

# The death of Ebony: The need for an effective interagency response to children at risk

A special report to Parliament under section 31  
of the *Ombudsman Act 1974*

October 2009



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The need for an effective interagency  
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NSW Ombudsman

Our logo has two visual graphic elements; the 'blurry square' and the 'magnifying glass' which represents our objectives. As we look at the facts with a magnifying glass, the blurry square becomes sharply defined, and a new colour of clarity is created.

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October 2009

The Hon Peter Primrose MLC  
President  
Legislative Council  
Parliament House  
Sydney NSW 2000

The Hon Richard Torbay MP  
Speaker  
Legislative Assembly  
Parliament House  
Sydney NSW 2000

Dear Mr President and Mr Speaker,

I submit a report pursuant to s.31 of the *Ombudsman Act 1974*. In accordance with the Act.  
I draw your attention to the provisions of s.31AA of the *Ombudsman Act 1974* in relation to  
the tabling of this report and request that you make it public forthwith.

Yours faithfully



Bruce Barbour  
**Ombudsman**



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# Foreword

On 3 November 2007, a seven year old girl died in tragic circumstances that caused widespread public concern.

Her death became one of the main catalysts for the NSW Government initiating a Special Commission of Inquiry into Child Protection Services in NSW, and for the reforms to the child protection system arising from that inquiry.

In a media release on 6 November 2007, I stated that my office had commenced an investigation into the involvement of several government agencies in the circumstances of that little girl and her family.

My investigation was completed in November 2008, and the report on that investigation was provided to all involved agencies and relevant Ministers, together with Mr James Wood AO QC, who was conducting the Special Commission of Inquiry.

Shortly after her death, the girl's parents were charged with her death. As the criminal proceedings – including sentencing – have now been finalised, I have decided to make a detailed special report to Parliament in relation to this matter. It is my view that it is important to be reminded about what can go wrong for children when agencies fail to work effectively, fail to work together, and fail to take shared responsibility for the care and protection of children. For this reason, I believe that there are sufficient grounds to outline the observations, findings and outcomes arising from my investigation into the actions of agencies involved with this child and her family.

I also believe it is important that the public is assured that my office has met its obligations to thoroughly investigate this tragic case.

NSW Supreme Court judge Robert Hume recently decided that the young girl's middle name, Ebony, should be made public. For this reason, throughout this report we have referred to her as Ebony.

This report provides a background of Ebony and her family's situation and an overview of agency involvement. It outlines this office's investigation and findings in relation to five key agencies and the steps taken by these agencies to address identified deficiencies. The report also considers the NSW Government's child protection reform plan and the proposed significant changes that are directly relevant to the problems discussed in this report.



Bruce Barbour  
**Ombudsman**



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# Contents

<b>Chapter 1. Background .....</b>	<b>1</b>
<b>Chapter 2. Overview of government agency involvement with Ebony and her family.....</b>	<b>3</b>
<b>Chapter 3. Our investigation and findings.....</b>	<b>7</b>
<b>Chapter 4. Department of Community Services .....</b>	<b>9</b>
4.1 The nature of our investigation .....	9
4.2 DoCS: legislation, policy and procedures .....	9
4.3 Chronology of DoCS' involvement with the family: 2000 – 2006.....	10
4.4 Our observations: provision of child protection services 2001 – 2006 .....	11
4.5 Our observations: handling of risk of harm reports received by the DoCS Helpline during 2005 and 2006.....	11
4.6 DoCS' involvement with the family: 2007.....	13
4.7 Our observations .....	14
4.8 Steps taken by the second caseworker and her supervisor to progress the risk assessment.....	15
4.9 Our observations .....	16
4.10 DoCS' handling of the 12 and 15 September risk of harm reports.....	16
4.11 Our observations .....	17
4.12 Completion of the risk assessment and transfer to Raymond Terrace CSC.....	17
4.13 Our observations .....	18
4.14 DoCS' actions to address the issues of concern identified in the Ombudsman investigation .....	19
4.15 Final recommendations and DoCS' actions to implement these.....	20
<b>Chapter 5. Department of Education and Training.....</b>	<b>23</b>
5.1 The nature of our investigation .....	23
5.2 DET: Legislation, policies and procedures .....	23
5.3 DET's involvement with the family prior to Ebony's death.....	24
5.4 DET review of its actions .....	27
5.5 Absenteeism .....	27
5.6 Response to safety and welfare concerns .....	28
5.7 DET's actions to address the issues of concern .....	29
5.8 Final recommendations and DET's actions to implement these.....	29



<b>Chapter 6. Department of Ageing, Disability and Home Care .....</b>	<b>31</b>
6.1 The nature of our investigation .....	31
6.2 DADHC: Legislation, policies and procedures.....	31
6.3 Chronology of DADHC's involvement with the family .....	32
6.4 Our observations .....	33
6.5 DADHC's actions to address the issues of concern identified in the Ombudsman investigation .....	36
6.6 Final recommendations and DADHC's actions to implement these .....	37
<b>Chapter 7. Department of Housing .....</b>	<b>39</b>
7.1 The nature of our investigation .....	39
7.2 DOH: Legislation, policies and procedures.....	39
7.3 Child protection concerns and DOH actions (2006 – 2007).....	40
7.4 Our observations .....	42
7.5 DOH's actions to address the issues of concern identified in the Ombudsman investigation .....	43
7.6 Final recommendations and action by DOH to implement these .....	43
<b>Chapter 8. The NSW Police Force .....</b>	<b>45</b>
8.1 The nature of our investigation .....	45
8.2 NSW Police Force: legislation, policy and procedures .....	45
8.3 DET referral to NSW Police.....	45
8.4 The actions of the NSW Police Force to address the issues of concern identified in the Ombudsman investigation .....	47
8.5 Final recommendations and action to implement these.....	47
<b>Chapter 9. Interagency response to child protection concerns for the children .....</b>	<b>49</b>
<b>Chapter 10. Reform of child protection in NSW .....</b>	<b>51</b>
<b>Chapter 11. Reforms in the context of our investigation.....</b>	<b>53</b>
11.1 Interagency coordination.....	53
11.2 High risk families.....	54
11.3 Habitual non-school attendance.....	54
<b>Chapter 12. Conclusion.....</b>	<b>55</b>

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# Chapter 1.

## Background

Ebony was aged seven years when she died on 3 November 2007. An autopsy determined that her death was due to chronic starvation and neglect. Her parents were charged in relation to her death on 17 November 2007. The NSW Supreme Court, sitting at East Maitland, heard evidence over five weeks and on 23 June 2009, the jury found her mother guilty of murder and her father guilty of manslaughter.

At the time of her death in November 2007, my office had identified that her death was 'reviewable' under section 35 of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*. Our review of the available material raised a number of questions about the adequacy of DoCS' response to concerns about the safety and wellbeing of the child and her siblings.

Accordingly, I determined to initiate an investigation into the matter.

At the outset, we should emphasise that the details in this report regarding the conduct of both parents have been taken from documents, and other evidence, provided to us by agencies relating to their involvement with the couple. We have made no findings about the parents because this is not our role. Instead, our sole focus has been on the response by involved agencies, based on their evidence of what their staff saw and heard.

We have also removed identifying information in this report for the protection of the individuals involved. We have named Ebony. We agree with comments by Supreme Court Judge Hume that a failure to grant Ebony a name would serve to perpetuate her abandonment.

At the same time that I made my decision to investigate this matter, the then Director General of the Department of Community Services wrote to me to advise that there was a long history of involvement by DoCS and other agencies with Ebony's family. He also asked that I investigate the matter.

In the following weeks, my office reviewed health, education, housing, and police records, and records held by the Department of Ageing, Disability and Home Care relating to Ebony and her family. Based on my review of these records, I decided to expand my investigation to include the actions of the Departments of Education and Training; Ageing, Disability and Home Care; Housing and the NSW Police Force, as they related to Ebony and her siblings.

It is well known that as a consequence of the death of Ebony, and that of a toddler who died at around the same time, the NSW Government established a commission to inquire into child protection services in NSW.

On 24 November 2008, Mr James Wood AO QC, handed down his report from the Special Commission of Inquiry into Child Protection Services in NSW.

In the introduction to his report, Justice Wood said that as criminal proceedings were underway but not yet finalised in relation to the deaths of the two children, the inquiry would not comment on the two cases. He noted that the deaths of both children had been the subject of comprehensive review by both my office and DoCS and that these reviews '*have informed the considerations and recommendations of the inquiry*'.

In response to Justice Wood's report, the NSW Government developed a five-year comprehensive plan to reform child protection in NSW. This plan *Keep them Safe: A shared approach to child wellbeing*, will result in significant changes to the child protection system in NSW.

In summary, the objectives of the plan are to make child protection a 'shared responsibility', with all relevant government agencies having prescribed responsibilities for ensuring the wellbeing of children. DoCS will respond to cases where there is risk of significant harm only. Relevant agencies will establish child protection units to assist their staff to determine cases of children at risk that warrant DoCS' intervention. Cases that do not meet the threshold for DoCS' involvement will be handled by the agencies themselves, either through referral to new regional intake and referral services established by non-government agencies, or through the resources of the agencies themselves.

This change will be supported by an expansion of early intervention services and an enhanced role for the non-government sector in the provision of services.

The reforms will also be facilitated by legislative change. In April 2009, relevant amendments to the *Children and Young Persons (Care and Protection) Act 1998* were assented by Parliament. At the time of writing, the amendments were pending proclamation. The facts in this report underscore the many challenges ahead.

The changes arising from *Keep them Safe* that are directly relevant to the problems and inadequacies identified through my investigation of the case are discussed in the final section of this report.



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## Chapter 2.

# Overview of government agency involvement with Ebony and her family

It is not the purpose of this report to discuss all of the evidence that this office considered in reaching our findings in this matter. However, for the purpose of providing context, the following provides a broad overview of agency involvement with the family from the time the parents married, until Ebony's death.

Ebony's parents married in May 1992. The mother was aged 18 and the father was 32. Each was on sickness benefits and each had a history of estrangement from their families.

Health records indicate that prior to her marriage the mother had had multiple hospital admissions for overdoses. At the time her pregnancy with her first child was confirmed, the mother was assessed as having suicidal tendencies and relationship problems. Health records show that throughout the following years the mother continued to experience anxiety, depression and pain as a result of a fall during her third pregnancy. She developed a dependency on Valium and painkillers.

Shortly after their marriage, the parents applied to the Department of Housing (DOH) for priority housing. The application was based on the mother's pregnancy and the father's chronic severe anxiety neurosis and long-term dependence on Valium.

Their first child was born in 1992. Their second child was born in 1994, followed by Ebony's birth in 2000. A fourth child was born in 2002.

The family remained in public housing until late August 2007 when they moved to the private rental property at Hawks Nest where Ebony died. Housing records indicate that the family generally paid their rent on time. DOH did not identify property maintenance issues as a concern until early in 2007.

The records indicate that the parents experienced difficulties managing the behaviour of their two older daughters from the time the children were toddlers. In 1998, the two older children were assessed by a paediatrician as having attention deficit hyperactivity disorder and the younger of the two as also having obsessive compulsive disorder. The paediatrician revised this assessment once the girls commenced school; however, in the following years the parents persisted with the view that both girls had behaviour disorders for which they required medication.

At all four schools that the two older girls attended between 1998 and 2005, chronic absenteeism was a major concern for education personnel. The children's teachers also had concerns about their extremely poor basic skills and their failure to progress, due to extremely poor attendance. Education staff also held concerns about the parents' use of medication to control the children's behaviour and that the children showed signs of physical neglect.

The family was first brought to the attention of the Department of Community Services (DoCS) in May 1993, when the oldest child was eight months old. DoCS received two subsequent reports in quick succession. These reports were both investigated and the allegations were not substantiated.

In the following six years, DoCS received no reports concerning the children.

When Ebony was born in 2000, she failed to thrive. The cause of this was investigated by health professionals but was not established.

In October 2000, the Department of Education and Training (DET) made a report to DoCS about the older two children's poor school attendance. In 2001, DET made further reports to DoCS on the same issue. In June 2001, DoCS allocated these reports to a child protection caseworker for risk assessment.

This marked the commencement of a two-year period of intensive involvement by DoCS with the family. Almost from the outset, the DoCS caseworker experienced significant difficulties working with the parents. They would not answer the phone, failed to attend the children's medical appointments, and would not allow the worker to sight Ebony. The two older girls continued to be absent from school. In January 2002, the department initiated care proceedings in the Children's Court because its informal attempts to get the family to engage with appropriate health, educational and support services had failed.

In March 2002, the parents' fourth child was born. In May of the same year, the Children's Court issued final orders which provided for DoCS' supervision of the family for nine months. The parents had also agreed to certain undertakings. When the parents failed to comply with these undertakings, and when it was established by medical staff that the fourth child was failing to thrive while in her parents' care, DoCS returned the matter to Court and removed the baby.

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For much of the rest of the year, DoCS pursued a case plan based on the removal of the three older children from their parents' care. By then, concerns had been identified that Ebony was also failing to thrive, and that she was experiencing global developmental delay.

After a period of non-cooperation and obstruction by the parents, matters improved. Late in 2002, the Children's Court ordered that the three older children were to remain with their parents. The period of DoCS supervision was continued until February 2003. The parents also undertook to ensure the older girls' school attendance. Separately, DoCS worked on a plan to restore the youngest child to her parents' care.

This plan changed after the parents disclaimed any responsibility for the baby's failure to thrive, and generally, for child protection concerns within the family. In October 2003, the Children's Court made final orders placing the baby under the parental responsibility of the Minister until she attains the age of 18 years.

After the supervision order expired in February 2003, DoCS did not receive any reports concerning the family for the remainder of that year and received only one report late in the following year from a concerned member of the community who knew the family. The DoCS Helpline determined this report did not warrant further assessment.

DET records indicate that the older two children's school attendance improved during the first half of 2003; however, school attendance was a matter of concern again for DET personnel by the second half of 2003 and thereafter. In June 2005, the parents removed the two older children from school. Despite the efforts of education personnel, they did not return to school until after Ebony's death in November 2007.

During 2003, 2004 and 2005, the mother took Ebony to see a number of health professionals about her short stature, low weight and behaviour. Her weight improved to the extent that by mid 2004 she was described by one paediatrician as '*overweight*' and by another who saw her in December 2005, as '*slightly obese*'. The health records all refer to the increasing difficulties the mother experienced managing Ebony's behaviour.

In 2005, a paediatrician diagnosed Ebony as having autism; however, this was never formally assessed. The child's paediatrician at the time referred her to the Department of Ageing, Disability and Home Care (DADHC) and a number of other support services. The mother accepted services from some of these but subsequently withdrew Ebony from the services on the basis that they made no difference to her behaviour.

In 2005, Ebony entered the education system by briefly attending a government-run preschool. When her parents withdrew her two older sisters from their schools in mid 2005, they also withdrew Ebony from the preschool. She returned to the preschool late in 2005 and was offered a place in a DET special school for the 2006 school year. DADHC assessed that she required case management and a range of therapy services including speech pathology, physiotherapy and occupational therapy and recommended that she receive these therapy services in the school setting.

During 2005, DoCS received six risk of harm reports concerning the children. Four of these were made by DET personnel and concerned the older children's school attendance; one was made by a medical officer and concerned the parents' capacity to cope with Ebony's behaviour; and one was made by a person who had been told of concerns for the children. None of these reports were allocated by DoCS for risk assessment.

From the beginning of 2006 until her death in November 2007, there is no record of Ebony receiving any services from any agency.

The parents accepted the school placement offer for Ebony in April 2006, but they failed to enrol her and she never attended the school or any other school prior to her death. In May 2006, DADHC made a risk of harm report to the DoCS Helpline about the child's failure to attend school. DADHC then closed its file for her.

During 2006, DoCS received three risk of harm reports concerning the children. One of these was made by a person who knew the family, one as we have noted was made by DADHC, and in late August DET made a further report concerning the older children's ongoing failure to attend school and the failure of the parents to enrol Ebony at the special school.

In November 2006, in response to the August report, DoCS made inquiries of the Department of Housing. DoCS was told that the family had not applied to move and that DOH held no child protection concerns. Inquiries of the person who knew the family established that they had no current information on the family. Inquiries of DADHC established that DADHC was not working with the family because of the family's lack of response. Inquiries of DET established that DET continued to be concerned for the welfare of the three children. DoCS then closed the report due to competing priorities.

In March 2007, DOH made a report to DoCS about the squalid state of the family's home. In early April, DoCS allocated this report for risk assessment. Caseworkers sighted the two older children during a home visit in April and a paediatrician saw the two older girls in May. However, despite the family living in the house until the end of August 2007, neither DoCS' caseworkers nor any other professional sighted Ebony prior to her death.

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Between March and April 2007, DOH supervised the father's cleaning of the premises. Thereafter DOH monitored the family's tenancy; however, DOH staff did not enter the premises again until after the family vacated it.

A concerned community member notified DET when she saw a removalist's truck outside the family's Matraville house on 31 August 2007. DET alerted police to the move and requested their assistance to locate the family's forwarding address. Police advised DET that they were unable to locate the address.

On 12 September 2007, a community member inspected the vacated Matraville premises and reported to DET that the house was filthy and that there was faeces all over the floor in Ebony's bedroom. Both DET and the community member reported these concerns to DoCS.

On 18 September, DoCS asked DOH for the family's forwarding address. DOH located the address on the removalist's invoice and provided it to DoCS on 19 September.

On 30 October, the DoCS office in Sydney transferred the children's child protection files to the department's Raymond Terrace office. The files were not allocated to a child protection worker until after the department was notified of Ebony's death on 3 November 2007.



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## Chapter 3.

# Our investigation and findings

Our preliminary examination of agency files raised questions about the actions of the Departments of Community Services, Education and Training, Ageing, Disability and Home Care, Housing and the NSW Police Force, as they related to this family.

We also considered relevant information provided by the Sydney South West Area Health Service and the South East Sydney Area Health Service in relation to the family.

Set out below is a summary of our investigation's findings and recommendations with respect to each of the five agencies that we investigated. We have also included information about how the agencies have responded to the issues that we identified from our investigation.

The recommendations in our final report took into account significant initiatives and projects that subject agencies had put in place to improve their delivery of services to vulnerable children and their families. We also took into account the Special Commission of Inquiry into Child Protection Services in NSW, and that this inquiry would be making its recommendations to the NSW Government by 31 December 2008.

We provided Justice James Wood with advice on the progress of our investigation in the context of his inquiry, and a copy of our final report was provided to relevant Ministers, Director-Generals, and to Justice Wood.





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# Chapter 4.

## Department of Community Services

### 4.1 The nature of our investigation

Our review of the children's child protection files raised concerns about the actions taken by DoCS in responding to risk of harm reports concerning Ebony and her two older sisters from 2005 onwards.

We decided to investigate DoCS' actions in responding to and handling risk of harm reports concerning these children.

