SG v CEO (Office of Children & Families) [2013] NTSC 67

PARTIES:	SG -v- CEO (Office of Children & Families) And RYD And TM & CD And RG
TITLE OF COURT:	SUPREME COURT OF THE NORTHERN TERRITORY
JURISDICTION:	COURT OF THE NORTHERN TERRITORY JURISDICTION APPELLATE JURISIDCTION
FILE NO:	21139665
DELIVERED:	10 September 2013
HEARING DATES:	5 July 2013
JUDGMENT OF:	BLOKLAND J
APPEALED FROM:	LOCAL COURT

CATCHWORDS:

APPEAL – Child Protection– Parental Responsibility – Appropriateness of long term order – Whether Chief Magistrate erred in a failure to take into account relevant considerations – Whether evidence sufficient to justify a long-term order – Whether third respondents have demonstrated parental capacity – Evidence insufficient to justify long-term order – Appeal allowed –*Care and Protection of Children Act* (NT) s 140

REPRESENTATION:

Counsel:

Appellant:	Mr Aughterson
First Respondent:	Ms Brown
Second Respondent:	N/A
Third Respondent:	N/A
Fourth Respondent:	Mr Hubber

Solicitors:

Appellant:	NAAJA
First Respondent:	Solicitor for the Northern Territory
Second Respondent:	N/A
Third Respondent:	N/A
Fourth Respondent:	Maleys

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IN THE COURT OF APPEAL
OF THE NORTHERN TERRITORY
OF AUSTRALIA
AT DARWIN

SG v CEO (Office of Children & Families) [2013] NTSC 67
No. 21139665

BETWEEN:

SG
Appellant

AND:

CEO (Office of Children & Families)
First Respondent

AND:

RYD
Second Respondent

AND:

TM & CD
Third Respondent

AND:

RG (by his legal representative Matthew Hubber)
Fourth Respondent

CORAM: BLOKLAND J

JUDGMENT

(Delivered 10 September 2013)

Introduction:

[1] On 18 April 2013 the Local Court (Darwin) ordered a protection order for a child, RG, (the fourth respondent in these proceedings), with a direction that the Chief Executive Officer (the first respondent) have long term parental responsibility until RG reaches 18 years old.

[2] This appeal is brought by RG's mother (the appellant). The appellant no longer has daily care and control of RG. She does not seek a change in that position. RG has been the subject of alternative care arrangements, whether by formal order or otherwise for much of his life. The appeal filed by the mother is supported by the third respondents TM and CD, who had been caring for RG just prior to the most recent series of protection interventions. RG, through his legal representative supports the appeal in the sense that he has expressed a wish to return to Maningrida and live with the third respondents particularly the male of the couple, TM.[1]

[3] In the event that the appeal is successful the appellant seeks a protection order be made giving joint parental responsibility to the first respondent, (the CEO) and third respondents (TM and CD), with daily care and control to the third respondents for two years. In the alternative, the appellant seeks a protection order be made giving parental responsibility to the first respondent for one year. The first respondent, the CEO, agrees with a number of the submissions made on behalf of the appellant, broadly

[1] Outline of Fourth Respondents submissions paras [10] and [11].

supportive of some of the grounds of appeal, however, even if the appeal is allowed, the CEO submits no other order should be made.

Background

[4] This matter has a significant history. I will deal with parts of it. RG is an Aboriginal child born on 8 October 2009, originally from Milingimbi but has resided for much of his life in Maningrida. It is common ground the CEO made an application for a temporary protection order on 10 November 2011 pursuant to s 103 of the *Care and Protection of Children Act* (NT) (the Act). As a result of that application, a temporary protection order was made giving daily care and control of RG to the first respondent the CEO. There had been earlier temporary placement agreements in place between the appellant mother and DCF made pursuant to s 46 of the Act.[2]

[5] On 23 November 2011, the first respondent made application pursuant to s 121 of the Act for a protection order for one year.[3] The order was sought for the following reasons: concerns that the appellant was unable to care for RG and provide him with his nutritional needs; that RG had a series of hospitalisations with "failure to thrive" and other health issues, with patterns of weight loss recurring when he was returned to the appellant's care; support plans that had been put in place with the appellant mother did not succeed; that this resulted in RG's further admissions into hospital; and

