CORONERS ACT, 2003

SOUTH  *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 31st day of May, the 8th, 9th, 10th 11th and 17th days of June and the 24th day of August 2021 and the 4th day of February and the 21st day of April 2022 , by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the deaths of Amber Rose Rigney and Korey Lee Mitchell.

The said Court finds that Amber Rose Rigney aged 6 years, late of 107 Jack Cooper Drive, Hillier, South Australia died at Hillier, South Australia on the 30th day of May 2016 as a result of external airway occlusion with compression of the neck.

The said Court finds that Korey Lee Mitchell aged 5 years, late of 107 Jack Cooper Drive, Hillier, South Australia died at Hillier, South Australia on the 30th day of May 2016 as a result of compression of the neck.

The said Court finds that the circumstances of their deaths were as follows:

1. Introduction

1.1. Amber Rose Rigney and Korey Lee Mitchell were brother and sister. They were aged 6 years and 5 years respectively at the time of their deaths on 30 May 2016. Their mother, with whom they lived at premises at Hillier near Gawler, was Adeline Yvette Rigney.[1] Ms Rigney also met her death on the same occasion on which her children died. She was 28 years of age. The children and their mother were murdered by Ms Rigney's partner, Steven Graham Peet, who also lived at the same premises.

[1] Adeline Yvette Rigney is also known as Adelaide Yvette Rigney

1.2. The cause of Amber's death was external airway occlusion with compression of the neck.[2]

1.3. The cause of Korey's death was compression of the neck.[3]

1.4. The cause of Ms Rigney's death was the result of compression of her neck combined with trauma to her head.[4]

1.5. On 6 April 2018 Peet was sentenced in the Supreme Court of South Australia for the murder of the two children and Ms Rigney. He had pleaded guilty to those murders. For each murder he was sentenced to life imprisonment. On 5 September 2018, on appeal by the Director of Public Prosecutions against the leniency of the original non-parole period that had been set by a single Justice of the Supreme Court, the Court of Criminal Appeal set a non-parole period of 36 years which was back dated to commence on 30 May 2016.

1.6. Ms Rigney and Peet had been living together since February 2016. Prior to that they had been in an intermittent relationship for some years. Initially Ms Rigney and Peet lived together with Amber and Korey at premises in Elizabeth North. In April 2016 they all moved to the premises at Hillier.

1.7. Peet was not the father of either of the two deceased children. The father was a man whom I shall refer to as B. B and Ms Rigney had been estranged for some time. There was a third child of their relationship. That child was a boy who will be referred to as S.[5] S was eight years of age at the time of the murders of his two younger siblings. B had custody of S owing in the first instance to an incident that had occurred in 2014 in which Ms Rigney had assaulted the child S and in respect of which a notification had been made to the child protection authorities and an investigation had ensued. For that reason S was not present at the Hillier address on the day of the murders. He resided with his paternal grandparents who were Mr Steven Egberts and Ms Janet Wells.

1.8. Ms Rigney and the three children were of Aboriginal descent. B, the father of the three children, was not Indigenous.

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[2] Exhibit C2a
[3] Exhibit C2b
[4] Exhibit C5a, page 4
[5] The identities of B and S are known to the Court

1.9. Peet was dealt with both by the original sentencing judge and by the Court of Criminal Appeal on the following factual basis which I adopt for the purpose of these findings. On the day prior to the murders Ms Rigney had been drinking and using cannabis and methamphetamine otherwise known as *ice*. The following morning after Ms Rigney woke, an argument developed between her and Peet. The argument involved an accusation by Ms Rigney that Peet had been unfaithful. During this argument Ms Rigney became physically aggressive and slapped and kicked Peet and hit him with a vacuum cleaner pole. Peet then struck Ms Rigney a number of times with a crowbar. He then dragged her to the laundry of the premises where he placed a cable tie around her neck and tightened it. The combined effect of the blows and the compression of the neck caused Ms Rigney's death. Not long after this event the two children woke. Peet made breakfast for them before going outside to smoke a cigarette. At this stage there was a knock on the door of the premises. When this occurred Peet placed the children in their rooms and told them to be quiet. He did not answer the door and ultimately the people who were there left. These people were officers of the Department for Education and Child Development otherwise known as Families SA. I will refer to this entity for the most part as the Department.[6] The Department officers were attempting to investigate the circumstances of this family. At some point, and possibly while the Department officers were still at the front door, Peet went back to each child and murdered them.

1.10. This sentencing factual basis which was supplied to the Supreme Court by or on behalf of Peet was in keeping with certain physically aggressive propensities that Ms Rigney had allegedly demonstrated in respect of B as well as another male, and also in relation to the oldest child S. Peet's assertions about methamphetamine use by Ms Rigney were supported by the fact that toxicological analysis conducted during Ms Rigney's post-mortem examination revealed the presence of both methylamphetamine and THC in quantities that suggested recent ingestion of ice and cannabis. The presence of ice in Ms Rigney's post-mortem blood also tended to support information that had been imparted on more than one occasion by notifiers to the Department that Ms Rigney had an ongoing ice habit and that this was significantly and adversely affecting her ability to care properly for the two children, Amber and Korey. There had been other negative elements in Ms Rigney's parenting skills that had also been reported to the Department

[6] If in these findings occasional reference is made to Families SA, it should be understood that this is also a reference to the Department

in the months leading up to the deaths of her and her two children. Ms Rigney had a significant child protection history of her own. She was a person who was well-known to child protection authorities, both as a child who had needed care and protection as well as in her capacity as a parent.

1.11. For a significant period of time leading up to their murders, the two youngest children, Amber and Korey, lived in an environment that was on any objective analysis dysfunctional, and that this was so to the knowledge and understanding of the Department who only very late in the piece, and when it was too late, attempted to do something about it. While nothing was previously known about Peet to suggest that Ms Rigney or the children had been at risk of harm from him in particular, it was in this milieu of dysfunction, neglect and occasional violence that the children met their deaths. Needless to say, responsibility for these callous murders lies with Peet. This inquest was undertaken to ascertain whether or not the deaths could have been prevented by the child protection authorities assuming a more vigorous role in relation to the protection of the two children. The answer to this question is that their deaths could and should have been prevented.

2. The issues examined in this inquest

2.1. The performance of the State's child protection authorities in relation to Ms Rigney and the two deceased children were the subject of a manifestly careful and detailed examination by Mr Wayne Lines, the South Australian Ombudsman. Tendered to the Court was the redacted report of the Ombudsman.[7] It is available on the Ombudsman's website. I have examined that report and its findings and recommendations. The Ombudsman's investigation was as the result of a complaint made by Mr Steven Egberts who was the paternal grandfather of S and the two deceased children. This complaint prompted an investigation by the Ombudsman into the issue as to whether the Department had erred by omitting to communicate with Mr Egberts and his partner, Ms Janet Wells, in respect of concerns relating to the care and protection of their late grandchildren. It is apparent from Mr Lines' report that he investigated that particular issue in some considerable detail and, as well, made detailed findings and recommendations in relation to the same. To my mind it would not be helpful for this inquest to cover exactly that same ground. Accordingly, although the issue as to

[7] Exhibit C12

communication was referred to in the evidence that was adduced at this inquest, I do not propose to make any further findings in relation to that issue beyond those made by the Ombudsman. I agree with the recommendations contained within the report, relating as they do to the sharing and disclosure of information where necessary to prevent serious risk to the health and safety of a person. It is clear from Mr Lines' report that at the time that he conducted his investigation he had an expectation that a coronial inquest would consider and evaluate the issue concerning the information about the family that was known and available to the Department at the time of the murders and whether the Department had taken the appropriate action in respect of that information. Although Mr Lines indicated that there was much he could say about the agency's response to the notifications it received about the mother, he decided that he would limit the scope of his investigation to the question as to whether the Department erred in omitting to communicate with Steven Egberts and Janet Wells in an appropriate manner. These findings will therefore be confined to the examination of the issue regarding the manner in which the Department dealt with the notifications that it received about Ms Rigney and the two younger children.

2.2. Mr Lines did make certain critical comments about the manner in which the Department dealt with some of the notifications in 2015 and 2016. As it so happens, the findings of this Court in relation to that issue are not inconsistent with the brief comments made by Mr Lines in his report. However, I should emphasise that this Court has examined the issue of the manner in which the notifications were dealt with completely afresh. The findings of this Court are findings based upon the evidence that was adduced in the inquest before me.

3. The witnesses

3.1. In this inquest three witnesses were called to give oral evidence. The first of those witnesses was Ms Avril Hale, a social worker employed by the Department and who was the Acting Supervisor of Assessment and Support Team E at the Elizabeth office of the Department. The role of Team E was predominantly to respond to notifications of alleged abuse or neglect of children. Ms Hale worked in the above capacity from approximately June 2014 to April 2016. Ms Hale reported to the office manager of the Elizabeth office. Ms Hale gave oral evidence concerning a number of the notifications made to the Elizabeth office regarding Ms Rigney and her children, as well as evidence concerning the notification originally made in relation to the alleged assault by

Ms Rigney on the child S. Ms Hale was the author of, or participated in the compilation of, a number of reports that were written in relation to proceedings in the Federal Circuit Court concerning custody of the child S.

3.2. The second witness was Ms Anne-Marie Scanlon, also an employee of the Department. In May 2016 she was the Assistant Director of Metropolitan Care and Protection Services at Families SA. Ms Scanlon played a role in arranging for the Gawler office of the Department to initiate an investigation into the circumstances of Ms Rigney's family in May of 2016.

3.3. The third witness was Ms Susan Macdonald who is the Executive Director of the Department of Child Protection as the State's child protection authority is now known. Ms Macdonald was responsible for conducting the internal Departmental adverse event review and was the author of the review's written report.

4. The Children's Protection Act 1993

4.1. At the time with which this inquest is concerned the Children's Protection Act 1993 (the Act) was the legislation that provided for the care and protection of children in this State. It was this legislation that described the duties and responsibilities of the State's child protection authorities, in particular the Chief Executive of the Department of Education and Child Development as well as the officers of the Department to whom the Chief Executive's powers were delegated. It also described the duties and responsibilities of the relevant Minister.

4.2. As will be seen, the Act imposed certain duties and obligations, particularly upon the Chief Executive, and therefore upon officers of the Department to whom his duties and obligations were delegated, to take action in certain circumstances involving children at risk of abuse or neglect.

4.3. Among the objects of the Act, as described in section 3, were to ensure that all children were safe from harm. Another stated object was to ensure that risks to a child's wellbeing were quickly identified and that any necessary support, protection or care was promptly provided.

4.4. The Act has been superseded by the Children and Young People (Safety) Act 2017 which came into operation on 18 July 2017.

4.5. The original Act governed the manner in which vulnerable children, such as Amber and Korey, would be protected by the Department. I should add here that on 28 April 2016, approximately a month prior to the deaths of the two children, the Act was amended in a number of respects that I shall mention. Although the amendments did not alter the fundamental duties and responsibilities of the Department, they are of some relevance and I will deal with that issue in this section of the Court's findings.

4.6. It is as well to explain the important features of the Act as they existed at the time with which this inquest is concerned.

4.7. Firstly, I should explain and identify certain concepts as they related to children who might have required protection under the Act as it existed at the relevant time. The concept of *abuse or neglect* of a child was defined within section 6(1) of the Act. The definition was as follows:

> '***abuse or neglect***, in relation to a child, means-
>
> (a) sexual abuse of the child; or
>
> (b) physical or emotional abuse of the child, or neglect of the child, to the extent that-
>
> (i) the child has suffered, or is likely to suffer, physical or psychological injury detrimental to the child's wellbeing; or
>
> (ii) the child's physical or psychological development is in jeopardy,
>
> and ***abused*** or ***neglected*** has a corresponding meaning;'

4.8. Another concept relating to a child to whom the Act might have applied, is that of a child being *at risk*. In this regard, section 6(2) of the Act stated as follows:

> '(2) For the purposes of this Act, a child is at risk if-
>
> (aa) there is a significant risk that the child will suffer serious harm to his or her physical, psychological or emotional wellbeing against which he or she should have, but does not have, proper protection; or
>
> (a) the child has been, or is being, abused or neglected; or
>
> (b) a person with whom the child resides (whether a guardian of the child or not)-
>
> (i) has threatened to kill or injure the child and there is a reasonable likelihood of the threat being carried out; or
>
> (ii) has killed, abused or neglected some other child or children and there is a reasonable likelihood of the child in question being killed, abused or neglected by that person; or
>
> (c) the guardians of the child-

(i) are unable to care for and protect the child, or are unable to exercise adequate supervision and control over the child; or

(ii) are unwilling to care for and protect the child, or are unwilling to exercise adequate supervision and control over the child; or

(iii) are dead, have abandoned the child, or cannot, after reasonable inquiry, be found; or

(d) the child is of compulsory school age but has been persistently absent from school without satisfactory explanation of the absence; or

(e) the child is under 15 years of age and is of no fixed address.'

As will be seen, of particular relevance to the issues in the case of Amber and Korey was the risk that the children could suffer serious harm to their physical, psychological or emotional wellbeing against which they should have, but did not have, proper protection. Also note that by this statutory definition a child was deemed to be at risk for two specific reasons. Firstly, a child was at risk if the child was of compulsory school age but had been persistently absent from school without satisfactory explanation of the absence. Secondly, a child was at risk if the child was under 15 years of age and was of no fixed address. Amber, who was at all material times of school age, was at risk for the first of those reasons. Both children at one point were at risk for the second reason as well. And they were at risk for a whole host of other reasons as will be seen.

4.9. An amendment to section 6 which took effect from 28 April 2016 expanded the scope of *significant risk* and *abuse or neglect*. The provision was amended by adding the following:

'(4) In assessing whether-

(a) there is a significant risk that a child will suffer serious harm to his or her physical, psychological or emotional wellbeing; or

(b) a child has been, or is being, abused or neglected,

for the purposes of the Act, regard must be had to not only the current circumstances of the child's care but also the history of the child's care and the likely cumulative effect on the child of that history.'

It will be readily accepted, I think, that even before this provision was added to the legislation, no notification of alleged or perceived abuse or neglect made to the Department could sensibly have been assessed without attention being paid to the known previous history of the child's care, or to the lack of such history, or with the likely cumulative effect on the child of that history to date. It is difficult to imagine

how any meaningful risk assessment in relation to children could ignore previous history. What the new provision meant, however, was that there was now a legislative mandate that such history be considered. In other words, it could not be ignored. Indeed, in my opinion it imposed on the Department an actual obligation to enquire as to whether there was any such history as might have existed in the records of that Department.

4.10. Part 4 of the Act related to notifications and investigations in respect of the abuse or neglect of a child. For these purposes, by section 10 of the Act the general definition of abuse or neglect to which I have already referred was expanded to include a reasonable likelihood, in terms of section 6(2)(b), of the child being killed, injured, abused or neglected by a person with whom the child resides.

4.11. I set out section 11 of the Act which dealt with notifications to the Department of abuse or neglect:

> '**11 – Notification of abuse or neglect**
>
> (1) If-
>
> (a) a person to whom this section applies suspects on reasonable grounds that a child has been or is being abused or neglected; and
>
> (b) the suspicion is formed in the course of the person's work (whether paid or voluntary) or of carrying out official duties,
>
> The person must notify the Department of that suspicion as soon as practicable after he or she forms the suspicion.
>
> Maximum penalty: $10 000.'

This provision imposed an obligation upon persons carrying out certain responsibilities, such as teachers, to notify the Department as soon as practicable of a suspicion on reasonable grounds that a child has been or is being abused or neglected. It will be noted that a notification needed to be made as soon as practicable. One would infer from that obligation that the Department would have had a corresponding obligation to deal with the notification as soon as practicable after it was received. The evidence will demonstrate that within the Department this did not routinely occur in respect of emailed notifications, and even then were not dealt with in accordance with the statutory obligations that the Act imposed on the Department under sections 19 and 20 of the Act that I will discuss below.

4.12. Section 14 of the Act in effect relieved the Minister or the Chief Executive of taking action in certain circumstances. I set out that provision:

> '**14 – Chief Executive not obliged to take action in certain circumstances**
>
> Nothing in this Act requires the Minister or the Chief Executive to take or initiate any action under this Act in relation to a notification of suspected abuse or neglect of a child if the Minister or Chief Executive is satisfied –
>
> (a) that the information or observations on which the notifier formed his or her suspicion were not sufficient to constitute reasonable grounds for the suspicion; or
>
> (b) that, while there are reasonable grounds for such a suspicion, proper arrangements exist for the care and protection of the child and the matter of the apparent abuse or neglect has been or is being adequately dealt with.'

The terms of this provision dictated that before any obligation upon the Minister or Chief Executive could be relieved, the Minister or Chief Executive, or their delegates, needed to be satisfied of certain matters being those matters set out in either of subsection (a) or (b). Clearly then, active consideration needed to be given to the issues identified in subsections (a) and (b) before any such satisfaction could be achieved.

