to a more preventative and collaborative model by sequentially accessing the three levels for prevention usually represented as primary, secondary and tertiary. The public health model is providing a policy framework for informing government intervention to better support vulnerable families.

3244. The report identified that historically, government support for at-risk children and young people has focused on tertiary interventions after abuse or neglect has occurred. In recent years, however, governments have been increasingly seeking to intervene earlier to support vulnerable children, young people, and their families. This method can be an effective tool for improving outcomes and can be more cost-effective in the long-term.¹⁰³⁰

3245. And from a public health approach more primary than secondary services should be available and more secondary than tertiary services. To that end an increase in the resources for early intervention and prevention services should be pursued as an option to divert families from the statutory child protection system.¹⁰³¹

3246. A new initiative being developed and implemented is “Step up for our kids service”.

3247. The review also identified the Silo structure and considered that it should not be the approach used, rather use of integrated services is best practice.

3248. Interestingly the report identified that

“the rise in demand for Child Protection services is, in part, due to a global shift in the breadth and scope of what constitutes child abuse and neglect. Child Protection services were established to respond to serious physical abuse, such as multiple fractures and bleeding on the brain. Child Protection now includes physical abuse, sexual abuse, emotional abuse, neglect, and exposure to domestic violence. The threshold for what constitutes abuse and neglect includes outcomes such as bruising, developmental delay and psychological harm. This broadening of the scope of Child Protection services has been gradual and has occurred without a fundamental reappraisal of the assumptions on which Child Protection services were established.”¹⁰³²

3249. Importantly an analysis of the Child Protection statistics shows there has been over the last 10 years a 24% increase in notifications (Child Concern Report) over the same. With a decrease in the number of finalised investigations. It was the report author’s view that it suggests fewer cases were meeting the legislative thresholds for statutory interventions.

3250. Having considered the statistics the report authors suggested that it is clear from the statistics there are two main subpoints in the child protection system at the front end

¹⁰³⁰ Glanfield p 35

¹⁰³¹ See figure 2 page 17 of the report for ACE schematics of the report to Child and Youth Protection Services.

¹⁰³² Glanville report page 38 citing Rodda activity commission 2016 report on government services, chapter 15, Child Protection services.

of the statutory system and at the point of placing children and young people in out-of-home care.

3251. In respect to the front end view it is clear that Child Concern Report do not meet statutory thresholds to warrant an investigation and only a very small number of reports investigated result in a substantiation of abuse and neglect. They concluded that extensive child and youth protection service resources are being used to sort out from the many notifications children who are genuinely at risk and potentially needing intervention to ensure their protection.

3252. It is clear that the themes from the report are early intervention, collaboration and an integrated service response coupled with improved sharing of information between agencies. There also needs to be a systemic review of the operation of the CYPS in the ACT.

3253. Interestingly one of the submissions by ACT Legal Aid covered the view that in some circumstances caseworkers make decisions without considering relevant information from parents, carers, or family members.

3254. It was also noted in the report that in the Dillon matter many agencies involved with the family treated the Domestic Violence Order in place as if it was a parenting order made by the family Court. The Family Law Council in its interim report notes “previous research has also shown that many families whose first point of contact with the legal system is a state or territory court, failed to access the family court to obtain the orders they need.”¹⁰³³

3255. The review referring to the Family Law Council noted that it was essential that the criminal law, child protection and family law systems along with relevant federal, state and territory agencies should be encouraged and supported to work collaboratively to achieve safe outcomes for children¹⁰³⁴. That is essentially an important outcome that must be achieved.¹⁰³⁵ Clearly, without collaboration, courts systems can compete and work against each other at times.

3256. Early prevention and intervention, improved access to services and service integration reforms are an important feature for ACT Government reforms. It was noted that the willingness of people to engage is crucial for the service to be effective.¹⁰³⁶

One finding noted the ACT lacks programs focused on the perpetrator’s behaviour, despite the fact that the perpetrator is the source of family violence. Secondly outputs and activities are focused on, rather than outcomes.¹⁰³⁷

Mandatory reporting

3257. The statistic in respect to responding to both mandated and voluntary reports identified that out of 44,538 reports, 6% resulted in substantiated abuse and neglect, 8% of investigations did not result in substantiated abuse or neglect, 72% of Child Concern

¹⁰³³ Glanfield p 53

¹⁰³⁴ Ibid

¹⁰³⁵ My emphasis

¹⁰³⁶ Glanfield p 55

¹⁰³⁷ Glanfield p 60 finding b

Reports did not proceed to a Child Protection Report, 23% were provided advice and referred to services and 8% were multiple reports of the same incident.¹⁰³⁸

3258. The statistics reveal that 80% of those cases did not meet the threshold for statutory intervention and appraisal).¹⁰³⁹

3259. The report author indicated that given the large number of cases involved in the latter category, there would be value in understanding what has been the service response, especially given families in contact with the child protection system may have multiple Child Concern Report.

3260. It was also not apparent to the enquiry whether there was any follow-up by CYPS when they do refer a case to community services in terms of whether the services were effective, in terms of service delivery, to the family. It was noted that Professor Camilleri made similar observations as part of his internal review.¹⁰⁴⁰ In that review he said;

“the 10 cases reviewed have usually seen passive referrals if a CCR (Child Concern Report) is not substantiated or no further action is decided. There was no active engagement by CYPS in nearly all the cases with only a few exceptions, to ensure the services are connected and that the family receives intervention, nor monitoring to see if the expected outcomes have occurred.”¹⁰⁴¹

Decision-Making

3261. An observation made by Muir and cited by Glanfield, on the reliance on professional judgement, said that child protection decisions can be subject to shortcomings of human judgement, the slowness to revise judgement in light of new evidence, reliance on verbal not written information and decision-making on (available evidence) when further evidence might or should have been gathered.

3262. In an article in relation to Common Errors of Reasoning in Child Protection, the report cited an article by Munro which stated;

“it was found that professionals-based assessment of risk on a narrow range of evidence. It was biased towards information readily available to them, overlooking significant data known to other professionals. The range was also biased towards the more memorable data, that is, towards evidence that was vivid, concrete, arousing emotion and either the first or last information received. The evidence was also often faulty, due, in the main, to biased or dishonest reporting or errors in communication”.¹⁰⁴²

3263. A critical attitude to evidence was found to correlate with whether or not the new information supported the existing view of the family. A major problem was that professionals were slow to revise their judgements despite a mounting body of evidence against them”.

3264. Glanfield referred to the Muir review and said;

“sound decision-making is dependent on the quality of information held. If information is incomplete or inaccurate, then this will directly impact on the quality of decision-making.”¹⁰⁴³

¹⁰³⁸ “ p 65

¹⁰³⁹ Glanfield p 65

¹⁰⁴⁰ Camilleri P 2015, referred to at p 66

¹⁰⁴¹ Camilleri P 2015, referred to at p 66

¹⁰⁴² Glanfield p 74 citing Munro E, (2000) p 5

¹⁰⁴³ Glanfield p 74 citing Muir P (2016) p 25

3265. The review also referred to the 'K' Review which found there was a lack of understanding of the thresholds when making an intake decision and no consideration of the impact of cumulative harm.¹⁰⁴⁴

3266. It was also noted that often the broader family members have the better understanding in relation to families and that current review arrangements do not give them a voice. Noting that in making difficult decisions in relation to child protection, the child protection agency should take account of all available evidence before making decisions.¹⁰⁴⁵

3267. In regard to life changing decision making where errors can never be entirely eliminated the Author noted what was said by The Hon. Justice Deirdre O'Connor;

"the responsibilities of government must include not only a system for making correct and fair decisions but also an effective mechanism for review of decisions if they do not comply with the objectives. Directly or indirectly, the government continues to exercise a significant amount of decision-making power and administrative review remains a useful tool of accountability both for individuals whose interests are affected by specific decisions, and, in a more general sense, for the community."¹⁰⁴⁶

Information Sharing

3268. The Glanville report indicated that there appears to be no absolute legislative impediment for sharing information with mandated reporters or relevant directorates. However, there is a lack of information sharing with privacy issues being cited as the reason for not sharing.

3269. In relation to information sharing with other jurisdictions. There was anecdotal evidence of perpetrators moving around jurisdictions to escape being reviewed by the care and protection authorities.

Recommendations

3270. Having considered the recommendations on page 78 of the Glanfield Inquiry, I adopt recommendations 11 through 16 as being relevant to this Inquest.¹⁰⁴⁷

The 'K' Review

3271. I note that this review was undertaken after the death of Bradyn and the injury to JL .

3272. I note the terms of reference included, the consideration of all relevant information held by youth protective services, conducting workshops for managers and Team Leaders to discuss the themes identified, and to provide a report to the Executive.

3273. The methodology undertaken was a review of documentation including those in respect to PE, TE and UE as well as Bradyn and JL.

3274. A detailed chronology was prepared and included in the review.

3275. The dominant theme of the review was the finding of consistently minimal application of risk assessment, despite child concerns or protection reports having prompts in the

¹⁰⁴⁴ Glanfield page 76 referring to K report (2016)

¹⁰⁴⁵ Glanfield p 74

¹⁰⁴⁶ Ibid

¹⁰⁴⁷ See recommendations

form of questions to encourage the Intake Worker to apply a risk assessment. Those included prompts to engage in a risk assessment. Those prompts were identified as having only a yes or no, or probable or not probable response with little text to demonstrate rationale or support the decision-making undertaken. Recommendations were then made to take no further action or close the case in most situations.¹⁰⁴⁸

3276. It was said that there was consistent use of the term ‘assessment of risk’ when no assessment had taken place and no evidence to support whether any assessment had taken place. K identified that

“In more than one case worker and Team Leader’s recommendations, it was unclear how the conclusion was reached that the father was willing and able to provide for the children’s care safety and well-being when the allegations were physical abuse by the father against the children, allegedly resulting in physical injuries. Of note was that these recommendations were made when in some instances the children hadn’t been sighted or interviewed, and if the father had been interviewed it was over the phone, ‘otherwise’ the assessment was made on the basis of previous reports having been received that had not progressed to an appraisal or had proceeded to an appraisal and the allegations were found to be unsubstantiated.”¹⁰⁴⁹

3277. The author of the report also identified that in relation to a response where injuries were sustained by Bradyn who was then taken to the Child at Risk Health Unit for assessment.

“The report provided outlined that the doctor was of the opinion that “the bruises are as a result of blunt trauma some of which are partially explained and others such as the bruises on his left cheek, left ear and red marks on his arms are of concern”. Under recommendations in subsequent report this report is referenced and summarised to no concerns raised and was used to assess subsequent physical injuries as ‘not of concern.’¹⁰⁵⁰

3278. I further note in the report the assertion that, despite detailed practice guidelines and tools regarding intake processes available to child and youth protective services at no point was a recommendation made to consider the impact of cumulative harm until the report of 15 February 2016 being the report which resulted in Bradyn’s death.¹⁰⁵¹

3279. A dominant theme was threshold analysis. The author opined that there was a lack of demonstrated understanding of thresholds. These thresholds are outlined in the OCYFS risk assessment frameworks. This framework outlined the process of assessment and decision-making which is made up of four distinct and complimentary assessments.

- (a) initial risk assessment (for a Child Concern Report)
- (b) protective risk assessment (for Child Concern Report)
- (c) ongoing Care and Protection risk assessment (appraisal)
- (d) continued assessment and review in the delivery of Care and Protection services (Care and Protection assessment)

3280. Each of the four assessments require a threshold decision, and the test is ultimately not whether the child had made a disclosure but whether the worker suspected on

¹⁰⁴⁸ K report page 6

¹⁰⁴⁹ Ibid

¹⁰⁵⁰ K report page 7

¹⁰⁵¹ My emphasis

reasonable grounds that the child may be in need of care and protection. The author identified that issue and said,

*“there was also a consistent practice where unless the reporter could provide details of a disclosure supporting that the injuries were nonaccidental, then the matter was recommended for no further action”.*¹⁰⁵²

3281. The author opined that it was unclear how multiple reports of alleged physical abuse of the children by their father, often in close succession could not have led the Intake Worker to the conclusion that based on the information at hand (alleged physical injuries to the children), coupled with the historical information, that the threshold of “suspicion on reasonable grounds” was not met.
3282. The author placed a caveat on the assumptions in so far as it was likely more information to support the decisions made was available, however there was no documentation available to support the decisions which underpinned those assumptions.
3283. The author further opined that it was evident from the records that the decisions to make no further assessment or intervention was because the alleged violent history was in relation to his relationship with SK and UN.
3284. Further, given the paucity of documented information available upon review and the lack of clarity in relation to specific questions asked of Graham Dillon at the assessment, the author raised the question as to how thorough the appraisals were in respect to any risk assessment in relation to the children, given, the direct allegations were not put.
3285. The author further examined the forensic technique undertaken when interviewing the children and opined that there was no evidence that skilful forensic examination was conducted or that the children’s account was challenged, particularly given the responses were most commonly “I don’t know” which was then accepted. Neither was there any documentation to suggest that Graham Dillon had been challenged or questioned about his behaviour, particularly given the history provided by the children.
3286. Of particular note was the comment in respect to the analysis of the only disclosure made by the children when they were with their mother, that interview was done some weeks after the disclosure and the possibility that the children had been coached by their father was never considered, K opined that;
- “the children felt safe enough while not in the care of their father to disclose abuse, and then, when back in his care were unable to pursue this line of disclosure given, they were back in the situation that possibly made them feel unsafe”.*¹⁰⁵³
3287. The author also reviewed the documentation in respect to utilising information gathering powers available to caseworkers for requests for information and for information sharing from interstate agencies for the purposes of decision-making about potential risk.
3288. The author revealed that there was only one such request and little evidence that the plans or actions were thoroughly investigated.