[2] This part of the history is substantially set out in the affidavit of Josephine Jamieson, 23 November 2011, AB 5-12
[3] Application, 23 November 2011, AB 1-2

that although the appellant was able to parent her oldest son, for reasons unknown, RG was not provided with his basic needs by the appellant at that time.[4]

[6] The term "failure to thrive" was also used at a later time by Dr Maclennan, who explained "[it] is not a precise term but means low weight for the child's age, or a low rate of increase in weight".[5] Additionally, Dr Maclennan reported RG had been malnourished, a more serious form of failure to thrive, putting him at risk of overwhelming infection and metabolic imbalance.[6]

[7] The appellant wanted the third respondents to look after RG until a decision was made by the Local Court.[7] In December 2011 RG was placed in the care of the third respondents who are his relatives. He lived with them in Maningrida.

[8] On 3 February 2012 an officer from the Department of Children and Families observed that RG was back in the community with extended family who appeared to meet both his physical and emotional needs: "He is happy and is thriving receiving a well balanced diet. The family ensures that he receives medication and attends any appointments that [RG] is required to

[4] Affidavit, Josephine Jamieson, 23 November 2011
[5] Statutory Declaration, 20 February 2012, AB 42-43
[6] AB 42
[7] Affidavit of TM, 17 May 2012, AB 40 on 15 December 2011

attend. He is now reaching his age appropriate milestones and developing accordingly. He is in a safe secure environment with loving carers."[8]

[9] In May 2012 amended applications were filed seeking that daily care and control be given to the third respondents and long term parental responsibility to the first respondent the CEO until RG attained the age of 18 years.[9]

[10] A DCF officer reported that RG's "cultural, spiritual, emotional and physical needs are currently being provided by his family and extended family members".[10] In terms of his health it was stated that RG was taken on a weekly basis to the Maningrida health clinic for checks. The clinic reported he was thriving and putting on weight. His immunisations were up to date and he was developing appropriately according to his age and stage of development. The family had advised he was eating a well balanced healthy diet.[11]

[11] On 2 July 2012, a further amended application was made for daily care and control to be given to third respondents and short term (2 years) joint parental responsibility to the first and third respondents.[12] In the supporting affidavit [13] the relevant officer said that while RG was being provided with 'appropriate supervision, shelter, clothing and nurturing', the third

[8] Affidavit of Josephine Jamieson, 3 February 2012 at 16, AB 19
[9] AB 23
[10] Affidavit of Josephine Jamieson, 10 May, 2012 (sic), AB 25-26
[11] Affidavit of Josephine Jamieson May 2012, AB 25-26
[12] AB 45
[13] Affidavit of Derek Fales, 2 July 2012, AB 49-51

respondents have 'struggled with [RG's] lack of interest in eating.' It was noted that at that time RG had been with the third respondents for six months. The DCF officer also referred to the fact that RG had a 'big weight loss' two months previously and had not fully gained the weight back; that he took no pleasure in eating and had developed behavioural issues.[14]

[12] In September 2012 the third respondents agreed to travel to Darwin with RG to be part of the development of an intensive feeding behaviour program for him.[15] RG was admitted to Royal Darwin Hospital between 3 and 20 October 2012 for the purpose of improving his feeding behaviour in the community under the guidance of a speech therapist and the Allied Health Team at Royal Darwin Hospital. It was hoped this would give guidance for future interventions in the community.[16] Of interest is that his admission weight at that time was 12.4 kg; his discharge weight was 12.5 kg. Dr Cornelius noted RG was well known to have failure to thrive since his second year of life and was admitted to hospital on a number of occasions. It was also noted RG lost weight initially during the hospital admission.

[13] After returning to Maningrida with the third respondents on 15 November 2012, Dr Cornelius, who had recently become engaged in RG's treatment, provided further information to Mr Fales of the DCF. Dr Cornelius suggested that, "a foster carer outside of his family outside the community be found". She stated "he might not gain weight extensively but at least will

[14] Affidavit of Derek Fales at AB 50
[15] Affidavit of Derek Fales, 24 September 2012, para 4
[16] Letter, Dr Anita Cornelius 25 October 2012, AB 112

not lose anymore. Whether we are able to turn around future chronic medical and mental problems is very hard to predict as the damage might already have been done".[17]

[14] Dr Cornelius stated that while TM, (one of the third respondents) "does fulfil all the requirements that Raphael needs" he "is not very present in the family."[18] In evidence before the Local Court, Dr Cornelius explained that TM had told her he was working for the night patrol; and that these were the reports from clinic staff and social workers. No recommendation was made by Dr Cornelius at that time as to the length of any placement in foster care.

