In late 2009, the Northern Territory Chief Minister and Minister for Child Protection appointed a Board of Inquiry to investigate the child protection system. The inquiry was prompted by a series of major departmental failures including the case of an infant boy who starved to death in the care of his mother. The baby died despite the fact that his mother had a long history of involvement with Northern Territory Families and Children (NTFC) and had neglected or abused other children in her care. The many witnesses to the infant’s demise included department workers who missed numerous opportunities to intervene. A last crucial chance to rescue the child came when department workers tracked the pair to an Alice Springs supermarket. Instead of seizing the obviously ill child immediately, they allowed the mother to take him to hospital under her own recognisance. She fled the state and the child was reported dead some days later at a roadside petrol station. The mother was eventually jailed for her actions.

Another well-publicised case concerned the death of a 12 year-old girl who had been placed with her great aunt after her teenage parents had to relinquish her. No background checks were performed on the aunt (who had previously lost a child to drowning) nor did case workers respond to numerous reports over several years from relatives and neighbours concerned for the girl’s welfare. Sporadic home visits revealed that she lived in crowded, squalid conditions, yet caseworkers did not remove the child or ensure that the care improved. The last time the girl was sighted, she was lying on the kitchen floor, incontinent and unable to walk as she writhed in pain caused by an advanced leg infection. Workers neglected to take her to a doctor or interview her without the aunt present. She died shortly afterwards, alone and in agony, in her back garden. The girl had apparently been moaning too loudly to remain inside.

During the subsequent inquest it was found that the aunt had a serious gambling habit, losing more than $1.6 million in benefits at a Darwin casino. While she played the poker machines, the children in her care were left unsupervised for extended periods. It emerged that informants had also warned the NTFC about this problem, as well as suspected sexual abuse. The aunt was eventually acquitted of manslaughter but the Department would soon find itself being judged – and found wanting.
Growing them Strong, Together

The Board of Inquiry released its report into the child protection system in late 2010. Entitled *Growing them Strong, Together: Promoting the safety and wellbeing of the Northern Territory’s Children* the report was a broad-ranging examination of a system in deep crisis. It was the latest in a long line of investigations into child welfare issues in the Northern Territory. Concurrent to the Inquiry, the NT Ombudsman was conducting her own investigation into more than 50 cases of concern. In 2007, the Federal Government had launched the Northern Territory Intervention. This was in response to the *Little Children are Sacred* report which revealed widespread child sexual abuse and neglect in remote Aboriginal communities. While the Intervention drew considerable criticism, it nonetheless sent a clear message to the nation that the Northern Territory government was failing its most vulnerable citizens. Moreover, the situation was so dire it demanded external oversight.

*Growing them Strong, Together* suggested that little had improved since 2007. On one level, NTFC (the child protection and youth services division of the Department of Health and Families) faced the same problems as child protection agencies in all Australian jurisdictions and much of the English-speaking world: difficulties in attracting and retaining quality staff, rising demand, insufficient resources, and increasingly complex cases. Recent decades had seen a major expansion in the role and responsibilities of protection services along with raised community expectations that workers could and should be able to prevent all instances of abuse – abuse that was often underpinned by a broad and deep-rooted range of socio-economic issues.

However, there were many factors specific to the Northern Territory which increased the challenge of child protection considerably. They included: a large Aboriginal population with a long held distrust of welfare authorities spread across many remote areas; high rates of substance abuse and familial dysfunction; as well as serious public housing shortages and widespread welfare dependence. Said the report:

“In broad terms, the Inquiry found that on most indicators the children of the Northern Territory, and particularly Aboriginal children, are significantly disadvantaged and exposed to more harm than their counterparts in other jurisdictions. They have much higher rates of diseases, and accidents and death rates for children are elevated across all age categories. Children in the Northern Territory are more likely to be raised in unsatisfactory environments and to be exposed to various forms of harm such as exposure to family violence, alcohol and drug abuse, physical and sexual abuse and neglect. They are more likely to be exposed to alcohol in utero, to contract otitis media with the resulting hearing loss, to be anaemic, and to experience the impact of developmental trauma.