¹⁰⁵² K Report page 8

¹⁰⁵³ report page 9

3289. In respect to Graham Dillon's historical criminal history being referred to in the material, no attempt was made to establish its veracity which could have been used in the risk assessment process.

3290. The report author also noted that there were delays in sign offs, documents being incomplete, and some lack of follow-up in relation to times for action to be recorded. Further the author opined that

"overall, the hard copy files were not an accurate and contemporary record. Large parts of the information available on CHYPS was not located on the hard copy file (e.g., six most recent Child Concern Report), the files were not folioed, and important information (CARHU medical assessment report regarding Bradyn) was only in hard copy on JL's file, not Bradyn's and not on CHYPS for either child."¹⁰⁵⁴

3291. The author, also noted shortcomings in the supervisory role noting that ("the Team Leader almost always agreed with the recommendations of the caseworker")¹⁰⁵⁵ There was a lack of scrutiny over case direction and a lack of quality assurance in the assessments.

3292. The author concluded that, whilst important to balance information available in context which may not always be available, scrutiny of practice and systems should occur during the review process with the aim ultimately to address immediate issues and ensure learning in order to prevent similar tragedies occurring.¹⁰⁵⁶

3293. It was noted that a risk assessment was first applied upon receipt of the fifth Child Concern Report, and it coincided with the first appearance of a Child Protection Report being made with an appraisal being recommended. It was suggested that "overall, information gathering, review of child protection history, risk assessment, application of thresholds and analysis was minimal and while at times came close to exploring the presenting issues, there was little evidence to suggest that this was ever done thoroughly, or effectively."¹⁰⁵⁷

3294. the major conclusion reached was that

"if more detailed analysis of information, history and risk, by the application of a risk assessment, consideration to the impact of cumulative harm, the application of thresholds to inform decision-making, coupled with forensic interviewing of the children and professional judgement based on sound assessment, then it is likely that the intervention pathway for this family's involvement Child and Youth Protection Services would have been different."¹⁰⁵⁸

3295. it was further found that

"despite the practice shortcomings in the early stages of Child and Youth Protection Services involvement with this family, practice did not improve, despite increasing number of reports, often received in clusters, and at times with overwhelming evidence to support an increased statutory intervention".¹⁰⁵⁹

¹⁰⁵⁴ report page 10

¹⁰⁵⁵ I b.i.d.

¹⁰⁵⁶ Ibid

¹⁰⁵⁷ report page 11

¹⁰⁵⁸ I b.i.d.

¹⁰⁵⁹ I b.i.d.

Executive summary

“Child and Youth Protection Services hold records of multiple child concern and Child Protection Reports alleging physical injuries to the children, allegedly perpetrated by Graham Dillon, with minimal documented application of risk assessment and subsequently varying degrees of statutory child protection intervention.”¹⁰⁶⁰

3296. The conclusion reached in the report was that four major themes emerged as part of the review that require immediate and ongoing work;

- (a) understanding and application of risk assessment, including cumulative harm in informing decision-making
- (b) understanding and application of legislative thresholds in informing decision-making
- (c) skills in relation to interviewing children and parents
- (d) information gathering and exchange, record-keeping, and supervision.

3297. The report also identified that the CYPS has undergone significant reform since 2016 with the implementation of an integrated management system and knowledge portal and integration of Care and Protection Services, Youth Justice, and Bimberi Youth Detention centre to form the Child and Youth Protection Services.

3298. It appears there is a focus on learning now, with extensive training to support reforms as well as an improved information management system and implementation of effective multi agency collaboration in keeping children and young people safe.

3299. Annexed to the ‘K’ Review is a chronology and analysis of documents commented upon in the report.

The Muir report 2016

3300. An independent review, by child youth protection services initiated in response to the Bradyn Dillon’s death.

3301. The report was a review into the death of Bradyn Dillon and the serious assault of JL. It was not initiated for the purposes of identifying systemic problems although it was thought possible it may highlight potential systemic weaknesses.

3302. It was also not to include matters examined by Laurie Glanfield in his review.

3303. Key findings – there were 22 Child Concern Report made to CYPS between 2012 and 2015 in relation to both JL and Bradyn Dillon.

3304. The issues identified included how information was collected (or not collected) and analysed, whether those issues had a direct impact on the decisions which were taken and the response which followed from those decisions.

3305. In respect to the risks identified the report author identified five.

¹⁰⁶⁰ K Report page 2

3306. emotional harm, physical and emotional harm, educational, neglect, and cumulative harm all suffered as a result of the actions between 2013 and 2015 of Graham Dillon who was the father of the children.
3307. There were significant concerns raised in relation to handling of the reports particularly in relation to bruising identified on the children in 2014 and 2015.
3308. The report author identified that there were a number of occasions where the evident risks were correctly identified yet at other times it was not clear that there was an apprehension of the risks facing the children.
3309. The report author identified a lack of clarity in relation to information which was taken into account in supporting various decisions, and some which were not supported by available evidence.
3310. It was also identified that the concerns of the paediatrician in 2014 were not acted upon nor were the disclosures of JL acted upon and there was no indication as to the reasons for those decisions.
3311. The author also identified that there was a failure to consider or assess the risk of cumulative harm to the children over the course of the case and that represented a significant systemic weakness.
3312. The author also identified apparent failures;
- (a) one was an overreliance on the views of one agency to validate Graham Dillon as a parent and a failure to undertake broader enquiry on that agency.
 - (b) case decisions were not always supported by the available evidence.
 - (c) lack of clarity in relation to disclosures made by the children and why they were not followed through internally and through referral.
 - (d) lack of clarity as to why the view of the paediatrician was not acted upon and the lack of evidence of follow-through.
 - (e) No other professional assessment of the children was ever sought
 - (f) and there was no use of a Declared Care Team to enable information sharing and to better engage other agencies
3313. the author identified that the schools were diligent in reporting their concerns and indeed there were eight CCR 's made. Only two of the reports represented better or good practice from a process perspective, the rest presented significant concerns in relation to process and decision-making.
3314. The author assessed that in totality there were significant issues which impacted on the quality and quantity of information available to CYPS. Mr Muir said there were significant issues about the way that the information had been gathered (or not gathered) and analysed by both caseworkers and Team Leaders.
3315. Mr Muir opined that after he had reviewed the documentation some of the reports were done well and in practice had potential to make caseworkers think about the matters and what had preceded their involvement, however in others it was clear that

the information was cut-and-paste from previous work and some of the histories were unsatisfactory and were very poorly constructed. Mr Muir opined that “when information is lost in human services cases, it does in my experience diminish the quality of decision-making” ¹⁰⁶¹

3316. Mr Muir also opined that there was a lack of critical analysis of the information by both caseworkers and Team Leaders. It appeared from the reports that there was little evidence to support that any supervisor had critically value-added information presented to them and that there were no progress notes or notations to support that the Team Leaders have done anything other than endorsed information placed before them.

3317. However, it appeared to him that despite that shortcoming there was still abundant information available on CYPS collectively in this case.

3318. It was his opinion that despite accurate capture of history and involvement no one had apparently considered patterns of behaviour presented in the collected information.

3319. The author opined that in the last half of 2014 there should have been sufficient information about the past history of violence perpetrated by Graham Dillon and the constant pattern of bruising to suggest that at least further investigation was warranted.¹⁰⁶²

3320. The Directorate policies and procedures are sufficiently clear to establish that this should have occurred, and he questioned why it was not done. It was his assessment that the trend was for people to focus on reports and concerns of events to be dealt with rather than a body of information to be assessed and analysed. There was also a tendency to rely on the decisions and outcomes of previous pieces of work rather than a fresh analysis of work.¹⁰⁶³

3321. Mr Muir also identified gaps in the progress notes and noted that there were, despite involvement with CYPS since 2012, no progress notes until 30 July 2014. After that time there were no progress notes made. There were almost none made in 2015. In his view these gaps represent gaps in organisational knowledge and a failure to understand what actions were actually taken and why.

3322. Mr Muir also details the poorly completed assessment of family vulnerability, noting that there was only one factor, not present in this family’s history, that being the age of a parent or carer, yet not one instance over the period of 2014 – 2015 were they satisfactorily recorded in intake forms, yet they were all apparently factored into decision-making.¹⁰⁶⁴

3323. Mr Muir further identified that at no point did anyone consider the need for a separate case analysis to assess the risk of cumulative harm. It is noted that the only time that box was ticked was the report of Bradyn’s death in 2016.

3324. In relation to investigation there was only one case where the investigation was done satisfactorily and even that level of questioning was identified as shallow, and

¹⁰⁶¹ Muir - page 27

¹⁰⁶² Ibid

¹⁰⁶³ Ibid

¹⁰⁶⁴ Muir – page 29

superficial questions asked with the answer accepted without clarification as to detail.¹⁰⁶⁵

3325. Mr Muir further identified a lack of recording of reasons for decisions in accordance with procedure. That was evident particularly in relation to the bruising that was referred to by CARHU with no plausible explanation of the bruising, yet the report reflected that the abuse was not substantiated with no reason recorded as to how that evidence was considered and why the evidence of the doctor was not regarded in that way.

In respect to training, Mr Muir identified that induction training provided to caseworkers was currently insufficient for the complexity of the tasks and the environment that they faced. Mr Muir, opined;

“in the information gathering that was examined in this case there are clear gaps. It is not clear at times whether there are gaps in practice or information recording or both.”¹⁰⁶⁶

3326. Mr Muir further opined that his assessment in relation to training was that;

“it was not a substantial causal factor in the issues identified in the terms of reference.”¹⁰⁶⁷

3327. In relation to supervision, Mr Muir identified that failures in this case were in his view, largely in relation to supervision and oversight of the case,

“because there was no evidence in all the material available to him that apparent shortcomings in practice were identified or corrected by Team Leaders”.¹⁰⁶⁸

3328. An audit of the supervision framework in 2015 found that.

- (a) the standards for the frequency of schedule supervision were not being met.
- (b) documentation of supervision did not meet the required standards.
- (c) no quality assurance activities in relation to supervision were detected in the course of the audit.
- (d) the skill base and practice of supervisors showed a high degree of variability
- (e) There was no formal system in place to escalate systemic issues that arose in the supervision process

3329. In relation to the risk of the children and particularly in relation to 2014 and 2015, CYPS had documents available on its web portal in relation to understanding and identifying the risk of physical harm. Those tools were ‘Risk and Safety Judgement Guide’ and ‘Recognising Abuse and Neglect in Practice’

3330. The first document referred to, Risk and Safety Judgement Guide identifies the consequence of abuse as serious if there is;

1. an observable injury or condition (e.g., Welt, bruise...)

¹⁰⁶⁵ Muir – page 29

¹⁰⁶⁶ Muir – P 32

¹⁰⁶⁷ Muir – P 32

¹⁰⁶⁸ Muir – P 33

2. A fearful/anxious child
3. where there is a repeated exposure to/or potential for physical harm from family violence.

3331. The second document gives guidance in recognising physical abuse and bruising in particular, it states; “children can have accidental bruising, but the following must be considered as nonaccidental unless there is evidence, or an adequate explanation provided;

- (a) Bruising in or around the mouth, particular in small babies which may indicate force-feeding
- (b) two simultaneous bruise eyes, without bruising to the forehead, (rarely accidental though a single bruised can be accidental or abusive)
- (c) repeated or multiple bruising on the head or on sites unlikely to be injured accidentally
- (d) variation in colour possibly indicating injuries caused at different times
- (e) the outline of an object used e.g., belt marks, handprints, or hairbrush
- (f) bruising or tears around a behind-the-ear load/indicating injury by pulling or twisting
- (g) bruising around the face
- (h) grasp marks on small children

3332. Given the number of documents held by the Directorate in relation to these children there should have been made a default assumption that these injuries as described should have been considered a serious and nonaccidental injury unless proven otherwise.¹⁰⁶⁹

3333. The analysis of the report particularly of 17 June (69418) was superficial and poor and despite there being a probable likelihood of past and future abuse no one was interviewed. There was an assessment that there was someone willing and able to protect the children, yet this assessment was made despite an extensively documented history of family violence and the fact that no one had seen Graham Dillon or the children for five months.

3334. Mr Muir then goes on to detail a number of reports made by teachers about bruising, some which were well documented with action undertaken by caseworkers and then recorded. Others however were not so well documented.