[15] TM acknowledged that while caring for RG he worked for the night patrol but by the time of the hearing of 3 April 2013, he had changed employment to that of a builder.[19]

[16] On 12 February 2013 RG was placed in foster care in Darwin. The foster carers are not from his community and are not Aboriginal. He remains in that care.

[17] On 4 March 2013, a further amended application was made for parental responsibility to be given to the first respondent until RG attains the age of 18 years. The basis of the application was that the CEO believed RG to be in need of protection and that the order applied for was the best means to

[17] Email, Dr Cornelius, 16 November 2012, AB 120-121
[18] AB Email Dr Cornelius, 16 November 2012, AB 120, Evidence, 22 February 2013, AB 316
[19] Evidence of TM, AB 370

safeguard RG's well being.[20] The grounds relied on were that RG had suffered or was likely to suffer harm because of an act or omission of a parent;[21] and the parents of the child were unable or unwilling to care for the child and that no other family member of the child was able and willing to do so.

[18] The long-term parental responsibility order giving parental responsibility to the first respondent until RG reaches 18 years was made on 18 April 2013.

[19] On behalf of the appellant it is argued the only issue relevant to the making of the order was the difficulty all parties had in relation to RG eating satisfactorily. Of the third respondents, TM was considered by the various professionals dealing with the situation to be loving and caring. RG was observed to have developed an attachment to the third respondents and extended family; he had been going fishing and hunting; he was speaking his language; the extended family met his physical and emotional needs; the environment was safe and secure with "loving carers".[22] Dr Cornelius advised she was told TM and CD were "good carers", particularly TM, although there was the issue of being absent due to working night shifts and therefore sleeping during the day. CD was less successful at feeding RG.[23] In evidence, Dr Cornelius said she "excluded" TM, in particular from remarks she had made about neglectful carers. She agreed there was a

[20] Application,4 March 2013, AB 151; Hearing Transcript AB 304
[21] s 20 (a)
[22] Affidavit, Josephine Jamieson, 3 February 2012, AB 17-19
[23] Dr Cornelius, letter, 30 October 2012, AB 112-114

strong bond between TM and RG; she agreed CD was caring towards RG.[24] TM gave evidence of his love and care of RG.[25] There are a number of reports of RG crying when he had to leave TM. The learned Magistrate found [26]:

> There is no doubt as to [TM's] willingness to care for [RG], although on the current state of the evidence, the same cannot be said of [CD]. It is clear from the evidence that there is a strong bond and a healthy sense of authority exercised by TM over RG and that their relationship is loving.

[20] Other evidence supported the appellant's proposition that aside the eating difficulties, RG was a well cared for, happy, normal child and was appropriately developed for his age. A number of DCF Officers made positive observations about RG in similar terms as those already summarised above.[27] He had clearly adjusted back into the community. His cultural, spiritual, emotional and physical needs were being met by the third respondents and extended family members.

[21] Departmental Officer Derek Fales gave evidence that RG "looks happy" and is "always clean" when he is with the third respondents;[28] that he generally would have extra snacks packed when at pre-school; he has never seen him untidy; and he is always in clean clothes when he goes to school.[29] Dr Cornelius' evidence was that RG interacts well with TM; that he has the

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[24] AB 320
[25] AB 368
[26] AB 537 at [52]; [53]
[27] See para [19] above, Affidavit, Josephine Jamieson, 10 May 2010; AB 27, and 17 May 2012, AB 34
[28] AB 184
[29] AB 185

normal range of emotional expression for his age;[30] although his weight is below where medically it should be, he was growing and was developing appropriately for his age.[31]

[22] On appeal, reference was made to the practice of the CEO ensuring and arranging for TM to come to Darwin to visit RG, while RG is in the foster placement in Darwin.

Relevant Findings of the learned Chief Magistrate

[23] The learned Chief Magistrate found that a long-term order of parental responsibility was the best means of safeguarding the well being of RG as, in her view, it was the only order that could give legal responsibility for RG to a nominated person for all of his life.