“Alarming numbers of children in remote areas do not attend school or only do so episodically, and their achievement levels are far below minimum acceptable standards. In many areas, children wander aimlessly around communities and become involved in dangerous or illegal activities. Recent data on developmental vulnerability (the AEDI) demonstrates that Aboriginal children in the Northern Territory are significantly more developmentally vulnerable than children in any other jurisdiction, Aboriginal or otherwise.”

Indigenous children made up just over 43 percent of all NT children but represented almost 75 percent of children taken into care. Despite this, they were still less likely to be reported than their counterparts elsewhere in Australia, perhaps reflecting enduring suspicion of authorities or a lack of faith that action would be taken. The report found that, at the time of writing, almost 900 notifications involving “at risk” children were still awaiting investigation:3

“The public would naturally expect that when they believe a child is being harmed and report this to the agency, the matter will be investigated speedily and effectively. This has not been the case for some time in many service delivery areas... The lack of capacity within the agency extends to the initial processing of notifications, normal case management activities and out-of-home care as well as specialist work units such as training and policy units. In short, the current system is unable to adequately respond to expressed concerns about the safety and wellbeing of children.”

Complicating the situation was a severe shortage of non government organisations (NGOs) involved in child welfare and the complete absence of Aboriginal-managed services in that sphere. What services existed were also concentrated in major population centres such as Darwin and Alice Springs. Moreover, delivering child protection services to remote communities could cost three to four times more than delivering services in urban centres. This added to an already considerable workload: “The Inquiry was advised and understands that, in the absence of a strong family support sector, child protection services have been expected to respond to a range of concerns and reports about child wellbeing, family difficulties and entrenched community problems rather than responding to reports of harm and injuries to children. The result is that these services struggle to do both tasks and have not been able to do either very well.” The NTFC also relied heavily on out-of-home care services – some 64 percent of children in care were placed in foster homes – and the number of children in these placements was growing. So were the costs per placement. Meanwhile, the pool of competent and available carers was shrinking. Finding suitable friends or relatives to provide kinship care was also a struggle.

A very unhappy family

Department overview

Although many interlinking factors were responsible for the parlous state of child protection, NTFC was frequently cited in submissions to the Board of Inquiry as the source of many issues and an amplifier of others. At August 2010, the Department reported a total of 503 full time equivalent (FTE) employees with 182 of those classified as part of the “professional stream” which included child protection workers, family support and out-of-home care workers, plus some therapeutic staff. The 2009

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3 ibid, p.18.
4 ibid.
5 ibid, p. 20.
6 ibid, p.22.
7 ibid, p.471.
operating costs for NTFC were reported as $94.4 million while the total budget was $83 million. There were five Branches within NTFC (Exhibit A):

- Care and Protection Services (CPS)
- Youth Services (YS)
- Family and Individual Support Services (FISS)
- Strategic Policy and Performance
- Business Services.

NFTC was part of the Department of Health and Families (DHF) which was responsible for a broad portfolio of health and community services. Although the number of child protection workers had increased during recent years, NTFC staff often used terms such as “poor cousins”, “low profile”, “absence of understanding” and “competition for resources” to describe their relationship to DHF. The Board of Inquiry had substantial difficulty determining exactly how the Department deployed its employees:

“The NTFC staffing profile itself is not easy to understand. The Inquiry could not obtain a clear or comprehensive picture of the workforce arrangements and requirements within the even broader Northern Territory child, family and community services of interlocking government and NGO services funded in a myriad of programs by multiple authorities and different levels of government. As with other jurisdictions, there is much complexity in the Northern Territory service delivery landscape where there is competition between all services for competent staff. There is an evident and urgent requirement to increase partnerships, collaboration and relationships between programs, agencies and personnel and to develop a more integrated child and family welfare workforce plan for the Northern Territory.”

Recruitment and retention

As was the case in other jurisdictions, recruitment of child protection workers was an area of ongoing difficulty. Frontline staff were often relatively young, inexperienced and poorly qualified compared to similar workers in the health/welfare/justice sectors, and typically paid less. In recent years, the NTFC (like many of its counterparts) had attempted to boost its ranks by recruiting staff from interstate or overseas. Many imports lacked the necessary cultural awareness to operate successfully; others were not adequately prepared for life in the Northern Territory. Local staff, meanwhile, often resented the bonuses paid to these workers and the differential treatment they received. Many submissions to the Inquiry spoke of this issue and related problems such as:

- “constant staff changes and people coming and going before they have proper orientation to the system”;
- “short term contracts”;
- “recruits being torpedoed in from overseas at higher pay and levels while the permanent staff look after them”;

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9 ibid, p.472
10 ibid, p. 21
• “nepotism in appointments particularly in relation to incumbents from other states”;
• “differential payments for new recruits without reference to longer term employees”;
• “people who struggled with the complexities of coming here and who have no idea about culture and isolation”.  