3335. Mr Muir identified a concern in relation to interviews with both Bradyn and Graham Dillon about their account of how the injuries occurred. They were consistent however JL was never asked directly about her bruising. What was of concern in the appraisal was the most significant disclosures made by JL who stated that sometimes Graham “hits them on the head and kicks them on the bum when they are not expecting it”. When asked if it hurts when she is hit on the head she said, “*no the boot hurts more*”.¹⁰⁷⁰

¹⁰⁶⁹ Muir – P 39

¹⁰⁷⁰ Muir – P 41

3336. When JL was further questioned as to how that happened JL physically placed a hand on her left and right side of the head and on the side of her face.
3337. Mr Muir opined that the lack of any apparent action in relation to the disclosures was concerning as there was no record at all that they were factored into the decision-making process. There was no recorded action at all in response to them.¹⁰⁷¹
3338. Further, Mr Muir identified that he had concerns that despite this disclosure the children were allowed to attend a GP who had never seen them before, rather than CARHU. No written report was received from the doctor.
3339. The next report of bruising, which was of considerable concern, was in August 2014, eight days after the completion of the appraisal. That report ultimately was well documented but a weakness in relation to the risk assessment process was the recording and assessment of vulnerability factors in the family. Despite 12 of the vulnerability factors being known to CYPS and clearly recorded in records, only one was indicated in the assessment.
3340. Despite there being concerns raised by the paediatrician, there was an over emphasis on the capacity of Graham Dillon to engage in the community supports available to him, rather than on whether the bruising was accidental or not.
3341. The Paediatricians concerns were also not acknowledged. Indeed, the AOR stated that there were no concerns regarding the bruising on Bradyn's face. Which was inconsistent with the report. It was noted that this was important because it became the basis on which a number of future CCR's were to be assessed.
3342. There was also the absence of information relating to absenteeism from school for at least two weeks during the appraisal. There was a question as to whether the children were enrolled at any school. This was noted in the progress notes but was not a factor in the write-up of the appraisal.
3343. In relation to that appraisal, it was noted that despite the implausibility of the explanations given for some of Bradyn's injuries and the paediatricians concerns, the abuse was not substantiated.¹⁰⁷²
3344. Mr Muir then goes on to review the reports, where a superficial analysis was undertaken which failed to provide an accurate account or analysis of the involvement of CYPS in relation to the five previous allegations of bruising to the children. In his view the risk analysis was poor, particularly given the bruising was of substantial concern and despite the last four intake reports assessing the risk of past abuse as probable (the fourth was not completed), this CCR assessed it as 'not probable'.¹⁰⁷³
3345. In relation to cumulative harm, Mr Muir opined that it was clear there was a series of escalating patterns of behaviour which to some extent was understood at the end of 2013, however in his assessment it was never fully appreciated by those responsible at the various times in relation to this case over the life of the agency's involvement.¹⁰⁷⁴

¹⁰⁷¹ I b.i.d.

¹⁰⁷² Muir – P 42

¹⁰⁷³ Ibid

¹⁰⁷⁴ Muir – P 44

3346. In relation to the integrated management system (IMS), despite his opinion that the risk assessment framework in 2014 was a well written document which provided clear and coherent guides to risk assessment and decision-making, it was not prominent on the integrated management system.
3347. Another factor identified was the large number of associated practice guide and tools containing information of varying quality. It was his opinion that staff cannot integrate this amount of dispersed information into practice because of the information being highly fragmented and it did not represent a coherent approach to supporting risk assessment and decision-making.¹⁰⁷⁵
3348. It was his view ultimately, *“that the intake form and CPR’s do not support the objectives of the risk assessment framework.”*¹⁰⁷⁶ It was also his view that in cases such as this one, staff simply tick boxes rather than engaged in a decision-making process based on the principles articulated in the framework. To support his assertion, he indicated there were almost no examples where the actual risks and harms were described.¹⁰⁷⁷
3349. It was his opinion that the assessment of risk and casework action must shift from the current method of what appears to be boxes to be ticked, rather than any fresh appraisal of the case circumstances and the totality of the information holdings. He was also of the view that definitions should be made clearer.
3350. As an example of a better framework Mr Muir identified a model of structured clinical judgement for decision-making which incorporates an actuarial approach.¹⁰⁷⁸ Following on from that approach, Mr Muir opined that there was too little emphasis on the risk that the bruising was not accidental and of the eight CCR’s concerning bruising to both children, there was only active consideration that they were nonaccidental injuries in two of them.
3351. It was also recognised that more emphasis was placed on disclosures or lack of disclosures by the children at the expense of proper investigation. Citing one instance where the school was encouraged to gather more information rather than the caseworker.¹⁰⁷⁹
3352. Mr Muir opined that despite a cluster of extremely concerning reports over 2014 and 2015, there was a singular lack of apparent recognition that the bruises may have resulted from assaults on the children, Mr Muir stated that; “despite policy documents being clear that patterns of behaviour are to be examined there is no evidence that this ever occurred in this case”.¹⁰⁸⁰
3353. Mr Muir outlined his interpretation of the policy guideline in the organisation and considered that

¹⁰⁷⁵ Muir – P 45

¹⁰⁷⁶ Muir – P 45

¹⁰⁷⁷ Ibid

¹⁰⁷⁸ Muir – P 46

¹⁰⁷⁹ Ibid

¹⁰⁸⁰ Ibid

“on the basis of the facts presented, that at some point in 2014, the bruising to the children should have been considered both serious and nonaccidental”.¹⁰⁸¹

3354. In relation to the threshold question in the risk assessment as to whether Graham Dillon was willing and able to protect children from future harm it was asserted that;

“the significant factor for assessment is that someone with parental responsibility who is willing and able to protect the children is the test.”¹⁰⁸²

3355. There was evidence that Graham Dillon was capable of caring for the children (apart from the bruising and non-attendance) it was reported that the children were always dressed appropriately and attended school with food. However, the fact that he was not consistently assessed as a possible abuser of the children together with a lack of basic investigation techniques and critical analysis of the information presented to CYPS; resulted in him being assessed in every risk assessment as being able to do both.¹⁰⁸³

3356. In relation to disclosures, Mr Muir considered that there was a heavy emphasis placed on obtaining disclosures from the children and that that was a central theme in a large number of the reports and also in the Police decisions on whether the children were in need of care and protection. Mr Muir opined “*children failing to disclose against an abusive parent should not be considered an unusual event, yet significant casework decisions were based on the lack of disclosure.*”¹⁰⁸⁴

3357. In relation to the lack of disclosure, it was Mr Muir’s opinion that there were alternative investigation techniques, and a number of mechanisms were available in the absence of disclosures.

3358. It was identified that appropriate interviewing techniques to test the veracity of the information being provided by the various parties would have been a technique, followed by professional assessment of the children by a psychiatrist or psychological assessment should have been considered. There was also the opportunity to convene a case discussion or case conference or convene a declared care team to assess the totality of the information available upon which decisions could be based. It was his view that none of that occurred in this case.¹⁰⁸⁵

3359. In relation to interactions with Police it was noted that referrals were made, and they were appropriate however not all procedures were followed in referral of matters to SACAT. There may have been a lack of best available information upon which Police were able to base their decisions because except on one occasion, Police were given event by event reports and it appears that there was no summary of the totality of the information held by the Directorate. It is noted that Police did not make any investigations or inquiries of their own either, or when it was determined that there were no disclosures from either children that fact appeared to consolidate their referral rejection.¹⁰⁸⁶

¹⁰⁸¹ Ibid

¹⁰⁸² Muir – P 47

¹⁰⁸³ bid

¹⁰⁸⁴ Mr Muir – P 47

¹⁰⁸⁵ Mr Muir – P 48

¹⁰⁸⁶ Mr Muir – P 48

3360. Mr Muir identified that there appeared to be a lack of a holistic approach to the analysis of the information held by CYPS. It appeared that caseworkers and Team Leaders concentrated only on the CCR's rather than an analysis of the patterns of events in the case.¹⁰⁸⁷ This analysis should have been undertaken and there is no evidence that it was.
3361. In relation to family vulnerability, Mr Muir considered that despite the Directorate holding considerable information pointing to this family having a significant degree of vulnerability, at no point did any caseworker or Team Leader accurately assess the state of the family vulnerability, despite their being 13 of the 20 factors that are assessed in the CCR intake report.¹⁰⁸⁸
3362. In relation to the risk of cumulative harm it was considered that the practice guideline on the subject was not particularly helpful because it focused mostly on neglect rather than the cumulative harm for all forms of abuse. It was his view that it should be rewritten, and he recommended the Victorian model as being particularly useful.¹⁰⁸⁹
3363. The author opined that there was no guidance or established process for undertaking a case analysis.¹⁰⁹⁰ *"it was clear that the failure to consider the risk of cumulative harm in this matter must be considered a serious systems failure"*.¹⁰⁹¹
3364. Reliance on CanFaCS and its strong advocacy and support of Graham Dillon was concerning, given so much weight was placed on its view to the exclusion of other potential sources. It was obvious that Graham Dillon said he was involved with relationships Australia, a treating doctor for his mental health, a Centrelink psychologist, the Bungee Program, and a church group. There was no evidence that enquiries were made with any of these groups. There was also no systematic engagement with the school outside of their role as notifies.¹⁰⁹²
3365. Mr Muir identifies these patterns, presented particularly by the end of 2014 and the decision-making undertaken as a result of it, this was in his view clearly difficult to understand. Despite the fact that by the end of 2014, the case presented clear, identifiable patterns of bruising and injury to both children. The children had at various stages made disclosures of abuse, a paediatrician had expressed concern as to some injuries, and the teachers clearly express their suspicions and concerns about the bruising. Despite those factors, there was no analysis of how an assessment was made and why those factors were not acted upon. The documentation was silent on those issues.¹⁰⁹³
3366. In relation to safety planning there was only ever one plan, and it was of very poor quality. It did not identify the risks, and the actions agreed upon were not specific and in no way related to the risk that was evident.¹⁰⁹⁴

¹⁰⁸⁷ Mr Muir – P 48

¹⁰⁸⁸ Mr Muir – P 49

¹⁰⁸⁹ Mr Muir – P 50

¹⁰⁹⁰ Ibid

¹⁰⁹¹ Ibid

¹⁰⁹² Mr Muir P – 52

¹⁰⁹³ Mr Muir – P 53

¹⁰⁹⁴ Mr Muir – P 54

3367. Mr Muir identified and highlighted that the issues identified in this section of the review was both concerning and puzzling and did represent a significant failure of the system in his view. He said that the decisions and actions were both difficult to understand or explain and he doesn't understand why they had occurred but considered that effective oversight by experienced Team Leaders may have assisted.¹⁰⁹⁵
3368. Mr Muir then considered implementation of improvements to practice and decision-making and particularly in relation to strengthening the risk assessment framework and quality assurance audit and compliance checks.

¹⁰⁹⁵ Ibid

COMMENTS

3369. In 2018, the Chief Coroner held a directions hearing, which included Counsel and the Coroner agreeing on issues to be considered during the course of the inquest proceedings.
3370. In 2019, I was appointed the Coroner in this matter. I note in submissions by some Counsel, there was an argument as to whether the issues agreed to and accepted by the Chief Coroner and the parties would bind me. I don't hold that view, particularly given the changing nature of the inquest as it unfolded. However, having said that, I am satisfied that the issues raised and agreed to by the Chief Coroner and the parties are appropriate and I adopt them.
3371. In order to understand how Bradyn and his sister, became so isolated, a comprehensive inquest was required. In order to understand the issue of isolation, it was necessary to look at what happened in the period around the first reports of bruising, which were reported by the teachers in 2014. It was also important to understand who knew what about those reports, and what was done in respect to the reports. That evidence was important to gain a contextual understanding of the circumstances which may have ultimately led to Bradyn's death.
3372. As I have already indicated, there is no doubt as to the cause of Bradyn's death. Graham Dillon relentlessly, viciously, and brutally beat Bradyn over a period of time. Those beatings ultimately caused Bradyn's death.
3373. Graham Dillon was sentenced on 4 June 2018 after pleading guilty to Bradyn's murder. Graham Dillon also pleaded guilty to inflicting grievous bodily harm upon Bradyn. The charges on the indictment indicate that the offences took place between 7 December 2014 to 15 February 2016. The sentencing remarks of Burns J have been hyperlinked to the digital version of this decision. Burns J referred to the 7 December 2014 to 15 February 2016 timeframe in respect to the infliction of grievous bodily harm, which included injuries to Bradyn's face.
3374. The evidence before me which I have summarised, clearly identified that a number of agencies were involved with the Dillon family between at least 2014 to 2015. Those agencies included ACT Child and Youth Protection Services, (CYPS), Canberra Fathers and Children Services (CanFaCS), ACT Education, ACT Health, the Australian Federal Police – (AFP), Sexual Assault and Child Abuse Team (SACAT) and DHHS of Victoria (as it then was).
3375. The involvement of these agencies throughout the course of that period has been set out in an annexure to the Territory's submissions. Having read through the annexure, I found it to be a very helpful summary in a narrative form of the intervention of the agencies. This narrative, along with the narratives provided by other Counsel are annexed to these findings as part of each parties full submissions.
3376. I have annexed the submissions of all Counsel because each of the narratives contained within them, whilst factual, was written in the context of their instructions and viewpoint.
3377. I have carefully read through these summaries and agree they are, on the whole, an accurate reflection of the narrative of source material before this inquest.

3378. I do not propose to summarise the submissions of Counsel. I have carefully read through all submissions and I have annexed the submission to these findings. I will however make comment where I think it appropriate to do so.