4.13. Division 2 of Part 4 of the Act dealt with the power to remove children from dangerous situations. Section 16(1) stated as follows:

> '**16 – Power to remove children from dangerous situations**
>
> (1) If an officer believes on reasonable grounds that a child is in a situation of serious danger and that it is necessary to remove the child from the situation in order to protect the child from harm (or further harm), the officer may remove the child from any premises or place, using such force (including breaking into premises) as is reasonably necessary for the purpose.'

The phrase *situation of serious danger* is not defined. Section 16 of the Act was at one stage invoked by the Department in order to forestall a recovery order for the return of S to Ms Rigney. It was not utilised in relation to Amber and Korey.

4.14. Division 3 of Part 4 of the Act concerned the investigations that might be conducted by the Chief Executive or his or her delegates, as well as the basis for applications for assessment orders from the Youth Court. I set out section 19(1) as follows:

> '**19 - Investigations**
>
> (1) If the Chief Executive-
>
> (a) suspects on reasonable grounds that a child is at risk; and

(b) believes that the matters causing the child to be at risk are not being adequately addressed,

the Chief Executive must cause an assessment of, or investigation into, the circumstances of the child to be carried out or must effect an alternative response which more appropriately addresses the potential or actual risk to the child.'

It will be noted that the obligation upon the Chief Executive to act either by causing an assessment of, or investigation into, the circumstances of the child, or to effect an alternative response, which more appropriately addressed the potential or actual risk to the child, was not discretionary once the relevant suspicion and belief referred to in the provision was formed. That the obligation is a mandatory obligation is evident from the use of the word *must*. The other matter worthy of note is that this provision clearly contemplates a suspicion on reasonable grounds being formed before the ensuing assessment or investigation or alternative response occurs. The formation of such suspicion does not depend on and is not necessarily formed on the basis of the outcome of any assessment or investigation or alternative response. On the contrary, it triggers such an assessment or investigation or alternative response. By virtue of section 19(3) of the Act, police powers could be utilised, without warrant in certain circumstances, to assist in an investigation, for example their powers of search, seizure and compelling persons to provide information. Police also had other powers in relation to the investigation of criminal offences, such as drug offences.

4.15. I set out section 20 of the Act:

'**20 – Application for order**

(1) If the Chief Executive is of the opinion-

(a) that there is some information or evidence leading to a reasonable suspicion that a child is at risk; and

(b) that further investigation of the matter is warranted or a family care meeting should be held; and

(c) that –

(i) the investigation cannot properly proceed unless an order under this Division is made; or

(ii) it is desirable that the child be protected while the matter is being investigated or a family care meeting is being held,

the Chief Executive may apply to the Youth Court for an order under this Division.

(2) If the Chief Executive suspects on reasonable grounds that a child is at risk as a result of the abuse of an illicit drug by a parent, guardian or other person, the Chief Executive must apply for an order under the Division directing the parent, guardian

> or other person to undergo a drug assessment (unless the Chief Executive is satisfied ta an appropriated assessment of the parent, guardian or other person has already occurred, or is to occur).'

There was considerable evidence given during the course of the inquest about the effect of section 20(2) in particular. A number of notifications were made to the Department that concerned allegations of abuse of the illicit drug ice on the part of the mother of Amber and Korey and of the detrimental effect this was having in respect of their care. It will be noted that if the Chief Executive, or his delegate, suspected on reasonable grounds that the child was at risk as a result of the abuse of an illicit drug by a parent, the Chief Executive was obliged to apply for an order under this Division of the Act. The mandatory nature of that obligation was again due to the use of the word *must*. I should also note here that on 28 April 2016 section 20 of the Act was amended by the substitution of subsection (2) and the insertion of two further provisions including a new subsection (3). The amended provisions were relevantly as follows:

> '(2) Without limiting subsection (1) or (1a), if the Chief Executive is of the opinion that a child is at risk as a result of the abuse of a drug by a parent, guardian or other person, the Chief Executive must apply for an order under subsection (1) directing the parent, guardian or other person to undergo a drug assessment.
>
> (3) However, the Chief Executive need not apply for an order referred to in subsection if he or she is satisfied that –
>
> (a) a drug assessment of the parent, guardian or other person has already occurred, or is occurring (whether pursuant to an application under this section or otherwise); and
>
> (b) that drug assessment is of a kind appropriate for the purposes of this Act; and
>
> (c) the results of the drug assessment have been, or will be, made available to the Chief Executive; and
>
> (d) in the case of a drug assessment that has already occurred - having regard to when the drug assessment occurred, an additional drug assessment under that subsection is not necessary.'

It will be observed that the obligation on the part of the Chief Executive to act on suspicion on reasonable grounds that a child was at risk as a result of the abuse of a drug by a parent was replaced with an obligation on the part of Chief Executive to act when he or she was '*of the opinion that*' the child was at that risk. The same mandatory obligation applied having regard to the use of the word *must*. The effect of this provision as it originally had existed was the subject of much comment in the findings

of inquests in relation to **Chloe Valentine** and **Ebony Napier**.[8] The amendments to section 20 were introduced by the enactment of the Children's Protection (Implementation of Coroner's Recommendations) Amendment Act of 2016. A perusal of Hansard does not shed any light on why subsection (2) was altered from '*suspects on reasonable grounds that*' to '*is of the opinion that*'.

4.16. It will also be observed that if the Chief Executive formed the necessary statutory state of mind in relation to a child being at risk because of abuse of an illicit drug on the part of a parent, and that these circumstances were not being adequately addressed, this of itself would have enlivened section 19(1) of the Act meaning that a more general assessment or investigation into the circumstances of the child or other action as envisaged in that provision would have to be carried out.

4.17. Section 21 of the Act set out the orders that the Youth Court might make where section 20 of the Act was enlivened and the Chief Executive accordingly exercised the mandatory powers under that provision. These orders included an order authorising an examination and assessment of the child or an order authorising or directing the assessment of a parent to determine the capacity of the parent to care for and protect the child. Such an order could direct a parent to undergo a drug assessment. Other potential orders included an order granting custody of the child to the Minister, an order directing a person who resided with the child to cease or refrain from residing in the same premises as the child and an order directing a person to refrain from having contact with the child.

4.18. Division 2 of Part 5 of the Act dealt with care and protection orders that might be made by the Youth Court. I set out sections 37(1) and (1a) of the Act:

> **'37 – Application for care and protection order**
>
> (1) If the Minister is of the opinion –
>
> (a) that a child is at risk; and
>
> (b) that an order under this Division should be made in respect of the child to secure his or her care and protection,
>
> the Minister may apply to the Youth Court for an order under this Division.

[8] Citations

(1a) If the Minister-

(a) knows or suspects on reasonable grounds-

(i) that a child is at risk as a result of drug abuse by a parent, guardian or other person; and

(ii) that the cause of the child being at risk is not being adequately addressed; and

(b) is of the opinion that the most appropriate response is an order under this Division for one or more of the following purposes:

(i) to ensure that the parent, guardian or other person undergoes appropriate treatment for drug abuse;

(ii) to ensure that the parent, guardian or other person submits to periodic testing for drug abuse;

(iii) to authorise or require the release of information regarding the treatment or the results of the test to the Chief Executive,

the Minister must apply to the Youth Court four such an order.'

These two provisions remained unaltered as at the time of the children's deaths on 30 May 2016.

4.19. Pursuant to section 38 of the Act the Youth Court could, among other things, grant custody of a child for a specified period not exceeding 12 months to a guardian of the child, to some other member of the child's family, to the Chief Executive of a licenced children's residential facility, to the Minister or to any other person the Court thought appropriate in the circumstances of the case. There were other powers that the Court possessed including placing a child under the Guardianship of the Minister until the child reached the age of 18 years.

4.20. It will be noted that like section 20(2) of the Act, section 37 also addressed the circumstance where a child was at risk as a result of drug abuse by a parent, guardian or other person and where the cause of the child being at risk was not being adequately addressed. In those circumstances, and where the Minister was of an opinion that the most appropriate response was a court order to ensure appropriate treatment or periodic attention testing for drug abuse, the Minister was obliged to apply to the Youth Court for such an order, the obligation again arising from the use of the word *must*.

5. Families SA relevant internal procedures

5.1. The Department for Education and Child Development Child Protection Manual– Volume 1 was tendered to the Court.[9] Among other things this manual described the procedures to be adopted by Families SA regarding processing of notifications made it in relation to the possible abuse or neglect of children. There was a three-tier system divided into Tier 1 investigations, Tier 2 investigations and Tier 3 responses. We are concerned here with Tier 1 and Tier 2 investigations.

5.2. In the first instance notifications were made to and received by the Child Abuse Report Line (CARL). This report line could be activated either by telephone or by email. A telephone notification would initially be assessed by the CARL worker who received the call. As far as emailed notifications were concerned, known as eCARL, the evidence was that in practice these might not be assessed for several days which to my mind sat uncomfortably with the obligation on a notifier to notify the Department as soon as practicable after the notifier formed a suspicion on reasonable grounds that a child has been or was being abused or neglected. One would have thought that there would be no point in having such a stringent duty imposed on a notifier unless it was processed within the Department with the same degree of immediacy.

5.3. In her oral evidence Ms Susan Macdonald, the Executive Director of the Department for Child Protection, explained the tiering system. She told the Court that having received the notification, the CARL worker would make a decision as to whether the notification involved a Tier 1 or a Tier 2 response. She explained that a Tier 1 notification involved a level of risk such as might be involved in a child being left at school and there was no caregiver willing or able to collect the child. Another example could involve a child being in imminent danger. This would obviously require a response on the part of the Department of some immediacy.

5.4. Ms Macdonald explained that a Tier 2 response involves an investigation that would need to be commenced within three days, five days or ten days. She asserted that the response of the Department, in terms of any orders that might be applied for from a Court, would depend on the outcome of such an investigation. It was apparent from the evidence as a whole that a Tier 2 notification could well involve a serious allegation

[9] Exhibit C18b

of abuse or neglect of a child but would not necessarily involve a situation of imminent danger requiring a Tier 1 response.

5.5. Ms Macdonald also described a procedure whereby a notified matter would be subjected to a notifier only concern or NOC. A NOC was a response, or more accurately the lack of a response, where a notification did not meet the criteria or threshold for intervention by the Department. A NOC effectively closed off a notification and no further action would be required or taken. The subject of the NOC is dealt with in the Department's Child Protection Manual.[10] This procedure applied to notifications in which a CARL worker considered that the report did not *constitute reasonable suspicion of child abuse or neglect* as defined by the Act. The procedure could also be used *when the information or observations on which the notifier formed his or her suspicion do not constitute reasonable grounds for the suspicion*. According to the manual, such an assessment might occur where the report was too vague, had imprecise concerns or no clear allegations of abuse, was too peripheral or was mischievous or of low credibility. The NOC process appears to be a reflection of the terms of section 14 of the Act (reproduced above) that relieved the Chief Executive of his or her obligations under the Act in certain circumstances. However, an available inference from this process was that in a case in which a NOC was not used to reject a notification, the assessment was that the report **did** constitute reasonable suspicion of child abuse or neglect as defined by the Act, **did** involve a report in which the information or observations on which the notifier formed his or her suspicion constituted reasonable grounds for the suspicion and **did not** involve allegations that were too vague, too imprecise, too peripheral or allegations that were mischievous or of low credibility. In these circumstances, save and except for a case in which under section 14(b) proper arrangements existed for the care and protection of the child and the matter of the apparent abuse or neglect had been or was being adequately dealt with, a matter that the Chief Executive had to be satisfied of and therefore had to give active consideration to, it is difficult to see how the Act could be complied with unless the notification was investigated.

5.6. However, another concept that was mentioned in the evidence was a Departmental response in which a matter that was not the subject of a NOC would nevertheless be closed without any action or investigation. This response was known as a CNA. The

[10] Exhibit C18b, page 105

Child Protection Manual[11] described the circumstances in which a CNA might be raised. The manual stated as follows:

> '**Closed no action – CNA**
>
> "Closed No Action" is a closure code within the child protection system which may be applied to a Tier 2 or Tier 3 notification when the District Centre has insufficient resources to conduct the requisite investigation or family meeting, and the subsequent associated follow-up work for that case in light of the priority and urgency of other cases.'

The document also stipulated as follows:

> - Any intake that has been closed for resource related reasons or because of inability to complete the investigation should be considered in any subsequent allocated intake.'

5.7. The manual also described the role of the supervisor of a District Centre:

> '**Supervisor role:** It is the role and responsibility of the District Centre Supervisor (of the team responding to child protection intakes) to assess the relative priorities of the incoming work and the team's capacity to respond. In situations where some, but not all of the current intakes can be allocated, it is appropriate to weigh up the relative seriousness of the intakes, and respond to those which suggest a threat to child safety or greater risk of harm.
>
> As soon as it is clear to the Supervisor that there will be no capacity to commence investigation or to convene a family meeting within a reasonable time from the date of intake of a notification, the Supervisor will recommend to the District Centre Manager that he/she authorise closure with CNA.'[12]

While the CNA procedure could not apply to Tier 1 notifications, the notion that Tier 2 notifications, which could nevertheless involve serious allegations of abuse or neglect, and/or involve the creation of a suspicion on reasonable grounds that a child was at risk, might be accorded no response whatsoever, was actively embedded in the Department's own internal procedures. There was certainly no statutory imprimatur for such a procedure. On the contrary, such a procedure flew in the face of the mandatory statutory duties of the Department to conduct an investigation in certain circumstances. Needless to say, an internally documented procedure such as the CNA could not supplant the legal obligations and responsibilities mandated by the Act. Insofar as these devices were deployed to close off an assessment of or an investigation into a matter that the Act stipulated *must* be so assessed or investigated, such processes were contrary to law. This was so regardless of resource considerations. The devices amounted to an egregious and sustained institutionalised flouting of the statutory

[11] Exhibit C18b, page 153
[12] Exhibit C18b, page 154

requirements relating to child protection. The failure of the Department to carry out its statutory obligations had been the subject of criticism in the findings of this Court in both the **Valentine** and **Napier** inquests.

5.8. As will be seen, both the NOC and the CNA were extensively utilised to close off investigations into serious allegations of abuse or neglect in relation to Amber and Korey.

6. Relevant events in 2014

6.1. Tendered to the Court were the Department for Child Protection casenotes in relation to notifications made in respect of Ms Rigney's children.[13] As a matter of law it is not generally permitted to disclose the identities of notifiers. To the extent that notifiers in these instances are capable of identification, although most of them are not, they will not be identified in these findings. However, the nature of the information imparted, the possible sources of these notifications and their repetition tended to lend much weight to the validity of that information, especially when accumulated.

6.2. Within the file relating to the oldest child S, there was a notification[14] that the children's mother, Ms Rigney, had been drunk the previous weekend and had been in an argument with neighbours that had resulted in the police attending and arresting Ms Rigney. This information had apparently been imparted to the notifier by the children's father. The notifier reported that in the last two weeks there had been threatening behaviour from the mother to the father and in particular that the mother had threatened to hit the father with a metal pole in front of the children. It was reported that the father wanted to remove the children from that environment. A further notification dated 20 January 2014[15], which refers to the earlier incident involving the mother allegedly threatening the father in front of the children with a metal pole, described a police attendance at the mother's residence on 19 January 2014. Police had attended after it was reported the parents were fighting outside the home in front of the children. The argument on this occasion consisted of swearing and yelling at each other by the parents. I mention these two matters as the incident in which the mother met her death with the two children, was not the first occasion on which Ms Rigney had allegedly been violent towards a

[13] Exhibit C10a and C10b
[14] Exhibit C10a, page 6
[15] Exhibit C10a, page 8

male partner when intoxicated. These two earlier reports were subjected to NOCs in both cases.

6.3. A further notification dated 3 November 2014 involved an incident on 24 October 2014 in which Ms Rigney reportedly texted the paternal grandmother of her three children to say that she had just hit S with a broom because S had touched his younger brother's penis in the bath. A further text stated that the paternal grandmother should come and get S because '…*if he's in my face… I'll bash him*'. The paternal grandmother then attended at Ms Rigney's home and collected S who was crying and had red marks on his left arm, back and left shoulder. S told the paternal grandmother that Ms Rigney had put her foot on his head underwater and tried to drown him in the bath. He confirmed that his mother had hit him on the arm with the broom and had done so repeatedly. The mother was spoken to about the matter and she said that S knew '*why he got a flogging*'. S, who had a shaved head, had a large tennis ball sized lump on his scalp.

6.4. The notification also asserted that in the past three months S had been seen with other bruises and had made other allegations of assault by his mother. S evidently had said that his siblings were not disciplined in the same way that he was and that Ms Rigney would only hit the smaller children if they did not eat their dinner. The evidence suggested that Ms Rigney lacked insight into the wrongness of her behaviour towards S. It was said that '*she could not understand why everybody thought that what she had done to her son was out of line*'.[16]

6.5. Within Families SA this notification was classified as Tier 2 with a five-day investigatory response. In the event this notification would be closed during 2015.

6.6. Following the incident to which this notification related it was agreed that the grandparents would continue to care for S until he had calmed down and felt safe to return to Ms Rigney's care. However, he continued to be fearful of her.