[24] Her Honour found that the best interests of RG in the circumstances involved removing him from the care of the third respondents. This was based on the finding that the malnutrition was severe in the sense there was potential for significant harm or even death.[32] Her Honour's findings acknowledged that it was clearly upsetting for RG to be physically separated from TM.

[25] Further findings will be discussed below as they relate to the particular grounds of appeal.

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[30] AB 333
[31] Affidavit, Derek Fales, 21 November 2012 citing Dr Cornelius, AB 116
[32] AB 539 at [58]

Applicable Law

[26] The best interests of the child are the paramount concern in any decision made under the Act.[33] The rights of the child must be given priority if they conflict with the rights of an adult.[34] In determining the best interests of the child a number of considerations are relevant:

s 10(1) (a) *protection from harm and exploitation*

s 10 (1) (b) *the capacity and willingness of family members to care for the child*

s 10 (1) (c) *the nature of the child's relationship with their family*

s 10 (1) (d) *the wishes and views of the child with regard to their maturity and understanding*

s 10 (1) (e) *the need for permanency in their living arrangements*

s 10 (1) (f) *the need for a stable and nurturing relationship*

s 10 (1) (g) *the child's physical, emotional, intellectual, spiritual development and educational needs*

[27] The Act gives primary responsibility to the family.[35] In this context the family includes relatives and members of the extended family associated

[33] s 10 (1)
[34] s 90 (2)
[35] s 8 (1)

with the child in accordance with relevant tradition, custom or practice.[36] A family is to be able to bring up a child in accordance with their language and tradition; the child is to be removed from the family "only if there is no other reasonable way to safeguard the well being of the child" and the child should eventually be returned to the family.[37] Decisions under the Act are to be consistent with the cultural, ethnic and religious values and traditions relevant to the child.[38]

[28] More particularly, pursuant to s 20 of the Act, a child is in need of care and protection if the child has suffered or is likely to suffer harm or abandonment because of acts or omissions of parents or other family members. If the CEO reasonably believes a child is in need of care or protection, the order sought should ensure the best means of safeguarding the wellbeing of child.[39] Additionally, a court must consider a range of factors pursuant to s 130 of the Act including recommendations given to the court for daily care and control; whether there is another person better suited to be given daily care and control; and the needs of the child for long-term stability and security. These principles are emphasised in the case of a long-term parental responsibility direction.[40]

[36] ss 13, 19
[37] s 8 (1)-(4) (b)
[38] s 12
[39] s. 121
[40] s. 130 (2)

Failure to take into Account Relevant Considerations in the Context of making a long term order in relation to a four and a half year old child. (Ground 2)

[29] A number of the grounds of appeal overlap. Much of the argument on Appeal was directed to whether the malnutrition suffered by RG could properly be described as "severe" and whatever the case, whether it was any more significant when RG was placed in the care of the third respondents from 15 December 2011 until February 2013 than with other carers. The context was that RG's failure to thrive was well established before being placed into the care of the third respondents; his condition continued to be a challenge, including during hospitalisations. It is not a case of neglect or other failure of any significance on the part of the third respondents. The third respondents are well acknowledged to be in a starkly different position than that of the appellant mother.

[30] On behalf of the CEO it was pointed out that RG had previously been removed from the community. He had multiple admissions to hospital prior to the third respondent's involvement in his care. On behalf of the CEO it is acknowledged RG was failing to thrive despite the care of the third respondents; although there was evidence that the care given by one of the third respondents (CD) was not satisfactory.

[31] In the circumstances of the ongoing failure to thrive, or malnutrition, it is a question of whether the long term order, at the time of the hearing was in

the best interests of RG. There was no evidence presented to the court to indicate whether RG had improved during the time he was with foster carers in Darwin prior to the hearing. Further consideration of the medical evidence is required.

Discussion of the Medical Evidence

Dr Maclennan

[32] When RG was three years and four months[41], Dr Maclennan described RG as having failure to thrive with mild bronchiectasis and that he has been malnourished. The problem was described as 'long standing' and an underlying medical condition had not been found. Seven hospital admissions were noted, although these were prior to the third respondents having care of RG. Dr Maclennan observed that when in Darwin or in hospital RG had demonstrated weight gain or weight maintenance, unlike when he is on the community. Much of the content of this report is relevant to the time prior to the third respondents having care of RG and it is difficult to draw any firm conclusions from it in respect of the third respondents.