Graham Dillon's lies

3379. Graham Dillon was a master manipulator. That statement is by no means meant to be a compliment. The point is well made when considering that Graham Dillon was able to manipulate a psychiatrist into believing he was schizophrenic. Graham Dillon did so by investigating, via Google, the symptoms of schizophrenia and then lying to the psychiatrist feigning those symptoms in order to gain a diagnosis. The Psychiatrist prescribed medication for his condition. He was successful in gaining a disability pension because of this diagnosis.¹⁰⁹⁶

3380. Graham Dillon manipulated the psychiatrist because he wished to access a Commonwealth Government disability pension. Graham Dillon also successfully manipulated staff from CanFaCS and CYPS by lying to them on a number of levels.

3381. Graham Dillon's lying and manipulation was extensive. Some of those lies are listed below.

3382. Graham Dillon lied

- (a) about family court proceedings, where there was none.
- (b) about being given custody of the two children when there had been no family court proceedings at all.
- (c) about SK being a 'meth addict' when she was not.
- (d) to the court about the circumstances he relied upon when obtaining a Domestic Violence Order.
- (e) to SK about withdrawing the Domestic Violence Order when he had in fact continued it and included the children on the Order.
- (f) to BP and NL in respect to the community-based programs that he would access both for himself and the children. (That lie was ongoing throughout the period CYPS and CanFaCS dealt with Graham Dillon)
- (g) about accessing a medical practitioner for the children, when they had no GP.
- (h) about obtaining and engaging with counselling services for himself and the children, in the period from June 2014 and August 2015 he did not engage with any community organisation, other than CanFaCS.
- (i) about physically hitting the children, causing some of the injuries they sustained. This included telling both teachers and CYPS workers that the children either fell off their pushbikes, were play fighting, or that the bruises were as a result of accident.

¹⁰⁹⁶ Evidence of UN

- (j) about the nature of the medical examination that was conducted upon Bradyn by CARHU
- (k) about the children being kidnapped and police conducting a home invasion and restored the children to his care

3383. As a result of those lies, CYPS caseworkers based their statutory decision making on the assumption that the information given to them by Graham Dillon was accurate. Graham Dillon's access to community supports was of particular significance in that decision making process.

3384. How did those lies affect the investigations conducted by caseworkers on the nine occasions reports were made? In order to answer that question, I have set out in summary the core business of CYPS.

Child and Youth Protection Services (CYPS) – a nutshell summary

3385. CYPS are governed by legislation. That legislation is *The Children and Young People Act 2008*, (the Act). CYPS also have practices, procedures, and policy in respect to their core business. That core business is the protection of children.

3386. Officers of CYPS are bound by the legislation and the practice, procedures, and policy in exercising their functions. Of particular importance are the threshold test at section 344 and 345 of the Act.

3387. The core business of CYPS is divided into 2 separate sections. One is the intake area and the other is the appraisal area.

3388. When a report is made to CYPS in relation to concerns about child safety the report is triaged by an Intake Officer. The Intake Officer will open a Child Concern Report and will investigate the complaint in respect to the child.

3389. Having investigated the complaint in light of the legislative provisions for children at risk, as well as the practice, procedure, and policies of the organisation, two things may occur, the Intake Officer will generate a report with recommendations, to either close the case or refer it on to the appraisal team. The recommendation is sent to the Team Leader for endorsement of those recommendations. The Team Leader may either endorse the recommendations or require further investigation to be made in the case of a closure recommendations. The Team Leader may also refer the case for an appraisal.

3390. In both situations the test at section 344 is to be applied. Section 344 states that

“a child or young person is at risk of abuse or neglect if, on the balance of probabilities, there is a significant risk of the child or young person being abused or neglected”.

3391. Section 345 deals with whether a child is in need of care and protection.

“A child is in need of care and protection if they have been abused or neglected or is being abused or neglected or is at risk of being abused or neglected and no one with parental responsibility for the child or young person is willing and able to protect the child or young person from the abuse or neglect or the risk of abuse or neglect”.

3392. Section 349 relates to the decision-making function of those making decisions about the child or young person. These include what is in the best interest of the child.

3393. Section 349 sets out the matters which are relevant for consideration. They include, the need to ensure that the child or young person is not at risk of abuse and neglect, any wishes expressed by the child or young person, the nature of the child's relationship with the parent or anyone else, the effect separation from that parent would have on the child... any abuse or neglect of the child or young person, or a family member of the child or young person and any court orders that may apply to the child or young person or a family member of that child or young person.
3394. Section 350 sets out the care and protection principles underpinning the legislation. These tests are the threshold tests in respect to determining the outcomes of the investigations.
3395. Where a recommendation is made that it should go to an appraisal, the Child Concern Report will be allocated to a caseworker for investigation. When allocated to a caseworker it is envisaged that an in-depth investigation of the matter will be conducted.
3396. Evidence was given that in the last 12 months 18,600 reports were made to the Intake Officers of CYPS and 3000 of them were investigated. Clearly that is a substantial number of reports for both intake and investigation. That information is important in understanding how CYPS goes about its functions.

What was known to CYPS as at 31 August 2015?

3397. A coronial inquest, by its very nature, is conducted in hindsight of the circumstances surrounding the death. I agree with Counsel that one must look at all of the evidence in light of that fact. One must not look at the evidence through the lens of hindsight. I have considered that submission and agree with it and have reflected on the circumstances as they were between 2013 and 2015, when CYPS and other agencies were involved with the Dillon children.
3398. Having taken that into account I have summarised what was known by CYPS in particular, as of 31 August 2015, the date the last report was closed.
3399. There had been two Child Concern Reports in 2012 involving Graham Dillon.
3400. There had been eight Child concern between 30 July 2013 and 15 December 2013. They involved Graham Dillon and allegations of domestic violence in respect to the family and on one occasion in particular toward Bradyn. One appraisal was conducted between 11 November 2013 and 24th February 2014. The appraisal was closed on the basis that appropriate protective measures had been identified.
3401. There were 9 Child Concern Report between 17 June 2014 and 12 August 2015 in respect to bruising on either Bradyn or JL or both of them. One appraisal was conducted by NL in relation to the 28 July 2014 Child Concern Report and one was conducted by PG in January 2015 in relation the information reported by BN from Victoria.
3402. All of the Child Concern Reports and appraisals were identified as not reaching the threshold test under the legislation and were closed. All of the recommendations led to the case being closed because there was a parent willing and able to protect the child or young person from harm, or the threshold test for being in need of care and protection pursuant to section 345 was not met.

3403. Given the number of Child Concern Reports within a very short timeframe an analysis of why the cases were closed and what was considered in relation to those closures is required.

Reports and Appraisals

3404. A Child Concern Report was made by teachers on 17 June 2014. The Intake Worker analysed the matter and noted that the children had been exposed to domestic violence in a prior report. The current report raised a suspicion regarding bruising to Bradyn's face, however it was found that there was insufficient evidence to indicate that the reported bruising was caused by nonaccidental means and a recommendation was made for no further action.

3405. The 28 July 2014 report was also made by a teacher because they observed bruising on both children. That bruising was observed to be on their faces. An investigation was undertaken and the reporter, DVCS, and SACAT were all contacted. A referral was also made to SACAT but was ultimately rejected because CYPS were unable to identify a specific disclosure of the abuse by the children.

3406. The teachers were concerned because the bruising did not sit right with them and it was suspicious. The teacher advised there had been 3 reports of facial bruising made previously and on this occasion the children did not want to give an explanation as to how they occurred.

3407. DVCS was contacted and reported to CYPS that both ex-partners had told them of their concerns in respect to Graham Dillon's ability to care for the children, because of prior domestic violence. Both of them considered that he was unsafe and neglectful, and they did not trust him with the children. That was different to what UN had told CYPS in 2013 in relation to her view as to whether he was a 'good father'.

3408. The Intake Worker considered that there was a probable risk of past or current abuse and neglect, and risk of future abuse and neglect and a recommendation was made to proceed to an appraisal to assess the injuries and the safety of the children.

3409. NL was allocated the case. I note that NL was new to CYPS and was employed at the entry level of experience for a caseworker. I also note that NL stated she did not have any significant training when she commenced and when giving her evidence stated that she could not recall getting any training at all. I note that her Team Leader advised that she was given a starters pack of training material. That may well be an important factor when considering the assessment that she undertook.

3410. Also of note was that NL had a worker KE, as her 2nd (secondary worker). Having considered all of the evidence given by CYPS caseworkers it appeared to me that no one seem to understand the role of what a 2nd was. Was it merely to go with them when undertaking home visits to act as a scribe or was it more? Was there an expectation that they would mentor the caseworker particularly when new at the job or it was merely as a 2nd person when attending home visits, for safety reasons?. That question was never answered satisfactorily.

3411. I also note that NL, during her student placement, had worked with BP from CanFaCS. That may also be important when considering why a certain course was taken and why

she accepted what BP told her about the community supports that were in place for Graham Dillon which turned out to be not true.

3412. That is also important because those circumstances were relied upon when conducting NL's analysis as to whether there was community supports available for Graham Dillon and the children. That conclusion, given the assumption that he had supports available, was determinative in deciding that he was a parent willing and able to care for the children.
3413. In order to understand why NL assumed that the information she was given was accurate, an analysis of what occurred during that investigation is required. NL undertook several enquiries including speaking with the teacher who made the report. There was discussion as to the prior bruising that had been observed including one that appeared to be in the shape of a handprint. When the children were asked about the various bruises they laughed and said they were fighting with each other.
3414. The Teacher also reported that she had been told by Graham Dillon that there were custody issues, that he had a protection order out against his former wife and despite having a shady past he appeared to genuinely care for his children as he was seeking a better life.
3415. NL had also spoken with the children who revealed that they had been slapped on the head by their father and kicked up the bum. JL demonstrated to NL where Graham Dillon had hit them on the face. The bruising observed was consistent with that disclosure. At the time of conducting the investigation and considering her recommendations, NL considered that this was not a disclosure by the children of abuse. I note that NL resiled from that viewpoint when giving her evidence, citing her inexperience at the time.
3416. NL also attended the family home and believed the explanations given by Graham Dillon as to how the children got the bruises. That was despite the fact that they were inconsistent with what the children said to the teachers. Graham Dillon then reassured her and told her that BP would be assisting him by providing financial assistance, accommodation, and other community support facilities. BP, who was in attendance backed up that assertion.
3417. NL was also told by Graham Dillon that he was attending mediation counselling with relationships Australia and was also attending a church support group. Graham Dillon told NL that he was abused as a child whilst in foster care. Graham Dillon told her that he had full custody of the children to protect them against their abusive mother. NL accepted that information without question.
3418. Despite the inconsistencies recognised by NL in what she had been told, despite being told by her Team Leader to conduct further investigations to corroborate the information they already had, NL failed to conduct that further investigation. The only investigation NL conducted in relation to corroborating the story was to contact BP at CanFaCS. NL accepted in her evidence that was a failing and she could not explain why it happened.
3419. It was conceded by NL that she should have obtained the information as requested by BU and also should have corroborated the history given by Graham Dillon,

particularly in relation to the custody of the children. NL had assumed that either KE or BU would follow up with her.

3420. Ultimately NL came to the view that whilst she had some concerns, she was satisfied that the children had good attachment to the father, and she was confident of the children's safety because he was willing to engage with CYPS.
3421. It appears from the evidence that NL relied on BP for information about Graham Dillon. BP had given her a lot of information in respect to Graham Dillon's ex-wife and the trouble she caused Graham Dillon. NL did not contact the ex-wife to clarify or determine the veracity of the statements made by Graham Dillon. It appears that BP accepted what Graham Dillon told him without question.
3422. In relation to the 28 July 2014 report of facial bruising, NL considered that the children should be examined by a medical practitioner. It was her understanding that she could not utilise CARHU because they required bruising to be fresh. Graham Dillon manipulated NL using his aggression and agitation, refusing to consent to the medical assessment that she considered appropriate in the circumstance. As a compromise NL suggested the family GP could conduct the examination.
3423. Graham Dillon insisted on arranging for a GP to examine the children allowing him to lead the narrative of information given to the GP. It appears that no history of previous bruising was given to the GP by CYPS. The GP reported that any bruising that was there was insignificant.
3424. Why was it that NL relied on what she was told by Graham Dillon, who was, for all intents and purposes a potential perpetrator of the abuse? Why did she also only rely on BP who was Graham Dillon's advocate?
3425. NL suggested that the reason was because she was so new at the job, that she knew BP well as she had worked with him and trusted him. This trust of her sources appears to explain why she accepted the positive features including the community safety net as well as the apparent good connection Graham Dillon had with the children, over the negative features of the bruising observed by the teachers and the disclosures, when she made the ultimate decision to close the case.
3426. Part of the assessment to determine whether a child is in need of care and protection is to conduct a balancing exercise with all of the information available both for and against whether further action is needed. NL had before her some good features in respect to Graham Dillon. Things such as the children were clean, well presented, the house was tidy and clean the children appeared to have been well fed. There also appeared to be a positive relationship between Graham Dillon and the children.
3427. It would appear that those factors, the house was in good order, the children were well looked after, and the positive behaviour of the children persuaded NL to accept that the positives outweighed the negatives and she concluded there was a parent willing and able to protect the children.
3428. That was despite the several reports of bruising made by the teachers. Clearly those bruises were concerning and should have been better investigated. That point was conceded by NL. Ultimately, balancing the positive against the negative, and having considered the positive assertions made by Graham Dillon and BP that he had

community supports in place, a decision was made that no further action would be taken.