6.7. In the event, the oldest child S would remain living at the premises of the paternal grandparents for the entire period from late 2014 when the bath incident had occurred until late May 2016 when the two youngest children and the mother were murdered.

[16] Transcript, page 153, Evidence of Ms Hale

6.8. In the intervening period there were protracted proceedings occurring in the Federal Circuit Court relating to the custody of S in which Ms Rigney was the applicant and S's father and grandparents were other parties to those proceedings. In due course the Court would take a keen interest in the welfare of Amber and Korey as well as that of S and an independent children's lawyer would be appointed to represent their interests. More of that later.

7. Notifications to the Department in 2015 and 2016

7.1. Before dealing with these notifications, I should mention some concerns that have been expressed by Mr Egberts and Ms Wells, the paternal grandparents, regarding the number of notifications in the possession of the Department and whether there has been complete discovery of the same to this Court. The concerns relate specifically to the number of notifications made by Amber's school. It will become apparent in this section of the findings, inferentially at least, that a number of notifications regarding this family had Amber's school as a possible source. The paternal grandparents' concerns were raised after the evidence and final addresses in this inquest concluded. I note that the same concerns were expressed to the Ombudsman during the course of his inquiry. Inquiries conducted by the Ombudsman and by Counsel Assisting this Court have not revealed any evidence of outstanding or additional notifications of either a formal or informal nature that are in the possession of the Department. I was not persuaded that it in the circumstances it was necessary to re-embark on a wholly new inquiry into these concerns.

7.2. The Departmental notifications insofar as they related to Amber and Korey need to be examined against the background of the notification in 2014 in relation to Ms Rigney's behaviour towards the child S. In January 2015 the Department had reached a determination that the alleged assault by Ms Rigney against S had been substantiated after an investigation had taken place.

7.3. Proceedings in the Federal Circuit Court were ongoing throughout 2015 and into 2016 leading up to the death of the mother of the two children in May of that year. Child S continued to reside with the paternal grandparents. I will deal in another section with the interaction between the Federal Circuit Court and the Department such as it was in relation to the custody of the child S. I shall describe the concerns entertained by the Federal Circuit Court in relation to the two younger children, and with the

endeavours of that Court to have the Department inform the Court as to the circumstances of the two younger children and indeed the Court's clear desire for the Department to participate in the proceedings, a desire that was consistently resisted by the Department during 2015 and the early part of 2016.

7.4. The casenotes for these notifications were tendered to the Court. In those casenotes Amber and Korey's custodial parent is generally described as 'the mother'. This can be taken as a reference to Ms Rigney.

7.5. <u>The notification of 27 January 2015</u>

This notification was made on 27 January 2015. It related for the most part to Amber who at that stage was 5 years and 4 months of age. The notifier reported that approximately four months ago Amber had lain on a couch and had rubbed the crotch area of her pants as hard as she could and that as soon as anyone entered the room she would stop. This activity had been witnessed on three occasions over approximately two years which led the observer to believe that the behaviour was ongoing and that the child had perhaps been interfered with. There was no supporting information in respect of that allegation. I pass no comment on that allegation as an indication of abuse or neglect of particular relevance. However, a further concern was expressed that Korey was still non-verbal which the notifier found concerning due to the fact that his age was 3 years and 11 months.

7.6. This notification was dealt with by way of a NOC, the recorded rationale for that decision being that the report did not have sufficient information or provide reasonable grounds to suspect abuse or neglect or that the child was at significant risk of harm.

7.7. <u>The notification of 26 August 2015</u>

The next notification was made by way of eCARL (emailed) dated 26 August 2015. The casenote in relation to this intake[17] suggests that the notification was not considered until 9 September 2015. This notification specifically related to Amber who was aged 5 years and 11 months at the time. The notifier expressed concerns about Amber during the period of May 2015 to August 2015. The officer dealing with this notification noted that there were concerns based around poor school attendance and worrying emotional instability and immaturity on the part of Amber. The report also recorded that the notifier had informed that Amber had attended the Ingle Farm Primary School and was

[17] Exhibit C10b, page 52

in Reception, but that her attendance since May had been very irregular. When Amber did attend school she was late and was often dropped at the side of the road which meant that she had to bring herself to the office, 'sign in' late and make her own way to class. It was reported that she was often collected late from school and that she had to take herself to the office to wait for her mother to collect her. On 25 August 2015, the day before the notification was made, the mother had called the school and had asked them to tell Amber that she was being collected by a taxi after school. A taxi arrived at 3:45pm, Amber having been dismissed from class at 3:05pm. There was no attendance by Amber at school the following day. The report states as follows:

> 'Amber's behaviours show a real struggle with emotional regularity. She cries very frequently and often for no specific reason. She has a hard time making friends due to attendance and her often loud, regular emotional outbursts. She is difficult to calm and struggles to verbalises (sic) her emotions. Amber needs a lot of 1:1 attention in class from teachers and often seems very vague. She is often tired and struggles with day to day tasks due to lack of concentration and ability.
>
> Her speech is very unclear and she is often very vague in discussions.' [18]

The casenote recorded that many attempts had been made to contact Amber's mother regarding the child's attendance but that the phone calls were never answered. Meetings had been arranged with the mother to discuss concerns with Amber's behaviour and emotions at school and her general school behaviours, but the mother never attended the meetings, giving the reason that she either forgot or could not make the meeting.

7.8. This notification did not supply any greater detail about Amber's non-attendance at school beyond what I have described in the preceding paragraph. However, it is inferentially available from the note that her failure to attend was an ongoing circumstance. The reader of these findings is reminded that by definition a child was at risk if the child was of compulsory school age but had been persistently absent from school without satisfactory explanation of the absence. This notification appears to have been the first occasion on which Amber's non-attendance at school was notified to the Department.

7.9. This notification was dealt with by way of a NOC, the recorded rationale for that decision being that the information in the intake did not meet the screening criteria for

[18] Exhibit C10b, page 53

the '*risk/ground definitions*'. To my mind this notification would have required further detailed scrutiny if it had been processed within a reasonable time and especially if it had been identified as coming from the school. In any case, it was at least worthy of an enquiry by the Department as to whether or not between 26 August when the notification was received and 9 September when it was finally looked at, Amber's non-attendance at school was persisting. That this notification supposedly did not meet screening criteria was probably a circumstance occasioned by that delay and was of the Department's own making. A moment's thought would have dictated that at face value the information was compelling. Amber's non-attendance at school had a compelling origin – she had no friends there, she cried a lot of the time, her transport arrangements to and from school were chaotic and she therefore probably did not want to go to school, and her mother did not make her go or could not be bothered. There was a suspicion on reasonable grounds that Amber was at risk. A NOC was hardly the appropriate response.

7.10. <u>The first notification of 21 October 2015</u>

This notification is dated 21 October 2015 and timed at 9:57am.[19] It purports to reopen the previous notification of 26 August 2015 to which I have referred. The reopening was noted to allow additional information about the same allegations/concerns to be recorded.

7.11. The casenote records that SAPOL had received a phone call from a male person in relation to his concerns that the mother had '*dumped*' Amber on him. The male person is named in the casenote. It is not necessary to identify that person for the purpose of these findings. I will refer to him as M. M reported that he had only known the mother for a couple of months and that over this time he had looked after Amber on and off. The mother had arrived on his doorstep and asked if he could look after Amber for a while. Amber had been in his care for '*the last few days*' and he had been unable to get in contact with the mother.

7.12. SAPOL had become involved in the matter and had attended M's home and reported that while Amber looked well, she was a bit anxious as to her mother's whereabouts. The attending officers had reported no concerns for Amber in M's care. M had two of his own children under 6 years of age and both were in his care. He told police that he

[19] Exhibit C10b, page 54

was happy to care for Amber but did not want her to be left with him long term. SAPOL attended at the mother's home and reported that no-one appeared to be home. Repeated unsuccessful attempts by SAPOL to contact the mother culminated in the mother eventually answering the phone and telling police that she had spoken to M and that everything was fine. She attributed the situation to her car having broken down.

7.13. The intake also recorded that SAPOL had contacted the paternal grandfather, Mr Egberts, as to whether his son, the father of the children, would be able to take Amber into his care. Mr Egberts had reportedly responded that he was unsure if it would be allowed due to the current Federal Circuit Court proceedings regarding the oldest child. Mr Egberts did report that court ordered access in favour of the father had not happened for months. Mr Egberts is recorded as having raised concerns about the mother leaving the child (Amber) with a stranger. Mr Egberts is recorded as having told SAPOL that he would be happy to take Amber and Korey into his care, although there were already five people residing in the home and that the housing conditions would become cramped if Amber came to reside with them full time.

7.14. The notifier reported that SAPOL had arranged with M that he was to re-contact police if the mother did not return to collect Amber from his care that evening, in which event police would escalate the situation and look for alternative care arrangements for Amber, possibly with the father and the paternal grandfather.

7.15. Interestingly, it is recorded that the notifier reported that M was unaware that the mother had another child, Korey, which seems to be reflective of the very casual nature of the relationship between Ms Rigney and M in whose care Amber had been placed.

7.16. This notification was also the subject of a NOC with an endorsement that there was no change to the previous assessment as the information provided did not suggest that the mother will not return for the child. However, it was noted that if further concerns were raised the notification could be reassessed.

7.17. <u>A further notification dealt with on 21 October 2015</u>

This in fact relates to an eCARL notification that was submitted on the previous afternoon, namely 20 October 2015. This emailed notification was apparently assessed in the late morning of 21 October 2015. The casenote[20] recites previous child protection

[20] Exhibit C10b, page 57

history dating back to 2011, and in particular regarding concerns raised around Amber's irregular school attendance, including arriving late at school, being picked up late from school and Amber displaying emotional irregularity and difficulty in making friends.[21] There is also reference to Amber's mother not attending meetings at the school to address those issues.

7.18. The notification is a lengthy and detailed one that inferentially originates from Amber's school which at that point in time was the Ingle Farm Primary School. The notification was that Amber had arrived at school that morning (20 October 2015) with another child who is named and who was apparently the child of M who in the previous notification of the same day was said to have had Amber dumped on him. M's child and Amber both stated that the mother had hurt Amber's father and that she was in jail. I do not believe that there is any independent evidence to the effect that Ms Rigney was in custody at this time, but this notification confirmed that Amber at that stage, for whatever reason, was in the care of M. When Amber had arrived at school she confirmed that she was staying with the other child's father, M. Four attempts were made to contact Ms Rigney's mobile phone and there was no answer. M stated that he hardly knew Amber's mother but was picking Amber up from school. Ultimately Ms Rigney was contacted. It sounded as if she was in the company of other persons. There was some awareness demonstrated as to what had been said between M and school staff. Ms Rigney asserted that she was stuck in Blackwood with car troubles and that M had verbal permission to take Amber home.

7.19. It was observed that there was some apparent inconsistency in the information to date as it had been said on the one hand that the mother's car had broken down and on the other that she was in jail. It is to be inferred, I think, that the conversation between the notifier and M in which this information had originally been imparted had occurred over the telephone. The impression was recorded that M had sounded intoxicated.

7.20. The casenote records Families SA concerns, mainly arising around the consistency of care for Amber who is described as an emotionally immature and sensitive little girl lacking in social skills. There is also reference made to her long-term absence and/or inconsistency of attendance at school, it being recorded that out of 50 days she had been absent for 21 days without a reason. It was recorded that staff had only become aware

[21] Exhibit C10b, page 61

of Amber's change in home circumstances due to the conversation initiated between Amber and M's daughter.

7.21. It is recorded that the mother is often very vague in conversation, never answers her phone when contacted by teachers. Amber has been collected from school alone by taxi before and the mother is often late to collect her with no reason. It was recorded:

> 'The care and wellbeing of Amber is a concern for teachers.' [22]

7.22. It appears that this was assessed as a Tier 2 matter with a required response time of ten days. However, it would not be acted upon,.

7.23. <u>A further notification on 21 October 2015</u>

It was in this notification that serious allegations concerning Ms Rigney's general behaviour were made quite apart from the concern adhering to the allegation that she had relinquished the care of Amber to a relative stranger. I will mention those matters in a moment. The casenote for this particular notification repeats the reference to Amber being currently in the care of the male person who is the father of Amber's friend at school.[23] This of course is M. It was asserted in the casenote that M hardly knew the mother whom he met through school about six months ago. There is reference to him having contact with school staff and stating that he could not continue to care for Amber as he is a single parent and suffers from depression. It was asserted that he had been caring for Amber for two days after the mother had left Amber at his place, stating that she was meeting '*her drug dealer*'. It was recorded that the current location of the mother was unknown and that she was uncontactable by phone. It was also recorded that M cared for Amber more through obligation rather than a desire to do that.

7.24. It was recorded that M reported that Ms Rigney had told him that all her family were '*fuckfaces*' and that she had no other family to leave the children with. She made reference to the older sibling S being in the care of the father. The mother stated that this was due to S '*looking like the father*'. I would add here that there were suggestions in the evidence to the effect that Ms Rigney would take her frustrations out on the child S because of his resemblance to his father.

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[22] Exhibit C10b, page 58
[23] Exhibit C10b, page 60

7.25. This casenote recorded further detail about Amber's poor school attendance. As well as the absence for 21 days out of 50 recorded for term 3, there had been absence in term 2 for 18 days out of 43. As far as the current term was concerned, she had been absent for 4 days out of 8. In fact the school records for Amber would reveal that in a year of school days she was absent for 106. She was late on 39 days and left early on 8 days. It was also recorded that due to Amber's poor school attendance she had trouble making friends and maintaining routine.

7.26. As to Ms Rigney's alleged behaviours, these were no doubt based on information received from the notifier. Those allegations were as follows:

> '- the mother is an Ice addict
> - there is no food in the family home
> - the mother doesn't know the children are in the home due to her being high on drugs
> - when Amber was left in (M's) care the mother was meeting her drug dealer
> - Amber shows fear of the mother when she has to go with her
> - the mother doesn't sleep at night and has visited (M) during the night screaming in the street demanding money
> - (M) has given the mother money to purchase food which has been spent on drugs
> - the mother is driving an unregistered car with no licence. It is unclear if the mother has driven the car with the children present.' [24]

7.27. This notification evidently caused the matter to be upgraded to a Tier 2 with a five-day required response that ultimately would not be acted upon.

7.28. <u>The ultimate fate of the 21 October notifications and of a further notification on 22 October</u>

Before discussing that fate it is as well to set out the recorded impressions and rationale for decisions that were made internally in Families SA concerning these notifications. Firstly, in the casenote for the third notification of 21 October 2015 it was recorded as follows:

> 'RN02 - The information from the informant raises concerns that the mother has a substance misuse problem that is interfering with her functioning and her ability to provide safe care for the children.
>
> NEG4 added for Amber as the mother has failed to make appropriate care arrangements for the child.' [25]

[24] Exhibit C10b, page 61
[25] Exhibit C10b, page 61

7.29. Against the earlier notification casenote it was recorded:

> 'RE1O - **Amber's social, emotional or cognitive development is seriously at risk** as direct result of the mother's behaviour eg the mother has left Amber in the care of people she hardly knows without making proper care arrangements for her. The mother also has been uncontactable and her location is unknown. The mother has shown no interest in or has made no attempt to contact the people Amber is staying with to negotiate proper care arrangements for her. The information indicates that **the mother's behaviour is also impacting on Amber's emotional wellbeing** who is lacking in social skills which are related to Amber's long term absence and inconsistent school attendance. The mother has displayed a reluctance to address the concerns around Amber's poor school attendance by not answering her phone and not attending meetings organised with the school to address the concerns. It has also been reported due to the mother's drug use, she is often not aware of the children being in the home resulting her not attending to their needs. If information is received that Amber is no longer being cared by (M) and the mother has not been located and resumed care then the information may need to be reassessed as a Tier 1.' [26] (emboldening added)

7.30. When properly distilled, the information imparted to the Department on 21 October 2015 was that Amber's emotional and cognitive development was seriously at risk, that her attendance at her school was consistently unsatisfactory by any proper educational standard and that at times her mother was simply unable to look after her, hence her being placed into the care of a virtual stranger. Superimposed on, and probably explaining that situation, was the powerful suggestion that Ms Rigney was an ice addict and that this circumstance had resulted in inadequate food within the family home, a lack of awareness on the part of Ms Rigney that the children were even in the home, that the reason that she was unable to care for Amber and had placed Amber in the care of another person was because she was meeting a drug dealer. As well, the mother at night allegedly attended M's premises and screamed in the street demanding money which she was given to purchase food but which she spent on drugs. There would be no reason to suppose that any of this information was mischievous, scurrilous or false. It certainly had a ring of truth to it as evidenced by Amber's truancy and the fact that she was placed in the care of a person whom the mother had simply met through the school. It is unsurprising that this compelling information actually appears to have been given credence by the Department. So much was evident from the endorsement in one casenote to the effect that the information raised concern that the mother had a substance misuse problem that was interfering with her functioning and her ability to provide safe care for the children, and in particular was having a serious impact on

[26] Exhibit C10b, page 59

Amber which was not being addressed. Indeed, all of this was prompting consideration within the Department that the matter may need to be upgraded to a Tier 1 which, as seen, involves an acute if not an emergency response. Nothing happened in terms of any investigation or other intervention.