[33] In May 2012 Dr Maclennan wrote that RG has severe malnutrition although had demonstrated some weight gain in the last few weeks and looked well with clear skin. Dr Maclennan suggested nutritional rehabilitation may be required in hospital, additionally she suggested speech therapy. In June

[41] Statement of 20 February 2012

2012 Dr Maclennan classified the nutrition problem as "chronic". She confirmed earlier observations in relation to oral hypersensitivity and associated behavioural issues. Further speech therapy was suggested, and it was noted that although RG was receiving speech therapy in the community, access was limited. She suggested if his failure to gain weight continued, a percutaneous gastronomy tube should be considered.[42] As her Honour noted; this is a most invasive intervention. Dr Maclennan stressed that a single cause of malnutrition could not be identified due to the chronic nature of the condition.[43]

Dr Stewart

[34] Dr Stewart is the Senior Medical Officer at Maningrida. In September 2012 he described much of the history; a great deal of it relating to when RG was in his mother's care, not when he was in the care of the third respondents.[44] Dr Stewart describes "since that time (moving to Maningrida) he has spent the majority of his childhood in moderate to severe malnutrition." At that time Dr Stewart expressed the opinion that RG's care with the current carers, (the third respondents), is appropriate and of good quality and "I would want to see him remain in their care."

[42] AB 61
[43] AB 61
[44] AB 84

Dr Cornelius

[35] In October 2012, [45] Dr Cornelius reported about the admission of RG into hospital. The aim of the admission was to improve RG's feeding behaviour in the community under the guidance of the speech therapist and the Allied Health Team at RDH. Dr Cornelius noted RG had not needed medical intervention in hospital for the previous 12 months. She described the third respondents as good carers, although TM was absent due to night shifts and CD less authorative and less successful in feeding RG. The relevant laboratory findings could be explained by long term malnutrition. She described the differing abilities of the third respondents in terms of assertiveness to enable RG to eat. TM, she regarded as successful, "without any problems"; CD, less interested, although with encouragement had, "moderate success."[46] Dr Cornelius noted RG lost weight during the hospital admission initially.

[36] Mr Fales from DCF reports Dr Cornelius told him on 19 October 2012 that the results for therapeutic intervention were not being achieved due to factors beyond the control of the family; consistency of therapists was an issue as well as instructions being lost on the ward; that she had no major medical concerns for RG but that the hospital admission had not been as

[45] AB 112-114
[46] AB 113

successful as she had wanted; outpatient services may be more suitable; nurses were having difficulty with their authority over RG.[47]

[37] Dr Cornelius advised with respect to RG's discharge from hospital that RG's weight was below where medically it should be; and that the speech pathologist had developed a reward system for RG. In an email of 16 November 2012 Dr Cornelius suggested a foster carer outside the community should be found to "look for a social environment that is able to provide him with consistent loving care, applying adequate parental skills and understanding his needs to be fed."[48]

[38] In a further report of 11 January 2013,[49] Dr Cornelius describes RG's weight for height "per definition is called severe malnutrition. [50] In evidence Dr Cornelius described his malnutrition as 'moderate' in October 2012.[51] Dr Cornelius confirmed her concerns in relation to CN but said TM and RG were bonding very strongly and TM was providing good care but he was often not available due to his work commitments.[52]

[39] In evidence Dr Cornelius said she had only been in the Northern Territory for six months, but based on discussions with senior colleagues with 20-30 years experience at the hospital, children from communities who have these difficulties improve their feeding behaviour when they are put into care

[47] AB 116
[48] AB 120
[49] See also report 9 January 2013 AB 144-146
[50] AB 127
[51] AB 333
[52] AB 127

situations outside of their communities.[53] When asked why she could not express her own opinion as a paediatrician about children suffering from severe malnutrition Dr Cornelius answered "because I feel I haven't been long enough here to have observed enough children myself to say."[54] Dr Cornelius was asked to comment on Dr Stewart's opinion (noted above) that speaks in positive terms of the third respondents. Dr Cornelius agreed she gave Dr Stewart's opinion weight because he had been in the community for seven years and had a lot more contact with RG and the carers than she had.[55] She agreed Dr Stewart was better informed on this that she was.[56]

[40] In my view the learned Chief Magistrate expressly mentions or in any event it is necessarily implied that she took into account a range of difficult issues. In my view, she *did* take into account, at least to some degree, the following matters enumerated in the Notice of Appeal: that the third respondents are loving and caring 'parents' with a demonstrated commitment to RG; the willingness of the third respondents to care for RG; and the principles set out under the Act.