Within the NTFC the Workforce Development Unit (WDU) was responsible for staff recruitment and retention, workforce reporting, training and professional development. Consisting of roughly eight people at any one time, the Unit acknowledged some serious deficiencies including:

• Chronic under-resourcing of the WDU itself;
• Low participation levels in core and other training due to low staff numbers and inability to release staff to access training;
• Ad hoc and inadequate staff induction and orientation;
• Delayed training of up to 12 months for some new staff;
• Absence of a clear process to meeting workforce needs for career progression/professional development;
• Lack of understanding and lack of mechanisms for compliance with statutory policies, procedures and standards.  

This tallied with the Inquiry’s observations that although solid and comprehensive policies and procedures were in place with regard to child protection practice and staff development, there was little sign of consistent or effective implementation. It was not unheard of, for instance, for new workers with barely weeks of experience to be sent straight into the field to conduct complex formal investigations or assessments. Orientation was basic, primarily covering administrative issues such as which forms to fill in. Few workers had any training whatsoever in child interviewing techniques or similarly fundamental skills. 

Workers assigned to remote communities (often part-time or casual workers) were even more ill equipped. A remote area worker noted that: “...you go out on the Monday, and the first community was about 600 km away. I would get there late in the afternoon, do some bits and pieces, spend the whole of the next day doing casework in the community and then drive to the next community which was about 100 km to 120 km down the track. [By yourself?] Yes. Actually, most of the time it was in a car not a 4-wheel drive because we could not get 4-wheel drives. No mobile phone, no radios. No 4WD driver training.” And there was little preparation for staff dealing with some of the most common yet confronting aspects of frontline work. Wrote one senior manager:

“The workers at this, and other Child Protection Services Offices, are threatened, abused, yelled and screamed at, spat at, are subject to threats of violence to themselves and directed at ‘blowing up the Office’, have things thrown at them, have cigarette lighters flicked in their faces and have experienced the Office reception areas being smashed up or some other form of aggression or violence on almost a daily basis yet

12 adapted from ibid, p.494.
13 ibid, p.483.
there appears to be no real concern from anywhere in the Department that this is unacceptable.”

Workload was another major issue for staff, yet the inquiry was advised by the Department that “there has never been nor is there now a workload indicator for the dedicated child protection services in place in Northern Territory. Hence there cannot be, nor is there, any reasonable measure or reporting of workload performance, pressure or stress at this time.” Recommended child protection caseloads varied between 10 and 25 per worker depending on the complexity of the cases; the Western Australian government had recently accepted a benchmark ratio of 1:15 for caseworkers. These recommended caseloads however did not account for the kinds of variables routinely encountered in the Northern Territory. Moreover, the amount of work involved also varied considerably depending on whether the case was under investigation or in a different phase. According to the Department’s calculations, the average caseload for child protection workers was 25, however it was close to 50 for some regional workers and there were individuals who reported caseloads in excess of 60 (Exhibit B). Caseloads in the Top End were generally more than double those in Alice Springs or Darwin (Exhibit B). Department calculations suggested that reducing the average child protection caseload to 1:15 would necessitate a 50 percent increase in casework staff. The burden of the workload was also compounded by the nature of the work, as one practitioner observed:

“The amount of paperwork is incredible for each and every child, and rightly so. We are dealing with the most vulnerable and often the most damaged portion of the population. It is not surprising therefore that it is also the most emotionally charged for all concerned. BUT… the flip side is that NTFC staff are now so caught up in justifying our actions on paper that we spend more time sitting at a computer than we do with our clients and their families...Surely this should be our core business. What is wrong with this picture?”