7.31. There was a further notification on 22 October. This included a description of an encounter with Ms Rigney at her home on the afternoon of 21 October 2015. The youngest child Korey was seen to be playing at the front of the house while the mother was inside the house. The intake recorded that the mother only answered questions in a very vague way and that she presented in such a way that she may have been under the influence of some substance.[27] The mother was informed that M had stated that he was not coping with Amber's care and that the mother should collect Amber from him. It was reported that Ms Rigney had in fact driven to M's address and had collected Amber. An informant stated that the mother would not be happy to have Amber back home. The notifier expressed a concern that the mother may have been under the influence of some substance and therefore was not capable of caring for any child. It was recorded that Amber did not attend school that day.

7.32. It is apparent from the notification documentation that information had come from no less than three separate notifiers.

7.33. There would be no further notification until late November 2015. I will deal with that notification in a moment. Notwithstanding the fact that the intakes of 21 and 22 October 2015 were assigned a Tier 2 status that required a ten day response which was then upgraded to a five day response, no further action was undertaken by the Department. There is no evidence that any further consideration was given to an upgrading of these intakes to Tier 1. The evidence demonstrated that no investigation was made by the Department in relation to the subject matter of these notifications. I infer that for the level of detail to have been available to the notifier, the information about Amber not attending school must have come directly from a source close to the school. It is clear in my view that the non-attendance meant that Amber had been persistently absent from school without satisfactory explanation of that absence. Accordingly, by definition she was a child at risk for this reason alone. It was not simply a case of there being a reasonable suspicion that Amber was at risk, there was positive information that this

[27] Exhibit C10b, page 78

was in fact the case to the knowledge of the Department. It required an assessment or investigation or other action to be taken pursuant to section 19 of the Act. This should also have triggered consideration being given by the Chief Executive to an application being made to the Youth Court for whatever order was believed to have been appropriate. This is so under section 20(1) of the Act. There was further information to suggest that Amber's being at risk when the whole matter was looked at in the round was generated by her mother's abuse of an illicit drug. Accordingly, there was an obligation upon the Chief Executive to apply for an order for that reason as well. Once suspicion on reasonable grounds that Amber was at risk as a result of the abuse of an illicit drug by the parent was entertained, there was no discretion but to apply for an order. The other mandatory response that was triggered by Amber being at risk was the obligation on the part of the Chief Executive to cause an assessment of or investigation into the circumstances of the child or other action under section 19 to be carried out. No such action occurred in response to these notifications.

7.34. <u>The notifications of 25 November 2015</u>

There were two notifications made on 25 November 2015. Both of these notifications were emailed by way of eCARL. Both notifications were not assessed within the Department until 1 January 2016. Both notifications related specifically to Amber, although the first notification also refers to the other children, Korey and S.

7.35. The first casenote states that the eCARL notification was received at 10:43pm on 25 November 2015. It refers to the Departmental records from August and October 2015 regarding Amber being left in the care of M for periods of time. Under a heading 'CP HISTORY' it is stated:

> 'Please note this report has been processed in line with the Quick NOC procedures. There will be minimal background and NO CP HISTORY recorded in this intake. For a full understanding of the family and its CP history, please review C3MS.' [28]

7.36. The first notifier reported that Amber had told her teacher at school that her mother, referred to in the document as Adeline Wilson, had pushed M, in whose care Amber had at one stage been placed, and that he had fallen and cut the back of his head. This had resulted in loss of a significant amount of blood. This assertion by Amber was recorded as having been corroborated by M's daughter.

[28] Exhibit C10b, page 83

7.37. The first notification of this date stated that additionally there had been inconsistencies with attendance and reliability of care for the children between Amber's family and M's family. It was recorded that after discussion between M and the school's support worker, there had been questions raised regarding the mother and her heavy drug use. In this notification Amber was described as very needy in class and that she received extra support from her teachers in respect of her emotional irregularity.

7.38. This notification was met with a NOC. The decision and rationale for this were as follows:

> 'REO5 risk grounds considered, yet not met. In review of this notification, and recorded history on C3, there is insufficient information which suggests that the family violence is chronic and/or severe; additionally, with no SDM threshold identified. This matter has been assessed as a NOC.' [29]

7.39. The second notification apparently received by eCARL at 11pm on 25 November 2015, and which was also not assessed until 1 January 2016, involved a notification that over a period of one week (recorded as being a Wednesday to Wednesday) Amber had come to school without any food or drink on three non-consecutive days. The temperature on one of those days, being 18 November 2015, had been almost 40°. The notification stated that this circumstance had happened occasionally over the year with the mother once or twice bringing the child's lunch into school during the day. It was recorded as follows:

> 'Amber is often very really hungry and has recently been smelling unclean also. Arriving late for school in the morning, she misses breakfast club provided at school by Family Zone services.
>
> Ingle Farm Primary School continues to support Amber and provides food and water when she comes to school with neither of these.' [30]

7.40. This second notification was also met with a NOC. Elsewhere in these findings I have referred to the criteria for using the NOC procedure. It is difficult to see how those criteria were met in respect of these notifications, particularly if previous notifications within Departmental records had been properly taken into account. It will be noted that the rationale for the NOC in respect of the first notification of this date refers to '*recorded history*'. The recorded history could only have supported the information within this notification regarding heavy drug use on the part of the mother as well as

[29] Exhibit C10b, page 84
[30] Exhibit C10b, page 85

Amber's emotional irregularity. There is no recorded rationale for the NOC decision in respect of the second notification, nor is there any reference within that notification to previous child protection history. The two notifications appear to have been assessed by two different people.

7.41. These notifications in effect corroborated information imparted in earlier notifications regarding Amber's performance at school. There was also repeated reference to the question of the mother's drug use and propensity to assault male companions. It would not be wise after the event to suggest that Ms Rigney's propensity to assault male companions might also one day involve physical retaliation by a male companion.

7.42. It will be borne in mind that both of these notifications were assessed well over a month after they were received by way of eCARL, meaning of course that they were also assessed well after the events that they recorded. It is not known why these two individual reports were not assessed earlier, except to say that this was not an uncommon circumstance within the Department. It is not known whether this effluxion of time influenced the outcome having regard to the fact that by 1 January 2016 no further notifications about Amber's welfare had been received in the five weeks since 25 November 2015.

7.43. <u>The notification of 17 January 2016</u>

This notification was communicated by telephone and was assessed on 17 January 2016. The casenote does refer to recent intakes on 25 November, 21 October and 26 August 2015.[31]

7.44. The topic of this notification was that the mother of Amber and Korey was a daily user of ice, drove an unregistered car while under the influence of ice with the children and had no food in the home for the children as she was always asking family or friends for food or loans for food. When asked as to how the notifier knew this, the notifier reported that they had seen the mother's drug use '*first hand*' including the mother having asked for money on 16 January 2016 for drugs and asking for a loan for food. As to the impact of this on the children, the notifier stated that they were always presenting as hungry as the mother spent all her money on drugs. It was also asserted that the children had trouble sleeping and that the mother often left them with unknown

[31] Exhibit C10b, page 86

people. It was recorded that the '*notifier states the mother has and will prioritise her drug use over the children*'.

7.45. This notification was accorded a Tier 2 status with a five-day response required. The decision and rationale was recorded as follows:

> 'RN02 - Sig risk of NEG - Substance Use - the children could be at sig risk of NEG due to ongoing reports regarding the mother's drug use and the impact on the children. Previous reports from multiple notifiers identify that it has been suspect that the mother has been substance affected when picking up children from a school and the child Amber arriving often without food. Past C3 history in collaboration with today's information meets the SDM criteria.
>
> RPA - Tier 2 (5) - There is a pattern developing regarding concern over the mother's alleged drug use and lack of food for her children and Kory (sic) is under the age of 4 Y.' [32]

7.46. Notwithstanding that assessment, on the following day the matter was closed, utilising the CNA procedure. So no further action was taken. The reason for the closure was recorded as follows:

> 'On 18/01/2016 the Manager and Supervisors form (sic) the Northern Assessment and Support Office met as part of regular workload meetings. In the previous week 8 Tier 1s and 1 Tier 2 had been received and allocated for further investigation.
>
> As such, there is no capacity to respond to this matter currently and this is being forwarded to the Manager for consideration of a closed no action closure outcome.' [33]

I have referred elsewhere in these findings to the CNA closure procedure as described in the Child Protection Manual. As seen, the Manual allowed for intakes to be closed for resource related reasons and this was so regardless of statutory obligations on the Chief Executive and his delegates to act.

7.47. No investigation or other action was undertaken in relation to this notification. There is no evidence that any effort was made to ascertain whether an office other than the Elizabeth office of the Department had the capacity to act upon this notification. The notification clearly should have been investigated and police resources enlisted if necessary.

7.48. <u>The notifications of 10 February 2016</u>

These notifications were received during the afternoon of 10 February 2016 and were three hours apart. They both appear to have been made by the same notifier. The

[32] Exhibit C10b, page 87
[33] Exhibit C10b, page

notification stated that the children, Amber and Korey, as well as their mother Ms Rigney, were '*currently homeless*'. The notifier advised that on 9 February 2016 the mother was meant to '*self-fund at a motel with the children, which had been funded by Housing SA*'. However, the notifier reported that they had all slept in a tent instead. The notifier stated that he or she was continuing to try to advocate for the family to stay in another motel. The notifier had no other information regarding the family.

7.49. The second notification suggested that the notifier called to report identical information to what had been reported three hours previously. It is not known why this notification was repeated. It appears to have been dealt with by two different officers of the Department. Both notifications were the subject of a NOC. There is only one decision and rationale entry and this relates to the first notification and it is as follows:

> 'Assessed as NOC as the information does not give reasonable grounds to suspect abuse/neglect or that the child is at significant risk of serious harm. Information is vague and lacks details and does not reach SDM Screening Criteria at this stage.' [34]

This appears to be a formulaic representation of the Notifier Concern procedures set out in the Child Protection Manual. No reasons are expressed in the casenote as to why such an assessment was made in respect of this notification. Rather than escalating concern for the children having regard to previous notified concerns, the impression created by this rationale entry would suggest the complete opposite.

7.50. Neither of the 10 February 2016 casenotes refer to any previous notifications in respect of the members of this family. If regard had been had to previous notifications there were a number of compelling inferences that could have been drawn from the information imparted in this latest notification. The homelessness of the family despite funding by Housing SA for a motel was very much in keeping with earlier information that Ms Rigney had squandered money on drugs. As well, the homelessness of this family could quite easily have been regarded as a natural extension of the turmoil that had been described in previous notifications and with the dysfunction that this family was experiencing, ostensibly at the hands of the mother. The whole scenario regarding this family, as had been reported to date from differing sources, could not have been viewed as anything other than credible.

[34] Exhibit C10b, page 99

7.51. Investigations carried out by police following the murders would confirm, through a friend of Ms Rigney, that in February 2016 Ms Rigney had been sleeping in the car with Amber and Korey and a dog.[35] In addition, the police investigation would confirm through Anglicare records that Ms Rigney herself advised that she and the children had stayed in a tent on the night of 9-10 February and the night of 10-11 February 2016. The same records would confirm the fact that from late January 2016 Ms Rigney and the children had been in and out of motel accommodation and had no fixed address. These circumstances could have been established had the notifications not been the subject of NOCs but had been investigated.[36] Far from the notification not giving reasonable grounds to suspect abuse/neglect or that the child was at risk, or that the information was vague and lacked detail, the information could have been confirmed as correct at the time the information was imparted to the Department.

7.52. I do not believe that the family's then current circumstances as they reportedly existed in January and February 2016 were ever communicated to anyone who could have assisted, particularly in relation to homelessness, such as the children's paternal grandparents, at least at the time these matters were reported to the Department. However, as will be seen in another section the Department would supply a report to the Federal Circuit Court in connection with the proceedings regarding the custody of S in which the matters that had been notified to the Department concerning the mother, in particular her ice usage and the fact that she spent all her money on that habit to the detriment of the hungry children, were referred to. This report was supplied on about 11 April 2016.

7.53. It is evident from these notifications that at the time they were received and assessed the question of homelessness was not explored to any great extent. However, it could not be known without further investigation whether the homelessness of the family was a circumstance that could be ongoing. The allegation was that the homelessness had been in evidence the night before the notification was made and was therefore not merely historical. As has been pointed out already in these findings, the Act stipulated that a child was by law deemed to be at risk if the child was under 15 years of age and was of no fixed address. If one was to accept that this family was meant to live in a motel but in fact had slept in a tent, the overwhelming inference was that the children

[35] Exhibit C5s, statement of Nadine Lisa Saunderson
[36] Exhibit C5t

were of no fixed address, at least temporarily. This fact alone dictated that the investigations should have been instigated. There was in reality no proper basis on which a NOC could have been considered to be the appropriate Departmental response.

7.54. As will be seen in the following paragraphs the next and final notification of 10 May 2016 would be the subject of an investigation that was interrupted by the death of Ms Rigney and the two children. There can be no question, however, but that on 10 February 2016 when these two notifications were received there needed to be a full, thorough and immediately initiated assessment and investigation pursuant to section 19(1) of the Act. It could have made all the difference as far as the fate of the two children were concerned. Apart from interrupting the chain of events that led to their deaths, there is little doubt that an investigation would have led to the detection of a set of circumstances surrounding this family that could have led to no response other than intervention on the part of the Department. The investigation should have covered the allegations of drug taking with possible police intervention, how the mother was funding that habit, how the mother was providing sustenance for the children, what arrangements were in place for the continuing education of the children and what her accommodation arrangements were at that point in time. Such an investigation could only have revealed the bleakest of pictures. It is difficult to see how the children could have been left in the custody of the mother on the basis of what a proper investigation would have revealed.

7.55. <u>The notification of 10 May 2016</u>

In a subsequent section of these findings I will discuss some background matters that preceded this notification.

7.56. This notification was received during the afternoon of 10 May 2016. On this occasion the casenote refers in some detail to the previous history involving the children Amber and Korey and the older child S. It also discusses the Federal Circuit Court proceedings which had been adjourned to 16 May 2016. In the 'Background' section of this casenote there is reference to reports of the mother's drug use and the physical violence towards other people that were witnessed by the children.[37] It also refers to the fact that there had been no intake investigated by the Department in relation to concerns for Amber and Korey to that point in time.

[37] Exhibit C10b, page 182

7.57. As far as the contents of this latest report were concerned, it was noted in the intake casenote that the notifier reported information that had been reported to him or her by another informant to the effect that the mother was using drugs daily and that the mother deals in drugs herself. The notifier stated that the mother used to smoke marijuana but has since been advised that the mother is now using ice on a daily basis. It was said that the mother was '*in a bad way*' and was '*on the stuff again*' referring to the mother's use of ice. It recorded that the notifier was advised of the current address of the family as the notifier's informant had recently visited the home and expressed concerns for the children because the mother was heavily using ice and was reported as acting erratically. The notifier's informant stated that the mother had been using ice for some time and that Amber had been exposed to this and had been witness to the mother using that drug. The notifier also advised that the mother had lost a substantial amount of weight over the past 12 months and that this was attributed to the mother's drug use. The notifier also indicated that he or she believed that the mother would flee interstate in order to avoid her children being removed from her care.

7.58. This intake was assigned a Tier 2 status with a five-day response. In the event, this would in fact be responded to by the Department in circumstances that I will later discuss. This notification was received approximately three weeks before the children's deaths. The rationale for the classification of this notification was based on the mother's substance abuse issue and the fact that the child protection history for the children had identified that the mother had a propensity for physical violence. So the assessment within the Department was as follows:

> '… it is reasonable to assume that in consideration of the mother's behaviours, current concerns, recorded history and the known effects of Ice, that the mother's drug use which is reportedly daily would be impacting on her parenting capacity which is evidenced by her non-attendance at court and reports that drugs are prioritised over the purchasing of food and accommodation and relationships with others placing the children at significant risk of serious harm.' [38]

7.59. By way of a separate internal Departmental email of 10 May 2016, it was stated that the information had emanated from a source that had a very good relationship with the mother '*and so information quite reliable*'.

7.60. It is difficult to determine why these clearly articulated assessments could not have been made earlier than May of 2016 and acted upon by the Department. In any event this

[38] Exhibit C10b, page

assessment, amounting as it did to information or evidence leading to a reasonable suspicion that the children were at risk, required consideration to be given pursuant to section 20(1) of the Act to the question as to whether it was appropriate for the Chief Executive to apply to the Youth Court for an order. In addition, this assessment, reflecting as it did the opinion that Amber and Korey were at risk as a result of the abuse of a drug by their mother, also brought the children's circumstances squarely within the amended section 20(2) of the Act. There was in my view a mandatory obligation for the Chief Executive to apply for an order from the Youth Court directing Ms Rigney to undergo a drug assessment. I reject the argument that any further investigation of the allegations contained within the latest notification was required before section 20(2) was enlivened. To have suggested that these repeated allegations of drug abuse affecting Ms Rigney's parenting behaviour to the detriment of the children required further investigation before any appropriate action could be taken by the Department would have amounted to being wilfully blind to the obvious.