[41] Although her Honour must have had regard to RG otherwise being a child of normal intelligence and disposition, the pressing problem before her Honour was the existence of malnutrition. While the positive aspects of RG's personality and development were important, they naturally were not the focus of her Honour's reasons. I therefore do not think ground 2.4 is made

[53] AB 313-314
[54] AB 315
[55] AB 332
[56] AB 332

out in isolation, namely, the assertion that her Honour failed to take into account "the only concern in relation to the fourth respondent is that he has problems with eating and suffers malnutrition and that otherwise he is a child of normal intelligence and disposition and is well cared for."

[42] In my opinion, however, a number of the remaining grounds are made out. Ground 2.5 suggests her Honour did not take into account that the eating issue may be short-term, and in due course RG will be able to feed himself. Given treatment is being provided to improve and hopefully resolve RG's chronic health problem, in my view it is difficult to justify a long term parental responsibility order in the circumstances. A short term order is without question appropriate, but to make a long term order for such a young child in the circumstances where the medical problem may well be overcome cannot in my opinion, in these particular circumstances be justified.

[43] Although the failure to thrive and malnutrition had been a chronic problem, it was not due to lack of care on the part of the third respondents, especially TM. There was evidence from Dr Maclennan[57]that therapy would be required for a long time. The context of this comment was in relation to speech therapy and is somewhat qualified by the statement "speech therapists can provide more details on the treatment approach. RG is receiving speech therapy but it is limited due to access to services". In my opinion this is far from a firm conclusion that the problem will be ongoing

[57] AB 77

and will require a long term order. It is not possible to find on the evidence that the therapy would be required at such intensity for many years. Mr Fales said in evidence that Dr Gargan indicated it would require up to a year to develop the necessary skills in relation to independent eating.[58] The evidence on this point would not seem to justify the long term order made.

[44] This is related in some respects to ground 2.6: "that there were difficulties with feeding RG and his weight changed marginally, or not at all, regardless of whether he was in the CEO's care or the third respondents". This was an important consideration given Dr Stewart's assessment, which although not as current as Dr Cornelius, reports on the circumstances as they were on the community and with the third respondents as carers. Dr Cornelius deferred to Dr Stewart's opinion, even though it might be qualified in some respects due to the timing of it being given. The learned Chief Magistrate acknowledged during the course of the hearing that there was no evidence that RG would improve in Darwin in terms of weight gain.[59]

[45] The appellant argues there was no psychological report before the Local Court. Although the first respondent CEO submits it has not been shown that a psychological assessment of such a young child would have been of assistance, it appears her Honour considered such a report would have shed light on whether RG suffered trauma by being removed from the third respondents. The social worker Mr Fales gave observational lay evidence

[58] AB 346
[59] AB 418

about how upset RG was to be removed from TM. Although it would be an error to speculate on what a psychological report could achieve, without one, the learned Chief Magistrate was left only with the observational evidence of Mr Fales. There was evidence that being removed was 'distressing' to RG who was 'crying and not wanting to separate from TM'. That evidence clearly indicated the separation was the upsetting for RG. A fair reading of the evidence indicates RG was strongly attached to TM.

[46] In my opinion, despite there being some grounds for concern as to whether CD alone would have been an appropriate carer, the evidence strongly indicates the third respondents together were committed, TM in particular, to assisting RG with his eating issues. The Senior Medical Officer at Maningrida was supportive of the arrangement. His opinion has already been referred to above.[60]

[47] Given the evidence indicated that RG's health status was much the same, no matter whose care he was in, (save that the care of the appellant previously given was clearly inadequate), there was not evidence sufficient in my opinion to justify the long term order. There was not sufficient evidence to conclude that the third respondents were not in the best position to care for RG, provided they were given appropriate medical support. When the other relevant considerations are taken into account, especially given the fact RG was in other respects thriving in his community, a community that he was culturally at home in, then provided his medical issues could be met, as far

[60] Above at [33]

as the evidence indicates, it was in his best interests to be cared for by the third respondents. These conclusions coincide with RG's expressed wishes.