Our investigation included the following steps:

- We reviewed DoCS' child protection files for the children and the out-of-home care files for the youngest child.
- We requested information about the staffing establishment of the DoCS office that handled most of the reports concerning the children.
- We interviewed DoCS staff who were involved with the family in 2001 – 2003, or who had case management responsibility for the children in 2007.

### 4.2 DoCS: legislation, policy and procedures

The *Children and Young Persons (Care and Protection) Act 1998* places significant responsibility on DoCS for the care and protection of children and young people. Under the legislation that was in operation during the relevant period, DoCS was the sole agency tasked with receiving and assessing reports about children and young people at risk of harm, assessing risk where the department believed that there was a likelihood of harm, and having lead agency responsibility where intervention was deemed necessary for the care and protection of children.

DoCS' Helpline was the single entry point for receiving and assessing risk of harm reports, and referring reports needing further assessment or investigation to DoCS Community Services Centres (CSCs) or Joint Investigation Response Teams. When undertaking an initial assessment of a new report to the Helpline, caseworkers are expected to review the child protection history and give consideration to any relevant history when making decisions about the level of risk and the urgency of the required response.

The secondary risk of harm framework was introduced by DoCS in 2002. Secondary assessment undertaken by child protection caseworkers based at CSCs aims to provide a holistic assessment, which substantiates risk of harm or confirms the safety of a child. If risk is substantiated, the assessment identifies the level of risk and the protective strategies required to ensure a child's safety.

The department's practice guidelines in 2007 state that, *'the general principle is that once [comprehensive secondary risk of harm assessment] is commenced, it must be completed'*. As a rule, the assessment is to be completed within 28 days of a case being allocated if harm or risk is not substantiated and within 90 days if harm or risk is substantiated.

All children for whom DoCS provides, or coordinates, a service must have a case plan. Case plans should be monitored, reviewed and should remain open on the relevant data base (KiDS) until all case plan tasks have been completed. New reports are required to be printed off and placed on a child's hard copy child protection file.

At the time of these events, departmental practice guidelines stipulated certain requirements for child protection matters requiring transfer from one CSC to another. These requirements included having a 'case meeting' prior to transfer. There were no such requirements for matters transferred from one caseworker to another working within the same unit.

In July 2006, DoCS released its policy on child neglect. This policy was developed in response to an increased understanding of the prevalence of neglect and its adverse impact on children's development. According to the neglect policy, *'it reflects a new focus on the severity of neglect and seriousness of the harm neglect can cause, including loss of life'*.

When a child or young person and/or their family change their place of residence, the CSC that has current case management responsibility for the case plan must complete the assessment and then transfer the case plan to the receiving CSC. According to the department's practice rules for transfer of case management, this can be negotiated depending on the situation of the child or young person.

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The forwarding CSC must alert the manager casework at the receiving CSC to the need for the transfer, conduct a case meeting and attach all paper records to the file before transferring the hard copy file. The receiving CSC must review the case plan within five working days of the files being received.

### 4.3 Chronology of DoCS' involvement with the family: 2000 – 2006

DoCS had extensive involvement with the family prior to Ebony's death.

The following facts concerning DoCS' dealings with the family between 2000 and 2006 are relevant to our findings and observations.

- DoCS' involvement with the family prior to 2000 was minimal. During this period, the department received three reports, two of which it investigated. These reports concerned the two older children. DoCS did not identify significant concerns regarding risks to the children.
- Ebony – the third child – was born in March 2000. Six months after her birth, DoCS received a report from the school concerning the older two children, about their poor school attendance and their general welfare. This was the first report DoCS had received about the children in six years. Two further reports concerning the older girls' absenteeism from school and general welfare were made to DoCS in the next 10 months. In June 2001, following receipt of the second of these reports, DoCS commenced a risk assessment.
- In January 2002, DoCS lodged an application with the Children's Court for an assessment order and for a supervision order. The reason DoCS initiated this action was because the parents were evasive, did not follow up referrals and the older children continued to miss significant amounts of school. DoCS had also identified concerns about Ebony's low birth weight and small size.
- The fourth child was born in early March 2002. She was born with significant health problems. DoCS applied for her to be included in the proceedings already before the Children's Court.
- While the matter was before the Court, all four children underwent assessment at the Sydney Children's Hospital. Additionally, a Children's Court Clinician completed an assessment. In her assessment report, the clinician noted that Ebony presented as '*an extremely worrying child*' because of her significantly delayed development. In relation to the older children, she stated that there was no medical reason for their poor school attendance. While the clinician concluded that the three older children were not at serious risk of harm, she said that they would need to be closely monitored by services.
- On 16 May 2002, the Children's Court issued final orders concerning all four children. These included a supervision order for nine months and undertakings from the parents. The objective of the orders was to ensure the older girls' regular attendance at school and the ongoing provision of appropriate services to meet the assessed needs of all four children.
- On 12 June 2002, DoCS removed the baby from her parents' care and applied for an Emergency Care and Protection Order. This action was taken because of medical concerns that the baby was failing to thrive while in her parents' care. As a result, she was placed in foster care.
- On 12 June 2002, DoCS also lodged a breach application with the Children's Court in relation to the parents' failure to abide by their undertakings.
- Between June and October 2002, DoCS' case plan was for the three older children to be brought into care. However, from mid October through to early December 2002, DET, DoCS and health professionals reported improved cooperation by the parents with authorities.
- On 19 December 2002, the Children's Court issued final orders for the three older children. The court ordered that the current supervision order and undertakings continue until expiration on 16 February 2003; that parental responsibility be shared for medical issues between the parents and the Minister for the remainder of the supervision order; and that, beyond the expiration of the supervision order, the parents undertake to ensure that the two older children continue to attend school on a full time basis for a further period of 12 months.
- The supervisory order for the three older children expired on 16 February 2003. Active supervision by DoCS of the children ceased after the order expired.
- In early 2003, DoCS' intention regarding the baby was for her to be restored to her parents' care. When her parents failed to acknowledge the reason for her entry into care and stopped visiting her, DoCS recommended that she remain in foster care on a long term basis. On 7 October 2003, the Children's Court issued a final order to this effect.
- DoCS received no risk of harm reports for the three older children in 2003.

- DoCS received one risk of harm report for the three older children in 2004. This was from a person who knew the family. As the reporter's concerns were based on hearsay, the information was retained at the DoCS Helpline.
- The Helpline handled six risk of harm reports concerning the three older children in 2005. Reported concerns included the inability of the parents to deal with Ebony's behaviour, the older children's ongoing failure to attend school, concerns that they were being kept at home by their parents, and concerns about the children being neglected within the family home. One of these reports concerning ongoing school absenteeism was retained at the Helpline. The other five were transferred to a CSC where they were closed without further assessment.
- The Helpline handled three reports concerning the children in 2006. A person known to the family contacted the Helpline in relation to the mother's poor health, the father's alleged drug use and alleged domestic violence. There were delays in the Helpline's processing of this report. The Helpline assessed the risk to be medium and transferred the report to the relevant CSC for a response within 10 days. In May, DADHC reported that Ebony had not taken up her position at a special school and was therefore missing out on important support. The Helpline assessed the risk to be medium and transferred the report to the relevant CSC for a response within 10 days. In August 2006, DET reported that all three children were not attending school, had not moved as reported by the father, and that the parents' statements that Ebony was sick, were not supported by medical certificates. The Helpline assessed the risk to be high and transferred the report to the relevant CSC for a response within 10 days.

The first two of the three 2006 reports were closed by the CSC without further inquiries. The August report remained at the Helpline until 1 October 2006 and resulted in inquiries being made by the relevant CSC five weeks later. It was subsequently closed in December 2006 due to competing priorities.

#### **4.4 Our observations: provision of child protection services 2001 – 2006**

Before considering the events that occurred in 2007, some observations regarding the actions taken by DoCS to respond to risk of harm reports concerning Ebony and her two older sisters between 2001 and 2006 are warranted. This is particularly so given that in many respects the problems experienced by the DoCS caseworker dealing with the family between 2001 and 2003, were not dissimilar to those experienced by the caseworkers dealing with the family in 2007. During both periods the father was reported as presenting as initially cooperative only to become evasive thereafter; caseworkers were not permitted to sight Ebony; and school absenteeism was an issue.

What distinguished the child protection casework between 2001 and 2003 was its intensity, persistence, thoroughness and child focus. Having one child protection caseworker involved with the matter over a two year period also provided a level of consistency and commitment.

During the period between 2001 and 2003, we found that the children's child protection files were comprehensively documented, case plans were regularly reviewed and there was a clear rationale for DoCS' actions. From 2005 onwards, this was not the case.

It is relevant to note that the caseworker who had carriage of the case between 2001 and 2003 told us that the very young age of Ebony and her younger sister at that time gave the matter some priority. The caseworker also observed that the youngest child probably would not have been removed from her parents' care had it not been for the actions and observations of the baby's paediatrician.

It is also relevant to note that between June and October 2002, DoCS' case plan was for all four children to be placed in care. Ultimately only the youngest child was removed from her parents.

While it is not for this office to review or comment on the merit or otherwise of decisions made by the Children's Court, departmental staff we spoke to all told us of the difficulties that they believed they experienced when pursuing 'neglect cases' through the Children's Court, particularly when the case plan was for the child to be placed in care.

#### **4.5 Our observations: handling of risk of harm reports received by the DoCS Helpline during 2005 and 2006**

In our view, it is difficult to reconcile the intensive involvement of DoCS with the family between 2001 and 2003 – which occurred as a consequence of concerns about the children's failure to attend school and their delayed development – and the department's repeated failure to respond to these same concerns when they re-emerged over a two year period from 2005.

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In this regard, between 2005 and 2006, DoCS received nine risk of harm reports concerning the three older children. During this period the two eldest girls' attendance at school was poor and in June 2005 they ceased attending school altogether. At that time the oldest child was 13 and her sister was 11. During the same period, Ebony who was then five, was diagnosed with autism and was referred by DET to a special school. She was also referred to DADHC for support.

In summary, the nine reports made to DoCS were about:

- the two older children's school attendance and eventual failure to attend school;
- the problems experienced by the family managing Ebony's behaviours;
- the concerns of a community member about Ebony being locked in her bedroom, her bedroom window being boarded up, and the older children not attending school;
- Ebony's non-enrolment and failure to attend school and the poor state of the family home; and
- domestic violence.

Our investigation identified a number of factors that contributed to DoCS' variable response to these nine reports, which raised essentially the same sorts of concerns that had resulted in the DoCS' intensive intervention with the family between 2001 and 2003. In short:

- When undertaking an initial assessment of a new report to the Helpline, caseworkers are expected to review the child protection history and give consideration to any relevant history when making decisions about the level of risk and the urgency of the required response. We found the Helpline's review of child protection histories for the children was inadequate between 2005 and 2006. Of the nine reports about the children during this period, only three identified that the youngest child was in out-of-home care. None identified that the three older children had been the subject of care applications, or that DoCS had applied for a breach of orders. Five of the checks failed to make any reference to the siblings' child protection history.

As a consequence of these failings, between May 2005 and May 2006, the Helpline did not provide the CSC responding to the reports with a full and complete picture of the known family history. These failings also compromised the Helpline's analysis of risk.

- While assessment of the nine reports was compromised by the inadequate history checks, this in turn resulted in an inadequate analysis of relevant information. As a consequence, the reported concerns were minimised. For example, repeated reports over time regarding the children's failure to attend school became an 'educational matter'.

Only in relation to the report made by DET in August 2006 about the children's ongoing failure to attend school, was there any evidence of Helpline staff analysing the reported concerns against the children's child protection history. On this occasion, the Helpline's analysis of the issues concerning the children's non-school attendance took into account the children's lengthy child protection history, the youngest child's removal and the reason for this, and the impact of non-school attendance on the children's wellbeing.

In our view, this was an accurate analysis of the information available to DoCS at the time. It was therefore concerning that this report – for which the Helpline assessed the risk to be high – remained at the Helpline for five weeks before being transferred to the relevant CSC for further assessment.

In a similar way, in March 2006 it had taken the Helpline six weeks to process the report made by a person who knew the family.

- None of the nine risk of harm reports were allocated to a child protection case worker for the purpose of visiting the family and undertaking a risk assessment. This was despite three of the reports being given a risk rating of 'high' by the Helpline. While some inquiries were made by DoCS in response to the last of the nine reports, there was no documented evidence to indicate that the information gathered through the inquiry process was analysed against DoCS' information holdings at the time. Most of the reports were closed due to 'competing priorities'.
- Contrary to DoCS' practice requirements, except for the last of the nine reports received during the period 2005 to 2006, none of the reports were printed off and placed on the children's hard copy child protection files. Without these records, the casework files did not provide an accurate overview of reported concerns for the children or DoCS' response.

In late July 2007, a student at the CSC was tasked with compiling a summary of the child protection files. Students do not have access to DoCS' database records. The summary therefore did not provide an accurate record of the reported concerns for the four children.

The child protection case worker who was allocated the case in August 2007 told us that she relied on parts of the summary record prepared by the student to inform her understanding of the case. Had she read the summary in full, she would have been led to believe that DoCS had received no reports concerning the children between 2003 and late 2006. Clearly this was not the case.

- On the issue of documentation, we also found that the children's files did not contain a record of certain conversations that – according to DET – occurred between DET and DoCS staff in relation to the children during 2006.

Problems associated with history checks completed by the Helpline is an issue that has been raised by this office over a number of years in the context of our child death review function. In undertaking this function, which includes trained and experienced Ombudsman staff independently scrutinising DoCS' electronic records (KiDS), we have found that it can take up to half a day – and sometimes longer – to obtain a solid understanding of relevant child protection history.

In response to our preliminary document, DoCS provided us with information on a range of projects to improve the functionality of KiDS. Since 2007, the department has attempted to improve history searches undertaken by the Helpline by training Helpline staff, updating the Helpline's business rules for person searching and recording child protection history on KiDS, using a quality assurance tool in the area of history checks and reducing the team leader to caseworker ratio at the Helpline to allow team leaders more time to review the quality of the reports produced. The Special Inquiry into Child Protection Services in NSW recommended, and the Government's plan of reform for child protection in NSW includes, improving the design and utility of KiDS.

## 4.6 DoCS' involvement with the family: 2007

On 13 March 2007, DOH made a report to the DoCS Helpline about the state of the family's premises. The Helpline assessed the risk to be high and on 14 March, transferred the report to the CSC that handled the previous reports, for further risk assessment within 72 hours.

In the following week, a DoCS child protection intake worker contacted a DET worker who said that none of the children were attending school. On 20 March 2007, the intake worker recommended the report could not be closed given the history of reports, the unhygienic state of the house, and the children's failure to attend school. A 'high priority allocation sheet' was completed. This noted DoCS' extensive involvement with the family, the removal of the youngest child for failure to thrive, the previous concerns about Ebony's development, the 2002 supervision order, and the subsequent breach of the undertakings. In the week commencing 2 April 2007, the CSC allocated the matter to a child protection caseworker for risk assessment.

The caseworker was instructed to do a home visit, interview the parents, ascertain the children's whereabouts, sight the children and interview them if possible. If necessary they were to obtain a police search warrant. The caseworker contacted the housing worker who said that the father was evasive and would not allow her to sight the children. The housing worker reported that she was concerned the children may be being kept locked in bedrooms. She told the child protection caseworker that the father was wishing to relocate the family to Gosford.

The caseworker visited the house but no one was home. She made another visit three days later. Again, no one was home but as the caseworker was about to leave the premises, the father pulled up in the driveway. The father told the caseworker that he was making arrangements for the children to be home schooled; that the two older girls were on dexamphetamine, and that Ebony had autism, some form of bone disease and was very small.

The father expressed concerns to the caseworker about the removal of the youngest child. He agreed to contact the caseworker the following day about a visit to see the children and to further discuss the issues. The following day, the father rang the caseworker and said that he had organised for the two older children to see a psychologist for the purpose of assessment for home schooling. He gave the caseworker the names of the family doctor and a paediatrician. There is no evidence that either of these doctors was contacted by the caseworker.

Arrangements were made for the caseworker to visit the family a week later. In the interim, the caseworker met with her supervisor. A decision was made to issue the parents with a notice requiring them to present the three children to the Sydney Children's Hospital's Child Protection Unit for medical assessment. The caseworker contacted the hospital to advise relevant staff accordingly.

As planned, on 20 April 2007, the caseworker and a colleague visited the family. The father would not agree to let the girls be seen by the Sydney Children's Hospital because of the family's previous involvement with the hospital in relation to the youngest child's removal. He said the three children had a paediatric appointment at the Prince of Wales Private Hospital on 23 May 2007. While at the house, staff from the Prince of Wales Hospital rang. The caseworker confirmed appointments for the two older children on 16 May and for Ebony on 23 May.

The caseworker sighted the two older children, who were observed by the worker to be physically within the normal range for their ages. When the caseworker inquired about Ebony, the girls said that she was next door; however, the father said that she was asleep in her room. A subsequent assessment report recorded '*Natural parents did not permit caseworkers to sight the youngest child*'.

Because the medical appointments for all three children were confirmed, DoCS did not issue a notice requiring the children to be medically examined.

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On 24 April, the caseworker who was allocated the case met with her supervisor. The manager caseworker told us that she was cognisant of the fact that the caseworkers had not sighted Ebony. Given the caseworkers' description of the older girls, she *'did not think there would be anything different for Ebony'*. In relation to the medical and psychological assessments, the manager caseworker said that she instructed the caseworker to make sure they happened. This instruction – as it related to the medical assessments – was not recorded.

On 4 May, DoCS received a copy of two reports and a brief letter from the children's mother. The reports – directed to DET – were from a private psychologist who recommended that the two older girls be home schooled.

On 16 May 2007, a paediatrician from the Prince of Wales Private Hospital rang the caseworker with concerns about the two older children. The doctor said that she was seeing Ebony the following week. The caseworker did not discuss the paediatrician's phone call with her supervisor as, on the same day as the phone call, the supervisor handed over case management responsibility to a new supervisor.

On 30 May, the caseworker made a home visit. No one was home and the house appeared vacant. The caseworker took no further action on the matter until 27 June 2007. On that day the caseworker phoned the paediatrician, DET, DOH and the psychologist who had recommended the two older girls be home schooled. The caseworker was told by the doctor that Ebony did not attend her appointment and the parents had cancelled subsequent appointments.

The psychologist, who had recommended home schooling for the two older children, said that his interview was based on a one hour interview with each child and on information provided by the father. No psychometric assessment was undertaken and the psychologist was not aware that the children had not been attending school.

The caseworker was unable to speak with relevant education or housing staff.

On around 12 July 2007, the caseworker and her new manager met to discuss her cases, as the caseworker was about to leave DoCS. Although nothing is recorded on file in relation to the family in question, it was agreed the caseworker would follow up with the paediatrician, education and housing staff. The caseworker did not make contact with the paediatrician or housing staff before she left. However, DET contacted the caseworker. The DET worker was concerned about the outcome of the private psychologist's assessment and told the caseworker that DET did not support home schooling for the children.