Dedicated department workers frequently became disillusioned with the realities of the job, often within a matter of months. Many pursued a career in social services specifically to help vulnerable children and families and, hopefully, prevent the need for permanent separation. Instead they found themselves cast in an investigatory/prosecutorial role with much time spent in court or preparing for court appearances. Many workers found the legal process extremely draining, combative and detrimental to building effective working relationships with families. This prompted many workers to seek opportunities elsewhere, especially at NGOs where they felt their skills could be better utilised in organisations more aligned to their own values. And even though NGOs couldn’t necessarily offer better remuneration, they could often provide better conditions or increased flexibility.

The result was a very high turnover rate at NTFC, estimated to be in excess of 25 percent department-wide but as high as 80 percent in some offices (Exhibit C).

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16 Ibid, p.474.
17 Ibid, p.475.
Chronic absenteeism was also widespread. However, research and numerous submissions suggested that workload issues and the stresses of dealing families in crisis, though significant, were not primarily responsible for the continual drain of staff. Rather, it was the organisation itself. Said one worker:

“People always say to me that my job in child protection must be really hard and I must see some terrible stuff. Well, the job can be challenging and horrendous. Abuse and neglect of children does happen, but the hardest part of my job that makes me the most upset and angry is the system I am working within. It is the system that re-abuses the kids and re-traumatises already vulnerable and traumatised children.”19

Management and culture

Many submissions to the enquiry described a toxic working environment within NTFC and a feeling of being continually under siege. Said the inquiry report: “Alongside the evidence of dedication and commitment, significant personal, organisational and professional trauma and unrest amongst NTFC staff is also evident. People talk about a work environment where distress and disruption are endemic and about their fear that there are ‘risks of [the] system becoming even more dysfunctional’ as result in part of ‘even more inquiries’. Many mention the fragility of both the system and the staff. Others express their concern about the ‘ politicisation of child protection’ and the worry that ‘the system could completely collapse if we unleash even more criticism’.”20 Management, or lack thereof, was a recurring theme with the WDU itself acknowledging significant issues:

- Major deficits in leadership and management training;
- Poor participation by senior practitioners, team leaders and managers because of case demands at the front line;
- Absent or “on the run” supervision and the inconsistency of supervisory skills amongst managers and team leaders.21

These problems seemed to extend all the way through to the upper levels of the department with a widespread perception that those in senior positions didn’t care about the difficulties frontline staff faced. Staff reported being “blocked” by those above them, management that was unwilling to recognise or respond to identified problems, failure to follow up on promises, little accountability for actions, a lack of innovation and an absence of respect or support. Some remarked that managers barely noticed whether their staff presented to work or not, let alone whether they were struggling to cope. There was also a pervasive feeling that, despite all the attention on child welfare and numerous assurances, nothing much had changed. A culture of bullying and scapegoating was widely remarked upon in submissions as well. Said one experienced ex-employee:

“Bullying occurred on an hourly basis as a result...of certain individuals [exercising] their power over staff member[s] who vocally disagreed to bad practice [and] poor decision making. When practitioners spoke out, these individuals were ‘frozen out’,

20 ibid, p.481.
21 ibid, p.469.
allocated more cases, expected to manage without adequate support from Family or Team Support Workers, ridiculed, [had] court matters pushed back and [were subject to] unrealistic expectations [which forced them] to leave the work unit.  

Another ex-staffer made similar observations:

“I have too much to say in terms of the bullying and harassment that takes place within Child Protection Services. It is these practices that immobilise and force good staff to leave the department to work elsewhere. It is a major problem that has left a legacy of malpractice, corruption that has further permeated a culture that serves to denigrate its workers, clients and systems - hence why community relations [are] terribly poor. No work has gone into changing the profile of this organisation, which is viewed by demoralised community as an organisation that further alienates people it is meant to serve, support and assist to overcome their problems and to make reunification a reality for most who have entered the care system, but are left to drift.”

Victims of bullying had little recourse. HR, noted one submission, offered little support amidst “a culture within the upper echelons of management that did not take kindly to criticism of any of the shortfalls of the department’s practices.” External criticism meanwhile prompted scapegoating: “When cases go badly, for whatever reason, the Department will pick a likely person and blame them on an individual and personal level for the incident.”