3429. On the information available to NL, at the time, the significance of the support in the community, the recommendation appeared, on the face of it, to be a reasonable outcome. The case was recommended for closure. That was endorsed by the Team Leader. I note this information excluded the disclosures made by the children as to how they were bruised.
3430. Eight days after that case was closed, a further report was made, this time with significant bruising observed on Bradyn's face. This report resulted in action being taken where an examination was conducted by a CARHU paediatrician. NL was the allocated caseworker.
3431. It was noted that Graham Dillon was clearly agitated and angry that CYPS had become involved again. There was also anger toward the school for having made the report. BP advocated on behalf of Graham Dillon advising NL that Graham Dillon was highly stressed by the referral. BP also stated that Graham Dillon had told him that the children were terrified of attending school because of what had happened to them. BP stated that Graham Dillon was a very proactive parent.
3432. I note that there was no investigation or interview with the children to establish whether they were traumatised by the medical check-up to the point where they refused to go to school.
3433. On this occasion it was asserted by Graham Dillon via BP that he would make arrangements with the Belconnen community services for counselling for the children and he was to enrol the children in the Bungee Program. No corroboration of those arrangements was ever made or followed up. Graham Dillon never arranged for the children to attend any community service programs, nor any counselling service or any religious organisations support group.
3434. Yet, NL and PG accepted without reservation the assertion made by BP that these programs would be in place. That was relied upon in relation to their decision-making as to whether the children were in need of care and protection and whether there was an adult willing and able to care for them. The reliance on those factors did not appear to address the issue of whether there was a risk of abuse.
3435. Graham Dillon also lied about enrolling the children in another school, being ACT primary school 2. During that period of time, he did not send the children to school and made the excuse to NL that they were awaiting a new house in another area. Ultimately the children returned to ACT primary school number 1 after inquiries were made by ACT primary school number 1 about whether the children were enrolled in ACT primary school number 2.
3436. Graham Dillon then advised NL on 23 September 2014 that the children were attending the Bungee Program and that SK was taking him to court to lift a protection order. Graham Dillon also told NL that SK had organised to have the children kidnapped and as a result the police conducted a home invasion and restored the children to the father's care. That information was not corroborated and was also a lie.
3437. NL closed the case after concluding that there were protective factors such as a positive report from the teacher about the interaction between Graham Dillon and the

children. That they presented well at school, that the CARHU assessment of the bruising to Bradyn's face indicated "no concerns regarding the bruising on Bradyn's face", there were no disclosures from the children, they had the support provided by CanFaCS and the positive reporting from BP about Graham Dillon's parenting ability.

3438. That together with the planned counselling sessions and engagement with community support groups were all positive factors. It was also noted that there were some negative risks factors such as nine previous reports to CYPS with four of those revealing bruising to the children, no disclosures by the children and no explanation as to how they occurred. Another risk factor noted was Graham Dillon's volatile and aggressive behaviour toward teachers and CYPS workers. Also taken into account, was the support provided by FQ who had her own CYPS history.

3439. Having considered all those factors, NL decided to close the case as she was of the view that there was a parent willing and able to care for the children and the children were not in need of care and protection because the threshold had not been met.

The 2nd appraisal

3440. The 2nd appraisal came about as a result of the (so-called) kidnapping of the children by their mother who took them to Victoria. I note that at the time SK took the children to Victoria, the Domestic Violence Order that she had been given by the court in the ACT did not have the children's names in it. An error had occurred in the registry and SK was given an order which did not include the children. Under the slip rule and at a later date that error was corrected. SK was not served with that correction until she was found with the children in Victoria.

3441. BE, a caseworker from DHHS Victoria contacted NL in respect to the kidnapping. NL advised BE that there had been reports received since June 2014 which were not substantiated, and no further action was taken in relation to them. She also advised that Graham Dillon had full-time care of the children and that he had a DVO against SK.

3442. NL then arranged for the Interstate Liaison Officer (ILO) to provide information to DHHS. An email, containing a collection of Child Protection Reports held by CYPS, was sent to DHHS on 5 November 2014. That email was sent to BN. Unfortunately, BN never open the email and did not therefore receive the information. BN could not explain why she did not receive the email, given it was recorded as in her email account.

3443. Ultimately the children were returned back to the ACT. A DHHS (as it then was) worker contacted CYPS to advise them that the children had been returned to the ACT.

3444. On 20 November BN telephoned NL to advise that they had concerns about the children, given they had made significant disclosures, and were devastated to learn they would be returned to their father.

3445. NL incorporated this information into the Child Concern Report number # 72483. NL assumed that as the children had been returned to Graham Dillon, if there was significant concern as to their safety, they would not have been returned to their father and DHHS would have taken emergency action. NL, did however, recommend the matter go to a Child Protection Report because of the suspicion that the children may be need of care and protection.

3446. NL also conducted a protective risk assessment and considered that Graham Dillon, given he had engaged the support of CanFaCS and community organisations, and given that the CARHU assessment resulted in no significant concerns being expressed, together with other protective factors such as attending community support programs and Graham Dillon engaging in counselling, was considered a protective parent.
3447. Despite that assessment, several risk factors were considered. Those were identified as five reports of allegations of physical abuse as well as the disclosure made by the children to DHHS workers together with Graham Dillon's family violence history, it was considered that, on balance, the matter should go to an appraisal. NL had identified that there was "a likely level of ongoing risk with limited protective factors in the home environment" That recommendation was endorsed by BU.
3448. BU referred the case to SACAT and a different caseworker, PG, was allocated to this appraisal because of the threats Graham Dillon had made to NL. NL was to be the secondary worker to PG.
3449. BU had referred the matter to SACAT, noting the history of the children's' interaction with CYPS, the CAHRU report of no significant concerns, although Bradyn had unexplained bruises to his face. SACAT rejected the referral and asked CYPS to take the lead. The information about "the concerns" was not accurate as the report stated they were of concern.
3450. PG was an experienced Child and Protection worker with many years' experience. However, PG was new to Australia and had not worked in the field of child protection for many years.
3451. PG was allocated the case on 12 December at a case conference. The history, concerns of physical abuse, both historic and current were discussed. A plan was developed to interview the children, assess the home environment, and develop a safety plan.
3452. PG spoke to Graham Dillon who told her about what had happened in Victoria and for her to contact BP who could give her any information she needed. MP had told PG that he had no concerns and referred her to BP. MP advised that BP considered that Graham Dillon had been discriminated against and particularly by DHHS. PG asked for the safety plan in place as Graham Dillon said he was supported by police, Bungee Program and CanFaCS. No investigation as to whether that was true was ever conducted to corroborate whether those safety measures were in place.
3453. As part of her investigation PG spoke to BP and also SK, by returning her call where SK had complained that she had not been able to contact the children as arranged. PG explained to SK that the children needed to disclose the abuse, for them to proceed to any action. PG also needed to speak with 'other services' to get feedback and SK should let her do her job so she could make a decision.
3454. That information was clearly inaccurate as there was and still is, no requirement for a disclosure to be made before action can be taken.
3455. PG contacted BN to follow up on the report made to CYPS by her in relation to the children. UN also contacted PG advising her of the violent past history perpetrated by Graham Dillon, as well as evidence of his drug use. PG required corroboration of those

assertions. UN also told PG that Graham Dillon was good at manipulating organisations to get what he wants. PG told UN that she required corroboration of the abuse and drug use before she could act.

3456. PG organised ahead of time the home visit, she also had printed up the consent form. PG sent an email expressing her opinion prior to the appraisal as to its likely conclusion, that being it would be closed.
3457. PG asked BP if he had any concerns, he said he did not. BP said that he would advise CYPS if he had welfare concerns. BP also told PG that there was no safety plan in place, despite Graham Dillon telling PG there was one. The only information gathering undertaken in relation to this appraisal appears to be from BP.
3458. The home visit occurred on 19 January 2015. Graham Dillon detailed his version of what happened in Victoria, which was spurious in the main. Almost all of it was untrue except for the drugging of himself by SK. Ironically, he said that the drug test result did not substantiate drug use. That was also a lie and the test result was never confirmed by CYPS.
3459. PG spoke to Graham Dillon's lawyer who told her that SK left out a lot of information when she spoke to DHHS, (who originally) sided with her. FL told her what the Magistrate had said. I note the Magistrate did not have the full story before him when he made his decision to return the children to Graham Dillon.
3460. This information had come from reputable persons being a lawyer and a Magistrate it was reasonable for PG to accept this information as accurate.
3461. PG also interviewed the children, and they did not disclose anything to her, appeared well and said they wanted to live with their father and did not like their mother as she had kidnapped them and took drugs.
3462. PG concluded at the end of the visit that she would recommend closure and told both Graham Dillon and BP of her decision.
3463. PG's rationale included that there were protective factors such as close interaction of the children with the father, CanFaCS involvement was ongoing and had good things to say about his ability to parent. This included comments such as he was the best father they had ever worked with! There was also support through a church, Bungee Program and FQ
3464. The risks noted were abduction by SK, 14 previous reports of domestic violence, custody issues, SK's drug use, CAHRU had no concerns as to the bruising as well as Graham Dillon suffering mental health issues. Also noted were the children's views that they did not want to see their mother. Taking those things into consideration, it was reasoned the threshold test had not been met, so no action was taken, and the case was closed. Other than those who were advocates for Graham Dillon, no inquiries of the other organisations or family members said to have been associated with Graham Dillon was ever made.
3465. Child Concern Report of 26 June 2015. The report from SK was dealt with by TN. SK had not had contact with the children and was concerned. SK also reported concern because of reports from Graham Dillon's brother who said the children suffered from malnutrition and the children were not going to school.

3466. TN noted the history with CYPS including that all reports including the 2 appraisals had not met the threshold. TN then contacted Graham Dillon about the allegations. Graham Dillon said he was still linked with CanFaCS, the Salvation Army who he saw every couple of weeks, and he was not taking drugs. Graham Dillon also said that the police had been around, and the kids saw the police and the children were attending school.
3467. TN contacted the school who said they had appropriate clothes and food, however there had been a lot of absenteeism, the children were well presented, and the family were accessing services. An analysis resulted in closure of the case as the threshold test was not met. The rationale was that Graham Dillon was 'committed' to engaging with professionals.
3468. There was no inquiry as to whether Graham Dillon was engaging with the supports, he told her about. That included CanFaCS and they had not been engaged with him for several months. That was another lie Graham Dillon told.
3469. 12 August 2015 was the last known report to CYPS. A teacher reported that yet another bruise to Bradyn's face was observed the week prior to this report. They were 4 small bruises on the left cheek, Bradyn gave initially no explanation then said he fell off his bike. Then this week the bruises were on the right cheek and Bradyn could give no reason as to why they were there.
3470. HC took the report. Previous CYPS history and concerns were noted by HC. The following day another teacher reported bruising that looked like five finger marks. The report was taken by SC who thought this report was a multiple of the previous report, it was not. SC did not engage in any further analysis, nor did he ring the school or schoolteachers who reported the various bruises, to clarify whether they were new or from the other report. The case was closed without further inquiry or analysis.
3471. There was a distinct pattern evolving from the CYPS case analysis history which is open on the evidence and which has largely been conceded by the parties.
3472. That involved the failure to corroborate the information Graham Dillon gave to the various workers who handled the Dillon children's case between 2014 and 2015. In relation to NL and PG they placed significant reliance on the information provided by BP from CanFaCS. They treated him as a very reliable source of information.
3473. Unfortunately, much of that information was given to BP by Graham Dillon. BP was his champion and advocate and truly believed what Graham Dillon told him. BP made no investigations to corroborate the information given to him by Graham Dillon. Graham Dillon manipulated him in the same way he did to everyone around him.
3474. The failing by CYPS in this instant was that they did not fully investigate the report made by the teachers and they did not corroborate the information of community support being utilised. Why did this happen?
3475. NL had a very good working relationship with BP and trusted him. From her experience BP was good at his job, that was to find housing for single fathers and their children. Clearly a difficult job and he did it well. It appears from the evidence that he also thought that he should be an advocate for the fathers. NL did not pick up on that fact when she relied on the information BP provided. It was accepted as fact. There was no inquiry as to the truth of the information.

3476. Ordinarily, that would not be of great importance, but that information was relied upon time and time again. Each report analysis used those elements in their case write off when determining whether the threshold test was met. Not one of the caseworkers in either intake or assessment checked the information relied upon for accuracy during the period June 2014 to August 2015.

3477. Graham Dillon had successfully manipulated each of those workers into believing that he had all the community supports in place and he had a champion to corroborate his assertions. It was also clear that he manipulated the children with fear and abuse to tell everyone who asked that he was a good dad and mum was horrible.

Bradyn's School Teachers

3478. I note that the Education Directorate (teachers) were not fooled by Graham Dillon and he was unsuccessful if his intention was to manipulate the truth when dealing with them. That was evident from their evidence and the reports they made in respect to the facial bruising they observed on the children. Not only did they observe the bruising they also observed the behaviours displayed by the children and the level of absenteeism which was often temporal to the bruising. The teachers also had significant contact with the children and were able to observe their behaviours. They also at times observed the behaviour of Graham Dillon. All of those factors led to their suspicions that the bruising that they saw on the faces of the children were not accidental.