7.61. It is also implicit from the content of the notification and from the assessment made in relation to it that the cause of the children being at risk was not being adequately addressed. This meant that section 37(1a) of the Act was also enlivened meaning that the Minister was obliged to give consideration to the matters set out in section 37(1a)(b) of the Act. There is no evidence that any such consideration was given.

8. Events following the receipt of the notification of 10 May 2016

8.1. It is firstly necessary to say something about the background to the receipt of the notification of 10 May 2016. Before the notification was made, the Department's Kanggarendi team, which was an early intervention Indigenous team within Families SA, were directed to enquire as to the whereabouts of Ms Rigney, Amber and Korey. At that time the Kanggarendi team had as its focus family support as distinct from assessment of risk. As I understood the evidence, it was not an investigatory body relating to child protection and would not have been properly equipped to make a robust assessment of the family's situation given that the focus of its operation was family support. However, it was ascertained that Amber was now enrolled at the Evanston Gardens Primary School. When contact was made with that school, Ms Rigney's current address was ascertained. On the same day, Kanggarendi team members attended the Evanston Gardens Primary School and there sighted Amber. From there they proceeded to Ms Rigney's address. At first she was not at home. However, she

returned to the premises while Kanggarendi staff were still present. Korey was with her as was Peet. Korey was observed to be clean, tidy and happy in appearance. On this occasion Ms Rigney engaged positively with the Kanggarendi workers. It appears that until this particular day, the Department had no knowledge of the family's whereabouts. It had been established that the family had moved out of the previous address on 25 January 2016 with no forwarding address provided. On the evening of 9 May 2016, as documented in an internal email within the Department[39], the author of the email was provided with information that Ms Rigney and her children had been living in the Elizabeth South/North area. The person who had imparted this information had also disclosed information concerning the mother's use of ice and had expressed concerns for the children, particularly surrounding Amber who was witness to her mother's use of ice. As alluded to earlier, the author of the email stated that the informant had a very good relationship with Ms Rigney and so the information was considered to be '*quite reliable*'.

8.2. On the same day that this email was sent, the CARL notification was made and was assessed as discussed in the previous section of these findings. This notification was then referred for investigation to the Gawler office of the Department.

8.3. On or about 13 May 2016 the Federal Circuit Court, which was dealing with the matter of the custody of S, was advised that the family had been located. Ms Rigney's address was also supplied. The information provided to the Federal Circuit Court was communicated by way of a letter written by Ms Trisha Handebeaux, the Family Court's liaison officer within Families SA. The letter was dated 13 May 2016. The letter refers to the Court's request to establish the whereabouts of the mother and to the fact that Kanggarendi had been able to locate her at her home on 10 May 2016. The letter described the interaction between Departmental workers and Ms Rigney when they had attended at the family's address. The letter also indicated that on 10 May 2016 a notifier had reported concerns to CARL in the terms that I have described in the previous section. The letter also advised, as was the case, that the Tier 2 intake had been referred to the Department's Gawler office for consideration. Furthermore, the letter advised the Court that the Gawler office would investigate and assess the reported concerns regarding the mother's alleged drug use. As part of the investigation Families SA would speak with the mother, the children and the children's school and would also

[39] Exhibit C10b, page 126

assess the living conditions of the family home in order to determine whether the children's basic needs were being met and to assess the mother's presentation. The findings of that investigation would be provided to the Court upon completion. The letter then requested the Court to adjourn the proceedings for a period of four weeks to enable that to occur.

8.4. On 16 May 2016 the matter returned to the Federal Circuit Court which made a number of interim orders that included the following:

a) Amber and Korey attend school each day.

b) Amber and Korey spend time with paternal grandparents each week from the conclusion of school on Tuesday until the commencement of school on Wednesday.

c) That Ms Rigney ensure that the children were present at school each Tuesday to be collected by the paternal grandparents. Ms Rigney was restrained from attending the school on such afternoons.

d) That Korey be enrolled at the Evanston Gardens Primary School.

e) That Ms Rigney file a notice of address for service within seven days.

f) Ms Rigney was restrained from using or consuming any illegal substances when the children were in her care.

The matter was further adjourned to 29 August 2016. The deaths of Ms Rigney and the two children occurred in the intervening period.

8.5. This letter of 13 May 2016 written for and on behalf of the Department was the first indication that the Department was prepared to intervene in the matter of Amber and Korey in the Federal Circuit Court. The Gawler office of the Department had the capacity to investigate the 10 May 2016 notification. Prior to that, the closure of Tier 2 notifications under the CNA process was said to have been due to a lack of capacity within the Elizabeth office of the Department. This of course begs the question as to why the earlier notifications had not been assigned to the Gawler office who did have the capacity to investigate. I will come back to that issue in another section of this document.

8.6. It will be noted that it was the intent of the Department to investigate the allegations of ice usage on the part of Ms Rigney and its effect on the children. These matters had

been already well documented, albeit from sources that were for the most part unidentified. Nevertheless, the observations made about Ms Rigney's ice usage and the effect it had on her ability to care for the children had been consistent. Indeed, by 10 May 2016 the information had been regarded and documented within the Department as '*quite reliable*'. To my mind this assessment triggered the obligation pursuant to section 20(2) of the Act to seek an order that Ms Rigney undergo a drug assessment. However, it appeared that at least the matter was finally going to be investigated.

8.7. Between 16 May 2016 and 30 May 2016 a number of visits or attempted visits were made by Departmental officers to Ms Rigney's home and to the children's school. On 18 May 2016 a visit was made to Ms Rigney's premises. She was not home. Attempts were made to contact her by phone but were unsuccessful due to the phone being reportedly disconnected. On the same day, Amber and Korey were visited at school and were interviewed in the presence of an Aboriginal education worker. It was clear during the interviews with the children that they both had a speech delay and were difficult to understand. Enquiries made at the school yielded a current phone number for Ms Rigney. Departmental officers were able to contact Ms Rigney and a home visit was arranged for the following day. However, the scheduled home visit did not proceed on 19 May 2016 because Ms Rigney rang to cancel the visit.

8.8. On 20 May 2016 Departmental officers attended Ms Rigney's address. However, they were unable to gain entry due to the presence of an aggressive dog. Ms Rigney was phoned from the driveway of the property. She told the officers that she was not at home. The officers informed her that there were a number of concerns that they wanted to investigate with her, including the need to examine her home to ensure that there were sufficient resources for the children. Arrangements were made for a home visit on 23 May 2016.

8.9. On 23 May 2016 the Department received a phone call from Peet who advised that he was calling on behalf of Ms Rigney. Peet asserted that she would not be home for the meeting that morning as the children were sick and required appointments with the doctor. It was confirmed through enquiries that the children were absent from school that day and that Peet had contacted the school to advise of the children's illness.

8.10. Thus it was that Ms Rigney was put on notice that the Department wanted to investigate her and her environment and to ensure that there were sufficient resources for the children. On 25 May 2016 the Department conducted an unannounced home visit. The dog was not present and there were no sounds from within the house. A note was left requesting Ms Rigney to contact the agency as soon as possible. No contact was made by her in response.

8.11. On 26 May 2016 Department officers undertook a second unannounced home visit. Initially it appeared that Ms Rigney was not at home. However, when the officers returned to their vehicle, Ms Rigney and Peet emerged from the house. The officers sounded the car horn to gain her attention. Ms Rigney approached the staff members and advised that Korey was home sick. Ms Rigney was informed of the child protection concerns, including the allegations about frequent substance misuse. Ms Rigney denied that she or Peet used ice daily, but acknowledged smoking cannabis for medicinal reasons. There was further discussion about her non-compliance with Federal Circuit Court orders. Ms Rigney invited the officers into the house. Korey was scantily dressed despite being allegedly ill and despite the fact that the temperature forecast was for a maximum of 18°C that day. Korey was crying when his mother and staff entered the house. The home was observed to be clean and tidy with basic belongings. The pantry had enough food for a few meals. Both bedrooms had toys on the floor but no beds or bedding. When asked about this, Ms Rigney said that the children slept on a mattress which she indicated was standing up in the hallway adjacent to the lounge room. She said that she had ordered beds that were due to be delivered the following Wednesday. A referral was made to the financial counselling team within Families SA to assist Ms Rigney in doing further planning in relation to resources to care for the children. Attempts to contact Ms Rigney to advise her of this referral were unsuccessful. It was deemed by staff that it was not possible to substantiate the concerns about drug use. That said, there could not have been anything to suggest that suspicions as to drug use could be regarded as allayed.

8.12. On 30 May 2016 Ms Rigney and the two children were murdered in the circumstances that I have already described. Also as indicated earlier in these findings, toxicology revealed that Ms Rigney had consumed methamphetamine (ice) prior to her death.

8.13. In the event, the allegations of the abuse of ice and its effect on Ms Rigney's ability to care for the children were in reality not investigated. This in part was due to the inability

of Departmental staff to pin down Ms Rigney to appointments. The unannounced visit of 26 May 2016 could hardly have refuted the suggestion that Ms Rigney was using ice. The observation can be made that consumption of ice and/or the possession of it, and certainly the trafficking of it, are criminal offences. All of these offences had at different times been notified to the Department by way of CARL or eCARL and an assessment had been made that the information was reliable. As well, the suspicion or opinion, whatever statutory formula was to be used, appears to have been entertained that the allegations were true. Accordingly, there does not appear to have been any reason why police could not have been notified of these allegations. Police intervention would at least have been able to conduct a search of Ms Rigney's premises. They would have had the power to do so by virtue of section 19(3) of the Act. This Court has commented in the past about the undue tolerance that the Department has historically exhibited towards drug use within dysfunctional families.[40] Although the comments were in respect of cannabis, the same if not more can be said in relation to harder drugs such as amphetamines.

9. Relevant features of the Federal Circuit Court proceedings

9.1. In dealing principally with the question of the custody of S, the Federal Circuit Court had also developed and shown a keen interest in the circumstances surrounding the welfare of Amber and Korey.

9.2. At one point Ms Rigney was ordered to submit to a urine test for the presence of illegal drugs and/or substances. Ms Rigney was drug tested on 27 November 2014. The test detected codeine and THC which is the active component of cannabis. On 19 November 2014 the Minister for Education and Child Development had been requested to attend (by representative) on the adjourned hearing date and to provide a written report regarding the investigations to date and any planned investigations for the future care of the three children, including Amber and Korey. A report dated 25 November 2014 was provided by Ms Hale to whom I have referred. Ms Hale signed the report in her capacity as the Acting Supervisor of Team E at the Northern Assessment and Support office of Families SA. The report, as it related to Amber and Korey, recorded that one notification had been made regarding their possible exposure to a domestic violence incident that had occurred between Ms Rigney and the children's

[40] **Napier** finding, paragraph 13.23

biological father in January 2014. It also recorded that although the child S on a number of occasions had been sighted with bruises and had explained his injuries as being the result of discipline from his mother, it was reported that the younger children had not been sighted with injuries of that nature. It also recorded that the mother had left the children in the care of the paternal grandparents and/or the father for long periods of time and without warning. In her letter Ms Hale informed the Court that Families SA respectfully declined to formally intervene in the proceedings at that time, but that they would continue to attend court hearings and provide information to the court as an amicus curiae.

9.3. A further report dated 17 December 2014 was provided by Ms Hale to the Federal Circuit Court. This was supplied in response to another order from the Court requesting information from the Minister. This report related for the most part to the child S and included reference to an attendance at the grandparents' home and a conversation with S in which S was adamant that he did not want to see his mother and was scared to return to her. S said that what his mother had done to him was '*scary*' and that '*mum drowned me*'. The report did not describe the circumstances of the other children.

9.4. On 18 December 2014 an independent children's lawyer was appointed pursuant to section 68L of the Family Law Act 1975 to represent the interests of the children S, Amber and Korey. To facilitate the appointment it was ordered that the parties' respective solicitors forward all relevant documentation to the Legal Services Commission of South Australia with a further order that the independent children's lawyer use his or her best endeavours to be in a position to make submissions to the Court on the adjourned hearing date which was 5 March 2015. An independent children's lawyer was duly appointed.

9.5. A further report written by a Department social worker and co-signed by Ms Hale dated 23 February 2015 and provided to the Federal Circuit Court also dealt primarily with S's circumstances and not those of Amber and Korey.

9.6. On 5 March 2015 the Court made a number of relevant orders regarding Amber and Korey. On that day the paternal grandfather and paternal step grandmother, Mr Egberts and Ms Wells, were joined as parties to the proceedings pending any formal application that they may file in respect of parenting orders relating to any of the children. At the same time an order was made that copies of any notifications regarding abuse

allegations relating to all of the children, including Amber and Korey, be provided by both the Department and SAPOL. The orders encompassed not only the provision of information regarding notifications or reports, but also required the provision of details of investigations and of the outcome or findings of any such investigations.

9.7. As part of the Federal Circuit Court proceedings the affidavit of the biological father of S, Amber and Korey was prepared and filed. This occurred in December of 2014. The salient feature of the affidavit was the expression of concern on the part of the father that Ms Rigney may be hostile and abusive towards S because he reminded the mother of the father. As far as the care of Amber and Korey were concerned the father's affidavit indicated that Ms Rigney had provided appropriate care for Amber and Korey and had not expressed anger towards them in the past, attributing that possibly to the fact that their physical appearance was not as similar to him as was that of S. The affidavit stated that the father was not currently seeking that Amber and Korey live with him, but asserted '*I do continue to hold concerns for the mother's care of the children*'.[41] The father said that he would amend his application and seek that Amber and Korey would live in his care:

> '…should Families SA determine that the children are not safe and seek to remove the children from the Mother's care, or should it be recommended by a Family Consultant during the course of the proceedings.' [42]

This affidavit was filed early in the course of the Federal Circuit Court proceedings, namely in December 2014. Thereafter, of course, there were the ultimately very concerning reports received during the course of 2015 and early 2016 about the mother's care of Amber and Korey.

9.8. On 4 February 2016 the matter came on before the Federal Circuit Court. There was no appearance by Ms Rigney. It was recorded that the Court and the independent children's lawyer were concerned about the welfare of the children; that recent reports had been made to SA Police or Families SA in relation to the mother's parenting of the child and about Amber's safety and her care. Earlier correspondence had indicated that the Department were disinclined to formally intervene in the proceedings. However, at the 4 February 2016 hearing the Department was requested pursuant to section 91B of the Family Law Act to intervene in the proceedings. The Court's order

[41] Exhibit C11, page 197, paragraph 55
[42] Exhibit C11, page 197, paragraph 56

went on to record that if the Department again declined to intervene, the Court would request that they provide a report to the independent children's lawyer in relation to any involvement with the children S, Amber and Korey over the previous 12 months. The proceedings were adjourned to 13 April 2016.

9.9. I have already referred elsewhere in these findings to Ms Handebeaux and her letter of May 2016. In response to the order of 4 February 2016 Ms Handebeaux wrote a different and earlier report to the Federal Circuit Court of Australia. This was the report that the Court had requested in the event that the Department declined to intervene. The request was for the report to be provided to the independent children's lawyer, but the letter is addressed to the Federal Circuit Court and was provided to the Court itself. This 11 April 2016 report[43] advised that there had been five notifications received since February 2015, two of which had been assessed as Tier 2 intakes. They were the intakes dated 21 October 2015 and 17 January 2016. The letter reported concerns related primarily to the mother's care of the children and allegations of neglect and drug use. As well it referred to Ms Rigney having left Amber in the care of a man she had only known for a few months. Ms Handebeaux's letter which was written in liaison with and/or approved for release by Ms Hale, advised that the October Tier 2 intake had been the subject of a closed no action, or CNA, '*as there was no capacity across the northern intake team to allocate the case*'. The letter described in detail the January 2016 Tier 2 intake which had involved allegations of the mother's daily use of ice and that she was spending all her money on that habit with the result that there was rarely any food in the home, that the children were always hungry and that the mother had and will prioritise her drug use over the children. The letter identified concerns that the mother was frequently substance affected whilst caring for the children. The letter stated that '*unfortunately*' this intake had also been the subject of a CNA '*due to full caseloads of social work staff*'. The letter also advised that in the week in which the January intake notification had been received, eight Tier 1 intakes had also been received and that there was no staffing capacity to allow allocation for investigation. The letter concluded as follows:

> 'At this point in time Families SA unfortunately have been unable to make any further assessment of this family and therefore can only reiterate what was previously communicated to the Court in the correspondence dated 23 February 2015. Families SA respectfully declines to intervene in these proceedings.'