**Stakeholder relationships**

While internal relations were poor, the same was true for NFTC’s relationships with NGOs, government agencies and other stakeholders. The Inquiry noted that very few NGOs had anything approaching productive or positive dealings with the department. NGOs were highly critical of the lack of cultural and procedural awareness displayed by workers and frustrated by constant staff turnover which severely compromised case planning and decision-making. Lack of consultation was another common complaint along with a lack of action for children at high risk. Some spoke of a kind of “institutional racism” where conditions that would be considered unacceptable for non-Aboriginal children were seen as normal for Aboriginal children. Said the report:

“Many workers spoke about the lack of preparation for the cultural context of practice: many workers had never worked with Aboriginal people before either as clients or as colleagues. ‘Working it out for yourself’ was frequently identified as the strategy for developing skills to work cross culturally. Where workers were afforded the opportunity to work with an experienced Aboriginal Community Worker they commented on the usefulness of this, and the sense of safety this collaboration provided. However, many workers did not have this opportunity.”

23 ibid, p.500.
24 ibid, p.501.
25 ibid.
26ibid, p.495.
In addition, NGOs were often unclear as to their role and responsibilities vis a vis the NTFC. Organisations that had attempted to clarify their relationship found themselves rebuffed. Meanwhile, other NGOs were wary of becoming too closely involved with the department. They worried about their autonomy and independence along with their capacity to accommodate the Department’s demands.

The situation was much the same with other government departments and agencies such as schools, hospitals and police. External professionals reported great difficulty working with NTFC, especially in getting an adequate and timely response to reports of abuse. The submission from Alice Springs Hospital observed that: “NTFC employees are often on short-term contracts, have had minimal orientation and do not have any orientation to the hospital resulting in poor communication, misunderstanding, lack of process and inconsistent procedures. This results in the inability to form strong inter-professional relationships.”

External professionals speaking out could also find their jobs in jeopardy. An episode of *Four Corners* screened in 2010 highlighted the story of a Darwin hospital social worker who had lodged a complaint about the NTFC’s failure to protect a vulnerable infant in the care of a violent uncle. Instead of getting a response, she was severely censured for her conduct.

Foster and kinship carers also had serious concerns. Many felt unsupported by the department and struggled to access the services they needed. Carers frequently cited communication difficulties which led to unclear expectations and a feeling of being kept in the dark. Numerous children in out-of-home care had significant cognitive/emotional/physical issues that were never properly outlined to caregivers. NTFC could move children from or between placements at a moment’s notice and with little regard for the carer’s situation or the children’s needs. Submissions to the inquiry observed that no initial training was given to foster carers who could go for years without training or reassessment. Kinship carers usually found themselves with even less support and sometimes also faced the wrath of embittered and deeply troubled parents. In recent years, recruiting and retaining committed and competent carers had become increasingly difficult – particularly carers within the Aboriginal community who were especially needed.

Carers (and indeed parents) who harboured concerns for children under state protection, or who were otherwise in dispute with the department, had few avenues for redress. Internal mechanisms for resolution were ineffective and complainants often feared retribution. Those determined to pursue their claims had little choice but to appeal to an external arbiter such as the Ombudsman or Minister. Investigations typically took months to complete, exacerbating the trauma and disruption for all concerned. Complainants or whistleblowers had little sense of transparency in dealing with NTFC which could cite “privacy concerns” as a reason for withholding information. Likewise, they had little faith that staff engaging in unethical or grossly incompetent conduct would ever be held accountable.

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The Report

The *Growing them Strong, Together* Inquiry report made a total of 147 recommendations many of which pertained specifically to the NTFC. Recommendations included a call for greater investment in child protection and family services. The report also suggested a shift in emphasis from a heavily forensic, risk-management approach to include community-based preventative and early intervention activities. Critics of the existing system noted that it tended to tie up a lot of resources while offering little practical assistance to children and families in crisis. Just over 10 percent of the NTFC budget was devoted to prevention and support services. The net result was that numerous children languished until their families had deteriorated sufficiently to attract intervention and, even then, could still easily slip through the net. In other instances, families that primarily required guidance and support got drawn into a highly adversarial system with limited scope to help.