The caseworker advised the education worker that the case was to be allocated to another child protection caseworker. No handover between caseworkers occurred, reportedly because of workload pressures.

When asked about the length of time between actions taken by the caseworker to progress the risk assessment, the caseworker's initial manager stated that at the time the first caseworker had carriage of the matter, she was one of only three caseworkers out of a team of seven who could be relied on to take on new work. These circumstances reportedly impacted on the first caseworker's capacity to complete less pressing tasks, such as those related to Ebony and her sisters.

## 4.7 Our observations

While we acknowledged that the father's reportedly evasive behaviour in 2007 may well have made the caseworker's job extremely difficult, we identified a number of problems in the way the risk assessment for the children was progressed, once the matter was allocated to the first child protection worker.

Many of these problems related to the significant delays that occurred. However, what was even more concerning was the fact that the key feature of the risk assessment - medical review of the three girls – was lost sight of in Ebony's case, when the file was transferred from the first to the second caseworker. In the circumstances – a change in caseworker and casework manager, a handover between casework managers of over 60 matters concurrently, and no handover to the newly allocated caseworker – critical information about what actions had occurred and what needed to be done, was lost.

In this regard we note that departmental practice guidelines stipulate certain requirements for child protection matters requiring transfer from one DoCS office to another, including the conduct of a 'case meeting' prior to transfer. There are no such requirements for matters transferred from one caseworker to another working within the same unit.

In the absence of any sort of handover between caseworkers, it was concerning that the second caseworker told us that she had the time to take only the most rudimentary steps to inform herself of the matter. In the absence of timely case review between the caseworker and her supervisor, this fact did not become apparent until many months later.

The information before us indicated that case review did not occur between the caseworker and a manager for the 12 weeks between 24 April and 12 July 2007. According to the new manager, she met with the first caseworker on 12 July as the caseworker was about to leave the department. There is no record of the case review that occurred on this date.

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In our view, there were insufficient steps taken by the first caseworker between 2 April and 25 July 2007 – the date she left DoCS – to progress the risk assessment. It was concerning that she did not check whether Ebony attended the appointment with the paediatrician until 27 June 2007, which was more than a month from when the assessment was meant to have occurred.

We were told by the first caseworker's supervisors that the reasons why she did not progress the assessment were twofold. The first concerned the caseworker's difficulty contacting the family. We did not accept this, as the documented evidence shows that after the home visit on 20 April 2007, steps to contact the family were limited to two attempted phone calls to the father on 2 and 3 May, and a home visit to the family on 30 May where she found no one home.

The second reason concerned the heavy child protection workload handled by the DoCS office in May and June 2007, and the impact of poor staff performance on the distribution of this workload. Because of the poor performance of others in the team, the first caseworker reportedly continued to be allocated the more complex of the new matters, even though it was known that she would be leaving the department in July. We were told that in these circumstances the case of the three children was not a priority in the caseworker's caseload.

The first caseworker allocated the case left DoCS on 25 July. Her notes arising from her phone conversation with DET on 20 July 2007 indicate that, by that time, the DoCS office had identified another caseworker to transfer the file to.

The second caseworker told us that she was officially given the case on 6 August 2007. The handover of the case from the first caseworker was scheduled for 25 July – the first caseworker's last day of work with DoCS. The second caseworker told us that because of competing priorities, this did not occur.

To assist in the handling of the matter, the manager casework arranged for the file to be reviewed and summarised by a student who was placed at the office at the time. We have already noted some of our concerns with the adequacy of the summary that was prepared.

The second caseworker told us that because of time pressures, she did not review the DoCS data base, the then current file or the past files for the children when she was allocated the matter. In fact, it appears that she took no steps to familiarise herself with the matter until the morning of 20 August, prior to a meeting with an education official. At that time, the one thing that she did was to look at the '2007' section of the summary completed by the student. This basically formed the basis of her understanding of the matter for the time she carried the case.

In our view, this set of circumstances was particularly concerning. The student's review of the events that had occurred in 2007 did not accurately reflect the case plan to progress the risk assessment. It made no reference to DoCS' contacts with the paediatrician or the paediatrician's concerns. Moreover, there were inaccuracies throughout the summary document which, when taken together, presented misleading information about the case. It was concerning to us that the unverified work of a student formed part of a case file.

The question of the adequacy of the summary aside, the second child protection worker – who was described as a 'senior caseworker' – did not adequately brief herself about a matter for which she was responsible for undertaking the assessment of risk. Had she even limited her review to examining the 'high priority allocation sheet' this would have provided her with a succinct summary of the critical issues.

But she did not look at this, and in her own words gave the DoCS data base a cursory view and read the last two pages of the 20 page file review that had been completed by the student. As a consequence, she did not know that the case plan was to have the three children medically assessed. She did not identify that DoCS had not followed up Ebony's appointment with the paediatrician. She did not know that Ebony had autism and had never attended school. She was not aware of the reason for the fourth child being placed in care.

After being allocated the case, the second caseworker had a number of days off work because she was unwell. Between 20 September and 9 October she was on sick leave. She also told us that she had a number of more urgent cases to deal with.

We understand that at the time the second caseworker was allocated the matter she was unwell. We also understand that she, like the first caseworker, believed that there were more urgent matters to attend to than the case the subject of our investigation. However, we could not avoid concluding that a contributing factor to the matter being seen as a lower priority was the compounding effects of inadequate analysis of known facts over time.

## **4.8 Steps taken by the second caseworker and her supervisor to progress the risk assessment**

As noted, other than taking a call from DET either on 6 or 8 August 2007, the second caseworker took no action to progress the risk assessment between the time that she was allocated the matter on 6 August until the meeting with a DET official on 21 August 2007.



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On 21 August the caseworker and a DET student welfare consultant discussed concerns about the adequacy of the private psychologist's risk assessment, prosecution by DET of the family for school absenteeism and the need to locate the children.

On the same day, the caseworker sought internal legal advice about what she would need to do to get the matter before the Children's Court. She told us that she did this because in her experience it was extremely difficult to succeed on a neglect case or in a case where the risks are not immediate.

She was advised by the legal officer to get the family's address, get evidence from DET regarding that department's concerns for the children, and visit the Matraville address for the purpose of telling the father that DoCS wished to sight the children within 24 hours.

The evidence indicates that the caseworker acted on some of the advice. However, there is no evidence that she made a home visit or took any other action to contact the father.

In relation to clarifying the family's address, the caseworker said that she contacted DOH and had several conversations with the housing specialist officer. She said that this contact was delayed because she was regularly on sick leave at that time. She said that she asked about Housing's current involvement with the family and a possible forwarding address. Information provided to us by DOH indicated the caseworker's initial contact with the housing specialist officer occurred on 18 September 2007.

## 4.9 Our observations

In our investigation report, we made three observations to DoCS about these events.

First, in our view the caseworker and her supervisor's assessment that DoCS was dealing with a 'neglect case' was based on an inadequate analysis of the known facts. A considered review of DoCS' holdings at the time would have raised a number of serious questions about the immediate safety and wellbeing of Ebony.

DoCS' staff told us that they assumed Ebony's circumstances were no different to those of her older sisters. It was our view that to assume that her circumstances were no different to those of her sisters, in circumstances where the sisters had been sighted and reported to be healthy in April/May 2007, was fundamentally flawed.

By mid 2007, DoCS had received information that Ebony was a seven year old child with significant disabilities who had never attended school, could not talk, was slow to walk, whose parents struggled to manage her behaviour, who received no services, whose room was boarded up, who had been living in squalid circumstances and who had not been sighted by any professional in 2007. An analysis of this information and the range of concerns should have led to a conclusion that Ebony's situation may well be markedly different from that of her sisters.

Secondly, there were no clearly documented outcomes arising from DoCS' meeting with DET on 21 August 2007 or from a subsequent meeting between the caseworker and legal officer.

In a preliminary report, we observed that DoCS had apparently made a decision to lodge a care application. Our view was based upon information contained in DET's records which indicated that on 28 August 2007, the (DET) student welfare consultant reported on a meeting with the DoCS caseworker on the case. The DoCS caseworker reportedly had said that she had instructions to seek a care application. She requested supporting evidence from DET.

DoCS responded to our preliminary report by indicating *'no decision was made then, nor subsequent to this meeting, to pursue a care application with the Children's Court. The caseplan at this time was to complete a risk assessment for the children'*.

The different positions reflected by these agencies demonstrate a broader problem relating to inter-agency communication and DoCS' failure to adequately record this and other decisions arising from the meeting of 21 August.

Thirdly, and relevant to our second point, there was no evidence of the caseworker and her manager reviewing the case following her meeting with DET, or for that matter at any time during the second caseworker's involvement with the case. Work load, the caseworker's periods of sickness and competing priorities reportedly contributed to this situation. This lack of review may well have contributed to the lack of rigour which characterised the risk assessment process.

## 4.10 DoCS' handling of the 12 and 15 September risk of harm reports

On 12 September, DoCS received a report from DET advising that on 31 August 2007, the family had moved out of their premises, to an unknown address. DET told DoCS that they had been contacted by a concerned community member, who said that cleaners were at the house. It was reported that there was faeces all over the floor in Ebony's room and the house smelt appalling and was filthy. DET said that they had serious concerns about Ebony's safety and welfare.

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The Helpline assessed the report as 'information only', on the basis that there was an open allocated plan and that the issues were known and reported, and forwarded it to the DoCS office handling the case on 13 September. There the report was directed to the allocated caseworker.

On 12 September, the DoCS Helpline also received a report from an anonymous person regarding the state of the family's premises. The caller noted that Ebony's room was boarded up and that the house smelt of urine and faeces. The house was reported to be full of rubbish, up to the knee in every room.

The Helpline assessed this report as 'information only' on the basis that the reported concerns were already known and transferred the report to the DoCS office handling reports for the family on 15 September.

On 14 September the caseworker emailed her manager and advised that the family had moved. She sought direction about whether an alert should be placed on the DoCS information system. On 17 September 2007, her manager told her to contact DOH. On 19 September, she did so. On the same day, NSW Housing provided DoCS with the family's new address.

## 4.11 Our observations

In our final investigation report, we made a number of points about DoCS' handling of and response to the September 2007 reports.

- First, there was the question of the Helpline's initial assessment of the 12 September report from DET. In our preliminary report, we observed that while there had been a report in March 2007 about the unhygienic state of the house, a report about similar concerns six months later was, in our view, new information. Likewise, the 12 September report contained new information that the family had moved. We observed that DET's concerns for Ebony's wellbeing, given the reported state of her room, appeared to have been given no weight. In these circumstances we observed that the Helpline's assessment of the report was inadequate.

In response to our preliminary report on this matter, DoCS submitted that while the handling of the 12 September 2007 report did not adhere to the Helpline's Business rule for history checks *'to the minimum standard required ... in the analysis of the report, the Helpline caseworker did correctly indicate the increased risk of harm for [Ebony] based on the previous removal of [the fourth child] from the family, as well as the ongoing concerns raised by various reporters. The matter was prioritised as a Stage 1 by the Helpline as information on KiDS suggested that the risk of harm issues for the children in relation to residing in squalor had been known by the CSC since March 2007. This calls into question the observation that the concerns about [Ebony] appear to have been given no weight ... and that the Helpline's assessment of the report was inadequate'*.

- Second, both the 12 and 15 September reports when transferred to the DoCS CSC handling the reports for the family went directly to the caseworker. There was no indication of any consultation between the caseworker and her supervisor about the information contained in the reports. We were told this practice is not unusual at the DoCS CSC. We also noted that the practice is consistent with the department's business rules regarding the recording and transferring of 'information only' reports. This means that a supervisor may not know what information has been transferred in.
- Third, there was discrepancy about what direction was given to the caseworker once it became apparent that the family had moved. The manager told us that she directed the caseworker to clarify with DOH what they had seen. The caseworker said that she was not aware of this direction – she understood that her task was to establish the family's forwarding address. While the latter was established, at no time did anyone at DoCS seek to clarify with the housing department the state of the premises vacated by the family. Given the department's case plan at the time was reportedly to complete a risk assessment, we were concerned about this lack of thoroughness in gathering relevant information.

## 4.12 Completion of the risk assessment and transfer to Raymond Terrace CSC

DoCS' practice guidelines state that *'the general principle is that once [comprehensive secondary risk of harm assessment] is commenced it must be completed'*. As a rule, the assessment is to be completed within 28 days of the case being allocated if harm or risk is not substantiated and within 90 days if harm or risk is substantiated.

On 20 September 2007, the caseworker went on sick leave for two weeks.

On 21 September, the manager casework at the Sydney DoCS office contacted Raymond Terrace CSC and provided that office with information concerning the case. Raymond Terrace indicated that they would discuss the transfer with the Sydney office when the secondary risk of harm assessment and other relevant documentation were completed.

On 9 October the caseworker returned from sick leave. She did some work on the risk assessment before leaving for another job within DoCS on 23 October.

On 26 October the manager casework completed the risk assessment and on 30 October, following a case transfer discussion with the manager of Raymond Terrace CSC, the case was transferred. Harm consequences for Ebony were assessed to be 'extreme', protective factors were not in place and the harm probability was 'highly likely'.

At the time of Ebony's death, the case had not been allocated to a child protection worker at Raymond Terrace CSC.

## 4.13 Our observations

In relation to the risk assessment that was completed the week before Ebony died, we made the following observations:

- The assessment was not timely and the process of assessment lacked rigour. Risk assessment for the case took 210 days. While the parents' evasiveness clearly contributed to delays, equally the low priority given to the matter over time, coupled with staff movements, were contributing factors.
- From the commencement of the assessment in April 2007, DoCS' gathering and analysis of information to inform the risk assessment was inadequate. Information held by DoCS was not effectively analysed. Assumptions were made. Relevant information held by other agencies was not sought. Consequently, in relation to Ebony, the assessment provided only limited comment on her specific circumstances. For example, the assessment states '*It is believed that [Ebony] also has a disability*'.
- As noted elsewhere, supervision of both caseworkers tasked with the risk assessment between April and October 2007 was inadequate. There was no clear case plan to progress the risk assessment once the case was transferred from the first to the second caseworker, and certain tasks were not completed. There was no structured, regular review which would have provided an opportunity to identify this.
- The initial case plan to have the children medically assessed was overlooked for Ebony, when the case was transferred from the first to the second caseworker. This was not reflected in the risk assessment.
- The actions of the second caseworker were clearly compromised by her poor health and workload. While acknowledging this, aspects of her work were less than adequate, particularly the steps she took to familiarise herself with the matter when it was initially allocated to her. Her lack of knowledge about relevant current and historical factors compromised her ability to complete the risk assessment.

In a special report to Parliament dated December 2004, this office reported on our findings arising from an investigation into DoCS and NSW Police following the death of a three year old boy on 14 September 2003. The advice provided by DoCS in response to those findings is relevant to our consideration of this matter.

In its response to our concerns regarding DoCS' response to the three year old boy who died, DoCS submitted the following:<sup>1</sup>

*It is a matter of public record, highlighted in the Kibble Report in early 2003 that the rate of allocation of cases to caseworkers across all levels of cases was around 30%. In the context of child protection reports these figures can well be understood ... Under such pressures staff could only attend to the most pressing matters where immediate safety was assessed as the critical issue.*

*The Government has sought to overcome the staff and systems resource issues for DoCS by an injection of \$1.2 billion over five years. The DoCS Blueprint for Change outlines our approach to improving the child protection system ...*

*The death of [the boy] occurred in September 2003. This was only three months after the commencement of funding under the Government's 5-year program to reform the NSW child protection system ...*

*The [children] clearly did not have the benefit of implementation of the reform package, where additional referral for supports and services could have been both appropriate and possible at various points. Referrals for support will increase with the roll out of the new resources and the implementation of the early intervention and prevention programs. These will improve the capacity of DoCS to refer cases for support and also increase the capacity of the NGO service system.*

*The concern raised in the provisional report relating to record keeping has been well documented previously. It has been the subject of many reports and updates to the Ombudsman's Office and will not be expanded upon here.*

<sup>1</sup> NSW Ombudsman Special report to Parliament; December 2004 page 23.

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*With the reform package fully implemented, DoCS could have afforded the ... children a secondary risk of harm assessment rather than taking a safety approach to the individual instances of concern. In relation to risk assessment, DoCS recognises the need to move away from an incident based approach to child protection and continues to invest in developing caseworker expertise in risk assessment. However, even with considerable training and support, it will take time to develop a workforce of adequate strength and experience to complete rigorous risk assessments.*

In our preliminary report, we commented:

*It is noteworthy that our concerns with the department's handling of the matter are not significantly different to those we expressed about the department's handling of the boy in 2003. This is despite a raft of initiatives implemented by DoCS over the past five years, including the release of DoCS' policy on child neglect in July 2006.*

In response to this observation, DoCS submitted that:

*Measuring the success of a reform package that was still being rolled out at the time, against a backdrop of a significant and steady increase in reports and on the basis of comparing two isolated, albeit tragic and high profile cases, is not helpful.*

We believe Ebony's case highlights significant ongoing practice and systems challenges, including those relating to increased reports. In response to the death of the boy in 2003, DoCS noted that the boy and his sister '*did not have the benefit of the reform package*'. In our view, Ebony's case well illustrates – like the 2003 death – the need to strengthen the response to matters of serious and chronic neglect.

Both this office and DoCS are fully aware that this issue is not isolated to a few cases. For this reason, we believe that our observations, as outlined above, are appropriate.

#### **4.14 DoCS' actions to address the issues of concern identified in the Ombudsman investigation**

DoCS provided us with information about how they were responding to the issues that we identified. DoCS' Child Deaths and Critical Reports unit undertook an internal review of the case and provided us with a copy of the review report. That report made a series of recommendations in relation to:

- the provision of a copy of the internal review report to the Executive Director Helpline.
- the provision of professional supervision sessions to caseworkers.
- a meeting with relevant regional NSW Health professionals to review interagency work with the family and options for improving future interagency work.
- the development of strategies to raise staff awareness about assessing risk of harm reports in a context of parental resistance and a history of child abuse and neglect.
- a review of its practice procedures *Engaging Families* and *Building Relationships and Predicting and Managing Occupational Violence* with a view to incorporating specific guidance for working with resistant clients.
- a review of practice procedures to determine the need for a specific procedure on utilising police assistance in child protection assessment and intervention.
- a review of *Client file procedures* to determine their adequacy.

In response to draft recommendations made by this office, DoCS:

- provided us with some information about the impact of additional resourcing at the CSC in Sydney which handled the reports for the family.
- advised us that it was developing guidelines to assist its staff to make effective care applications in cases where there is child neglect.
- clarified that DoCS managers are responsible for informing relevant agencies of the progress of care proceedings.
- advised that it was reviewing its caseworker practice procedures *Transfer of Case Management and the Case Plan*.
- said that it would facilitate a meeting with DOH to clarify DOH's concerns regarding risk of harm reports made by their staff about child neglect. Executive management from the DoCS Helpline would attend the meeting.