3479. Clearly the children at least on one occasion disclosed to the teachers that they suffered physical abuse inflicted by Graham Dillon. As described in the evidence that was clearly a disclosure of physical abuse. Unfortunately, the caseworker handling the report on that occasion at the time did not consider it to be a disclosure. Subsequently they conceded that it was.

3480. I found the schoolteachers to be diligent, honest, and thorough in reporting the bruising on the children. They were clearly concerned for the children's safety and welfare when making the reports. They were also not biased in the way they reported their observations of the relationship between Graham Dillon and the children.

DHHS

3481. DHHS involvement in this matter was limited to 3-19 November 2014.

3482. DHHS became involved with Bradyn and JL after their mother SK took the children from where they were living with their father in Canberra and moved them to Shepparton in Victoria.

3483. Graham Dillon had advised that there was a Domestic Violence Order out against SK and that the children were listed as being on the order which did not allow for contact by SK with the children.

3484. AFP contacted CYPS to see whether there were any issues with the safety of the children in the care of the mother. CYPS responded and sent the information they had on the children. CYPS responded advising that there was a Domestic Violence Order out against the mother which included the children.

3485. On 4 November 2014 CF, an after-hours case worker, called NL informing her that she had received a police report about the children. NL advised that there had been reports in respect to the children, but the cases had all been closed.
3486. NL advised CF that the children had disclosed they were scared of their mother and that she was a drug user. NL also advised that the children were in the care of Graham Dillon and that he had a Domestic Violence Order out against the mother which included the children.
3487. NL then contacted DHHS through the ILO who then sent a collection of Child Protection Reports held by CYPS. NL also opened a Child Concern Report. After having sent the information to the DHHS by the ILO, NL closed the case because the children were in another jurisdiction with the proviso that it could be reopened if the children return to the ACT.
3488. The information sent by ACT CYPS did not include reports from 5 November 2013, nor did it include recent reports of 28 August 2014, and 13 and 14 October 2014. It is unclear why those reports were not sent with the other material at the time.
3489. DHHS through CF conducted several enquiries with police and her supervisor. Having considered all the material that she had gathered and with the agreement of her supervisor she issued a section 241 warrant as a protective intervener so that the police could search for the children. A safe custody warrant was issued.
3490. On 5 November 2014 the case was transferred to the intake team and then on to the investigation team. During the process of transferring the case through the team, the uploading of the information received from ACT CYPS was not done. The email was sent to BN who did not read it and therefore it was not uploaded onto the system.
3491. The children and their mother were located on 12 November 2014. BN and CO interviewed both the children and also the mother. SK told both Caseworkers that she had raised the children and that Graham Dillon had only recently had them in his care. That was supposed to be for a very short period of time while she spent some quality time her other daughter. Graham Dillon then refused to return the children to her. At the time she was pregnant with another child and was unable to retrieve the children at that time. Graham Dillon then kept the children and they lived with him and his new partner for approximately 18 months prior to (kidnapping) event.
3492. SK outlined Graham Dillon significant violent behaviour of physical and psychological abuse and that he had spent time in jail in Tasmania. SK told them of the significant violence perpetrated against her as well as UN. Ultimately SK told caseworkers that she was scared for the children's safety and that is why she returned them to Victoria to be with her.
3493. Graham Dillon had alleged that SK was using methamphetamine, SK opted to give a urine sample because she said she had not been consuming methamphetamine. A negative test for methamphetamine was confirmed on analysis.
3494. DHHS also interviewed the children, and they did not disclose any concerning matters regarding either of the parents and said they felt safe with each of them. The children disclosed that they would prefer to live with their mother and see their father sometimes.

3495. DHHS also interviewed BK, the eldest daughter of SK. BK told the caseworkers of violence she had witnessed and that he had perpetrated upon the children both physically and emotionally. That he threatened that he would kill them and sent her a message telling her that he told Bradyn and JL that she was dead. BK also stated that he sent a message to UN telling her that he would kill her. BK told DHHS that Graham had tipped ICE into her bag and that 'they' had to put it down the sink.
3496. DHHS also attended at the home where the children were to live and considered it to be a suitable place for them.
3497. DHHS then assessed the situation as, that the children were not at serious risk of harm in the care of their mother but there is evidence that there may be serious risk in the care of their father because of his extensive violent history. A plan was invoked that an application could be made for emergency care placement with the mother, after further enquiry and substantiation of Graham Dillon's violent history and that is what happened.
3498. DHHS also contacted BP who gave certain information which was inconsistent with the information that they had been provided with.
3499. An application was made, and an interim order was granted on 14 November and the matter was to return to court on 17 November 2014.
3500. The system in Victoria at the time was a new one for making the application. A Form B was completed for the purposes of informing the magistrate hearing the matter of the basis for the application and the grounds upon which DHHS sought the order.
3501. DHHS organised safety precautions given SK's fear that she would be assaulted by Graham Dillon at court. On 17 November 2014 the matter came before the court and was heard by magistrate 2. All parties were represented by solicitors. SK was not in court but was at the offices of the Department due to the safety issue.
3502. Graham Dillon had organised letters of support from BP on behalf of CanFaCS. They supported Graham Dillon getting the children back. DHHS had made enquiries of various organisations including CanFaCS and CYPS. BN had contacted CYPS and left a message for NL, unfortunately, that message was never given to NL in time for the court proceedings. The court proceedings recommenced in the afternoon session however it is unknown as to exactly what time it finished.
3503. Those letters of support for Graham Dillon as well as the Domestic Violence Order which was submitted was important because the magistrate ordered that the children be returned to Graham Dillon. It appears that the magistrate took the view that because SK had taken the children in contravention of the protection order she should not be rewarded for that behaviour. It is unfortunate that the magistrate was not also advised that there had been an error in respect to the Domestic Violence Order by the courts in the ACT and that as far as SK knew the children were not on that order. It also appears that the magistrate focused on the positives submitted to the court by Graham Dillon's solicitor and little evidence led in contradiction of those submissions was made by either SK's solicitor or the solicitor for DHHS. That is not a criticism of the solicitors as it appears that they did not have the information available to them at the time.
3504. After the magistrate granted the order and the children were advised of the result, the children then disclosed significant abuse perpetrated by Graham Dillon upon them.

That included where the abuse had occurred and also a recent timeframe as well. The children were distraught and did not want to return to their father. SK assisted in calming the children down, but this took a considerable amount of time. SK, despite being very upset by the outcome was very impressive in calming the children and reassuring them. This was noted by the caseworkers.

3505. An issue arose as to whether DHHS could have returned the matter to the court given the disclosures made by the children. This was a new and significant disclosure which the magistrate was not aware of. I have considered all the evidence in regard to this question and in my view DHHS did all that they could, considering the limited time available to them prior to the children being taken by Graham Dillon.
3506. That was because Graham Dillon was picking the children up within 20 minutes or thereabouts from making the disclosure. It was late in the afternoon and the options available to them were extremely limited. I make no adverse comment in respect to the failure to take any further action as in my view the options were very limited, were time-consuming and given the children would be returning on the bus with their father to Canberra immediately, any further reasonable recourse was unavailable to them.
3507. After the children had been returned to Canberra, BN contacted NL on 20 November 2014 and as a result of that information NL opened a Child Concern Report. Following that phone call NL and PG tried to contact BN on a number of occasions both by phone and email in relation to generating information for CYPS. Unfortunately, that information was not sent by BN and no further phone calls were conducted by BN to CYPS. There appeared to be some confusion as to whether the ILO should have been involved in the exchange of information. Ultimately no information was generated to CYPS.
3508. That was the extent of DHHS involvement with the Dillon children, save for some contact with SK requesting material be sent to CYPS. The involvement of DHHS was short and significantly was some 18 months prior to Bradyn's death.
3509. It was clear that there was miscommunication and confusion in respect to information sharing between DHHS and CYPS. That information should have been provided by DHHS to CYPS as requested. It was also conceded that it was a failure in procedure to not upload the information sent from CYPS to DHHS, and upload it onto the DHHS database, although there was some explanation as to why that did not occur.
3510. Having taken into account the limited involvement with DHHS and the effluxion of time between their involvement and Bradyn's death, in my view, it could not be said that anything that occurred at that time could be considered as causing Bradyn's death.
3511. I find there is no causal nexus between DHHS involvement and Bradyn's death. The incidents are too remote and therefore are beyond my jurisdiction.
3512. Having said that I note that DHHS has undergone significant changes to its policy and procedures since Bradyn's death. These have been outlined in the evidence of UC and referred to by Counsel for Victoria in her submissions.

The Experts

3513. I heard from 3 senior practitioners in child protection. One from Victoria and two from the ACT. I have summarised their evidence in my findings.

3514. UC from DHHS provided an overview of the circumstances surrounding the children being found in Victoria. UC also provided some very helpful insights into how the system could be made better.
3515. UC conceded that caseworkers and DHHS did not on at least two occasions come up to best practice standards.
3516. One of the issues identified was in relation to information sharing. Information was sent to DHHS and ultimately that information was not acted upon because the email was not uploaded to the system and the case worker did not open her email and therefore the information was not available to give to the magistrate.
3517. The second issue was in relation to failing to return the call from CYPS after the children had returned to the ACT.
3518. UC also concluded that the information sharing should have been conducted through the ILO and conceded that the ILO policy was not followed.
3519. UC regarded three matters which had been identified in the recommendations from the Royal Commission into Domestic Violence in 2015 and the Batty inquest. Those matters were in relation to legislation and policy governing information sharing between organisations, complex confusing and restrictive policy and procedure and the lack of an information culture of sharing information as well as a reliance on outdated IT which impedes information sharing.
3520. I note these issues were also identified in the Glanfield and Muir Reports
3521. Since that Royal Commission there have been new policies and procedures implemented in respect to greater information sharing in Victoria. It also includes sharing that information interstate through the ILO.
3522. UC opined that the ILO should be the first contact in any information sharing because of the nature of the work, the timeliness for response and also the historical nature of some of the reporting periods.
3523. UC also referred to the federal government's Connect 4 Safety (C4S) initiative and the ILO processes in each state and territory. The rollout for all jurisdictions for the Connect 4 Safety is expected to be by 2022.
3524. UC also identified a system for a specific portal where domestic violence reports can be accessed by both police and by care and protection. It is a central portal called L 17. This aids in information sharing between organisations.
3525. In relation to Bradyn's matter, UC opined that the previous history of family violence was severe, and this was a factor in the assessment of the risk of a possibility that it may also happen to the children.
3526. UC also referred to the Victorian policy where after a certain number of reports are made, this triggers a particular response for investigation of the matter. That response increases the level of evidence contained in the report.
3527. UC also suggested that more focus is targeted at reflective practice particularly in relation to cumulative harm and the effects of it upon children.

3528. In relation to further developments, UC opined that they have increased their professional development and have increased recruitment and the level of expertise, encouraging people from outside of care and protection to apply for positions in care and protection. Victoria has also made a career advancement pathway for those in the care and protection space.

3529. In relation to what was described as 'white noise' reports, UC stated that there are now memorandums of understanding and development of practice and procedures in relation to the organisations who are required to make mandatory reports, so that they understand better what is required of them.

Comments in relation to KO

3530. KO indicated that there had been a lot of changes to the practice policy and procedure of CYPS and largely that was available in the information portal which is now available for all staff to use. I note that he indicated that the cumulative harm practice guide has not yet been updated and that would seem to me to be an important piece of information for those who are to assess the information received from reporters to the agency.

3531. I accept his view that information sharing, and collaboration is a fundamental aspect of care and protection work area. It is also fair to say that contact between agencies through the ILO is the appropriate course to take when contacting other jurisdictions, however there is some room for direct contact, caseworker to caseworker if the matter is urgent but that should also include the ILO.

3532. Clearly what happened in Bradyn's situation was there was some caseworker-to-caseworker contact, rather than through the ILO, the caseworker contacted did not receive the message as they were unavailable for some days and were not apprised of the contact or the urgency of the matter until it was virtually too late.

3533. A remedy for this situation has already been canvassed by some of the witnesses and it would appear that whilst contact caseworker to caseworker may be appropriate in some circumstances it should also include the ILO.

3534. KO recognise that it was an importance for staff to abide by policy and procedure. In the case of contacting a parent, it was his view that one would be very cautious in contacting a parent who could be the abuser in a case of abuse. KO also recognise that it could cause extreme risk to the children. The reasons underpinning the policy not to contact a parent if there is a risk, they are a potential perpetrator of the harm, is a common-sense approach as most likely why the policy was in place at the time when CYPS had involvement with the Dillon family.

3535. It is unclear on the evidence before me whether caseworkers considered that policy in relation to contacting Graham Dillon about the bruising to the children's faces.

3536. KO suggested that his practice when closing the case where there may be a risk of abuse but not sufficiently so to warrant taking action, is to get feedback from the school's or other agencies involved in the case who can then monitor of the situation. I agree that is an important consideration when closing the case and in my view that point is well made and should have been followed.