*Growing them Strong, Together* outlined the kind of child protection system its authors wanted to see, one where NGOs, communities and the NFTC worked together to improve outcomes for children. Suggestions included the development of:

- a dual pathway intake and assessment process involving the NFTC and NGOs;
- a better defined primary focus for NFTC;
- the creation of 20 Community Child Safety and Wellbeing teams for growth areas;
- the establishment of place-based, inter-agency, Community Child Safety and Wellbeing teams;
- an expansion of the scope of children and family centres in remote areas to include secondary and tertiary level services;
- the development of more children and family centres in areas of need;
- a new collaborative approach to child protection decision-making in urban areas; and
- a re-development of the child safety and wellbeing roles of other government agency workers.²⁸

There was also recognition of the need for more “home-grown” caseworkers, particularly those from an Aboriginal background or who had extensive experience in working with communities. *Growing them Strong, Together* generally recommended an 18-month time limit to begin addressing the organisation’s most complex issues. But some observers wondered whether such a radical transformation would be possible in a department with so many problems. In July 2010, Clare Gardner-Barnes was appointed the Executive Director of NTFC, three months before the release of the Inquiry report. She would be later appointed as head of the new Department of Children and Families (DCF) in May 2011 when NTFC was split off from DHF.

Exhibit A: 2010 Organisational Chart NTFC
## Exhibit B: Child protection caseloads NTFC

<table>
<thead>
<tr>
<th>Region</th>
<th>No. of 'open' cases</th>
<th>No. of case workers P1/P2</th>
<th>Average caseload</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Australia</td>
<td>487</td>
<td>23</td>
<td>21</td>
</tr>
<tr>
<td>Top End (inc. Darwin Remote, Katherine and Nhulunbuy)</td>
<td>846</td>
<td>18</td>
<td>47</td>
</tr>
<tr>
<td>Darwin</td>
<td>920</td>
<td>49</td>
<td>19</td>
</tr>
<tr>
<td>Total</td>
<td>2253</td>
<td>90</td>
<td>25</td>
</tr>
</tbody>
</table>

## Exhibit C: NTFC turnover rates

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Total Separations 2008-09</th>
<th>Percent Annual Turnover Rate 2008-09</th>
</tr>
</thead>
<tbody>
<tr>
<td>NTFC Division Wide</td>
<td>92</td>
<td>26.46</td>
</tr>
<tr>
<td>NTFC Executive</td>
<td>2</td>
<td>40.68</td>
</tr>
<tr>
<td>Budgets &amp; Finance</td>
<td>1</td>
<td>8.57</td>
</tr>
<tr>
<td>Child Protection Services (Branch Wide)</td>
<td>60</td>
<td>30.73</td>
</tr>
<tr>
<td>Executive</td>
<td>5</td>
<td>146.34</td>
</tr>
<tr>
<td>Darwin</td>
<td>21</td>
<td>24.32</td>
</tr>
<tr>
<td>Top End</td>
<td>9</td>
<td>24.22</td>
</tr>
<tr>
<td>Central Australia</td>
<td>20</td>
<td>35.14</td>
</tr>
<tr>
<td>Remote Aboriginal &amp; Community Workers Team</td>
<td>1</td>
<td>14.29</td>
</tr>
<tr>
<td>Mobile Child Protection</td>
<td>4</td>
<td>67.61</td>
</tr>
<tr>
<td>Out of Home Care Branch Wide Area</td>
<td>11</td>
<td>26.24</td>
</tr>
<tr>
<td>Youth Services – Branch Wide</td>
<td>3</td>
<td>23.84</td>
</tr>
<tr>
<td>Youth Services Executive</td>
<td>2</td>
<td>37.5</td>
</tr>
<tr>
<td>Youth Justice Policy &amp; Program Support</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Darwin Family Support Centre</td>
<td>1</td>
<td>66.67</td>
</tr>
<tr>
<td>Alice Springs Family Support</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Family &amp; Individual Support Services – Branch Wide</td>
<td>15</td>
<td>28.5</td>
</tr>
<tr>
<td>Family &amp; Individual Support Services - Executive</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Family &amp; Parenting Resources</td>
<td>1</td>
<td>33.33</td>
</tr>
<tr>
<td>Domestic &amp; Family Violence Policy Team</td>
<td>11</td>
<td>45.67</td>
</tr>
<tr>
<td>Sexual Assault Referral Centre</td>
<td>3</td>
<td>16.4</td>
</tr>
<tr>
<td>Policy &amp; System Support</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
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