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## 4.15 Final recommendations and DoCS' actions to implement these

We asked DoCS:

1. Whether it had implemented any initiatives to address the child protection resourcing issues at the DoCS office that handled the case.
2. If so, DoCS' assessment as to whether the initiatives had been effective and the evidence to support its assessment.
3. If not, whether DoCS intended to implement any initiatives to address the office's child protection resourcing issues.
4. Given DoCS' advice that it was developing guidelines to assist its staff to make effective care applications in cases where there is child neglect and was reviewing its casework practice procedures *Transfer of Case Management and the Case Plan*, we asked DoCS to provide advice on the progress of these reviews and to provide a copy of guidelines and amended casework practice procedures when they were available.
5. To ensure its child protection staff are made aware of the limitations on Department of Housing staff in relation to entering the homes of DOH tenants, and the implications of these limitations for DoCS staff in their monitoring of children who are living in DOH accommodation and who are reported to be at risk of harm.
6. For advice on the outcome of its meeting with the Department of Housing about that department's concerns regarding risk of harm reports made by its staff about child neglect.
7. For a progress report on the implementation of recommendations arising from its internal review of the case.
8. To advise us of any outcomes arising from its meeting with relevant NSW Health professionals in relation to interagency work.
9. About its arrangements for forums in the department's Metro Central Region where agencies can discuss cases of shared concern.

DoCS has provided us with progress reports on the action it has taken to address the above matters. According to the department:

- In relation to initiatives to address the child protection resourcing issues at the DoCS office that handled the case, DoCS:
  - established an additional intake manager casework at the office which handled most of the reports concerning Ebony and her sisters. This has allowed for more comprehensive review of incoming reports. As a result, child protection teams no longer perform intake functions. Community partners now have one intake manager casework as a point of contact.
  - trialled a project in the Metro Central Region to better manage CSC capacity. This system has proven to be effective in identifying spikes in workloads and a basis for determining what actions can be taken to support CSCs with workload spikes. Following consultation with relevant stakeholders, this system will soon be available to trial across the state.
  - implemented a regionally based professional supervision compliance tool which ensures professional supervision is occurring in the Metro Central Region (December 2008).
  - implemented a weekly high priority case allocation meeting at the CSC which handled the reports concerning Ebony and her sisters (February 2009). The meeting requires the attendance of the entire management team. These meetings are minuted.
  - filled all child protection casework specialist positions in the Metro Central Region. This provides staff at CSCs with weekly and specialist consultancy sessions for complex cases, casework practice coaching, group sessions for new caseworkers to support their induction, access to case practice reviews, workshops to target specific casework practice issues such as working with resistant clients, engaging families, and intuitive and analytical thinking. The latter reiterates *'the importance of revising risk assessments, carefully reviewing files, and incorporating history into risk assessments, reviewing judgements about risk when new information becomes available and maintaining the child as the centre of the assessment'*.
  - advised that the trial of the department's CSC quality reviews would be completed in July 2009 and will be rolled out state wide following endorsement of any required changes.
- DoCS has developed guidelines to assist staff to make effective care applications where there is child neglect.
- DoCS' revised casework practice procedures for *Transfer of Case Management and the Case Plan* would be completed mid 2009.

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- DoCS is making arrangements to ensure its staff have a clear understanding of the role that DOH staff may have in monitoring children reported to be at risk. DoCS has met with DOH to address the latter's concerns regarding risk of harm reports made by their staff about child neglect. In April 2009, DoCS Metro Central Region held an interagency seminar with staff from the Department of Housing. Ninety staff attended from the two agencies. Presentations were delivered on respective roles in working with children, systems for monitoring children at risk of harm, methods for following up on child at risk reports and information exchange between the two agencies. These interagency meetings will continue to occur for each local area on a quarterly basis and will be reported on as part of each area's Quarterly Business Report.
  - In April 2009, DoCS and NSW Health representatives met to discuss interagency issues relating to Ebony's case. DoCS is currently co-ordinating a meeting with NSW Health to discuss state wide strategies regarding a clear escalation policy and the possibility of high level regular case coordination meetings to discuss cases where complex medical issues are identified.
  - DoCS is continuing to progress implementation of the recommendations arising from its internal review of the case and it provided specific details of the action it had already taken.
  - DoCS is actively involved in child protection interagency forums in the Metro Central Region and it provided specific advice on this initiative.

DoCS also provided advice on its activities to strengthen interagency collaboration and cooperation at a state wide level, consistent with the Government's plans for child protection reform.



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# Chapter 5.

## Department of Education and Training

### 5.1 The nature of our investigation

Given the mounting evidence of chronic school non-attendance by the children in this matter, we had questions about the adequacy of DET's persistence with an approach with the parents which appeared to be based on conciliation.

After the two older children were withdrawn from school in June 2005, more senior departmental staff appeared to become involved. Although senior staff were involved, and notwithstanding DET staff documenting concerns about the parents' failure to enrol Ebony in school and her non-attendance, DET did not prosecute the parents. This was despite a student services executive meeting in February 2007 deciding to move to prosecution and similar action being contemplated by DET in October 2007.

The information before us also raised a question as to whether DET had taken all reasonable steps from a child protection interagency perspective to address the concerns it had identified for the children's safety and welfare.

We decided to investigate DET's actions in responding to the absenteeism of the three older children from school and DET's actions in responding to concerns about the safety and welfare of these children.

Our investigation included the following steps:

- We reviewed DET's files for Ebony and her two older sisters.
- We asked DET to review the adequacy of its actions in responding to the children's school attendance and the failure of the parents to enrol Ebony at school. We also asked DET to review the adequacy of its response to concerns about the safety and welfare of the children.
- In response, DET established a working party of suitably qualified officers to undertake the review. The group analysed documents related to policy, procedures and legislation; interviewed 14 DET officers; and considered the actions taken by these officers against relevant legislative and practice requirements.
- DET provided us with a detailed statement arising from its review.

### 5.2 DET: Legislation, policies and procedures

The *Education Act 1900* places the legal responsibility for ensuring a child's enrolment and/or attendance on the parent. Section 22 of the Education Act requires students between the ages of six and 15 to be enrolled at a government or registered non-government school, and to attend whenever instruction is provided, or to be registered with the Board of Studies for home schooling. Section 23 of the Act provides that a parent is guilty of an offence if the parent fails to cause a child's enrolment and attendance as required under section 22.

The DET school attendance policy approved on 1 December 2005 was implemented in Term 1, 2006. The policy allocates responsibility for initial responses to 'unsatisfactory attendance' to school principals – they have to promptly investigate and initiate appropriate intervention strategies. Principals are also required to inform the school education director of attendance problems and issues, including regular information about students for whom chronic non-attendance is an issue.

The procedures to resolve attendance difficulties are based on regular follow up of unexplained absences by contacting parents promptly. Additional school-based strategies beyond early telephone contact with families include student and parent interviews, reviewing a student's educational program, referring to a school counsellor or outside agencies, and support to children and their families from school-based personnel.

If the school's efforts to resolve non-attendance are unsuccessful, support can be requested from the regional Home School Liaison Program (HSLP). Such requests are not to be approved in circumstances in which the school has not attempted a wide range of interventions to resolve non-attendance.

HSLP support for an individual case is generally limited to 10 weeks but an extra 10 weeks can be allocated if appropriate. Cases are to be regularly reviewed and principals advised of progress.

Where HSLP intervention has been unable to restore regular attendance, the school education director can consider legal action against parents to resolve the matter. Throughout the period from 1991 to 2007, prosecution was officially stated to be the option of last resort. According to School Attendance Policy 6.6.1, where school and regional interventions fail to resolve attendance, parents are to be invited to attend a conciliation conference. Where parents are invited to a conference but fail to attend without reasonable cause, the policy states that the matter should be referred to the Student Welfare Directorate for consideration of prosecution.



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DET issued a memorandum on 20 February 2008 affecting the implementation of certain timelines in the policy. These became effective in Term 2, 2008.

Under section 71 of the *Education Act 1990*, a parent who wants to home school their child must apply in writing to the Minister for Education and Training, for registration of the child for home schooling. Section 72 requires an authorised person (that is from the Office of the Board of Studies) to approve home school. Approval is dependent on an authorised officer visiting the premises where the child is to be home schooled and satisfying themselves that the program of learning will meet the needs of the child and the relevant requirements of the minimum curriculum for schools. The responsibility for delivering the educational program rests with the registered parent.

DET teaching staff and certain other DET officers have a mandated responsibility under the *Children and Young Persons (Care and Protection) Act 1998* to recognise and report harm or risk of harm to children and young people due to child abuse and neglect.

### 5.3 DET's involvement with the family prior to Ebony's death

The following chronology concerning DET's involvement with the family is relevant to our findings and observations.

- In 1998, a primary school made a risk of harm report to DoCS concerning the oldest child's behaviour.
- In 1999, the father attended a meeting with staff at the primary school. He reported that he medicated both the girl and her younger sister for attention deficit hyperactivity disorder to control them after school. Both girls had frequent absences during their time at the school.
- In March 2000, the primary school made a risk of harm report to DoCS concerning bruising around the second child's eye.
- The girls transferred to another primary school in April/May 2000. In June, the school wrote to the parents of the girls about absenteeism and parental failure to attend two scheduled meetings. A home school liaison officer was allocated to the case. This officer made a home visit in August 2000. In October 2000, the school principal made a risk of harm report to DoCS regarding both children's poor school attendance and the impact of this on the children. The father attended a meeting at the school in October and agreed to work with the school to improve attendance. In early December, a DET district superintendent wrote to the parents about their legal obligations and scheduled a conciliation conference. The father later advised of his inability to attend due to a trip interstate. DET staff made a home visit and spoke to a neighbour who reported that the family was at home.
- DET rescheduled the conciliation conference for February 2001. The father declined to attend on two occasions. In March, a senior DET official advised that the case should be referred for consideration of prosecution. New dates were set for meetings in May and June 2001 – but the parents failed to attend. The father made an unscheduled visit to the primary school in June 2001 and agreed that his daughters would resume school that month. A risk of harm report was made by DET to DoCS regarding absenteeism.
- In August 2001, the case was referred by DET attendance staff to the department's legal branch for consideration of prosecution if action by DoCS did not ensure school attendance. DET legal services wrote to the parents on 30 October 2001, foreshadowing legal action unless regular attendance resumed within 30 days. The children did not return to school in 2001 and legal action did not commence.
- In January 2002, DoCS lodged an application with the Children's Court for an assessment and supervision order. In February 2002, the DET prosecution file was marked inactive because DoCS had taken the matter to the Children's Court. The children's primary school was to monitor attendance and report weekly to a student welfare consultant.
- In March/April, the primary school provided reports about the two older children to the Children's Court Clinic and, separately, to a Sydney Children's Hospital paediatrician. On 16 May 2002, the Children's Court issued a nine month supervision order with undertakings including that the parents would ensure the children's attendance at school and that they would also ensure the children received appropriate medical assessment and treatment. On 11 June 2002, DoCS notified the Children's Court that the parents had breached their undertakings.<sup>2</sup>
- The children transferred to a third primary school in October 2002. On 19 December 2002, the Children's Court issued final orders for the three older children. The court ordered that the current supervision order and undertakings continue until expiration on 16 February 2003; that parental responsibility be shared for medical

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<sup>2</sup> In response to our preliminary report, DET submitted that it was not aware of these proceedings. However, we note that on 31 May 2002, DoCS held a case conference attended by a representative of the children's school and other relevant agencies. The school reported school attendance was once again an issue and that there was no evidence of bullying. The case plan arising from the conference was to take the matter back to court. On the basis of DET's involvement in the case conference, it appears to us that DET would have been aware of the Children's Court May 2002 order, and should have been aware of DoCS' intention to return the matter to court.

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issues between the parents and the Minister for the remainder of the supervision order; and that, beyond the expiration of the supervision order, the parents undertake to ensure that the two older children continue to attend school on a full time basis for a further period of 12 months from 19 December 2002. In response to our preliminary report, DET submitted that it was not advised of the *'granting of orders on 19 December 2002'*.

- In 2003, the two older girls' attendance was initially deemed satisfactory but then worsened. In August, the school wrote to the family, noting that the older child had missed a total of 2.6 years (522 days) of school since kindergarten; the second child had been absent for 2.4 years (484 days) since starting school. The school reported that the girls were struggling academically because of these absences. The home school liaison program was re-engaged. The home school liaison officer documented various contacts with the family for the rest of the school year.
- In April 2004, a student welfare consultant advised the school that the children's attendance was satisfactory. Monitoring would continue and the case would be 'filed down'. In June, a teacher noted the older child had been absent for 17 days out of 36. In August, the school wrote to the parents, noting that both girls had a 48 per cent attendance rate for the year and foreshadowing another referral to the home school liaison program. The case was re-referred to the program in September 2004.
- The older child started the 2005 school year at a high school. The school noted information from a DET official that the father had a severe personality disorder, his family was frightened of him, he had intimidated DoCS, the mother was self harming, a baby had been removed at birth, and DoCS had advised that the case was closed. The second child remained at a primary school.
- After a series of absences – supported by medical certificates in at least some cases – the parents withdrew both girls from school on 7 June 2005 because of what they alleged was ongoing bullying. In written advice, they indicated that the family would be moving.
- In May, August and November 2005, the primary school made reports to DoCS about the second child's failure to return to school. The November report noted that the child was believed to be living at her usual address and was being withheld from school. The high school made similar reports to DoCS concerning the older child's absenteeism in June, August and November 2005. In relation to the latter, DET files record *'DoCS will not be taking action'*.
- The home school liaison officer discussed the case with the school education director in September. DET then evidently established contact with the parents and convened a meeting on 18 November 2005. The meeting resulted in DET documenting an agreement that the parents were to seek assessments for the two older children to inform their resumption of school attendance. The parents provided a psychologist's report – recommending home schooling – 18 months later (May 2007).
- In December 2005, Ebony was offered a place at a special school.
- At some time between 8 December 2005 and 8 February 2006, DET informed DADHC that Ebony had been offered a place at the special purposes school. DADHC records of a subsequent conversation with the special school staff note that the school would take the lead role regarding school attendance, and an apparent agreement that the school would contact DADHC when Ebony started school.
- In February 2006, regional DET staff met to discuss educational supports for all three children. Participants subsequently sought advice from DADHC and DoCS about supports. DADHC said a needs assessment for Ebony was underway and that her sisters were not listed as eligible for support. No reply from DoCS is on the files.
- In April 2006, the family accepted the school placement for Ebony. In August, the special purposes school reviewed the placement, noting that the regional office and the home school liaison officer were negotiating the child's attendance. The home school liaison officer visited the family home in August 2006 and left a note – the mother responded by fax, reporting that the family GP had recommended Ebony start school in 2007 for health reasons and that the psychologist was unable to see the older girls until mid September.
- According to the police, on 25 August 2006, DET contacted a police youth liaison officer, and notified the officer of truancy issues concerning the three children. Two weeks later, the home school liaison officer advised the youth liaison officer he had visited the children's home but had been told to go away. The youth liaison officer offered to attend the home with the home school liaison officer if he held concerns for his safety or security.
- On 25 August 2006, DET made a report to DoCS concerning the absenteeism of the two older children and concerns for six year old Ebony.
- In October 2006, regional DET staff discussed the family with a DoCS specialist caseworker. Documentation regarding this contact also instructed staff to ensure follow up and an urgent meeting with DoCS. In October, DoCS contacted DET in relation to the August report.

- In late November, DET noted in records that the local DoCS office had reported liaising with Housing and that Housing was to visit the family and report *'anything unusual'* to DoCS. DADHC reported to have stopped working with the family because of a failure to engage. A DET meeting with the parents was scheduled for 19 December. The parents did not attend.
- On 30 January 2007, the father phoned a student welfare consultant. He said his children were staying with an uncle [apparently on the Central Coast] and might be away for months and that the mother was about to have major surgery. The student welfare consultant tried unsuccessfully to persuade the father to have the children attend school at their new location.
- In February 2007, a student services executive meeting noted concerns about Ebony not attending school. Further, a concerned member of the community was said to be raising unspecified concerns with DET staff. At the meeting DET decided to contact DoCS and move to prosecution. The file does not indicate whether this occurred.
- In March 2007, the special school applied for home school liaison support, noting that Ebony had never attended. DET contacted the DoCS CSC, where an intake worker advised DET about a new report on the family and queried DET's progress on the case. DoCS reported that the children had not been sighted by any agency and that the parents were thought to still be in Maroubra.
- In July 2007, regional DET officials discussed the case and a student welfare consultant made a home visit – there was no response but a concerned member of the community reported a screaming young child and claimed the mother and children rarely left the house. The student welfare consultant reported the information to DoCS. The student services officer documented contact with a private psychologist, who in April 2007 had assessed that the children should be home schooled due to the children suffering anxiety, depression, and obsessive compulsive behaviour.<sup>3</sup>
- A further home visit, on 26 July 2007, was made following a community member's advice to DET that somebody was home. The father reported that his family was away and were planning to move to the Central Coast. DET sent a letter to the father scheduling a meeting for 3 August 2007. The father did not attend.
- On 28 August 2007, the student welfare consultant reported a meeting with the DoCS caseworker on the case. The DoCS caseworker reportedly had said that she had instructions to seek a care application. She requested supporting evidence from DET. Earlier in this report we have noted that DoCS denies that DoCS had made a decision to pursue a care application in the Children's Court.
- On 31 August 2007, a concerned member of the community advised DET that the family was moving that day. The student welfare consultant went to the home but had no response. She reported the situation to a school education director who emailed police advising of DET's concerns for the children, and in particular Ebony, and requesting police locate the family. The police told DET they were initiating inquiries to find the family. Separately, the student welfare consultant suggested that the case also be referred to more senior DoCS officials. There is no evidence on the DET file that this occurred.
- On 12 September 2007, a concerned member of the community informed the student welfare consultant of the filthy condition of the vacated home. The student welfare consultant made a report to DoCS and asked the school education director to inform the police. The file does not indicate whether this occurred.
- In October 2007, the department was preparing a summary of actions taken in relation to the girls' non-attendance for the purpose of pursuing the prosecution of the parents.

In summary, for the two older children the main and recurring concern of the department was the children's chronic absenteeism from each of the schools they attended. The children's teachers were also concerned about their extremely poor basic skills and failure to progress as a result of non-attendance.

In relation to Ebony, the major concern was her failure to attend school.

DET staff documented concerns about the parents' use of medication to control the behaviour of the two older children. In relation to this, DET staff at various times also noted or reported concerns about discrepancies between the girls' compliant, quiet behaviour in class and the parents' ongoing claim that they were uncontrollable at home. DET staff also noted at various times, and in reports to DoCS, that the children showed signs of physical neglect.