[43] Exhibit C16, annexure AMJH4 to the affidavit of Ms Hale

9.10. Ms Handebeaux's letter is an extraordinary document. Its content amounts to an admission of dereliction of duty on the part of the Department. This is no criticism of Ms Handebeaux or Ms Hale. The report had been requested by the Federal Circuit Court, that was the sorry state of affairs in the Department at the time and that was the report that had to be written. If there is any merit in this letter it is that it at least had a measure of candour. It is perplexing how such a letter could ever be written by a government department, especially by one that twice in the space of a year had been excoriated by findings of this Court in both the **Valentine** and **Napier** matters in respect of similar neglectful conduct. Just as extraordinary is the fact that the letter was provided to another court that had expressed a pointed interest in the welfare and safety of the children who were the subject of the letter and in respect of whom, according to the letter, the Department had done, and was seemingly still prepared to do, nothing.

9.11. Regarding the Court hearing on 13 April 2016 the only attendance recorded was that of the paternal grandparents appearing in person and of a solicitor appearing for the independent children's lawyer. Ms Rigney did not attend. On that date the Court made an order that the independent children's lawyer make inquiries to ascertain the address of the mother and of the school enrolments of the children and that the lawyer should liaise with the Department to locate the children's whereabouts. The Court again made orders concerning the Department providing the Court with notifications regarding abuse and the outcome of any findings or investigations relating to the same.

9.12. On 4 May 2016 the matter came on again before the Federal Circuit Court. On that occasion Ms Rigney again did not attend. The Court ordered that Ms Rigney attend in person at the next Court hearing scheduled for 16 May 2016 and indicated that a warrant for her arrest may issue if she failed to attend. A solicitor for the Crown attended at the 4 May 2016 hearing. That practitioner was ordered to liaise with the Department and to advise the Department of the orders made that day.

9.13. I have referred elsewhere to Ms Handebeaux's other letter to the Court of 13 May 2016 in which the Department advised the Court that the Gawler office would investigate the latest notification which was that of 10 May 2016. I have also previously referred to the court appointment of 16 May 2016 and to the orders that the Court made that day. Ms Rigney did attend on that occasion and is recorded as having sought the opportunity to obtain legal advice. It will be recalled that one of the Court's orders was that Ms Rigney refrain from using illegal substances while the children were in her care.

It appears from Ms Rigney's post mortem toxicology that this order would be more honoured in the breach than the observance. This would be the last court appointment prior to the murders. As referred to elsewhere in these findings, the Department did initiate an investigation in response to the notification that had been received on 10 May 2016.

10. The evidence of Ms Avril Hale

10.1. I have referred to Ms Hale elsewhere in these findings.

10.2. Ms Hale was an acting supervisor at the Elizabeth office. For the most part Ms Hale was involved in the matter of the child S. In her evidence Ms Hale was at pains to describe the unmanageable volume of work that was the lot of the Elizabeth office staff from 2014 to 2016. She said that the volume of intakes that were coming into the office on a daily basis was rather extraordinary and that all of the social workers were at capacity. It was said that this set of circumstances that accounted for the lack of action on the part of the Elizabeth office.

10.3. Ms Hale testified that in relation to the matter of the child S the Department did not have a direct investigational role. SAPOL and the Child Protection Service (CPS) did have such a role and would continue to advise the Department's supervisor in relation to the progress of their investigations. In the event, the notification relating to the assault on S was closed by the Department with no action. The Department would await any reports from the CPS or SAPOL. Ms Hale said that in any event she considered that Amber and Korey were not at risk to a point where she believed she had any statutory authority to intervene in relation to them. The impression had been that S had been '*scapegoated*' by Ms Rigney and that the other children were safe.

10.4. It was revealed during the course of Ms Hale's evidence that in its report the CPS had recommended that Families SA consider a parenting capacity assessment of Ms Rigney. Such an assessment in fact did not occur despite the recommendation. Ms Hale explained that her decision not to make a referral for a parenting capacity assessment was based on her knowledge and understanding that an assessment would not have reached the threshold for allocation because in the normal course of events there was only a six week period in which it could be undertaken. Ms Hale also believed that she did not think that the mother would in any case engage with a

psychologist from Families SA as '*she was very clear with my staff that Families SA we were not welcome in her world*'.[44]

10.5. Ms Hale said that she did recommend a Principal Aboriginal Consult consultation. In the event Ms Rigney was referred to the Aboriginal Family Support Services (AFSS). This referral was designed primarily to obtain support for Ms Rigney and was a process in which she was perceived as being more likely to engage. Ms Rigney initially indicated some willingness to engage with that service and in fact signed a referral, but ultimately did not engage. Ms Hale indicated that the Department closed its file. Ms Hale stated that in any case the service would not have been looking into the safety of Amber and Korey. Rather, the Department would have been looking at supporting the mother to build the skills to enable her to continue caring for the children. The failure of Ms Rigney to engage with the service did not trigger Families SA's case being reopened. Regarding the failure of Ms Rigney to engage with AFSS, Ms Atkins, counsel on behalf of Mr Egbert and Ms Wells, asked Ms Hale:

> 'Q. So that puts you on notice, doesn't it, that there's been no work done on her parenting skills.
>
> A. That is correct.
>
> Q. So any concerns that existed in regard to the safety of the younger children, at the time that the elder sibling was removed, must remain.
>
> A. Yes. We weren't - yes, you're correct, however the concerns with relation to the other children were not as pertinent at that time and we're compelled to work only with the case that is open for the child that is open, and this information asks specifically for those children in that system. So in terms of our policy, procedure and guidelines, we focus on that. If there were concerns that met the threshold for us to intervene with the other children, we would have notified those to CARL and that would have raised another notification for us to be able to - well, to consider opening - for CARL to consider opening. So in terms of this, my focus was on the safety and wellbeing of the eldest child and did not take into consideration, aside from my assessment that there were protective factors around them in that the grandparents were seeing them every fortnight. The grandparents had said to me that they weren't as concerned about those children as they were about the eldest child at that stage. This was in 2014, so at that stage I think the wheels were just starting to fall off. There wasn't enough that met the threshold to intervene with regard to the younger children, and I'm making an assumption there. ' [45]

On questioning by me, Ms Hale agreed that Ms Rigney's refusal to acknowledge any child protection concerns that had been raised in respect of the eldest child, and her

[44] Transcript, page 102
[45] Transcript, pages 158-159

feeling of justification of her behaviour towards that child, could have given rise to a risk that she might adopt the same mindset in relation to the other children.

10.6. In the course of her evidence Ms Hale made a number of important acknowledgments and concessions.

10.7. Ms Hale conceded that there was no investigation undertaken in relation to the safety of the two children and that this had been due to a lack of resources.[46] Had her office had the capacity, and had a team member been available to do the necessary investigation and who '*was not breaking already*', she would have undertaken a full investigation. This is especially so given that one of the notifications had involved a Tier 2 five day response which met the threshold for, to use Ms Hales' words, '*absolute intervention by the Department*'.[47] But Ms Hale said that she did not have the capacity to be able to facilitate that. She said:

> 'I had no staff and there were no staff available across the entire Elizabeth office for me to be able to do that. ' [48]

Asked as to what could or should have been done had resources been available, Ms Hale listed a number of resources that in the normal course of events would have been brought to bear in respect of a full investigation. This would have included a team of two social workers conducting a full investigation involving interviews with the mother and the children, the calling for reports from other sources and consultations with the principal social worker with a view to making a decision as to whether or not the Department would intervene by removing the children or seeking investigation and assessment orders from the Court. As well, there would be the question of undertaking the necessary drug tests. Importantly in my view, Ms Hale said that parallel to all of those undertakings, the Department would have been consulting with the wider family and enquiring whether or not they had the capacity and the willingness to look after the children or take them into their care. Asked as to the possible role of the grandparents, Ms Hale conceded that she did not recall saying to the grandparents anything about lack of resources to do the job that they were meant to be doing. She agreed that resource implications should not be kept secret from people who might be affected by those resource implications. For instance, she agreed that if potentially affected members of

[46] Transcript, page 121
[47] Transcript, page 122
[48] Transcript, page 122

the public were properly informed of resource limitations, they could go to their Member of Parliament or relevant Minister to draw attention to the difficulty.

10.8. Ms Hale also acknowledged that serial notifications from the same source might add to the weight that should be accorded to the information imparted. She agreed that this was so especially if the information being serially imparted was emanating from an organisation like a school or a counsellor, or from someone acting in a professional capacity. This of course would naturally apply to a series of notifications that had a particular child's school as their source.

10.9. Ms Hale conceded that poor school attendance without explanation was a factor that is considered to place a child at risk. Naturally, that concession needed to be made because it has a statutory basis. Ms Hale went on to say that such a circumstance would generally trigger a notification response similar to that pertaining to a Tier 1 notification which involves an absolute obligation to investigate.[49] In my view this can be readily understood for a number of reasons. If a child was consistently absent from school, it might raise a question as to the child's current state of wellbeing or safety. As well, truancy is obviously a matter that requires immediate rectification.

10.10. In cross-examination by Ms Atkins, Ms Hale made a worrying concession in relation to the notifications that the mother was a drug addict. The lack of investigation into that issue meant that one would never know the gravity of the underlying circumstances. But Ms Hale said that they did not have the '*legs to go out there and to do it, to have a look*'.[50] Ms Hale was asked what could or should have occurred if they had possessed the capacity to investigate and had then established Tier 1 levels of concern. Ms Hale conceded that such an investigation could have resulted in the immediate removal of the children. Ms Hale suggested that if there had been evidence of use of amphetamines or ice as might have been revealed in an unannounced visit to the home, then advice would have been given to the police about that as well.[51] In my view it almost goes without saying that, if upon investigation the allegations concerning drug use were proven to have been correct, then removal of the children from Ms Rigney would have been a seriously considered option to pursue. In this regard Ms Hale acknowledged that the allegations concerning Ms Rigney's use of ice and her

[49] Transcript, page 176
[50] Transcript, page 189
[51] Transcript, pages 189-190

having to purchase it with whatever source of funding she had, and having regard to the suggestion that Ms Rigney was demanding money for drugs and not sleeping at night, all amounted to compelling information[52]. She acknowledged that without any further investigation one would not hesitate to take that information at face value. Ms Hale said:

> 'Absolutely. That's why it was graded as a tier 2 five day, which requires investigation.' [53]

She agreed that however the allegations might be graded, they had required immediate investigation. She said '*within five days of receipt, absolutely, yes*.' This acknowledgment is correct.

10.11. Ms Hale acknowledged that the use of the NOC in circumstances where the previous history and earlier notifications were not examined was a systems issue that needed addressing and was a very significant systems failure.[54] Clearly this acknowledgment is also correct.

10.12. Ms Hale was questioned by me as to whether it had been appropriate, if not essential, for the grandparents to have been told all of the information in possession of Families SA, particularly in relation to Ms Rigney's drug taking and consequent neglect, and whether they should have been told that the Department did not have the capacity to investigate and should be investigating it. To this Ms Hale said with conspicuous understatement that such information would have been '*helpful*' for them to make a decision as to whether or not they should intervene.

10.13. In cross-examination by Mr Kalali of counsel assisting, Ms Hale agreed that at the time the allegations involving S were being considered there had been a lost opportunity for early intervention in assessing the mother's capacity to care for Amber and Korey.[55] I agree with that acknowledgment.

10.14. Ms Hale was naturally questioned about the 11 April 2016 letter to the Federal Circuit Court in which the Department had outlined the concerns that had been expressed in relation to Amber and Korey and in which the Department had indicated that it declined

[52] Transcript, page 191
[53] Transcript, page 191
[54] Transcript, page 197
[55] Transcript, page 216

to intervene in that court's proceedings. It will be remembered that Ms Hale had a role to play in the preparation of the letter. Ms Hale said this:

> 'So from recollection, Tricia Handebeaux, who is - when there was a liaison between the Family Court and the department, Tricia contacted me because I was the last person to have written a report to the court from the department on this particular matter and she contacted me to say 'We need another report'. At that point, I said 'I can't. I do not have the capacity to be able to write that report. I can, you know, let you know what's going on, but I've got, you know -'. By that stage, I was - the Elizabeth office had stopped one of the - so there were four teams then at the Elizabeth office. One had been transferred, changed into a protective intervention team because we were holding far too many of those cases and were not giving justice to parents to be able to work for family preservation and reunification. So we dedicated one of the teams to work doing that work and the other team because we didn't have the staff wasn't there anymore so there were only three teams. I was then the supervisor of the protective intervention team and I had no capacity across the office at all to provide a report so I just had a conversation with Tricia Handebeaux on the telephone around the situation and she took that information and wrote her report.' [56]

Ms Hale said that she would have read this report before it was sent.[57]

10.15. Asked as to why the various comments of the Federal Circuit Court Judge about the concerns held for the two children were not brought to the attention of the Department's executive body, and whether they had understood the seriousness of the investigation and the need for the resources to conduct one, Ms Hale said:

> 'I don't think I can answer. I was just conducting it as much as best as I could and at that stage I hadn't considered raising it. I was in liaison with Crown who was representing us in the Family Court providing advice around what we needed to do. I didn't raise that as a concern. It just was part of the whole situation at the Elizabeth office that was continually being raised up. It was something that was using up resources. I'm sorry I can't give an answer. I don't know. ' [58]

10.16. I shall deal separately in another section with the evidence of Ms Hale, Ms Scanlon and Ms Macdonald concerning the section 20(2) issue relating to the requirement for a mandatory drug assessment.

11. <u>The evidence of Ms Anne-Marie Scanlon</u>

11.1. In May 2016 Ms Scanlon was the Assistant Director of Metropolitan Care and Protection Services at Families SA. In early May 2016 she was copied into email correspondence regarding a request from the Federal Circuit Court for the Minister for

[56] Transcript, page 108
[57] Transcript, page 109
[58] Transcript, page 236

Education and Child Development to intervene in the proceedings involving the children of Ms Rigney. Prior to that Ms Scanlon had not had any direct involvement with that matter.

11.2. In her oral evidence Ms Scanlon spoke of the information imparted on 10 May 2016 and the notification that was raised in relation to that information. Ms Scanlon told the Court that she was instrumental in having the most recent address of Ms Rigney confirmed. This was achieved through the involvement of the Kanggarendi team which I have spoken of earlier in these findings.

11.3. Ms Scanlon also told the Court that when she became aware of the notification, she had no reason to doubt the reliability of the information contained in it, describing as it did alleged drug use on the part of the mother and the potential exposure of the children to it. Ms Scanlon contacted the manager of the Gawler office because at that point it was known that the family were in the Gawler area. She contacted Gawler to ensure that the staff in that office knew that the intake was coming their way and that it would need to be investigated.

11.4. It is apparent from Ms Scanlon's evidence that what may have provided the impetus for action finally being taken was the content of an internal email chain of early May 2016 that was instigated by an email dated 5 May 2016 from the solicitor of the Crown Solicitor's Office who had attended the most recent hearing of the Federal Circuit Court to a number of Department officers including Ms Scanlon. The email referred to the request made by the Federal Circuit Court that the Minister intervene in the matter and to the fact that this request would need to be formally responded to. The email noted that the Minister had declined to intervene on the basis of resource constraints. As seen earlier this had in fact be signified to the Court. The email stated categorically that the children were not attending school and were therefore at risk. This in fact was accurate advice both factual and legal. The email went on to say that the Court was very concerned about the issue of capacity at the Elizabeth office as per Ms Handebeaux's letter of 11 April 2016 and again reiterated that the children were at risk but that resources prevented intervention. That is why the Crown Solicitor had been ordered to attend court. The email urged the recipients of it that the matter needed to be raised at Executive Level of the Department. The email, in a somewhat challenging tone, and a tone that was entirely appropriate, requested the Department to provide instructions for

her to advise the Court that if the Department persisted in declining the Court's request for intervention, that this was so despite the known risks to these children.

11.5. Within a few days of the email chain the Kanggarendi team was engaged to contact the family. It was as a result of this that the notification of 10 May 2016 was created. The Gawler office was then notified. This of course all begged the question as to why the Gawler office had capacity to investigate when the Elizabeth office allegedly did not. During the course of Ms Scanlon's evidence the following exchange took place regarding the state of affairs as at early May 2016 when the Crown Solicitor's email was received:

> 'Q. Were you aware that the Elizabeth office at that point in time did not have the capacity to investigate this family.
>
> A. Yes.
>
> Q. Just on that while I think of it you ultimately referred this matter on to the Gawler office didn't you.
>
> A. As there was two processes that started quite quickly. One was the request from the Family Court for intervention and then within a few days the notification was raised which then went to the Gawler office.
>
> Q. And they appeared to have the capacity to investigate that latest piece of information.
>
> A. Yes.
>
> Q. How did they have the capacity and the Elizabeth office not have the capacity.
>
> A. Different offices would have experienced different demand in the number of cases coming into that office and their capacity to respond to those requests.
>
> Q. Could Elizabeth office which I've heard was chronically under the pump as it were refer matters to the Gawler office.
>
> A. Occasionally if there was a very high number of urgent matters requiring response that could be escalated and negotiated to try and get a response to those cases and that may sometimes involve seeking the assistance of other offices. ' [59]

Ms Scanlon acknowledged that she had been aware that the Elizabeth office had been taking no action in relation to Tier 2 notifications that were coming to them and that this had been due to the large volume of notifications, in particular the many Tier 1 priority response notifications that the Elizabeth office had received. Ms Scanlon also said that her Director was aware of the lack of resources and capacity at the Elizabeth office to deal with Tier 2 cases and that indeed she had understood that this resource and capacity difficulty at Elizabeth went all the way to the Chief

[59] Transcript, page 287

Executive.[60] Ms Scanlon in this regard referred to the anticipated conclusion of the Royal Commission. This was also mentioned elsewhere in the evidence and was something of a make weight excuse for not doing anything.