[48] The short period of time between the guidance given to the third respondents about the management of his eating issues in October 2012 and the report of Dr Cornelius of 16 November 2012 recommending removal cannot be ignored. The evidence indicated little change could be expected in one month.[61] As has been pointed out on appeal, no interpreters were utilized to assist the third respondents in the hospital instruction. It is no wonder the third respondents did not comprehend the full import of what would be required to improve RG's health. The CEO agreed on appeal that the lack of interpreters when giving the third respondent instructions is an important factor that has not been addressed in her Honour's reasons.

[49] The evidence indicates the issue with malnutrition was a fluctuating situation. It has variously been termed 'moderate' [62] and "severe".[63] It is obviously chronic, however not at all times severe. It is clearly a serious health problem, but there is no evidence supportive of a proposition that this is due to care provided by the third respondents. The evidence indicates RG's significant medical condition continues in some form, no matter whose care he has been in.

[61] AB 327, 328
[62] AB, 54; 326; 333
[63] AB 74; 77; 57; 127

[50] The first respondent the CEO concedes there was no evidence that a long term order of Parental Responsibility would guarantee permanency in RG's living arrangements, however, suggests the evidence does not mean it would not lead to permanency. This is a matter that to some extent needs to be determined by inference, however, given the strong bond that had developed between RG and TM, that arrangement is more supportive of permanency than the other evidence (or lack of it) that was before the Local Court.

Ground Three – Capacity of The Third Respondents and Associated Issues

[51] The first respondent the CEO, acknowledges a level of uncertainty about the question that was posed in her Honour's reasons concerning the capacity of the third respondents to care for RG.[64] The CEO accepts the evidence shows TM had the capacity to care for RG.

[52] In relation to the learned Chief Magistrate's conclusion that "the only evidence that RG has been appropriately fed by TM and CD comes from themselves and is inconsistent with all the medical evidence as to the reason for his malnutrition"[65], the first respondent, the CEO, effectively agrees this is contrary to the evidence. Dr Cornelius had stated 'TM.... does fulfil all

[64] AB 537, para [52].
[65] AB 534, para [40].

the requirements that RG needs'; [66] and 'TM ..... providing good care including his feeding'.[67]

[53] The first respondent also agrees the learned Chief Magistrate failed to take into account TM's changed work circumstances. TM was assessed critically in terms of being a carer when he was working for night patrol, and therefore sleeping during the day. His employment had changed and his capacity to care for RG had improved prior to the hearing in the Local Court.

[54] The first respondent the CEO concedes the learned Chief Magistrate did not appear to take into account other carers in the community such as RG's grandmother; nor the evidence of 'unintended traumatic implications' on RG's overall mental and physical development.

[55] Having reviewed the evidence, I agree the concessions are appropriately made. The appeal will be allowed. This is a difficult matter. RG's health is the primary concern, however, it appears that if the third respondents are given appropriate instruction in language, they have the capacity to meet appropriate standards of care. Much of the evidence indicates they were already meeting that appropriate standard but for RG's complex medical problem.

[66] AB 120
[67] AB 126

Conclusion

[56] There is not justification on the evidence available to warrant a long term order of parental responsibility giving parental responsibility of RG to the first respondent the CEO until he reaches the age of 18.

[57] As the evidence stands, RG is still in need of protection given his health status, however, if the third respondents are given instruction on his feeding and nutrition needs, there is no reason on the evidence to conclude that once this issue is dealt with that the third respondents would not be appropriate carers in terms of having daily care and control.

[58] In my opinion it is, however, premature to order joint parental responsibility to the first and third respondents with daily care and control to the third respondents.

[59] As the evidence stands, there should be a short term protection order giving parental responsibility to the first respondent, the CEO. The third respondents should be given an opportunity to receive some further instruction. The matter should be assessed by the CEO at the conclusion of the short term order bearing in mind that if the CEO is not satisfied at the end of that term that it is not in the best interests of the child to be returned to the third respondents, the CEO may apply to the court for an extended order.[68]

[68] *WM and FM v CEO* [2012] at [25].

[60] One reason I have taken the view that a short term order is justified is because of the speech therapy being more readily available in Darwin as opposed to Maningrida; but on the state of the evidence that does not justify a long term order.

[61] Before making orders under s 143 of the Act, I will hear the parties as Counsel for the first respondent CEO indicated there were matters to be drawn to the Court's attention before final orders are made.