At various times between 1998 and 2005, DET staff also documented concerns about the abusive, intimidating and threatening behaviour of the father and ongoing, unsubstantiated claims by the mother that her children were bullied at school.

<sup>3</sup> In response to our preliminary report, DET submitted the psychologist *'incorrectly used the words 'home schooling' in his one page report about [the two older children]. Home schooling was not being considered'*.

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## 5.4 DET review of its actions

At our request, DET undertook a review of its actions. As noted, DET advised us that the department had established a working group of suitably qualified officers to prepare the response to this office.

At the outset, DET told us that there were a number of facts relevant to both this office's and the working group's consideration of matters pertinent to the family.

First, Ebony was never enrolled by her parents in a school.

Second, between 2001 and December 2006, there were limitations within the Education Act which, for practical purposes, made it impossible for DET to prosecute in relation to non-enrolment of a student. These practical limitations were remedied in December 2006.

Third, DET clarified that the parents did not apply to enrol the two older children in distance education or to have them registered for home schooling. DET has no power to make decisions regarding home schooling – this is the purview of the Office of the Board of Studies. The Board of Studies had no record of the parents applying to home school their children. Moreover, home schooling was never considered as an option for the children by DET officers.

Taking these facts into account, DET provided the following advice in its statement to this office.

## 5.5 Absenteeism

According to the department's advice, its working group identified a number of areas concerning absenteeism of the older two children, where the adequacy of the department's response can be questioned.

The working group found that DET should have brought the cases to prosecution in a more timely manner. Specifically, the working group found that:

- The children's cases should have been referred back to DET's Legal Services Directorate for reactivation of prosecution proceedings when the two older children's attendance started to decline again in April 2002.
- From April 2002 until July 2007, reactivation of prosecution proceedings should have been a priority in the case management of the home school liaison interventions with the family. Reactivation of the prosecution of the parents should have been initiated by the district superintendent on advice from the student welfare consultant.
- Home school liaison staff did not realise that, regardless of the family providing medical certificates, staff could refer the matter to prosecution and that a magistrate could decide not to accept the medical excuses if they were not considered to be genuine or reasonable.
- Home school liaison staff and their supervisors incorrectly believed that they had to restart the whole intervention process and persist with cases until *all avenues* of intervention had failed when, in fact, the intended course of action was that officers should move cases to prosecution after *reasonable* avenues of intervention had failed.

The working group also found in relation to the question of prosecution, that DET staff continued to press the parents to comply with the requirements of the Education Act, despite their providing medical certificates and other explanations for their children's non-attendance and non-enrolment. The working group found that DET could/should have:

- developed and implemented more detailed home school liaison case management plans for the intervention with the children.
- supervised the home school liaison officers working with the children more closely.
- challenged the medical certificates provided to cover the children's absences and proceeded to refer the cases for prosecution so as to formally test these excuses.

In relation to the issue of prosecution, we accepted and concurred with DET's observations and findings.

The working group also found that DET staff should have clarified with DoCS its expectations of DET's responsibilities for the management of the two older children's school attendance, once care proceedings had been initiated in the Children's Court (late December 2001). This action should have been initiated by the district superintendent or the relevant school education director.

We agreed with this observation. Had the agencies consulted, it is possible that both would have been in a better position to address the older children's school absenteeism as it re-emerged as a concern in 2003. Significantly, throughout 2003 the children's parents were subject to an undertaking to the Children's Court that they would ensure the children attended school. As previously noted, in response to our preliminary report, DET told us that it was not aware of this undertaking.

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## 5.6 Response to safety and welfare concerns

In relation to the safety and welfare of school aged children who are not enrolled or who are not attending school, the working group told us that DET's responsibilities are to:

- require parents to meet their statutory obligations to cause their children to enrol or attend school.
- report any risk of harm concerns to DoCS and formally escalate any concerns in the absence of a sustained response by DoCS.
- respond to any requests from DoCS consistent with the child protection interagency guidelines.

Against this background, the DET review found that relevant education officers appropriately raised concerns about the welfare of the children. *'However, the adequacy of [DET's] actions could be questioned in terms of Education failing to engage [DoCS] operational managers in formal or strategic discussions regarding [DET's] concerns about what appeared to be the lack of a sustained [DoCS] response to the family.'*

We agreed with this finding. In doing so we noted the advice provided to us by DET that *'while en-route to a ... meeting unrelated to the [family] ... a chief education officer from Sydney Region, raised Education's concerns regarding the [family] with Community Services' regional director'*.

We also agreed with DET's comment that this verbal communication *'should have been followed up more formally in writing with senior Community Services [DoCS] officers'*.

In relation to Ebony, the working group found that a risk of harm concern existed due to her non-enrolment and DET's knowledge of the family and schooling history. *'Education's statutory obligation was to notify Community Services. This was done through phone calls to [DoCS] officers throughout 2006 and 2007 requesting interagency assistance to get [Ebony] enrolled and in two reports to the helpline in 2007 expressing concerns for her whereabouts.'*

We agreed. The evidence indicates that appropriate reports were made by DET to DoCS concerning Ebony's non-enrolment.

In relation to the failure of the parents to enrol Ebony, the working group found that *'From December 2006, DET had the opportunity to bring the case of [the third child's] non-enrolment to prosecution and should have done so.'*

We agreed.

Separately, the review found that DET could have put in place more detailed case management plans for the home school liaison intervention with the children. Specifically in relation to this issue, the working group found that:

- While there was evidence of activity by the home school liaison officers in the children's cases, *'the case management plans only outlined initial strategies such as gathering information and meeting the family. The case management plans are not detailed and do not contain specific strategies for dealing with [the family]. The case management plans lack specific targets. This would have made it difficult for home school liaison and student services staff to have assessed accurately how and when to implement alternative strategies and decide when to escalate the cases for higher level intervention. On review, case management plans should have been clearer and more detailed'*.
- *'Detailed case management plans should have been developed immediately each time the children were (re) referred for home school liaison intervention. Better monitoring and supervision of case management plans and targets should have occurred throughout the time the children were active on home school liaison officers' caseloads from 2000 to 2005'*.

The working group also found that the department could have *'Provided a higher level of state office support to, and communication with, regional staff to assist them in managing the home school liaison program'*.

In our final report, we found that DET's actions in relation to the question of the children's school enrolment and attendance were inadequate.

We also considered the adequacy of DET's actions in responding to concerns about the safety and welfare of the three children. We found that in the main, DET staff took adequate and appropriate steps to respond to concerns about the children's safety and welfare. However, we concurred with DET's assessment that senior DET staff should have escalated the case with senior DoCS staff when in late August 2007 and early September 2007, DET reached the view that the DoCS response to the children's circumstances was insufficient.

## 5.7 DET's actions to address the issues of concern

In a statement of information, DET advised that it has put in place a number of improvements to processes relating to school attendance. According to DET's statement:

- On 20 February 2008, DET issued instructions to senior DET staff regarding '*much stricter timelines for regional attendance program personnel in dealing with cases of non-enrolment and poor attendance with prosecution at a much earlier stage if compliance remains inadequate*'. These instructions became effective in the second term of 2008.
- The department is '*exploring alternative options to imposing a fine in relation to an offence of failure to enrol a child or ensure his or her attendance at school*'. DET advises that while fines are effective in improving school attendance in some instances, in others, they have no effect.

Additionally, DET's working group identified the need for:

- more intense and regular training and professional learning opportunities for home school liaison officers and their supervisors.
- improved state office communication with, and direction to, regions to assist them in managing the home school liaison program.
- an amendment of the care and protection legislation to ensure that successive school principals both within and across schools are able to be provided with details of risk of harm reports made by any of their predecessors, and not be prevented from doing so by the provisions of the Commonwealth privacy legislation.
- home school liaison staff to seek police assistance on home visits where an occupational health and safety risk assessment has identified safety risks

On 1 April 2008, the Government announced it would be introducing amendments to the Education Act, with the objective of expanding DET's options for dealing with poor school attendance.

In response to our preliminary report, DET's working group said it:

*holds the view that there should be a new provision in the Child Protection Interagency Guidelines for the mandatory provision of information, reports and, if relevant, court orders to agencies involved with a child(ren) who are the subject of child protection orders. This would result in awareness by agencies of any impost of conditions such as the reporting of non-attendance.*

## 5.8 Final recommendations and DET's actions to implement these

In our final report we recommended DET:

- (1) Advise this office of any actions proposed by DET to address the concerns identified through its review of the case, in relation to:
  - a. the need for more intense and regular training and professional learning opportunities for home school liaison officers and their supervisors
  - b. the need for improved communication with, and direction to, regions to assist them in managing the home school liaison program
  - c. ensuring that home school liaison staff seek police assistance on home visits where an occupational health and safety risk assessment has been undertaken and safety risks have been identified.
- (2) Provide advice to this office on:
  - a. how the department proposes to monitor the effectiveness of its reported improvements to processes relating to school attendance implemented at the commencement of 2008
  - b. DET's assessment as to whether the initiatives implemented to date have been effective and the evidence to support its assessment.

DET provided this office with detailed advice on the actions the department has taken to improve its processes relating to school attendance. In summary:

- Since the beginning of Term 2 2008, the department's processes involving legal action taken against parents who fail to comply with the responsibilities under the *Education Act 1990*, to ensure school enrolment and regular attendance at school, have been strengthened.
- Legal action is no longer a last resort approach but a proactive approach with streamlined procedures and a shortened timeframe for the completion of these processes.

- The department is evaluating the effectiveness of its various strategies – including prosecution – on school attendance during 2009. The department advised us that a limited study has, to date, indicated that in *'about 44% of cases, prosecuting parents had a positive effect on student attendance'*.
- Meetings have been held with regional attendance teams to support the implementation of the revised processes involving legal action.
- Updated *Home School Liaison Program Guidelines* have been placed on the department's intranet site.
- These guidelines have subsequently been updated to include advice on and the process for seeking police assistance prior to undertaking home visits when an occupational health and safety issue may have been identified.
- Regular video conferencing has been scheduled between the department's Student Welfare Directorate and all regional school attendance teams.
- Regional attendance coordinators who supervise home school liaison officers are being included in home school liaison training.
- A Teaching and Learning Exchange website has been established on the department's intranet specifically for regional attendance teams. This allows questions to be posited with all participants able to view discussion and participate in an online forum. The site is moderated by staff from DET's Student Behaviour and Attendance Unit.
- A position of Coordinator, Student Discipline and Home School Liaison Support has been created and filled.

At a recent meeting between DET and this office, the department further advised that the arrangements to better support the Home School Liaison Program are continuing to be implemented with resultant improvements generally. The department also advised:

- There will be an additional 25 Home School Liaison Officers at the commencement of Term 1, 2010. Currently there are 85 positions. Enrolment and attendance data will be used to inform decisions about where the positions will be placed.
- There will also be an additional 11 Aboriginal School Liaison Officers, bringing the number in NSW to 26. The department is currently exploring options with the Attorney General's Department of NSW in relation to greater community/elder involvement in resolving Aboriginal attendance issues.
- Noting that the role of Home School Liaison Officers is to offer extra support to schools where the school has been unable to resolve attendance issues, DET is developing a good practice guide for its attendance teams which will include information about how to increase engagement with local services to support school attendance.
- DET is now publishing prosecution figures for non-attendance. According to the department, there is anecdotal evidence that the letters telling parents prosecution will commence are resulting in significant improvements in many cases. Of those that have gone to prosecution, half of the briefs have been withdrawn because the issues have been resolved by the court date.

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# Chapter 6.

## Department of Ageing, Disability and Home Care

### 6.1 The nature of our investigation

DADHC had contact with the family after Ebony was diagnosed by a paediatrician as having autism in 2005. The paediatrician referred her and her family to DADHC for support services.

Our preliminary examination of Ebony's DADHC files raised questions about the adequacy of DADHC's case management of her between late 2005 and mid 2006.

In particular, we had concerns about the department's decision to close its file for her when it knew that she was not attending school, and would therefore not be receiving the therapy services that she required.

We also had concerns that DADHC closed its file for her when it had made a risk of harm report to DoCS and had then established that DoCS did not intend to allocate the case to a child protection worker.

We decided to investigate the case management provided by DADHC to Ebony.

Our investigation included the following steps:

- We reviewed DADHC's files for Ebony and those of her younger sister.
- We asked DADHC to review the adequacy of its case management service to Ebony from February 2006 onwards. We sought detailed advice from DADHC in relation to:
  - i. the adequacy of the actions taken by DADHC to assess her needs and develop an individual plan for her;
  - ii. the adequacy of the actions taken by DADHC to ensure she received the services identified by the needs assessment;
  - iii. the adequacy of the department's review of her individual plan;
  - iv. whether any other action should have been taken by the case manager / manager access, and if so, any reason why this action did not occur;
  - v. the adequacy of the department's record keeping; and
  - vi. the adequacy of the supervision provided to her case manager.
- Following its review, DADHC provided us with a statement of information.

In our preliminary report, we noted our finding that through its actions, DADHC failed to meet its responsibilities to Ebony, and that given her known circumstances, this was unreasonable.

In response to our preliminary report, DADHC said it did not accept this finding.

Having carefully considered the comments made to us by DADHC in response to our preliminary report, we remained of the view that the case management provided by the department to Ebony was inadequate. DADHC's comments and our response are discussed below.

### 6.2 DADHC: Legislation, policies and procedures

DADHC's Prioritisation and Allocation policy states that children (0 – 5) with global developmental delay and children (6 – 12) with intellectual disability fall within DADHC's target group.

According to the policy, each new eligible client requesting disability services is to be offered a 'needs assessment' to clarify his or her specific needs. The needs assessment, the goals generated from the needs assessment and the requests for service are to be documented as the client's initial Individual Plan.

When seeking services to meet client needs, DADHC case managers will consider the full range of disability services available, including those available through other service providers.

In the event that no contact can be made with the client or family, the manager informs the Intake Panel. The Intake Panel reviews the intake information, determines the status of the referral (closed or open) and informs the manager if further action is required.



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DADHC's Prioritisation and Allocation policy states that a case manager is required where there are complexities because of the client's needs or the number of services involved, or where the family lacks the skills and resources to provide an adequate response to the needs of the client.

DADHC's *Living in the Community: Putting children first* policy states that DADHC has responsibility to 'convene meetings to discuss progress, care issues and any other matters that might have a bearing on the outcomes for children/young people and their family'.

DADHC's child protection policies and procedures provide guidance to departmental staff on their responsibilities for identifying and reporting child protection concerns.

The Memorandum of Understanding between DoCS and DADHC specifies that where a case concerning a child with a disability is reported to DoCS and it is determined that the child is not in need of care and protection, case management responsibility lies with DADHC.

The *NSW Interagency Guidelines for Child Protection* require agencies to consider their role after they make a report to DoCS, including how they can continue to support a child and family, and how they can monitor the child's situation for additional signs of abuse and neglect.

### 6.3 Chronology of DADHC's involvement with the family

The following chronology concerning DADHC's involvement with Ebony and her parents is relevant to our findings and observations.

- On 20 January 2003 a paediatrician at the Sydney Children's Hospital diagnosed Ebony – then almost three – as having moderate global developmental delay. On 3 February 2003, Tumbatin Clinic referred Ebony to a DADHC Community Support Team (CST) for the provision of case management, speech and occupational therapy.
- On 14 February 2003, the mother advised DADHC that services were in place for Ebony and that she did not require services from DADHC. DADHC advised Tumbatin of the outcome of the referral and took no further action in relation to the referral.
- In May 2005, the paediatrician again referred Ebony to the CST. On this occasion, the referral was for behaviour intervention and speech pathology. The referral noted that Ebony came from a *'dysfunctional family that are chronic non attendees for appointments. DoCS have been involved with the family and the youngest child is now living with a foster family. Mum has a past history of dependence on pain killers. DoCS are not involved with [the child]. The paediatrician is considering a notification'*. The paediatrician also advised that Ebony was attending a pre-school. DADHC attempted to conduct a needs assessment on two occasions in May and once in June. On 18 July, Ebony's preschool told DADHC that the parents had withdrawn her from the preschool as the family might be moving. DADHC subsequently closed its file for Ebony.
- For reasons that remain unclear DADHC reopened the case and attempted to contact the family in November 2005. DADHC made arrangements with the mother to complete a needs assessment on 7 and 8 December 2005. Ebony was assessed at the pre-school. She was observed to have limited communication. The assessment identified the need for speech pathology, occupational therapy, physiotherapy services and case management services. The assessment noted that Ebony had a lovely smile, would soon be six, and *'would be best suited to attending school'*. She was noted to be *'achieving well at her current placement'*. The assessment recommended that Ebony receive therapy services in the school setting. According to a statement of information, while the assessment did not identify any specific concerns about Ebony's health or safety, there were *'concerns about [Ebony's] developmental attainments and the need to provide her and her family with a comprehensive early intervention service'*. DADHC did not sight her again after December 2005.
- At some time between 8 December 2005 and 8 February 2006, DET informed the DADHC case manager that Ebony had been offered a place and accepted for enrolment at a special school.
- On 8 February 2006, the DADHC case manager conducted a home visit. The mother indicated that Ebony had not commenced school. The case manager arranged to go with the mother to the school for an initial visit on 10 February. On that day, the case manager accompanied the mother to the school.
- On 20 February 2006, the DADHC case manager attempted to contact the parents by telephone to check on Ebony commencing school. There was no answer.
- On 12 May 2006, the principal rang the DADHC case manager to advise that Ebony had not commenced school. The principal wanted to explore what support could be offered to the family to facilitate school attendance. In response to this contact, the DADHC case manager and A/Manager Access conducted a home visit. There was no answer, and a note was left seeking contact.

- On the same day the DADHC case manager made a risk of harm report to DoCS. According to DoCS' record of the report, the case manager reported that Ebony had not attended school all year and was not attending appointments. When DADHC visited the family *'there was lots of rubbish in back yard.'* DADHC left a card but the family were *'notorious for not responding'*. The case manager also told DoCS that *'DADHC is a voluntary service'*; that Ebony was missing out on important support; that the referring doctor [to DADHC] had refused to supply the mother with dexamphetamine to control Ebony's behaviour in May 2005; and that the initial referral to DADHC was for behavioural issues.
- On 2 June 2006, an acting DADHC manager contacted DoCS to clarify the status of the risk of harm report. The manager noted *'They [DoCS] have rated the referral as not needing a case manager. Asked that a file note be made stating we are going to request a combined Dept Ed/DADHC/DoCS [meeting]'*. The manager then referred the matter back to the case manager to *'take over'*.
- On 29 August 2006, the DADHC case manager recorded *'Have had 2 contacts [with] DET re [Ebony]. Has not attended school as yet. DET are taking action. Transport has been approved. DET to contact us if she commences school'*.

## 6.4 Our observations

In our view, DADHC's actions in response to the January 2003 Tumbatin Clinic referral concerning Ebony were reasonable. DADHC took appropriate and timely steps to respond to the referral. The mother's advice to DADHC at the time indicated that Ebony was in receipt of appropriate services. DADHC advised the referring agency of this and closed the case.