11.6. In many ways Ms Scanlon's evidence was startling, and in a sense heartbreaking, insofar as it revealed that, while it might be drawing a long bow to suggest that the Gawler office had unlimited resources comparatively speaking, the fact of the matter was that it did have the resources to investigate the matter in May 2016 and may well have had the same resources at their disposal at earlier points in time if they had been asked to provide them. As will be seen in the next section, Ms Macdonald, the Executive Director of the Department, largely confirmed this.

11.7. Among other concessions, Ms Scanlon in her evidence agreed with Mr Kalali in cross-examination that the information that made reference to Amber being absent from school for numerous days at a time had meant that under the Act her absences placed her at risk.[61]

12. The evidence of Ms Susan Macdonald

12.1. Ms Macdonald was the Executive Director of the Department for Child Protection. Ms Macdonald conducted the Department's adverse event review and authored its report. The report was tendered to the inquest. Ms Macdonald also prepared an affidavit which was also tendered.[62] Ms Macdonald gave oral evidence in the inquest. Ms Macdonald's material is voluminous. It is not necessary to refer to all of it. Ms Macdonald had no personal involvement in the matter of Ms Rigney and her children before their deaths.

12.2. In Ms Macdonald's witness statement, she acknowledges as follows:

> 'It has been recognised in review of this matter that information sharing, in particular with B (name substituted), Ms Wells and Mr Egberts was limited. It is acknowledged that a more transparent approach to information sharing could have equipped B (name substituted), Ms Wells and Mr Egberts with a better understanding of Families SA's intentions. In particular on the occasions when the reports were closed without further investigation or assessment, this may well have influenced what if any action the grandparents may have taken.

[60] Transcript, page 314
[61] Transcript, page 305
[62] Exhibit C18

> In relation to Amber and Korey, Mr Peet was never the subject of reports made to Families SA. Notwithstanding this, sharing the information that was known to Families SA about Korey and Amber with Mr Egberts and Ms Wells, as well as Families SA's involvement, may well have influenced their chosen course of action.' [63]

12.3. In the course of her evidence Ms Macdonald also acknowledged that, had an investigation been conducted, included among Departmental intervention options were possibly having the children placed with the grandparents or under the care of the Minister.[64] I would add that placement of Amber and Korey with the grandparents could have depended on the capacity of the grandparents to take them at different times over the course of the 18 months or so that this matter unfolded. In any event, capacity or otherwise could never have been regarded as an excuse for not removing the children to an environment where they were not at risk. If they required removal, then they should have been removed and that was not a matter that would or should have depended on the capacity of the grandparents to take the children.

12.4. Ms Macdonald made further acknowledgements and concessions that included:

(i) A number of the notifications that were dealt with by way of a NOC were inappropriately dealt with.[65] In particular, the NOC relating to the notification concerning Amber's lack of attendance at school which was not processed until 1 January 2016, when processing within 48 hours was the standard, meant that in effect an opportunity for a staff member to contact the school to speak to the school further about the matter was lost. Ms Macdonald explained that at that time there was a significant backlog in the processing of eCARL notifications.

(ii) The notification of 10 February 2016 which contained information that the mother had slept in a tent with the children having received funds for proper accommodation from Housing SA had given rise to a suspicion that Amber and Korey had no fixed address in terms of section 6(2)(e) of the Act. She further agreed therefore that the children fell within the statutory definition of being children at risk.[66] Ms Macdonald accepted that this notification should have been screened in and that both limbs of section 19(1) of the Act had been satisfied, namely that there was suspicion on reasonable grounds that the children were at

[63] Exhibit C18
[64] Transcript, page 443
[65] Transcript, page 327
[66] Transcript, page 441

risk and that the matters causing the children to be at risk were not being adequately addressed.[67] Ms Macdonald agreed with Mr Kalali of counsel assisting that it followed that the Chief Executive was mandated to carry out an assessment or an investigation into the circumstances of the children and that there had been a failure on the part of Families SA to carry out that lawful mandate.[68]

(iii) Ms Macdonald also ultimately agreed with Mr Kalali that the allegations concerning drug taking were not sufficiently assessed.[69] At first she appeared to resist the suggestion that this also triggered a further assessment or investigation under section 19(1) of the Act, asserting that the allegations that had come in were largely untested. However, she agreed with Mr Kalali that this lack of understanding as to what the risks were was due to the fact the Department had not conducted any investigation of them.[70] To my mind what Ms Macdonald had been asked to acknowledge was obvious, namely that there had been suspicion on reasonable grounds that the children were at risk as a result of the abuse of an illicit drug by their mother which not only triggered the obligation on the Chief Executive to apply for an order for a drug assessment, but also triggered a mandatory obligation to cause an assessment of or an investigation into the circumstances of the children, none of which occurred.

12.5. Ms Macdonald was questioned about the assertions of lack of resources at the Elizabeth office, a matter that was documented at the time of these events and referred to in some notification documentation. Ms Macdonald acknowledged that in late 2015 she had been aware of the resource issues at the Elizabeth office.[71] Asked as to whether she had been aware of any action that was being taken in response to those resource difficulties, she said:

> 'It was a time - no, I'm not aware of the actions that were being taken. It was a time when the department was under - you know, under close scrutiny. There was a Royal Commission that was in progress and the approach at the time was really around waiting for the recommendations of that Royal Commission to look at how to reform the system.' [72]

[67] Transcript, page 442
[68] Transcript, page 442
[69] Transcript, page 439
[70] Transcript, page 439
[71] Transcript, page 415
[72] Transcript, page 415

It is difficult to see how the anticipation of the recommendations of the Royal Commission would excuse a government department from complying with its statutory obligations.

12.6. Ms Macdonald asserted that the notifications regarding the mother's drug use and the fact she spent her money on drugs rather than on food had been closed without further action because of a 'resource issue'. She said that it was not able to be allocated at the Elizabeth office. There ensued the following passage of cross-examination by Ms Atkins on behalf of Mr Egberts and Ms Wells:

> 'Q. Can I suggest that a couple of simple things could've been done instead of closing this file: firstly it could've been passed to say the Gawler office to investigate.
>
> A. That would've been possible, yes.
>
> Q. Because we heard evidence yesterday that the Gawler office had capacity to investigate tier 2 matters.
>
> A. Yes.
>
> Q. Or the grandparents could have been informed of the information that you had and asked if they would apply to the Family Court to take the children.
>
> A. Indeed, that could've been a path; it was a missed opportunity.
>
> Q. And neither of those steps were taken.
>
> A. No they weren't.
>
> Q. That was at a time when the department was aware of the abuse of the elder child.
>
> A. Yes that's true.
>
> Q. And they were aware that the Family Court was asking them to intervene in the Family Court proceedings in relation to these three children.
>
> A. Yes.' [73]

It will be noted that Ms Macdonald's evidence about the capacity of the Gawler office was the same as that given by Ms Scanlon. The evidence that the Gawler office would have had capacity to deal with earlier notifications at a point in time earlier than May 2016 was unchallenged. I accept the evidence that the Gawler officer at material times earlier than May 2016 would have had capacity to deal with earlier notifications had they been asked to do so. This in itself would obviously bring into question the assertions documented in Department records to the effect that Tier 2 notifications about the children were not investigated because of resource limitations at the Elizabeth office. Ms Macdonald's evidence about capacity prompted me to question her more

[73] Transcript, page 416

closely about that issue. Ms Macdonald accepted the proposition that having regard to the nature of the information which was the subject of the 18 January 2016 notification, the file should not have been closed off. The following passage of examination then ensued:

'Q. Now, in such circumstances where a file has to be closed because of the lack of capacity in that particular office, would it not be the obvious thing to do to make an inquiry of other offices as to whether they had the capacity.

A. It would have been something that's available to staff, managers, the director, at the time. The reality for the department at the time was that all of the intake and assessment offices, or front-end offices, as we would call them, were all closing cases without action. So every office was in a very similar situation to what Elizabeth was. Elizabeth had higher levels of volume and would close more matters without actioning them, but every office in the metropolitan area had a practice of closing without actioning. So my point about that is that it would have been difficult to find capacity across the system.

Q. Was there a case for upgrading this matter to a tier 1.

A. The tier rating doesn't necessarily reflect the seriousness of the information; the tier rating is more reflective of the imminency of danger, yeah.

Q. The tier 1 relates to the acuity of the circumstances.

A. Yes, yes.

Q. But if a matter simply does require investigation, then would it not be prudent to, even if it is a fiction, to upgrade it to a level where it will get that necessary attention.

A. It's not the way that the tiering system works, that - I do understand what you're saying, but I - it's not a practice that's been employed, no.

Q. No, looking at the situation as of 18 January 2016, are you able to assure this court and the people in this courtroom listening to your evidence that circumstances such as these regarding these two children and the reports that have been made to date would now not go unaddressed in your department.

A. As we saw in my affidavit, that there are still matters that are closed without action. Yes, there are.

Q. What about this case, though. Are you saying that this case again would be closed without action.

A. I don't think that this case would be closed without action because I think the work that we have done around the Family Court team and I think the work as we have discussed today, the close relationship that this matter had with the Family Law Court would have meant that we could have drawn some resources from that central team in order to investigate this matter and, in fact, is what has happened since that time.

Q. You see, there was information in this latest report and indeed in previous reports that this woman was using ice.

A. Yes.

Q. And one aspect of the alleged neglect of the children was that she would neglect them when going out to see her dealer to get ice.

A. Yes.

Q. Now, clearly, the woman was engaged in criminality, you agree with that.

A. That was the allegations that were raised.

Q. Yes. She is a possessor and user of a prohibited substance.

A. They were the allegations, yes, yeah.

Q. Right, and insofar as she is alleged to be going out to meet a dealer and as a result of which she is neglecting her children, there's criminality on the part of somebody else, isn't there, namely, the dealer.

A. Yes, potentially, yes.

Q. Now, why would something like - a set of circumstances like this as they existed in January 2016 not be reported to the police for their investigation.

A. Yeah. The matters that we refer on to the police for their investigation from our department are more related to crimes that might be committed against children.

Q. If there is neglect in respect of children that's caused by criminal behaviour, then why would the police not be interested in that.

A. Well, they may well have been interested in it.' [74]

12.7. Ms Macdonald also acknowledged that it would have been important for notifiers in these instances to have been informed that Families SA were not going to do anything about their notifications. Ms Macdonald conceded that the provision of feedback such as that to a notifier may well change the course of action that the notifier might then take. That was a concession well made in my view.

12.8. Ms Macdonald also stated in her Adverse Events Review Report that while an assessment of Ms Rigney's circumstances had been made in May 2016 in response to the most recent notification received, the assessment was undertaken in a '*perfunctory way*'. She said:

> 'Review of that assessment revealed that Ms Rigney's significant history of trauma, her behaviour involving the assault of another child, and the importance of cumulative harm was not afforded sufficient wright in formulating the case.' [75]

In cross-examination by Mr Kalali, Ms Macdonald indicated that in her view the assessment conducted by the Gawler office was not complete. Asked to elaborate, Ms Macdonald told the Court that she had wondered from a practice perspective about

[74] Transcript, pages 421-423
[75] Exhibit C18

whether Ms Rigney's own history of trauma had been sufficiently taken into account. Ms Macdonald suggested that Ms Rigney's pattern of avoidance behaviour despite efforts to engage with her was perhaps not given sufficient weight. Ms Rigney was quite avoidant and the question was whether the Department should have been more assertive with her.

12.9. I agree with those observations.

12.10. Finally, as far as the interaction with the Federal Circuit Court was concerned, in her evidence Ms Macdonald stated as follows:

> 'I think this is obviously quite a significant issue for this matter that we - prior to 2000 and - I actually wasn't in the department at the time but my understanding it was between 2013 and 2014, we did have a Family Court team that was disbanded and so the relationship with the Family Court and the Federal Circuit Court was significantly comprised by the disbanding of that team and at the time that this matter was referred to us, you know, there was one administrative officer that was interfacing with the Family Court or the Federal Circuit Court. And you know the relationship between child protection jurisdictions and Family Law Court jurisdictions is critical and that's a national, you know, that's nationally recognised, that's not just obviously particular to South Australia. And the fact that we didn't have a relationship to speak of with the Family Law Courts at that time meant that information was poorly exchanged, communication was poor, it was, you know, it was a very compromised situation for our department.' [76]

I also agree with those observations.

13. <u>The section 20(2) issue - previous coronial recommendations</u>

13.1. I have referred to this issue in previous sections of this finding.

13.2. The information imparted to the Department via various notifications was that Ms Rigney was a user of drugs in particular cannabis and ice and that this was affecting her parenting capabilities. Her post-mortem toxicology established that there was evidence of both substances in her system. Police investigations undertaken after the murders would confirm through people who knew Ms Rigney that she had used both substances.

13.3. The failure of the Department to use section 20(2) of the Act has been the subject of coronial scrutiny and comment in the past. I refer to the findings of this Court in the

[76] Transcript, page 342

inquest of **Chloe Valentine**[77], the findings of which were delivered on 9 April 2015, and the inquest in relation to **Ebony Napier**[78], in which the Court's findings were delivered on 28 January 2016.

13.4. In both of those findings this Court made observations in relation to the mandatory obligation imposed upon the Chief Executive where there is suspicion on reasonable grounds that a child is at risk as a result of the abuse of an illicit drug by a parent. As was pointed out in the **Valentine** inquest[79] by the then State Coroner, Mr Johns, the operation of section 20(2) is triggered not necessarily by positive evidence of abuse or neglect but by a suspicion that a child is at risk of abuse or neglect as a result of drug use. In commenting on the failure of the Department to utilise this provision despite ample evidence that Chloe Valentine had been at risk as a result of the abuse of methamphetamines and cannabis by her mother, the mandatory obligation upon the Chief Executive to apply for an order from the Youth Court for an order directing her mother to undergo a drug assessment was not complied with. The State Coroner regarded it as an indictment of Families SA that its practice in ignoring the obligation under section 20(2) was so completely divergent from the clear terms of that provision. Accordingly, Mr Johns made a recommendation in the following terms:

> 'I recommend that Families SA should strictly comply with section 20(2) of the Children's Protection Act with immediate effect. Furthermore, that the Minister for Child Protection Reform draw the evidence of Mr Harrison and my remarks concerning section 20(2) of the Act to the attention of the President of the Legislative Council and the Speaker of the House of Assembly with the request from the Coroner's Court of South Australia that the President and the Speaker draw to the attention of their respective Houses the flagrant disregard of section 20(2) by Families SA.' [80]

13.5. The Mr Harrison referred to in that passage was Mr Tony Harrison, the Chief Executive of the Department of Education and Child Development. Observations similar to those of Mr Johns were made this Court in the matter of **Ebony Napier** in which the facts surrounding her lack of care were said to have been a '*perfect fit*' for the operation of section 20(2) of the Act[81] but where, again, the provision's mandatory obligations had not been complied with. There had been evidence in the **Napier** matter to suggest that a serious injury to **Ebony Napier** that had been sustained some time prior to her death had been contributed to by the father's abuse of cannabis and that there was reason to

[77] Inquest 17/2014
[78] Inquest 16/2015
[79] Paragraph 13.2
[80] Paragraph 22.4
[81] Paragraph 9.19

suppose that his continued use of cannabis placed Ebony at risk. There was evidence available that demonstrated that Ebony was at least at risk of suffering serious harm to her physical, psychological or emotional wellbeing or of further abuse or neglect and that the parents of Ebony were unable to care for and protect her. Further, there was reason to suppose that this risk to Ebony had been posed as a result of the abuse of cannabis by the father, or at the very least there was suspicion on reasonable grounds that such a risk was in existence. In that case there had been no application made under section 20(2) in circumstances where it would have been almost inevitable that a court to whom an application was made would have made an order authorising a drug assessment to determine the capacity of the father to care for and protect Ebony **Napier**.