3537. It was clear from KO's evidence that decision-making incorporates balancing competing factors utilising the current policies and procedures and having regard to the legislation. It also appears that the rationale for many of the decisions that were made in relation to the Dillon children was an emphasis on supporting the family rather than taking statutory interventions.
3538. It would appear that that was the emphasis that the caseworkers took in respect to the Dillon family. Unfortunately, there was no independent contact with those organisations who were relied upon to have that monitoring role. The misinformation given by Graham Dillon to both BP and CYPS which resulted in no community supervision was not independently checked and it should have been.
3539. KO advised that training by specialist teams is now part of the training package and allows for extensive training for new starters. This is a positive outcome in respect to training of staff. That together with the introduction of the knowledge portal and the new database system will make it easier for staff to access that information.
3540. In his management role KO identified several areas which have been improved such as improved training, greater collective responsibility, better information sharing. In respect to what could be better KO opined that it would be having enough staff with relevant experience and having enough time to review and consider cases. KO identified that an Intake Worker may have up to 12 cases per day and a Team Leader up to 50 per day to endorse. These are extraordinary numbers, and it appears that it would not be possible to give them more than just a cursory glance.
3541. It was suggested that of those 12 cases perhaps some would only take a short period of time to analyse and make a decision about. It is also clear that others would require considerably more time. The time allocated should be sufficient to give time to review and reflect on the case. Unfortunately it appears that that is a luxury that the Intake Workers do not have.
3542. That problem could be solved by a better triage process which separates the 'risk of abuse cases' from the 'in need of care cases'. There was some evidence that this may be of assistance in time management at intake.
3543. In respect to the Dillon children the reports were dealt with fairly expeditiously and as KO opined multiple reports of bruising over the period the reports were made was significant and should have been looked at more thoroughly. Although he emphasised that he was looking at it with hindsight bias, the fact remains that at the time up until the final 2015 reports, CYPS knew that there had been those multiple reports of bruising which were potentially nonaccidental and yet in 2015 the cases were closed without further enquiry. Those latter reports should have been reviewed more thoroughly and that was accepted by some of the caseworkers in their evidence.
3544. KO identified that there were things missed and the organisation has learned from those mistakes. Having accepted that, KO opined that Bradyn's death was not the usual outcome in respect to the types of reports of bruising made by the teachers in relation to the children.

Policy, Policy Guidelines and Procedures

3545. In relation to recognising physical abuse and bruising in particular it was clear on the evidence that CYPS had a significant number of policies, procedures, and practice guidelines available to them. Those included guidelines in relation to recognition of physical abuse and in particular, bruising to children.
3546. It was known by all staff that these policies and guidelines were available to them, however it would appear that not all of them had read them or if they read them, had not recalled the contents.
3547. The policy guidelines are clearly designed to assist those considering information as part of their investigation. The guideline clearly states that whilst bruising can be accidental there is some bruising which should be considered nonaccidental unless there is evidence to explain it is not.
3548. Of note in the Dillon case, is the policy guideline in relation to observations where repeated or multiple bruising on the head, or on sites unlikely to be injured accidentally are present, they should be considered to be nonaccidental unless there is evidence to support that they were accidental. That included variation in colour of bruising and any outline of an object which includes a handprint. Or just bruising around the face is sufficient to warrant that interpretation, that is; that all of those types of bruising should be considered nonaccidental unless proven otherwise.
3549. Part of the matters to be taken into account when considering whether the bruising was nonaccidental is also set out in the policy guideline document on the same page. These include explanations that are inconsistent with an injury, or where, several different explanations are provided for that injury. They are matters which should be considered.
3550. It is not clear on the evidence, whether those factors had been fully considered in relation to the reports of bruising to the faces of the children. On a number of occasions there was either no inquiry or a very limited one. That issue was also explored as part of the findings in the K and Muir reports. I have set out a summary of their findings in that regard.

The K, Muir, and Glanfield Reviews

3551. Following Bradyn's death, CYPS initiated an internal review (the 'K' Review) to specifically review the circumstances surrounding his death. The second review, the Muir review, was an external review in relation to Bradyn's death which was not to include systemic issues but reviewed the circumstances surrounding Bradyn's death. It focussed on the file material available on CYPS records. The government's response to Bradyn's death was to conduct an inquiry, the Glanfield review with a focus on reviewing the system level responses to family violence in the ACT (Glanfield Inquiry 2016)
3552. In respect to the Glanfield Inquiry the government accepted all 31 recommendations of that report which identified the need for changes to legislation, policy, practice, and culture.
3553. The Glanfield Inquiry recommendations aligned broadly with 4 key outcomes. They include creation of a collaborative and information sharing culture, improved

assessment referral and case management processes for vulnerable families and children, improvement to the quality of and transparency in CYPS decision-making and practices and improve oversight of the system responses to ensure recommendations are implemented.

3554. The evidence heard in the inquest in my view reflects the need for those improvements some of which were recognised by Laurie Glanfield in his report. Some of those themes have become apparent throughout the evidence received in this inquest, in particular, obtaining parental consent when investigating a report. The Glanfield review considered that issue was a significant constraint on the ability of CYPS to investigate Child Concern Report. Glanfield recommended legislative amendment to provide an alternative process which was not as cumbersome. I would endorse the recommendation as being appropriate for the government to implement.
3555. Another theme was lack of feedback to notifiers of child concerns reports and recommendation eight recommended that if matters do not proceed, referral to support services for the family must be considered. It was also considered to be appropriate to collaborate with the providers of that support to ensure those families are supported. I would add to that, any notifiers be given feedback as to the outcome of the report, particularly when they are mandatory reporters or family members.
3556. Another theme which became apparent in this inquest was the need for further training particularly in relation to family violence and I note one of the recommendations in the Glanfield Inquiry included specific funding to deliver training on family violence for frontline workers. That was agreed to in the ACT government's response to the Glanfield Inquiry.
3557. Witnesses expressed a desire to improve several areas including information sharing, decision-making and oversight. I note that Glanfield has made recommendations in respect to those issues. In my view the information sharing issue became a dominant theme in this inquest particularly in relation to the cross-border or interjurisdictional aspect. I fully endorse the recommendation made by the Glanfield Inquiry for the need for information sharing and I note that the ACT government recognised the need for legislative amendments authorising information sharing and the necessity of addressing cultural issues which will underpin the success of it.¹⁰⁹⁷
3558. The issue of un-enrolment of children was also reviewed by Glanfield. Recommendations twenty-six dealt with the issue of un-enrolment of children and recommended that when a child is unenrolled from school and there are concerns in respect to that child, the Education Directorate should advise CYPS of the un-enrolment and also confirm with the parent, the enrolment in the new jurisdiction. It is up to CYPS to inform their counterparts in the new jurisdiction that the family of concern has moved to their state or territory
3559. That was a fundamental issue in respect to this inquest. How was it that the children became so isolated? The evidence in my view, is clear, that Graham Dillon purposefully unenrolled the children so that they would not come to the attention of their teachers. The teachers were unable to confirm that the children had been enrolled

¹⁰⁹⁷ ACT government response to family violence.

in another school because there was no ability for them to do so. Graham Dillon had informed the school that he would be enrolling them in New South Wales.

3560. There was no process for the ACT Education Directorate to contact New South Wales at that time. Recommendation twenty-six is a recommendation that I would have made, and I endorse the recommendation.
3561. The 'K' Review was initiated directly after Bradyn's death and was an internal review specifically in relation to Bradyn and JL. The 'K' Review was a document analysis of what had occurred during the time CYPS had involvement with the children.
3562. The Muir report was also initiated as a result of Bradyn's death and was to be reviewed on the documents as an external review process.
3563. The author of the 'K' Review identified several themes in respect to the documentation generated as a result of Child Concern Reports and Child Protection Reports.
3564. I have set out in detail a summary of the report and considered that there were several themes which ran throughout all of the reports
3565. Several of those themes included, risk assessment, cumulative harm, relying on one source for information and making assumptions about information when no, or insufficient enquiry had been made to corroborate that information.
3566. There was also the issue of contacting the potential abuser and relying on information provided by that person and also the belief that unless the child discloses abuse no further action can be taken. These issues were addressed in the reports with recommendations as to how to improve the system.
3567. The Muir report also identified themes consistent with the themes reported by both Glanfield and K. I have set out the Muir report in summary which outlines those themes identified.
3568. Having considered very carefully the evidence before me together with the three reports exhibited before me, it appears there is a fundamental lack of understanding in respect to application of the legislative requirements and the policy guidelines, when assessing risk of abuse. This could potentially inhibit the ability for a caseworker to make a finding that the children were at risk and therefore in need of care and protection.
3569. The evidence from a number of witnesses suggested that the policies, procedures, and policy guidelines were difficult to access at times and were not well understood. That may reflect why there was a lack of understanding as to assessing risk.
3570. I note that most witnesses had not seen or read either the 'K' Review or the Muir report. I found that rather disturbing given the excellent work that had been done to identify the shortcomings and failings attributed to CYPS.
3571. The major conclusion of the 'K' Review was important information and should have been disseminated to those at the frontline to better assist them in their task of risk assessment. The conclusion reached was important because it focused on the main part of their casework. It is worth repeating given that a number of the matters identified were conceded by the witnesses in evidence before me.

“the major conclusion reached in the ‘K’ Review was that if more detailed analysis of information, history and risk by the application of a risk assessment, consideration to the impact of cumulative harm, the application of thresholds to inform decision-making, coupled with forensic interviewing of the children and professional judgement based on sound assessment, then it is likely that the intervention pathway for this family’s involvement in child protection would have different”

3572. I also note most of the witnesses had heard of the Glanfield Inquiry but very few had read it.

3573. Having considered all of the evidence as well as submissions by counsel together with the reports I received, I have come to the conclusion that no one could have predicted the outcome that eventuated. It is my view that no one could have predicted that Graham Dillon would murder his son.

3574. Despite the numerous reports which indicated that there was potentially abuse being perpetrated by Graham Dillon, none of those reports could be said to have been a precursor to what eventuated.

Causation

3575. A threshold question in relation to CYPS, was whether, the failings identified by witnesses in their evidence and in the two reports commissioned by CYPS after Bradyn’s death, to examine specifically the involvement of CYPS, had some causal link in relations to Bradyn’s death.

3576. Part of the Coroners function is to find, inter alia, the manner and cause of, in this case Bradyn’s death.

3577. The question as to what that means appears to be a grey area in respect to how far into the “chain of causation” a coroner may go to ascertain the cause of death¹⁰⁹⁸. The ACT Coroners Act does not define the concept of causation. Generally, causation is a concept utilised in both the civil and criminal law.

3578. Authorities on the position have been referred to already in these findings. They include *Harmsworth v the State Coroner*, *R v Doogan*; *Ex parte Lucas – Smith and March v E&MH Stramare Pty Ltd*. To some extent those decisions have limited how far a coroner might go in enquiring as to the cause of death.

3579. In *Chief Commissioner of Police v Hallenstein [1996] 2 VR 1*, Hedigan J found a statement of principles enunciated by the High Court in *March v Stramare*

“applicable to the concept of contribution which within the Coroners’ Act 1985 (Victoria), is concerned with the causes of death and who contributed to it”¹⁰⁹⁹.

3580. Similar views were expressed by the full Court of the ACT Supreme Court in *Doogan Ex parte Lucas Smith*.

3581. There are also limits imposed in terms of remoteness of a factor’s impact upon the occurrence of a death. Clearly factors which are anterior to the proximate cause of

¹⁰⁹⁸ Freckelton and Ranson Death Investigation and the Coroner’s Inquest p 638

¹⁰⁹⁹ Chief Commissioner of Police v Hallenstein cited in Freckelton and Ranson page 641

death contextualise that cause. However, there is no or little helpful authority in respect to the degree of remoteness of enquiry and findings permissible for coroners¹¹⁰⁰

3582. I note, Freckelton and Ranson concluded that

“in practice, the question for coroners’ courts is one of remoteness and it is customarily stated that the distance from the proximate event that the coroner should travel in finding causation is a matter of common sense”¹¹⁰¹

3583. This conclusion comes back to my point that the answer to the question of causation will vary. Common sense seems to be an important factor in deciding that matter. I note that Lord Salmon in *Alphacell Ltd v Woodward* made the following observation;

“I consider... That what or who has caused a certain event to occur is essentially a practical question of fact which can best be answered by ordinary common sense rather than by abstract metaphysical theory”.¹¹⁰²

3584. I have taken that common-sense approach in determining the cause of Bradyn’s death. That requires consideration of the antecedent factors prior to his death.

3585. I note that the last report made to CYPS by the teachers was in August 2015. That was a period of 6 months between the report and Bradyn’s death.

3586. I have grappled with this issue of causation particularly given it was such a short period of time between the last report and Bradyn’s death.

3587. There have been ‘sliding door moments’ of opportunity during the time CYPS were involved with the children and in particular Bradyn. Opportunities to recognise that the children were at risk of abuse were lost.