In our preliminary report, we observed that to a certain point in time, DADHC's other actions in relation to Ebony appeared to be reasonable:

- DADHC's response to the paediatrician's May 2005 referral of Ebony to DADHC for behaviour intervention and speech therapy was timely.
- DADHC's actions to engage the mother in the needs assessment process were appropriate.
- On the basis of advice from Ebony's preschool that she had been withdrawn and the family were moving, DADHC wrote to the mother requesting contact and, when there was no contact, closed the file. Given the pre school's advice, the decision to close the file was in our view reasonable.

In our preliminary report, we observed that it was not clear why DADHC reopened the matter in November. DADHC did not provide any clarifying information on this matter. Nevertheless, we observed that DADHC's actions to progress the needs assessment of the child in November and December 2005 were appropriate.

The needs assessment determined that Ebony required therapy services (speech pathology, occupational therapy and physiotherapy) and that these services should be provided in the school setting. This decision was reasonable given that the school is equipped to manage therapy provision and Ebony was to commence school the following month. The assessment also identified that Ebony required case management services. Given the family's known circumstances, this assessment appeared to acknowledge her needs.

The steps taken by DADHC to actively link Ebony and her mother to the school in February 2006 appear to have been reasonable.

According to DADHC notes and advice, it was agreed that DET would pursue the issue of Ebony's school attendance and would inform DADHC when she commenced school. Accordingly, between 20 February – when the DADHC case manager unsuccessfully attempted to contact the mother – and May 2006, when the school contacted DADHC to seek assistance regarding Ebony's school attendance, DADHC made no attempt to contact the family.

In our preliminary report, we observed that given DADHC had identified that the school would be the appropriate place for Ebony to receive therapy services, it was unclear to us why DADHC did not ask the school to advise the department in relation to her non-attendance rather than attendance. In making this observation we were cognisant of DADHC's Prioritisation and Allocation policy which states that a case manager is required where there are complexities because of a client's needs or the number of services involved, or where the family lacks the skills and resources to provide an adequate response to the needs of the client.

Put simply, if Ebony was not attending school, it was likely that she was not receiving the required therapy services, and was therefore in need of DADHC's case management service.

In our preliminary report we also observed that:

- DADHC's actions immediately following the school's request for assistance in May 2006, including the making of a risk of harm report to DoCS, were appropriate. DADHC's follow-up with DoCS to establish what action that department proposed to take in response to the report was also appropriate.

- DADHC's actions following the receipt of DoCS' advice that the report would not be allocated to a child protection worker were inadequate, particularly given Ebony's known circumstances.
- Despite DADHC's advice to DoCS that DADHC was going to request a combined meeting between DET, DADHC and DoCS, DADHC did not pursue this option.
- DADHC did not respond to advice from DET – noted on the DADHC file on 29 August 2006 – that Ebony was not attending school. This was even though DADHC:
  - had assessed that Ebony's access to a range of therapy services was a high priority for her
  - had concerns for her and her ongoing development, especially in the home environment
  - knew that her family had difficulty engaging with services. Therefore, if she was not attending school, DADHC would have had cause to believe that it was unlikely that she would have been receiving these therapy services elsewhere
  - knew that Ebony's younger sister had been placed in long term care
  - knew that her parents struggled to manage her behaviour.

In our preliminary report we also noted that the Memorandum of Understanding between DoCS and DADHC is clear regarding case management responsibilities for children with disabilities reported to DoCS, and that DADHC had such responsibilities for Ebony. We noted that the *NSW Interagency Guidelines for Child Protection* require agencies to consider their role after they make a report to DoCS, including how they can continue to support a child and family, and how they can monitor the child's situation for additional signs of abuse and neglect. We observed that despite these responsibilities, DADHC closed the matter.

During the course of our investigation, we asked DADHC to review the adequacy of the actions it took to ensure Ebony received the services identified by the needs assessment. DADHC told us that '*DADHC was unable to provide a service to [Ebony] either at home or at school without further contact with her family being made*'.

We also asked DADHC to tell us whether any other actions should have been taken by the case manager and her supervisor, and if so, any reason why this action did not occur. In a statement of information, DADHC told us:

*there is no documentation about why there were no further attempts made to contact the family. The Metro South Region has introduced the practice for all Managers Access to request client files be presented as part of the regular supervision process. This will ensure better compliance with record keeping requirements.*

In our preliminary report we stated that in our view, this advice failed to address the pertinent issues as the department had closed the matter when it had case management responsibility. Part of this case management responsibility was to ensure that there was an adequate response to Ebony's needs. We concluded that while acknowledging the difficulties in contacting the family, DADHC's failure to meet its responsibilities to the child was unreasonable.

We also said that DADHC's actions regarding the circumstances under which it closed Ebony's case, raised a question about the supervision provided to the DADHC case manager. In a statement of information, DADHC told us:

*it appears from the insufficient detail on file and on CIS [Client Information System] that there was not a sufficient level of supervision regarding written record keeping. There may have been too strong a reliance on verbally discussing [the child's] issues, and the required actions to be undertaken, without monitoring of formal record keeping.*

The statement provided information on the steps DADHC was taking to improve case management supervision.

We said that in our view, the department's response again failed to address the pertinent issues. Our concern was that a case manager was able to close a matter where the need for DADHC case management was clearly apparent, and that this was not identified through case management supervision.

In response to our preliminary report, DADHC submitted that the department did not accept our finding that it failed to meet its case management responsibilities to Ebony. Moreover, DADHC said that we had appeared to '*assess DADHC's action against the full knowledge of the case that is now held, rather than against the limited information about the risks to [the child] known to DADHC at the time*'. In support of its position, DADHC stated:

- *DADHC was not able to provide further case management in the absence of a supervision order or on direction from the Department of Community Services (DoCS) or the NSW Children's Court. DADHC was not able to support school attendance without the statutory intervention of the Department of Education and Training (DET). As a result, DADHC's case management role in this situation was limited.*
- *The [preliminary report] omits the requirement in DADHC's intake policy for parental or guardian consent and the impact this has on DADHC's role within the DoCS/DADHC Memorandum of Understanding, and the Child Protection Interagency Guidelines.*

- DADHC advised DoCS that it could not continue case management without consent. In August 2006, DADHC was aware that DET was following up on the non attendance and advised [DET] that DADHC would not take any further action until Ebony was attending school.
- DADHC's closure of the case in September 2006 was done on the basis that DET had the responsibility for the follow up of non attendance at school and the 'DET would contact DADHC if Ebony commenced school'.
- The [preliminary report] does not acknowledge that the lack of information sharing about the case contributed to the lack of information held by DADHC. The [preliminary report] highlights that the level of risk to Ebony was not assessed in a systematic way. For instance, there was no information sharing between DoCS and DADHC about Ebony's history or the nature of DoCS' past involvement because the mandatory report made by DADHC in May 2006 was closed.

DADHC further stated:

*The assessment that DADHC failed in its case management responsibility is not supported by the information provided in the [preliminary report]. The statement that 'despite' responsibilities under the NSW Child Protection Interagency Guidelines that 'DADHC closed the matter' implies that DADHC held child protection concerns for Ebony and that the case was closed in this context. This is incorrect because DADHC's concerns, as stated in the mandatory report to DoCS, were about the lack of access to therapy services. DADHC did not have the child protection history held by DoCS. The closure of the case by DoCS meant that there was no opportunity for DADHC to gain this information.*

*It is DADHC's view that the closure of the case reflects the following issues, not a failure of responsibility:*

- DADHC's case management role as a voluntary agency is limited;
- The full history of the family was not collected or pieced together and assessed; and
- As a result of this, other agencies especially DADHC, were not aware of the child protection risks.

In its response, DADHC acknowledged that there were actions that the department could have taken; however, in doing so said that it did not consider that these 'omissions constitute a failure of case management responsibility on behalf of DADHC'.

*It is considered that a request to senior DoCS officers to review the DoCS' decision to close the mandatory report on the grounds that [the child's] parents were refusing therapy services for Ebony and that this affected her development would have been an appropriate action.*

*It is also accepted that organising a meeting with agencies to discuss the family's refusal to meet Ebony's therapy needs, as included in DADHC case records, would also have been appropriate.*

In its response DADHC also observed that:

*The [preliminary report] also includes the comments that the actions identified by DADHC to address issues relating to the provision of services to Ebony are inadequate. The actions identified by DADHC to improve record taking and supervision arrangements would allow a supervisor to identify the need to raise the matter with DoCS at a more senior level.*

Taking DADHC's comments into account, we made the following observations.

DADHC stated that it did not hold child protection concerns for Ebony, but rather, its concerns for her were about her lack of access to therapy services. It was on this basis that the mandatory report was made to DoCS.

We questioned this advice given the *Children and Young Persons (Care and Protection) Act 1998* states that mandatory reporting applies where 'a person has a reasonable ground to suspect that a child is at risk of harm' and given that there was sufficient evidence at the time for the DADHC manager to make a mandatory report. DADHC staff had identified Ebony's need for therapy services and that these were a prerequisite to her realising her developmental potential. DADHC knew that she was not receiving these services in the school setting, and it knew that she was unlikely to be receiving these services elsewhere. It also knew there had been child safety concerns for a sibling, resulting in that child's removal. The department knew that Ebony came from a 'dysfunctional family' that had difficulty managing her behaviour.

DADHC argued that in the circumstances – the absence of parental consent and the absence of a supervision order and/or direction of DoCS and/or direction by the NSW Children's Court and/or statutory intervention by DET – DADHC's case management role was limited.

In relation to these matters, we made the following observations.

First, we could not find on DADHC's file any documentation which indicated that the child's parents had withdrawn their consent for her to receive services. While we acknowledged that between 20 February and 12 May 2006 DADHC made two unsuccessful attempts to contact the family, it was unclear to us how lack of contact with, or by, the family constituted withdrawal of consent.

Second, DADHC argued that without parental consent, its provision of services to the child and her family was dependent on the statutory intervention of other departments – namely DoCS and DET. Putting aside the issue of consent it appeared to us that DADHC’s position failed to take into account *its* statutory responsibilities. Section 29A of the *Children and Young Persons (Care and Protection) Act 1998* notes:

*For the avoidance of doubt, it is declared that a person who is permitted or required by the Part to make a report is not prevented, by reason only of having made that report, from responding to the needs of, or discharging any other obligations in respect of, the child or young person the subject of the report in the course of that person’s employment or otherwise.*

In this regard, we reiterated our previous observation that when DoCS told DADHC that the case would not be allocated for risk assessment, DADHC had a duty to take case management responsibility for the child. According to DADHC’s own policy,<sup>4</sup> this would have included convening meetings with DET and DoCS to ‘discuss progress, care issues and any other matters that might have a bearing on the outcomes for children/young people and their family’. If DoCS did not participate, there was an onus on DADHC to escalate the matter to a more senior level.

DADHC argued that we did not acknowledge that the ‘lack of information sharing about the case contributed to the lack of information held by DADHC’ and elsewhere that ‘there was no information sharing between DoCS and DADHC about Ebony’s history or about the nature of DoCS’ past involvement because the mandatory report by DADHC in May 2006 was closed’.

In relation to these matters, we made the following observations.

First, as suggested above, DADHC had to take some responsibility for what we believed to be an inadequate exchange of information between DoCS and DADHC. At no time did DADHC seek information from DoCS which could have informed its case management strategy.

Second, DADHC’s statement that DoCS’ closure of the May 2006 report prevented exchange of information between DoCS and DADHC implied that there must be an open report for information to be exchanged between the two departments, and that DoCS must initiate the exchange. This is incorrect. Pursuant to s.248 of the *Children and Young Persons (Care and Protection) Act 1998*, DoCS could have provided information to DADHC relevant to the child’s welfare and wellbeing following a request for this information from DADHC.

In its response to our preliminary report, DADHC acknowledged that it would have been appropriate for the department to convene a meeting with agencies and to escalate the matter with senior DoCS staff. However, DADHC asserted that its failure to do either of these did not constitute a failure of case management responsibility on its part.

We disagreed. At the time and in the circumstances, both actions were prerequisites for Ebony receiving the services she required. That DADHC neither convened a meeting nor escalated the matter represented inadequate performance.

We also made certain observations in relation to DADHC’s statements that the department requires the consent of a parent or guardian to provide services to a child, and that the absence of such consent has an impact ‘on DADHC’s role within the DoCS/DADHC Memorandum of Understanding, and the Child Protection Interagency Guidelines’.

In our final report, we stated that we appreciated and acknowledged that DADHC does require consent to provide services. However, we believe that key components of effective case management include a commitment to, and skills for, engaging families including those who may have some initial reluctance to accept support. In circumstances involving vulnerable children, if a family rejects much needed support, there is an onus on DADHC to assess whether the family’s failure to accept services warrants a report to DoCS. In addition, as we have already stated, the making of a report to DoCS does not absolve the department’s responsibility to that child.

## **6.5 DADHC’s actions to address the issues of concern identified in the Ombudsman investigation**

In response to our request for advice on how DADHC considered the issues and deficiencies identified by the investigation could be addressed, DADHC said:

*DADHC’s previous response identified record taking and supervision as issues. These two areas remain key factors in addressing issues raised by the investigation.*

*In the Metro South Region, regular meetings have been established between the Regional Manager Access and relevant DoCS Director, Child and Family to develop joint approaches to working with children and young people with a disability that are within the target group of the MoU.*

<sup>4</sup> *Living in the Community: Putting Children First.*

The Metro South Region has also acted to improve the supervision arrangements for clinical staff. All Community Support Team staff members are provided with regular monthly administrative supervision with the manager and where it is relevant, have joint administrative and clinical supervision with the manager and senior clinician.

As part of the Case Management Reforms under Stronger Together, DADHC has significantly increased the number of staff providing case management services across the State. Recruitment has recently been completed for an additional 124 positions. These include Case Manager and Manager Access positions. In addition senior staff members have been recruited for each region who will be responsible for reviewing and improving practice standards and consistency of case management practice across the state.

As part of supervision processes, staff are required to provide an up to date caseload planner document which provides a record of the clients, service plan dates, key issues and intervention strategies which assists in informing the supervision discussions and allows review of practices.

As part of this process, the Region will be trialling the use of a manager supervision checklist and protocol. This is a quality improvement tool to provide managers with guidance for supervision sessions with their staff, to regularly review client file information and the Client Information database in relation to service provision, and provides for issues to be identified and actioned.

DADHC advised that:

*DADHC and DoCS are currently evaluating the DoCS DADHC MoU and it will be revised on completion of the evaluation to improve its effectiveness as a tool for a collaborative approach in meeting the needs of children and young people with a disability.*

DADHC also said that the need to improve interagency communication and information sharing was an issue arising from the investigation.

## 6.6 Final recommendations and DADHC's actions to implement these

We made the following recommendations to DADHC:

- (1) As part of DADHC's case management reform agenda, DADHC should review the findings of this investigation and consider any changes which may be required to the department's case management framework to enhance the prospect of vulnerable children who may be at risk of harm receiving appropriate services. The department's review should have particular regard to:
  - a. appropriate strategies for engaging with and responding to those families with children and young people with disabilities who need case management services but may be reluctant to accept such support (particularly in circumstances where the child or young person may be at risk of harm)
  - b. DADHC's commitments and responsibilities under the DoCS/DADHC MOU, the NSW Child Protection Interagency Guidelines, and section 29A of the *Children and Young Persons (Care and Protection) Act 1998*
  - c. the adequacy of DADHC's practice guidelines for case management.
- (2) DADHC should ensure that its staff providing services to children and young people with a disability and their families have an adequate understanding of the provision of section 248 of the *Children and Young Persons (Care and Protection) Act 1998* as they relate to the exchange of information with DoCS.

In response to the above recommendations, DADHC provided us with detailed advice on changes it has made over the past two years to improve the department's capacity to respond to the needs of children and their families. DADHC has said that these changes will assist the department improve its response to vulnerable children. We agree.

DADHC is currently reviewing its policies, procedures and practices to take account of DADHC's responsibilities arising from the Wood Inquiry as they relate to protecting children and working preventatively. DADHC has advised that based on its analysis of our investigation findings, priority areas for review will include:

- prioritisation of access to services
- assessment and planning policies and procedures
- policy and practice regarding case closure.

Arrangements have been made for DADHC to brief us about these changes in late 2009.

DADHC advised that its intention in relation to the revised Memorandum of Understanding with DoCS is that the MOU will commit both agencies to collaborate in case management of a child or young person with complex behaviours and disabilities and risk of harm or in out-of-home care. *'This case management would extend to circumstances where there is an identified need to support the family to prevent the risk of the child or young person entering either voluntary or statutory out-of-home care'*.

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DADHC states that this collaborative approach will be especially important in light of the changes to the child protection system arising from the Wood Inquiry.

DADHC advised that it will review and improve resources to assist case managers including templates, checklists for the preparation of plans, case conferences and other key initiatives to support staff in working with children and families. *'In line with these improvements, the Case Management Framework will also be reviewed'*.

Finally, DADHC advised that its policy and practice guidelines will include the legislative changes recommended by the Wood Inquiry as they relate to child protection information sharing provisions. These changes will be supported by training programs.

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# Chapter 7.

## Department of Housing

### 7.1 The nature of our investigation

The family lived in public housing between 1992 and 2007. DOH identified squalid, filthy conditions in the family home in late February 2007, after a contractor declined, on occupational health and safety grounds, to work inside the house to install a new stove. The matter was referred to a specialist DOH worker. She conducted several home visits, made a report to DoCS on the day of the first visit in early March 2007 and followed up with DoCS. She remained involved until satisfied the house had been cleaned.

In August 2007, DOH staff were aware that the family was preparing to move from their Matraville premises.

We were concerned that no one at DOH alerted DoCS to the move. We were also concerned that no one at DOH made a report to DoCS about the squalid state of the vacated premises.

We decided to investigate DOH's actions in responding to concerns about the safety and welfare of the children.

Our investigation included the following steps:

- We reviewed DOH's files and records for the family.
- Based on our review of this material, we asked DOH to provide us with a detailed statement.
- DOH provided us with the requested information.
- We interviewed certain DOH staff involved with the family while they lived in Matraville.

In response to our preliminary findings and observations, DOH said that there were reasons why its staff did not make a second report to DoCS after the family left their Matraville premises without notice. We acknowledged the department's comments but remained of the view that a report was warranted.

Our reasons for reaching this finding are detailed below.

### 7.2 DOH: Legislation, policies and procedures

During the period the family lived in DOH premises, DOH client service officers had a mandated responsibility under the *Children and Young Persons (Care and Protection) Act 1998*, to recognise and report harm or risk of harm to children and young people due to child abuse and neglect.