13.6. The Court in the **Napier** matter repeated the recommendation of the State Coroner in the **Valentine** matter regarding the use of section 20(2).[82]

13.7. The **Valentine** finding squarely put the Department on notice as from 9 April 2015 that section 20(2) contained mandatory obligations imposed upon the Chief Executive and therefore upon those to whom his powers were delegated. That message was reinforced less than a year later when on 28 January 2016 the same observations that had been made in the **Valentine** inquest were made in the **Napier** finding. As well, the same recommendation regarding the use of section 20(2) was repeated. Both of those findings were delivered at a time prior to the murders of Ms Rigney and Amber and Korey. It is also to be observed that all of the notifications regarding the alleged use of ice by Ms Rigney and the effect that it had on her parenting abilities occurred in the months following the delivery of the **Valentine** finding. Other relevant information regarding the same topic would be placed in possession of the Department in the weeks following the **Napier** finding. It also needs to be recognised that these were repeated notifications and notifications which in the event were regarded by their assessors as credible in terms of the content regarding Ms Rigney's use of ice. To my mind they raised an ever-increasing suspicion on reasonable grounds that Amber and Korey were at risk as a result of the abuse of ice by their mother.

13.8. That the Department continued to ignore the mandatory obligations contained in section 20(2) of the Act following the **Valentine** finding in particular is to be deplored. This is especially so having regard to the fact that following the delivery of the **Valentine** finding on 9 April 2015 the Chief Executive of the Department, Mr Harrison, had issued a series of circulars reminding Families SA staff of the impact that the **Valentine**

[82] See paragraph 14.3 of the Ebony **Napier** finding

findings and recommendations should have on their work. One such circular to staff of the Department entitled '*A message from the Chief Executive*', and sent personally by the Chief Executive, was circulated by way of email on Friday 1 May 2015. The circular was in the following terms:

> '**Chloe Valentine Coronial Inquest update**
>
> The Coroner has made a recommendation that Families SA should strictly comply with section 20(2) of the Children's Protection Act 1993 with immediate effect. Section 20(2) states:
>
> > If the Chief Executive suspects on reasonable grounds that a child is at risk as a result of the abuse of an illicit drug by a parent, guardian or other person, the Chief Executive must apply for an order under this Division directing the parent, guardian or other person to undergo a drug assessment (unless the Chief Executive is satisfied that an appropriate assessment of the parent, guardian or other person has already occurred, or is to occur).
>
> Staff are reminded of their obligations to utilise the full existing provisions within the Children's Protection Act 1993, including but not limited to section 20(1) and (2) which set out requirements for investigation and assessment orders, including applications for drug assessments.
>
> Further information and training for staff about application of this section will be provided.
>
> Tony Harrison
> Chief Executive.' [83]

13.9. Although the mandatory nature of the obligation imposed by section 20(2) was not specifically highlighted, the terms of the circular were clear enough, especially when it could reasonably have been expected that the Department's officers who had a delegated responsibility for the carrying out of the obligation under the provision would have read, or would read, the **Valentine** finding.

13.10. This circular was the subject of the cross-examination of witnesses in this inquest. I have referred to Ms Hale in these findings. In her evidence she was questioned about the emails and circulars of the Chief Executive. Asked as to whether there had been any significant change in the processes that her section adopted as a result of the **Valentine** findings or as a result of the emails, Ms Hale insisted that there was-

> 'a significant increase in the anxiety and concern of the leadership in Elizabeth to be able to attend to these investigations in the manner in which we were being asked to do so, given the limited resources that they had at the time.'

[83] Exhibit C13, page 5

She asserted that they did not have the resources and that everything kept coming back to resources. Specifically, regarding the impact of the Harrison circular of 1 May 2015 in respect of section 20(2), Ms Hale said that she could not recall when the intake that had raised allegations that Ms Rigney was a regular ice user had come in. She said that in October 2015 she was not involved in an investigative capacity at that stage such that they would not have been able to ask questions about her ice usage. Clearly somebody else could have though. As to the Harrison circular itself, Ms Hale said that she recalled seeing that document. Ms Hale could not answer the question as to whether or not Mr Harrison was ever advised following the distribution of his circular that contrary to what he was urging his staff to do, his staff were not actually doing it.[84] She agreed that if the direction was not being complied with due to resource concerns, it would have been appropriate for Mr Harrison to have been advised about that.[85]

13.11. Ms Scanlon who was later involved in this matter and was instrumental in the matter of Ms Rigney finally being assigned to the Gawler office for investigation in May 2016, was also asked about section 20(2) of the Act, her knowledge of the effect of it and of the Harrison email. She told the Court that the Chief Executive's duties and responsibilities under a provision such as section 20(2) were delegated to supervisors withing Families SA. She said that she was aware of the legislative requirement concerning the obligation of the Chief Executive to make an application to drug test a parent where there was a risk of abuse of a drug that might be impacting upon the care of a child, but stated that in her role she was not familiar with the implementation of that obligation.[86] However, she said that her understanding of the legislation was that concerns regarding drug use would need to be recorded and assessed and that an intervention or an investigation needed to be commenced before they could activate any of those provisions of the legislation.[87] Asked by Mr Kalali of counsel assisting in cross-examination what her understanding of the threshold of satisfaction or suspicion needed to be before the procedure could be utilised and the Youth Court moved for an order for a drug assessment, Ms Scanlon said that it was her understanding that if in the course of an investigation there was a suspicion that there was drug use that was impacting negatively on the parenting or care of the child, that they would then be able to seek an order. Asked as to what kind of evidence would be required she suggested

[84] Transcript, page 246
[85] Transcript, page 247
[86] Transcript, pages 263 and 306
[87] Transcript, page 306

that they would be looking for evidence of drug use and physical suspicion from the presentation of the parent. She suggested that there may be other factors that would lead one to the belief that drug use was occurring. Asked specifically as to whether persistent and repeated information provided to the Department would be such evidence, she said:

> 'Yes, I think there are multiple ways that we may form that suspicion, but I would agree that that would also constitute reasonable grounds to go to the court for that.' [88]

13.12. However, Ms Scanlon appeared to suggest throughout her testimony that evidence that would be required to enliven section 20(2) would have to emanate from an actual commenced investigation. As to whether information from a reliable source would trigger the obligation under the provision, she said:

> 'I would say that those concerns have been raised. I would say an investigation at that point hasn't commenced in that they're - at that point I don't understand that there had been any interview with the mother or commencement of an investigation process. There had been those concerns raised.' [89]

Ms Scanlon agreed that there would be a possible role for police in the investigation of a parent's drug use given its criminality and particularly having regard to the fact that that the person would probably have a drug dealer.[90] This was an appropriate concession. Clearly the police do have such a role.

13.13. Ms Scanlon acknowledged that she would have seen and read the email of Mr Harrison of 1 May 2015. She regarded it as a '*reminder*' of their obligations to utilise section 20(2) of the Act. As to whether there had been further information and training provided to staff following that email, Ms Scanlon said she could not specifically remember exactly what training there had been. She was not case managing at the time. She did believe that further practice guidance had been provided.[91] There is no evidence of what it was. In any event, as has been seen, and whatever the training was if anything, in the coming months it fell on deaf ears.

13.14. Ms Macdonald who conducted the Department's adverse event review and who gave evidence in the inquest was also questioned about section 20(2) and Mr Harrison's emailed circular. It is of some note that the statutory obligation in section 20(2) and its

[88] Transcript, page 308
[89] Transcript, page 309
[90] Transcript, page 310
[91] Transcript, page 312

possible role in the matter of Amber and Korey was not mentioned in her adverse event review report. However, in the course of her evidence before me Ms Macdonald agreed that the section 20(2) obligation to apply for the order from the Youth Court was triggered at the moment that the relevant state of mind of the Chief Executive was formed.[92] She was asked:

> 'Q. So it's not a question of 'Well I'm of the opinion that this child is at risk as a result of drug abuse and I will wait and see what happens', that's simply not an option, the action has to be taken immediately, does it not, under the provision as it existed then.
>
> A. Yes.' [93]

13.15. Ms Macdonald was asked the following question by me:

> 'Q. You've conducted your investigation and you've been taken to the various documents that are relevant in this case into the course of your evidence. What counsel is asking you is whether, in your view, it would have been a valid exercise for the Chief Executive, or those to whom his powers were delegated, to have suspected on reasonable grounds, that these two children were at risk as a result of the abuse of an illicit drug by the mother.
>
> A. Yes. It was something that required further assessment and investigation. There were reasonable grounds to suspect that.' [94]

13.16. However, asked by Mr Kalali as to whether the Chief Executive had been mandated to apply for an order under section 20(2), Ms Macdonald said as follows:

> 'Because there hadn't been an assessment of the risk and because there hadn't been an assessment of the impact of Ms Rigney's illicit drug use, that next step of drug assessment hadn't been arrived at that point in time.' [95]

Clearly not satisfied by that answer Mr Kalali asked:

> 'Q. Is what you are saying, correct me if I am wrong, is that the Chief Executive has to conduct an assessment in order to establish when the Chief Executive has reasonable grounds.
>
> A. What I am saying is the allegations of drug use hadn't been assessed or investigated by the department. So to move onto then compelling Ms Rigney to have a drug assessment, that the foundation for that hadn't been established because we hadn't investigated or assessed the circumstances of the allegations that had been raised.' [96]

[92] Transcript, page 359
[93] Transcript, page 359
[94] Transcript, page 438
[95] Transcript, page 445
[96] Transcript, page 445

13.17. However, there then followed a passage of questions and answers between Mr Kalali and Ms Macdonald that culminated in the following exchange:

> 'Q. Yes and I am suggesting to you that that information was sufficient to suspect on reasonable grounds that the child was at risk as a result of an abuse of illicit drug by the parent. So I am suggesting to you that those notifications in that window, taking the cumulative effect of all of the information that was available to you, that was enough grounds to invoke s.20(2), do you agree with that.
>
> A. I accept what you are saying, yes.' [97]

Mr Kalali put it to Ms Macdonald that an application should have been made to the Court directing Ms Rigney to undergo a drug assessment. Ms Macdonald would only allow that it *could* have been made. To my mind the correct answer was that an application *should* have been made. It was not a matter of the Chief Executive or his delegate considering whether his or his delegate's reasonable suspicion could lead to the exercise of a discretion as to whether the application could be made. Once the relevant suspicion as to drug use was formed, and after the 2016 amendment once the relevant opinion as to that was held, there was no legal option other than to make the application for a drug assessment to the Youth Court. The only exception to this would have been if the Chief Executive, or those exercising his delegated authority, had been satisfied that an appropriate assessment had already occurred or was to occur. In Ms Rigney's case there was no basis for any such state of satisfaction.

13.18. Finally, Ms Macdonald agreed that drug abuse in a family environment could manifest itself in a number of adverse circumstances regarding children. She agreed that those circumstances could include possible neglect, leaving children in the house on their own while the caregiver is doing other things such as sourcing drugs, malnourishment, lack of clothing, accidental injury at home or in a motor vehicle, inconsistent or nil accommodation and truancy. I asked Ms Macdonald:

> 'Q. So if you were evaluating information that a person, that a caregiver of a child is abusing drugs, then you would also be implying (sic) to look for the possible manifestations of that drug problem, would you not.
>
> A. Yes.
>
> Q. Including those matters that I've just enumerated.

[97] Transcript, page 446

A. Yes, other than to add that many of the matters that you described can also be present in neglecting families where there is no drug abuse.' [98]

13.19. It will be observed that most if not all of those elements were involved in the environment of the children Amber and Korey. They could only have strengthened suspicions or opinions regarding drug use.

13.20. Whether or not the suspicion of drug usage should of itself have triggered an application to the Youth Court for an order for a drug assessment of Ms Rigney is somewhat moot when it is borne in mind that there was a host of other information including truancy, homelessness, lack of sustenance for the children and the general dysfunction of this family that should have triggered a Departmental investigation under section 19 of the Act, an investigation that should have been initiated well before May of 2016.

14. Conclusions

14.1. The conclusion of the Court is that the deaths of Amber and Korey were preventable.

14.2. During the course of 2015 there were many opportunities in which the Department should, pursuant to its statutory obligations, have intervened at least by way of an investigation into the circumstances of this family. Even if the children were not removed from the custody of their mother, a Departmental investigation would have revealed the completely unsatisfactory nature of the manner in which the two children were being cared for. This family required extremely close scrutiny and supervision. The mother's amphetamine usage should have been the subject of an examination and have been curtailed. To my mind the police should have been asked to investigate these allegations.

14.3. If intervention of the part of the Department had occurred in 2015 and in early 2016, the course of events would have been altered such that it is highly unlikely that on 30 May 2016 Ms Wilson Rigney would have been in the exact same circumstances that she found herself in at that time. This is so quite apart from the possibility that by that time the children may have been removed from her care.

[98] Transcript, page 452

15. Recommendations

15.1. Pursuant to Section 25(2) of the Coroners Act 2003 I am empowered to make recommendations that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the inquest.

15.2. In this matter I was not urged by counsel to make any particular recommendation. This may well be reflective of a number of circumstances. Firstly, as alluded to, very soon after these events new child protection legislation came into effect. Secondly, the report of the Child Protection Systems Royal Commission was handed down in which many recommendations for change were made. Thirdly, and specifically in relation to the deaths of Amber and Korey, there were the recommendations of the Ombudsman.

15.3. Ms McDonald's affidavit describes a number of measures that have been implemented since the events with which this inquest is concerned. It is not necessary for this Court to pass comment in the absence of knowing exactly how those measures are working in practice. It was beyond the scope of this inquest to conduct any such inquiry.

15.4. I should record, however, that Ms Macdonald's affidavit describes an overview of the child protection system in the years 2017-2021 as well as the reform of child protection and family support systems. The affidavit also deals with measures to improve the further exchange of information between family courts and agencies and organisations responsible for responding to and managing family safety risk. The document in particular deals with requests to intervene in family law proceedings. Ms Macdonald reports that in June 2019 the Court Services and Liaison Team assumed oversight of all requests made by the Family Court pursuant to section 91B of the Family Law Act 1975 to intervene in family law proceedings. This centralised role was implemented to promote a streamlined consistent response to requests to intervene. Ms Macdonald's affidavit also speaks of the co-located child protection practitioner in the family courts.

15.5. Ms Macdonald also spoke of a new DCP Manual of Practice which was released in December 2019. She asserts that this document provides for a more integrated and contemporary approach to child protection practice that is tailored to South Australia's legislative and cultural context. As seen earlier in these findings, the existing Practice

Manual was a completely unacceptable document insofar as it enshrined practices that were contrary to law.

15.6. Ms Macdonald also states in her affidavit that from the information available about the services offered to Ms Rigney and the children following the assault of S in 2014, it would appear that the assertive engagement and intervention model now in place would have more proactively engaged Ms Rigney, including addressing the reasons behind her avoidance of therapeutic invention.

15.7. The Macdonald affidavit also deals with the question of information sharing and in particular the recommendations of the Ombudsman regarding that issue. Ms Macdonald describes a particular measure providing for the use and disclosure of information where it is considered necessary to protect a person from risk of serious harm, a measure that is intended to address the relevant recommendations of the ombudsman.

15.8. As I say, in the absence of an inquiry into the effectiveness of these measures it is not possible for the Court to judge how the measures have worked in practice

15.9. What this inquest has highlighted, however, is the folly of governments ignoring coronial and other recommendations. I speak again of the course of the continuation of unlawful practices within the child protection authority despite coronial findings in the **Valentine** and **Napier** inquests that identified those practices. In my opinion what is required is a broad review of all coronial and other recommendations, including recommendations of the Ombudsman and of the Royal Commission, relating to child protection. I recommend that the Premier of South Australia, the Minister for Child Protection and the Chief Executive of Child Protection cause a review of all coronial and other recommendations relating to child protection in the State of South Australia with a view to the implementation of the same.

15.10. For the most part the issue in this inquest concerned the non-adherence to statutory obligations imposed on the child protection authority due to alleged resource deficiencies. It is manifest that such a situation should never be allowed to develop and be tolerated ever again.

15.11. Accordingly, I make the following recommendation in this matter. I direct it to the Premier of South Australia, the Minister for Child Protection and the Chief Executive

of Child Protection. I recommend that a complete review be conducted in relation to all of the statutory obligations contained within the Children and Young People (Safety) Act 2017 so as to ensure that practices within the Department align with those statutory obligations. Such a review should consist of an examination of all documented and undocumented internal Departmental procedures so as to ensure that they comply with all statutory obligations contained within child protection legislation. I also recommend that on completion of such review, an assessment be made to ensure that the carrying out of all statutory obligations under the Children and Young People (Safety) Act 2017 are fully resourced to enable those duties and obligations to be carried out without exception.

15.12. As seen above, in my view there was sufficient information in the possession of the Department to constitute suspicion on reasonable grounds that Amber and Korey were at risk and in particular were at risk as a result of the abuse of an illicit drug by their mother. When the Department finally acted in May 2016 and endeavoured to investigate the circumstances of the family, police were not engaged to assist in that investigation as could have been the case pursuant to section 19(3) of the Act as it then was. I accordingly recommend that the Chief Executive of Child Protection remind all staff of the Department of the need, especially where there are allegations involving abuse of an illicit drug placing a child at risk, to consider whether in the circumstances police powers in their capacity as child protection officers pursuant to the provisions of the Children and Young People (Safety) Act 2017 should be utilised to assist in any assessment or investigation pursuant to that Act.

Key Words: Homicide; Domestic Violence; Child Protection

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 21st day of April, 2022.

Deputy State Coroner