3588. A number of factors conspired against Bradyn and his sister. In relation to CYPS, those factors included¹¹⁰³

- a. A consistently minimal application of risk assessment,
- b. Practice shortcomings in identifying the cumulative harm of domestic violence upon the children, or failure to note that it was taken into consideration if they did,
- c. Practice shortcomings in identifying the thresholds in respect to disclosures made by the children when assessing the risk of harm
- d. Practice shortcomings in respect to documentation particularly in relation to the children’s history and risk assessment.
- e. Practice shortcomings in investigations into the accuracy of information given by either Graham Dillon or BP

¹¹⁰⁰ Freckelton and Ranson Death Investigation and the Coroner's Inquest page 638 – 639

¹¹⁰¹ Freckelton and Ranson Death Investigation and the Coroner's Inquest page 641

¹¹⁰² *Alphacell v Woodward* [1972] ALL ER 475 cited in Freckelton and Ranson, Death Investigation and the Coroner's Inquest page 641

¹¹⁰³ The K report pages 6-10

3589. There were other factors at play as well, such as the volume of work at the front end of CYPS in the intake area. That volume was in the order of 18,600 cases last year. That is an enormous number of cases to consider at the intake point. It would be extremely difficult to conduct thorough analysis with that number of cases coming through the door.
3590. In relation to the 2 appraisals conducted by caseworkers, one caseworker had only just commenced at CYPS and had no prior experience but was given the Dillon case. In relation to the other worker, she had only just arrived in Australia and was unfamiliar with the system in the ACT.
3591. During investigation at the intake stage on several occasions there was no investigation involving the mandated reporter, and reliance was placed heavily on the prior reports where it was found that there was no risk of abuse or little risk of abuse and there was a parent able and willing to care for the children, therefore the case was closed.
3592. Reliance was also placed heavily on one source in respect to the family circumstances in relation to community supports and the like. There was no investigation into whether the community supports were in place.
3593. CYPS placed great weight on what Graham Dillon told them. There was no independent corroboration of what he told CYPS. There was little truth in what he told CYPS, but his assertions were relied upon.
3594. Little if any weight was placed on the information Bradyn's mother and Graham Dillon's ex-wife gave to CYPS in relation to their experience of significant domestic violence perpetrated by Graham Dillon. That information turned out to be true. Interrogation of Graham Dillon's criminal history would have corroborated their version in respect to domestic violence.
3595. There was no investigation in relation to the reports made by the teachers on 15 August 2015. Too much reliance was placed on the previous reports where the outcome was 'no concerns and no further action'. All of these failings or missed opportunities were sliding door moments. The opportunity to thoroughly examine and investigate all of the reports was lost.
3596. The question remains, whether the 9 reports made in relation to the children were sufficient for CYPS to consider taking action, by removing the children from Graham Dillon's care. Not one of the reports indicated that that was the appropriate course. Collectively not one of the reports considered that the children were at risk of abuse and all of the reports considered that there was a parent willing and able to care for the children. That parent was Graham Dillon.
3597. Those were the lost opportunities, the sliding door moments where they fell through the cracks.
3598. It would be improper to speculate as to what would have happened had those sliding door moments been different. I will not do so.
3599. Did the failure by CYPS to take action during those opportunities contribute to the cause of Bradyn's death? Is there a sufficient causal nexus between the last time CYPS were involved with the Dillon children and when Bradyn died?

3600. The report of August 2015, was the 9th such report of bruising on Bradyn and JL. Whilst the bruising was clearly significant, particularly given the number of reports of bruising and the absenteeism temporal to that bruising, the nature of the injuries found on Bradyn and also JL were not such that, as at, 15 August 2015 one would anticipate they would be sufficiently predictive of the serious injuries found on the children in February of 2016.
3601. There is a temporal lacuna between that report and Bradyn's death. In that period of 6 months no child protection organisation or community organisation was involved with the children.
3602. I am satisfied that Graham Dillon intended to purposefully hide the children from the view of mandatory reporting organisations. By unenrolling the children in school, no one had eyes on them. Graham Dillon lied to CYPS and BP about the community organisations that he claimed supported them.
3603. BP had not had any contact with Graham Dillon for some months prior to August 2015. The only eyes on the children were teachers. I am satisfied that is also why Graham Dillon took them out of school and did not re-enroll them in any other school. I have no doubt that was the purpose of unenrolling the children.
3604. Having considered all of the evidence as well as submissions by counsel together with the reports I received, I have come to the conclusion that no one could have predicted the outcome that eventuated. It is my view that no one could have predicted that Graham Dillon would murder his son.
3605. Despite the numerous reports which indicated that there was abuse being perpetrated by Graham Dillon, none of those reports could be said to have been a precursor to what eventuated.

Comments about Filicide and Domestic Violence in General

3606. Last week there was a news report that a father had killed his 9-month-old daughter by jumping off a cliff. Two women were reportedly killed by their male partners in Queensland, this month the inquest into the death of the Jack and Jennifer Edwards was handed down. Their father followed Jennifer home from school and shot them both whilst they were cowering in their bedroom.
3607. One year ago, Hannah Clarke and her three children died at the hands of her ex-husband, the children's father. Luke Batty died in 2014 as a result of his father beating him to death. In the ACT we had an attempted filicide of two children by their mother in 2019.
3608. All of those deaths were as a result of family violence.
3609. This inquest is about family violence resulting in filicide. I note counsel for the Territory in his comments at paragraph 66 of his submissions referred to the inquest and the death of Luke Batty. In that inquest his Honour Judge Gray, the then State coroner, opined that having heard from the experts the crime of filicide was a rarity. I would like

to think that was true however given very recent news of father's killing their children it is unfortunately, not such a rarity at all.¹¹⁰⁴

Comments about SK and UN

3610. I found SK to be a very impressive witness. She was able to give accurate and concessionary evidence when required. It was clear that despite her desperate attempts to engage with various agencies about her well-founded fears for her children's safety, those concerns fell on deaf ears.
3611. SK said she felt that she was looked down on by those agencies and in my view having considered all the evidence that was probably true. It would appear that this was one reason why she was not able to get the help that she so desperately needed to help her children.
3612. I would like to commend SK and how she did everything in her power to save the children, unfortunately she was not listened to by those who should have listened to her. Ironically as it turned out SK was required to corroborate her version, yet the perpetrator was never asked to corroborate his allegations about SK. That is not an unusual phenomenon. I note what her Honour, the State Coroner for NSW, said in her findings in relation to Jennifer and Jack Edwards about women not being believed when they make complaints about domestic violence.¹¹⁰⁵
3613. UN was a very impressive witness who gave a good history of the historical abuse she suffered at the hands of Graham Dillon. UN was treated with the same lack of respect that SK experienced, perhaps for the same reason. The evidence before me suggests that both witnesses were not believed. The reason, it seems to me, was because of what appears to have been concerns that UN and SK had ulterior motives when making these reports, such as to enhance their success in future family law proceedings. There were no family law proceedings on foot for either SK or UN, and nobody made enquiries to establish that fact. The real situation was that both women were extremely concerned for the safety and welfare of the children. That reason was clearly well founded.
3614. The history of abuse perpetrated against these two women was horrific. Graham Dillon was controlling, manipulative and violent in the extreme, behaviour that is not untypical of violent men perpetrating significant domestic violence against women and their children. Graham Dillon was cunning with his abuse, so as to ensure that both women would not confide with anyone because of his extreme behaviour and their resulting fear.
3615. As history shows us, that behaviour was also deployed by Graham Dillon in relation to both Bradyn and JL.
3616. Bradyn was a quiet and extremely polite little boy. His teachers were very fond of him and described him as courteous and respectful. Bradyn was a child who contributed positively in group situations.

¹¹⁰⁴ The murder of Luke Batty, the murder of Jack and Jennifer Edwards, the murder of Hannah Clark and her three children, the suspected murder of Kobi Shepherdson. The attempted filicide of two children in the ACT in 2019.

¹¹⁰⁵ Inquest into the deaths of John, Jack and Jennifer Edwards [49].

3617. His teachers said that he “*consistently contributes to a safe and welcoming class environment and that he consistently contributes to a safe and welcoming playground environment*”. I lament that we as a society could not contribute to his safety.

Condolences

3618. I wish to express to SK and JL the courts condolences and sympathy for the loss of Bradyn in these terrible circumstances. By all accounts he was a delightful little boy whose life was cut short by a sadistic monster who was his father.

3619. I would also like to convey that his death was not in vain and there is a legacy that he leaves with us as a community.

3620. That legacy includes learning from the circumstances surrounding Bradyn’s death so that frontline workers get better training in relation to domestic violence. To also find solutions to reduce the scourge of domestic violence upon our community

Findings

3621. Bradyn Stuart Dillon was born 25 October 2006 at Royal Hobart Hospital Hobart.
3622. Bradyn Stuart Dillon died on 15 February 2016 at 20:25 hours at Calvary Hospital Bruce in the ACT, aged 9 years and 4 months.
3623. Death was caused from a closed head injury; the closed head injury was caused by sustained repeated blunt impact injuries over a period of time which were non accidental in nature. The closed head injury was secondary to these repeated impacts.
3624. Graham Dillon, Bradyn's father, caused the closed head injury by sustained, repeated blunt impact injuries inflicted upon his son Bradyn, which ultimately led to his death.
3625. Graham Dillon was able to inflict sustained violence upon Bradyn (and JL) by deliberately and increasingly isolating them from their community from late August 2015 until Bradyn's death.

Recommendations

3626. I find that there is an issue of public safety in connection to the death of Bradyn Dillon pursuant to s52 (4) of the Coroners Act 1997. In relation to s57(3) of the Coroners Act 1997 I make the following recommendations:

CYPS

- (1) Renewed training initiative with a focus on
 - i. strengthening the understanding and application of risk assessment, including cumulative harm.
 - ii. strengthening the understanding and application of legislative thresholds in informing decision making.
 - iii. strengthening the understanding of forensic interviewing of children and parents.
 - iv. the role of supervision, to include provision of improved quality assurance of decision making and administrative functions.
- (2) Continue funding for the induction training package for new frontline workers.
- (3) Funding and investment in training front line managers and team leaders to develop and strengthen skills in risk analysis and quality assurance.
- (4) Consider legislative changes in relation to the definition of how a child concern report is defined from a 'caller defined model to an 'intake defined model'.
- (5) Funding a greater number of staff at the intake level of CYPS.
- (6) Funding to be provided for junior staff in intake to develop and enhance their skills in front line work which includes risk assessment and cumulative harm.
- (7) Consider the establishment of an Intake Consultation Team for complex cases.
- (8) Continue funding of the Case Analysis Team with a view to increasing staff numbers .
- (9) Funding to engage a team of trainers in relation to providing mandatory reporters with skills to identify matter which require reporting to CYPS and those which could be referred to appropriate community organisations.
- (10) Consider legislative changes to include that mandatory reporters are advised of the outcome of their reports.

ACT Education Directorate

3627. Improvement of school tracking system to strengthen Part 6.1A of the Education Act 2004

- (11) Adopt a formal process
 - i. to require parents to advise the school where a child is being unenrolled to give details of where the child will be enrolled, or home schooled.
 - ii. where a child, the subject of CYPS involvement, has been unenrolled, to alert CYPS that the child has been unenrolled and the name of the school where they will be enrolled or the address for home schooling.
 - iii. obliging the Education Directorate to contact the new school to confirm enrolment and if enrolment is not confirmed then the Education Directorate must make a mandatory report to CYPS of that fact.
 - iv. making child tracking in the ACT to be mandatory for all schools.
- (12) To adopt and implement the National Schools Reform Agreement 'Unique Student Identifier' (USI) for the purposes of having a national information exchange scheme.
- (13) To participate in the management of the interjurisdictional data transfer scheme project through the Education Council of Australia.

Information Sharing Between Organisations and Interjurisdictionally

- (14) Expand the usage of the Connect 4 Safety Federal initiative to incorporate a health service provider component .
- (15) Continue to evolve the relationships between CYPS, ACT Education, SACAT DVCS and other community organisations through the use of liaison officers.
- (16) Enhance information sharing between CYPS and ACT Education in relation to real time enrolment data and identification of children at risk in conjunction with the proposal for mandatory child tracking.
- (17) Recommend that the Attorney General at the next meeting of State and Territory Attorneys General, raise with his counterparts the establishment of a national data base for children at risk.

3628. I endorse, and invite the ACT Government to implement, the recommendations from the Glanfield, Muir and K reports and invite the implementation of those recommendations which have not yet been implemented.

I certify that the preceding three thousand six hundred and twenty-eight [3628] numbered paragraphs are a true copy of the Reasons for the Findings of Her Honour Coroner Hunter.

Associate: Georgina Price

Date: 29 April 2021

Annexures (available on the Coroner's Court website)

Annexure A – Schedule of anonymised individuals and their roles
Annexure B – Charges against Graham Dillon relating to Bradyn and JL
Annexure C – Extract of Bradyn Dillon's autopsy summarising injuries
Annexure D – The Glanfield Inquiry
Annexure E – Counsel Assisting's Submissions
Annexure F – Counsel for the ACT Submissions
Annexure G – Counsel for the DFFH Victoria Submissions
Annexure H – Counsel for the AFP Submissions
Annexure I – Counsel for SK Submissions
Annexure J – Counsel for PG Submissions
Annexure K – Counsel for BU Submissions
Annexure L – Counsel Assisting's Submissions in Reply
Annexure M – Counsel for the ACT Submissions in Reply
Annexure N – Counsel for PG Submissions in Reply