DOH's Child Protection policy stated that the department's specific role was to:

- Recognise and report to DoCS any reasonable suspicion that a child or young person is at risk.
- Promote and safeguard the safety, welfare and wellbeing of a child or young person at risk by promptly responding to requests for housing assistance from DoCS for clients who meet the Department's eligibility criteria.
- Use [DOH's] best endeavours to comply with such requests by providing assistance appropriate to the immediate housing needs of the child, young person or their family.

Under DOH's Child Protection Procedures, staff who had current concerns about the safety, welfare and wellbeing of a child were required to immediately discuss [matters] with a senior client service officer specialist, senior client service officer, or Team Leader. If there were reasonable grounds for suspecting the child or young person was at risk, any of the senior staff identified above had to promptly report the matter to DoCS.

In May 2007, the department published changes to its Child Protection Policy to take account of the NSW interagency guidelines for child protection intervention. DOH workers were advised that the policy '*now supports the principle that protecting children and young people in the community requires interagency collaboration and recognises that this responsibility goes beyond the role of DoCS.*'

The *Residential Tenancies Act 1987* allows landlords, including DOH, to inspect properties no more than four times in a 12-month period, if the tenant has been given not less than seven days notice. Under section 24, the landlord also has access in certain circumstances including an emergency, by order of the Tribunal, to carry out necessary repairs, or at any time by consent of the tenant.

The department's Client Contact policy states that the department will visit a tenant's property for purposes including annual smoke alarm inspections; assessment of the condition of the property (at least once every two years); and, on request from the tenant, for emergency or responsive maintenance.



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The department will conduct additional client service visits during a tenancy if they are needed to provide a more intensive tenancy management approach for clients who are experiencing difficulties managing their tenancy.

### 7.3 Child protection concerns and DOH actions (2006 – 2007)

The following chronology concerning DOH's involvement with the family is relevant to our findings and observations. Our focus was on DOH's actions after November 2006.

- On 21 November 2006, DoCS issued a section 248 request for information to DOH about whether Ebony's family continued to reside at Matraville and whether there were *'any child protection concerns noted by officers from DOH'*.
- DoCS' records note a phone conversation between a DOH Team Leader and a DoCS child protection caseworker on 22 November 2006. The DoCS' file note records *'The last [DOH] contact with the family was around October this year in relation to some maintenance issues. Nothing unusual had been observed ... will send someone to check out and would get back to DoCS if there is anything that is a cause for concern'*.
- On 24 November 2006, the Maroubra DOH team leader recorded *'P/C to DoCS. DOH records indicate family still at address. No concerns from housing at this point'*. In a statement of information, DOH told us that the team leader had only one contact with DoCS; that a home visit had not been requested in the s248 issued by DoCS; and that DOH staff did not visit the family's residence on or about 22 November 2006.
- On 17 January 2007, a senior client service officer (technical) visited the family's property to inspect the external eaves. The officer observed the premises were in an appalling state. When asked how he cooked, as the stove appeared to the housing officer to be unusable, the father responded that the stove had not been working for two years and that there was no water in the kitchen taps. The following day, the acting DOH Team Leader requested a client service officer to arrange a property inspection.
- On 25 January 2007, DOH was advised that the contractor, who attended the property to install a new gas stove, was unable to complete the work because of pests and the smell at the residence. A new work order was requested to allow the property to be cleaned prior to installation of the stove.
- On 7 February, the father rang the Maroubra DOH to discuss a client service visit. The father would not commit to a time for the visit, reporting that his wife was being treated for cancer. The client service officer agreed to a visit on 8 March; however, a senior officer *'directed that a 7 day letter be sent to the tenant for a CSV. If the tenant will not allow the CSV, the Snr will CTTT (Consumer Trader and Tenancy Tribunal) to gain entry to action the CSV requested by the SCISO/Tech as contractor will not complete work orders due to property condition'*. On 7 February, the client service officer advised the father of a proposed client service visit for 23 February.
- On 22 February 2007, the client service officer visited the family's premises with a call note concerning the client service visit the following day. The officer recorded her observations, *'Went around to the rear yard, back yard covered in rubbish right up to doorstep ... Matter now considered bad property issue'*. The father telephoned the client service officer in response to the call note. He claimed that his wife was recovering from cancer and asked that the visit be postponed. The client service officer insisted on the visit the following day and recorded in the file *'won't go down the hall'*.
- On 23 February, the client service officer conducted a client service visit at the Matraville property. The client service officer recorded her observations in relation to the rear yard, kitchen, lounge and hallway, noting that she was not permitted to see the rest of the property. She observed that the lounge and hallway were cluttered with things and rubbish and that the kitchen was infested with cockroaches, mice and spider webs. The client service officer wrote to the father concerning the issue of unsatisfactory property care.
- On 27 February, the client service officer made a referral to the senior client service officer specialist. The referral noted the names and ages of the children, concerns with the state of the property and the father's advice that he would be away for two weeks from 26 February. Under the heading *'comments and concerns'* the client service officer noted *'Property care needs immediate attention as the 3 Daughters are living in this un-cleanliness. There has been previous DoCS involvement for information concerning children's welfare'*.
- On 28 February, the senior specialist recorded that she accepted the referral and had contacted DoCS. In relation to her contact with DoCS, she recorded *'spoke with [intake worker] – case closed following inability to gain access. Can't get through on telephone – DoCS closed because of this without further investigation'*. The senior specialist noted the father's request that her home visit be postponed until 12 March 2007.
- On 12 March, the senior specialist interviewed the father at the Matraville property. She noted in her report following the visit that the property care was *'appalling'* and that the property was infested with cockroaches and spiders. The father would not let the DOH officers enter the bedrooms because his wife was recovering from hospitalisation. The father said that the state of the property was due to his children suffering from attention deficit hyperactivity disorder. The senior specialist directed the father to clean the property and

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made a report to DoCS. She also recorded *'Follow up with intake at the Department of Community Services. Case unallocated at present, although concerns are noted and concurrence of need of further investigation'*.

- On 13 March 2007, the senior specialist made a risk of harm report to the DoCS Helpline.
- The senior specialist visited the Matraville property on 26 March 2007. She noted the improved state of the property. She also noted that the window in one of the children's bedrooms was covered in plywood. She recorded that the father advised that someone had thrown a rock and requested that the *'wood stay in place for safety reasons'*. The father advised that he was in process of moving to the Central Coast. The senior specialist recorded that the father *'does not hold himself or family responsible for the current state of his property'* and that she had made a follow up report to *'intake at the Department of Community Services who have considerable concerns in regards to the children's welfare'*. She advised DoCS that the children were not present during the visit; that she had not sighted the children; and that the father said that the children were being home schooled in West Gosford. DoCS advised the senior specialist that the case was to be allocated to a child protection caseworker.
- On 5 April 2007, the senior specialist made a further home visit to the family. She reported to the acting team leader via email that the father was aggressive during the visit; that he complained about the failure of DOH to attend to his property for over two years; that he refused to allow entry to the bedrooms and raised concerns about complaints being made about him to DOH by a concerned community member. The mother was home but none of the children were sighted. The senior specialist noted that she had spoken with DoCS and *'have been informed that they have allocated a caseworker for this family'*.
- On 10 April 2007, the senior specialist contacted the allocated DoCS child protection caseworker and requested a section 248 request for the purpose of DOH providing photos of the Matraville property to DoCS.
- On 14 April, the acting team manager noted that he had spoken with the father who advised that the stove had been installed. The acting team manager also noted the senior client service officer specialist's comments *'re property care and DoCS involvement'*.
- On 3 May 2007, the senior specialist emailed the allocated DoCS caseworker, enquiring whether DoCS had made contact with the family.
- On 4 May, the DoCS allocated caseworker emailed the senior specialist and advised that she had visited the family on 20 May; spoke with the two older girls; and that *'the department [DoCS] will remain involved and is currently following-up with the reported concerns/needs of all the children'*. The caseworker sought advice from the senior specialist regarding whether the family had applied for a transfer to the Central Coast.
- On 4 May 2007, the senior specialist emailed the caseworker, advising that the family had not made an application for transfer. She also advised *'I will be handing the file back to the team as there is no need for me to be involved anymore'*. On the same day, she returned the file to the DOH team *'for monitoring'*, noting DoCS' ongoing involvement. The acting team manager noted the advice and returned the file to the client service officer with the direction. *'Please continue to monitor [the] tenancy'*.
- Between May and August 2007, the client service officer made several home visits to the property and attempted to call the father on several occasions. She did not make contact with any of the family during this period.
- In July 2007, the father told DOH staff of his intention to move to a private rental. DOH staff advised the father that he would be eligible for relocation expenses as the Matraville property was earmarked for sale. DOH put the father in touch with removalists.
- On 4 September 2007, the removalist presented an invoice and keys for the Matraville property to the Maroubra DOH office. While the family did not provide a forwarding address at any time, the Hawks Nest address was on the removalist's invoice.
- On 10 September 2007, the client service officer inspected the vacated premises with another departmental officer. She observed the house to be filthy and made arrangements for it to be cleaned. She stated to us that she raised a question with her team leader about the children. The team leader could not recall this conversation.
- On 18 September 2007, a DoCS child protection caseworker contacted the senior specialist in relation to the family's whereabouts. The DOH officer located the removalist's invoice and advised DoCS. On 19 September DOH received a section 248 request for information from DoCS regarding *'any known forwarding address, any possible address to locate [the third child]'*. On the same day, the senior specialist provided the Hawks Nest address to DoCS.

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## 7.4 Our observations

### 7.4.1 November 2006

There was a discrepancy between DOH and DoCS about whether, on or about 22 November 2006, DoCS requested that DOH undertake a home visit to the family's premises. A DoCS file note and that department's subsequent discussions with other agencies indicate that DoCS was of the view that it had made such a request.

On the other hand, DOH says that it had no record of such a request. The relevant DOH officer also told us that she could not recall such a request being made. On 24 November, having checked DOH records, she told the DoCS caseworker that DOH had no child protection concerns for the children. At the time, this advice was correct.

While no home visit occurred, there is no evidence that the DOH worker intentionally misled DoCS. The situation does however highlight the critical importance of clear communication between agencies in relation to child protection matters.

### 7.4.2 Report to DoCS

The actions taken by the client service officer and specialist client service officer in relation to identifying concerns for the children, and reporting these to DoCS on 12 March 2007, were reasonable and consistent with DOH's practice guidelines and mandatory reporting requirements.

### 7.4.3 Actions taken by the senior specialist following the report to DoCS

The actions taken by the senior specialist following the report to DoCS were thorough. She monitored the father's progress to clean up the property and she reported this progress to DoCS. She followed up with DoCS to establish if a child protection worker had been allocated the case and she followed up with the allocated child protection worker to clarify what action DoCS was taking. She asked the DoCS caseworker to send her a section 248 notice so that she could provide DoCS with relevant photos of the family's premises. She informed DoCS when her involvement in the matter ceased in May 2007. In all respects, these actions were reasonable.

### 7.4.4 Actions taken by DOH between May and when the family vacated the property in September 2007

Given DOCS' advice to DOH in May 2007 that DoCS would be remaining involved with the family and would be following up the reported needs and concerns regarding the children, it was reasonable for DOH to believe that this would occur. In the absence of any contact from DoCS between May and until after the family vacated the property, DOH had no reason to believe that there were ongoing concerns regarding the children's safety and welfare, or that DoCS would not have been aware of the family's intention to move.

In response to our preliminary report, DOH submitted that we should also recognise that the client service officer took appropriate steps to monitor the tenancy. In this regard we note that the evidence indicates that the client service officer made numerous attempts to speak with the father in relation to the ongoing state of the property and in relation to his reported intention to leave the property.

### 7.4.5 Action taken by DOH concerning the filthy state of the vacated property

On 10 September 2007, the client service officer visited the vacated Matraville property and observed the property to be filthy. She told us that she reported this to her team leader and arrangements were made to clean the property. She also said that she raised the question of the children with the team leader and was told that senior client service officers were attending to this issue. The team leader told us that she could not recall this conversation.

In our preliminary report we said that, in our view, given the state of the property, a report to DoCS was warranted. In response, DOH submitted that:

*This [finding] may need further consideration. The [document] recognises that given DoCS' advice to DOH in May 2007 that DoCS would be remaining involved with the family and would be following up the reported needs and concerns regarding the children, it was reasonable for DOH to believe that this would occur. This does help explain why a further risk of harm report was not made.*

While we acknowledged that DOH may have believed that DoCS was following up this matter, in light of what was directly observed by housing staff concerning the filthy state of the property, we believed that contact with DoCS by DOH should have occurred given the concerns held by the client service officer for the children.

#### 7.4.6 Action taken by DOH to inform DoCS of the family's whereabouts

The evidence before us indicated that it was not until 18 September 2007 that DOH became aware that DOCS was seeking a forwarding address for the family. DOH officers took appropriate action to locate the forwarding address and provided this to DoCS as soon as the address was located.

### 7.5 DOH's actions to address the issues of concern identified in the Ombudsman investigation

In its response to our preliminary report, and in an earlier submission, DOH identified a number of issues the department considered relevant to its role and child protection interagency collaboration more broadly in NSW.

- DOH noted that although a mandatory reporter, *'Housing NSW is not given priority on the call line for reporting suspected child neglect. It is suggested that consideration be given to Housing NSW being such priority'*.
- DOH commented on section 248 of the *Children and Young Persons (Care and Protection) Act 1998*. *'While a person making a report to DoCS is protected, the act should make clearer that privacy laws do not operate where child protection is an issue. The collaboration which is at the heart of the Interagency Guidelines should be supported by law and should not require officers of various agencies to request that DoCS issue a section 248 notice requesting information'*.
- DOH also explained limitations impacting on the department in relation to child protection matters. Firstly: *The role of Housing NSW is as a provider of social housing and its staff are recruited and trained for a housing role. They have obligations to report child protection matters to the relevant authorities and they seek to manage tenancies in ways which are appropriate to people with complex needs – including providing staff who work more intensely with families with complex needs, as happened in [this] case, on their housing issues. In [this] case, significant efforts were made to help the family sustain their tenancy and to report concerns to child protection authorities on several occasions. Case workers are professionally qualified to monitor child protection in a manner which housing workers, who bring together an altogether different set of skills to bear, are not.*

Secondly, in relation to statutory limitations the department told us that:

*Recognition of the statutory limitations with which agencies operate is also an issue which needs to be considered. It is only through its rights under the Residential Tenancies Act that Housing NSW can monitor a tenancy. The difficult position of monitoring a tenancy for the purpose of gleaning the living condition of children is not recognised by the Residential Tenancies Act.*

Elsewhere the department told us:

*Those rights [under the Residential Tenancies Act] allow the Department to monitor a tenancy within tightly constrained statutory conditions and thus only incidentally infer the condition under which children may occupy premises. In fact, it could be said that the Department ran the risk of monitoring the tenancy so closely vis a vis the tenancy laws to interfere with the peace and quiet provisions of the tenancy.*

### 7.6 Final recommendations and action by DOH to implement these

We made the following recommendations to DOH:

- (1) The Department of Housing should ensure that the Team Leader involved with decisions regarding the [family's] tenancy in the second half of 2007, is advised of the finding of this investigation as it relates to the conduct of DOH.
- (2) The Team Leader's training needs should be assessed in the context of the department's child protection policies and procedures.
- (3) The Department of Housing should meet with DoCS to discuss its concerns regarding the priority given to reports made to the Helpline by Housing about neglect.

DOH advised that it has implemented the first two recommendations. DOH has also met with DoCS and further meetings are planned.



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# Chapter 8.

## The NSW Police Force

### 8.1 The nature of our investigation

On 6 September 2007, a senior DET officer contacted a senior police officer about the family and sought police assistance to locate them. The following day, police advised DET that they had not been able to locate the family. Given the information provided by DET to police, we had concerns about the adequacy of the police actions to locate the family.

We decided to investigate the actions taken by police to locate the family when alerted by DET to concerns about the family in September 2007.

Our investigation included the following steps:

- Following a review of relevant police records, we asked the NSW Police to review the adequacy of the actions it took to locate the family when alerted by DET to concerns about the family on 6 September 2007. We asked the NSW Police Force to provide us with a statement detailing the results of its review.
- The NSW Police Force provided the requested statement.

In our preliminary report, we set out our preliminary view that the police response to these concerns was inadequate. In response, the NSW Police Force contested this finding.

We took into account the information provided by the NSW Police Force and remained of the view that the actions taken by police to locate the family were inadequate.

Our reasons for reaching this finding are discussed below.

### 8.2 NSW Police Force: legislation, policy and procedures

Members of the NSW Police Force have a mandated responsibility under the *Children and Young Persons (Care and Protection) Act 1998*, to recognise and report harm or risk of harm to children and young people due to child abuse and neglect.

### 8.3 DET referral to NSW Police

On 6 September 2007, a senior DET officer rang a senior police officer about the family and subsequently sent the police officer two emails about the family.

The advice provided to us by DET about the background to and nature of the conversations between the DET officer and police officer was as follows:

*Local Education officers were not aware of any ongoing response by the Community Services Centre [DoCS] to concerns that had been raised about the family. As a result the [student welfare consultant] requested advice from the home school liaison program manager about an appropriate course of action to ensure that there was an immediate response to local concerns for the safety and whereabouts of the children. The program manager advised [the student welfare consultant] that if genuine fears were held for the wellbeing of the children, especially [Ebony], then the Police should be notified.*

*The [senior DET officer] did not notify a more senior [DoCS] officer because she assessed that notifying [the senior police officer], was more likely to result in an immediate response, namely locating the whereabouts of the family.*

The first email after the conversation included a four page document which provided a detailed description of the DET Home School Liaison Officer's attempts to address the children's school absenteeism. It also included details of DET's contact with DoCS during this period; advice that the six year old girl had autism and another child was in foster care; information about a citizen's concerns that the children were rarely sighted and that one of the children screamed a lot; and information that this child's window had been boarded up. The attachment also included advice that the neighbour's concerns had been reported to DoCS.

Shortly after forwarding the first email, the senior DET officer sent the senior police officer a second email providing 'additional information' concerning the family. The second email was as follows:

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*This additional contextual information on the family outlines our concerns.*

- *The younger, disabled daughter has not been sighted all year. The family has now moved to an unknown destination and there are concerns for the well being of this young girl.*
- *On 31 August a [person] reported that a removalist truck (the removalist's name provided) had arrived at the [family] home. [Emphasis added] The [student welfare consultant] and the [home school liaison officer] visited the home but the truck and the family had left. The [person] reported seeing the 2 older girls but not the younger, disabled daughter.*
- *Since 8 August [2007] 9 calls to [the father] have not been returned and a couriered letter requesting a meeting hasn't been responded to.*
- *Parents have repeatedly rejected support from the Home School Liaison Team by stating that the girls were on the Central Coast with friends and relatives. They were unwilling to enrol the children in short term placements there despite being away for lengthy periods of time. They were also unwilling to provide an address on the Central Coast when assistance regarding enrolment was offered.*

The senior DET officer asked the senior police officer to make enquiries about the family's whereabouts. The senior police officer provided the above information to the person who he tasked to make these enquiries.

The Police Oversight Data Store (PODS) record the police actions to locate the family as follows:

*... on September 7, 2007, the EB YLO completed a number of I-ASK inquiries to try and track down the whereabouts of the family. Included in these I-ASK inquiries were RTA records, gas and electricity bills, Telstra, Optus and Vodafone bills, interstate criminal records and electronic roll details ... On September 12, 2007, the YLO received returns from the I-ASK inquiries with all coming back with a nil find on any new information in relation to the whereabouts of the family. Information is still awaiting to be received from the Australia wide electoral details.*

According to DET, the senior police officer emailed the school education director on 7 September 2007, and told her that police inquiries had not revealed any further information and that he had initiated action through the State Intelligence Section.

Against this background, we asked the NSW Police Force to review the adequacy of the actions taken by police to locate the family when requested to do so by DET on 6 September 2007. In doing so, we noted that our particular concerns were why police did not contact DoCS or the Department of Housing regarding the family's whereabouts; and why police did not contact the removalists to secure the family's new address.

In a statement to us, the NSW Police Force provided an outline of the actions taken by police, and said:

*While the email from [the senior DET officer] of 6 September 2007 appears to be clear in its terms, it would also seem that conversations with various officers from the Department of Education that preceded and followed the email may have created an impression in the minds of the recipients that the phrase 'well-being' was to be understood in terms of the young person's non-attendance at school, rather than in terms of an imminent risk of harm.*

*... The [senior police officer] does not refer to the [senior DET officer] as having made any reference to concerns for the welfare or well-being of the children in her telephone call to him on 6 September 2007 which preceded the email on 6 September 2007. While the email from [the senior DET officer] to [the senior police officer] appears to be clear in its terms, it may be that the conversation which preceded the email may have left an impression with [the senior police officer] that primarily emphasised the concern for well-being in terms of the children's absence from school, but also with a concern for their 'general welfare'.*

*[The senior police officer] states that he briefed the other officers that the concern was that the children had not been at school for some time and that the parents were not returning calls left by the Department of Education. He also expressed that there was a concern for the general welfare of the three children as they had not been seen for some time.*

*From the information provided by [the officer overseeing the inquiries] it is apparent that he understood the 'concerns for the well-being' of the child in the context of the child's non-attendance at school rather in terms of an imminent threat to the child's welfare. It would seem that this perception may have led him to classify the COPS event as 'occurrence only' rather than as a 'child at risk' event, such that there was no mandatory report to the Department of Community Services ...*

In relation to making inquiries of DOH, police told us that they did not know that the family was residing in public housing. In relation to contacting DoCS, police provided the following statement:

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*From the bare information contained within the email, it appears that it would have been appropriate for police to record the matter on COPs as a 'child at risk' event rather than an 'occurrence only' event. This would have resulted in the information giving rise to a 'mandatory report' to the Department of Community Services who may have held an address.*

In response to our query about why police did not contact the removalist company, the NSW Police Force told us that:

*[The officer tasked with making the inquiries] did not notice the reference to [the removalist company] within the information supplied to him by the [the senior police officer].*

*... Police may have considered approaching the removalist company to see if they had relocated the [family] and whether they would be prepared to volunteer information as to where they had relocated the [family]. Police could not have compelled the disclosure of that information.*

The NSW Police Force submitted that:

*When the actions by the attending police officers are assessed by reference to a request from DET for assistance with a longstanding school absenteeism problem, then that response, although not perfect in hindsight, was not unreasonable.*

In our final report the position we took was as follows:

We agreed with the NSW Police Force that it would have been appropriate for police to record the information provided by DET on 6 September 2007 concerning the children, as a 'child at risk event'.

In doing so, we acknowledged that police discussions with DET officials *may* have led police to understand that the primary focus of DET's concerns was the children's non-attendance at school and not their immediate safety. However, the evidence clearly shows DET provided documentation to police which states '*The younger, disabled daughter has not been sighted all year. The family has now moved to an unknown destination and there are concerns for the well being of this young girl*'. It also indicates past and possibly current DoCS' involvement with the family.

Whatever the police understanding of DET's concerns for the children was, we acknowledged that police responded promptly to DET's request to locate the family. Police also advised DET of the outcome of its inquiries as soon as these were available.

While we recognised the inquiries were made promptly, we remained of the view that, in all these circumstances, those inquiries were inadequate. As we had previously stated, it was difficult to understand how the three officers who handled DET's request to locate the family, either did not note that the removalist's name had been provided to the police or did not direct that inquiries be made of the company.

It is possible that had the police who dealt with DET's request to locate the family understood that DET held concerns for the immediate safety and welfare of the children, they may have placed more emphasis on pursuing enquiries with the removalist.

It was for this reason that our recommendations focussed on ensuring that arrangements for the exchange of information between the two agencies are adequate.

## **8.4 The actions of the NSW Police Force to address the issues of concern identified in the Ombudsman investigation**

The NSW Police Force said that it was:

*hopeful that the role of the Special Commission of Inquiry into Child Protection Services in NSW and the Ombudsman's investigations and reporting in respect of this matter will ultimately improve interagency co-operation and provide more efficient and effective protection for children and young people in New South Wales.*

## **8.5 Final recommendations and action to implement these**

We made the following recommendations to the NSW Police Force.

- (1) As soon as practical, the NSW Police Force should facilitate a meeting with DET to:
  - a. review the adequacy of the exchange of information between the two agencies in relation to the case; and
  - b. consider more broadly the adequacy of the current practices between the two agencies in relation to the exchange of information about children of concern.



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The NSW Police Force advised this office that they have met with staff from the DET and agreement has been reached on strategies to minimise the likelihood of miscommunication between the agencies occurring in the future. The NSW Police Force advised that a Memorandum of Understanding between the NSW Police Force and DET deals specifically with the exchange of information, and is currently under review. We have asked for a copy of the reviewed MOU when it is available.

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## Chapter 9.

# Interagency response to child protection concerns for the children

In addition to the observations and findings referred to above, this case illustrates very clearly what can go wrong for children when agencies fail to work effectively, fail to work together, and fail to take shared responsibility for the care and protection of children.

The *NSW Interagency Guidelines on Child Protection Intervention* identifies DoCS as the agency with lead responsibility for coordinating the response where intervention is necessary for the care and protection of children. The stated responsibilities of other agencies are to identify and to report children at risk of harm; to provide services in accordance with their own legislative, policy and practice requirements; to ensure staff have relevant child protection training; and to ensure that systems are in place for the effective exchange of information in child protection matters.

In our view, the interagency child protection response to the family was inadequate from 2005 onwards.

Despite agencies in the main fulfilling their mandatory reporting requirements, there was little evidence of effective interagency collaboration. For example, once DADHC made a report to DoCS about Ebony's non-attendance at school, that department effectively took no further action in relation to her circumstances. We have commented elsewhere on the adequacy of DADHC's actions in providing a case management service to her.

We have also commented elsewhere on the adequacy of the risk assessment that DoCS initiated concerning the children in April 2007. The facts show that it was not timely, lacked rigour, and was not adequately informed by information held by agencies other than DoCS. In these circumstances it was not until late in October 2007 that DoCS assessed the children were in need of care and protection.

In the interim it is apparent that DET lost confidence in DoCS' ability to respond to its concerns for the children and resorted to seeking assistance from the police. However, in this process it appears that the concerns for the children's safety were either not well articulated by DET or not well understood by police. It is significant to note that the two agencies' understanding of why DET was concerned to locate the family is so different.

Separately, DET should have formally raised its concerns about DoCS' response to the child safety concerns for the children with senior DoCS staff, but didn't. Rather, according to DET, a conversation about the children occurred in a car initiated by a senior DET officer with a senior DoCS officer. We note that there is no evidence that the discussion led to any further consideration of the matter between the two agencies. We can reasonably speculate that those working directly with the family were unaware of the discussion. There is no evidence that it had any bearing on the case.

A lack of clarity and precision was also evident in the communication between and within agencies at other times. In late 2001, the children's school told DoCS that DET was moving to prosecute when in fact DET's legal branch had made no such decision. In late 2006, a DoCS worker formed a view that DOH was conducting a home visit. DOH states that no such undertaking was given. In August 2007, a DET worker left a meeting with DoCS with a firm understanding that DoCS had decided to take the case to court. Again as discussed elsewhere, this was not the case.

Significantly, in each instance the incorrect understanding arising from these exchanges of information had some bearing on the case direction and subsequent agency actions. This case highlights the importance of rigorous and clear exchange of information between agencies in child protection matters.

The *NSW Interagency Guidelines on Child Protection Intervention* state that the provision of a coordinated and comprehensive system for protecting children and young people is the responsibility of all government and non-government agencies. However, the fact remains that the system in place in 2007 was dependent on DoCS assessing that a child was in need of care and protection for a coordinated action to be triggered. Where there was no such finding, there was less likelihood that agencies would work closely together to address risk of harm concerns for children.

The case is illustrative of this problem. Although concerns for the children's safety and welfare had been identified by both DADHC and DET, and the need for a collaborative interagency response to these concerns had been identified by both agencies, in DoCS absence neither agency pursued such a course. On the contrary, after discussing the need for interagency collaboration to address Ebony's situation, DADHC closed its file for her knowing that DoCS had not allocated her case for risk assessment. At no time did DET staff formally raise that department's concerns about the adequacy of DoCS' response to the children with senior DoCS staff.

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Other factors which appear to have diminished the effectiveness of interagency collaboration in relation to the case were the changes in personnel within agencies handling the case; inadequate documentation within agencies of case management strategies; and some problems with the exchange of information between agencies as discussed above. The failure of the agencies with responsibilities for the children's welfare, to establish strategies to deal with the parents' evasiveness, was also a contributory factor.

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# Chapter 10.

## Reform of child protection in NSW

On 24 November 2008, Mr James Wood AO QC, handed down his report from the Special Commission of Inquiry into Child Protection Services in NSW.

In March 2009, the NSW Government responded to the inquiry by releasing a plan of reform for child protection. *Keep them Safe: A shared approach to child wellbeing* is a five-year plan to change the way in which children and families are supported and protected.

*Keep them Safe*, supported by amended child protection legislation, contemplates fundamental changes to the way in which child protection services are designed and delivered in NSW. The cornerstone of the changes is to make child protection a 'shared responsibility'. All relevant government agencies will have prescribed responsibilities for ensuring the wellbeing of children. Child protection will encompass universal services and enhanced early intervention and community based services. The non-government sector will become a more significant partner in the provision of these services.

The main components of reform outlined in the Government's *Keep them Safe* include:

- A change to the mandatory reporting threshold, with mandatory reports to DoCS required only where there is 'risk of significant harm'.
- Relevant agencies – NSW Health; Department of Education and Training; NSW Police Force; and the Department of Human Services (covering Juvenile Justice, Housing and Ageing, Disability and Home Care) – will establish 'Child Wellbeing Units'. The Units will provide advice to mandatory reporters regarding whether concerns constitute 'significant harm' and should be reported to DoCS, and possible service responses where there is risk but not one of significant harm. In the latter cases, agencies will be responsible for referral of families and children to appropriate support services, or for providing assistance to them directly or in conjunction with another agency or agencies. Child Wellbeing Units will be established in October 2009, and will become fully operational on the first school day of 2010.
- Regional Intake and Referral Services (RIRS), managed by non-government organisations, will be established to provide referral services to link children at risk and their families to appropriate services. RIRS will be trialed in three locations for a 12 month period from January 2010.
- There will be an increase in services available to families and children, including universal services and early intervention and community based services. The NSW Government has committed \$750 million over the next five years for systems and new services to implement *Keep them Safe*. In addition to \$170 million allocated to systems changes such as the establishment of Child Wellbeing Units and RIRS, there will be:
  - \$114 million for prevention and early intervention services
  - \$25 million for services for Aboriginal children and young people
  - \$58 million for acute services, including intensive family preservation services
  - \$220 million for out-of-home care.
- The capacity for information exchange between relevant agencies working with children at risk and their families will be improved. The *Children Legislation Amendment (Wood Inquiry Recommendations) Act 2009* allows for a greater exchange of information between government agencies and non-government organisations, where information relates to the safety, welfare or wellbeing of a child or young person.
- There will be a focus over the next five years on building the service capacity of the non-government sector. 40% of the increased funding allocated to the implementation of *Keep them Safe* will be directed to non-government organisations.
- There will also be significant change within DoCS, to assist the department's revised role in dealing with cases of significant harm. All DoCS CSCs will be subject to a 'quality review', that will examine CSC leadership and team management, support systems, compliance with policies and procedures and culture. DoCS' information management technology, caseworker guidance and supervision and professional development processes will also be enhanced through a range of specific initiatives.



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# Chapter 11.

## Reforms in the context of our investigation

In his introduction to the report of the inquiry, Mr Wood said that as criminal proceedings were underway but not yet finalised in relation to the deaths of the two children that prompted the inquiry, the report would not comment on the two cases. He noted that the deaths of both children had been the subject of comprehensive review by both my office and DoCS, and that these reviews *'have informed the considerations and recommendations of the inquiry'*.

In addition to providing the inquiry with our review and investigation work relating to Ebony and her family, my office made a number of specific submissions. The submissions were relevant to the issues we identified in examining agency responses to Ebony and her family, and were further based on observations informed by our broader work on child protection matters.

In the context of our investigation, the NSW Government reform plan proposes significant changes that are directly relevant to the problems and inadequacies we identified.

Set out below are three of the critical issues we raised to the inquiry that are particularly relevant to our investigation, related recommendations arising from the inquiry, and the response of the NSW Government.

### 11.1 Interagency coordination

The findings of our investigation underscored the critical importance of effective information exchange and coordination between agencies.

Since the commencement of our child death review function, we have consistently identified the need for improved interagency collaboration and coordination of responses to children at risk.

Our reports of reviewable child deaths have raised specific issues about the importance of Section 248 of the *Children and Young Persons (Care and Protection) Act 1998* and gaps in the system where agencies other than DoCS seek to exchange information with each other about child protection issues. We have previously recommended that the Government consider amending section 248 to allow for an agency that is a 'prescribed body' under the Act to furnish or request information relating to the safety, welfare and wellbeing of a child or young person, or class of children or young persons, to another prescribed body.

In the context of the 2006 review of the Children and Young Persons (Care and Protection) Act, we submitted to government that our work had identified significant problems with information exchange in a child protection context. We noted the problems appear to arise from perceived legal impediments to information exchange, and poor understanding of what information can be exchanged, when it should be exchanged and who can exchange it.

In our submissions to the inquiry relating to interagency cooperation and privacy and information exchange, we again strongly recommended reform in this area. We identified key areas requiring an interagency response, and identified the main components of effective multi-agency forums. We stated our view that, at a minimum, police, schools, health services and relevant non-government organisations, should be able to exchange information with each other without having to rely on DoCS to pass on critical information, and without being restricted by privacy concerns.

The inquiry noted the lack of a clear and workable structure for the flow of information between agencies in NSW, and the multiple concerns of human service agencies in this regard. The inquiry agreed with the principles we enunciated, and our observation that areas such as serious and chronic neglect, parental substance abuse, serious mental health issues and high risk domestic violence matters, were particularly suitable for coordinated cross-agency work.

The inquiry recommended a number of strategies, including cross-agency training in relation to interagency coordination and collaboration; legislative changes to require relevant agencies to coordinate with others in meeting the protection and care needs of children; and changes to the performance agreements of agency CEOs requiring them to demonstrate how they have ensured collaboration with other agencies in child protection matters.

In relation to information exchange, the inquiry recommended that the *Children and Young Persons (Care and Protection) Act 1998* should be amended to permit the exchange of information between human services and justice agencies, and between such agencies and the non-government sector, where the exchange relates to the safety, welfare and well-being of a child or young person. The inquiry characterised this change as delivering 'essential elements' required in relation to privacy and information exchange. The inquiry noted that further development would benefit from input by each of the key agencies in conjunction with the Privacy Commissioner and the Ombudsman, and by reference to Queensland's legislation relating to the issue.

In line with commitments made in *Keep them Safe*, in May 2009, the Government introduced and passed changes to the care legislation to reflect this recommendation.

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## 11.2 High risk families

For a range of reasons that have been set out in this report, including multiple reports of risk of harm, Ebony and her family should have been considered a 'high risk' family in the child protection context. The need for better identification of, and response to, high risk families has been an ongoing issue raised through our work.

In our submission to the inquiry on assessment and early intervention and prevention, we raised this issue and noted that DoCS had inadequate systems in place to allow rapid and systematic identification of these families. In particular, we referred to the need for DoCS' information systems to generate management reports that identify those families which are most frequently reported to the department. In this regard, DoCS' own research demonstrates that a relatively small percentage of families generate a large proportion of risk of harm reports. We also argued that the NSW Police Force's improved use of its information holdings to target its resources provides an illustration of how DoCS could improve its effectiveness through employing a similar strategy.

In relation to case management, our submission to the inquiry on interagency cooperation noted that multi-agency case management forums tended to focus on high-risk adolescents with significant offending profiles at the expense of younger children who may be more vulnerable. For this reason, we proposed multi-agency case management models that focus on the most vulnerable children and families.

The inquiry closely considered the issue of 'high risk' or 'frequently reported families', and noted:

*while some agencies have put in place structured approaches to data and information exchange, those efforts have been largely ad-hoc and limited by privacy concerns. This is a potentially important piece of work which is likely to ultimately be cost effective. If the privacy laws are amended as recommended in this report, the inquiry supports further work being done to identify those families and offer appropriate assistance.*

The inquiry recommended that each key agency identify their 'high end users'. The inquiry noted that an integrated case management response to these families would include participation by relevant non-government organisations, and should include the adoption of mechanisms for identifying new families, and for enabling existing families to exit with suitable supports in place.

As part of *Keep them Safe* the NSW Government said that it would commence a 'Frequently Encountered Families' case coordination project in selected locations on a local basis, before implementing the project more broadly. The project will focus on families that are either:

- Already high end users of government services, for whom a coordinated response will ensure more effective use of existing resources; or
- Known to multiple agencies but not yet high end users, where earlier intervention may prevent significant future harm.

## 11.3 Habitual non-school attendance

Ebony never attended school. Ebony's sisters had extremely poor school attendance, and did not attend school at all from 2005 until after Ebony's death in late 2007.

Our submission to the inquiry on mandatory reporting issues pointed out that habitual non-attendance at school of a child of mandatory school age means that the child is being deprived of a fundamental right relating to their development. For this reason, we recommended that the Commission consider the inclusion of habitual non-attendance as a specified ground requiring a risk of harm report to DoCS. In a submission relating to young people at risk, we noted high rates of non-attendance at school and limited rates of prosecution by DET, and the subsequent need for adequate resourcing and support in the area of home-school liaison.

In its report, the inquiry noted it shared concerns that frequent and habitual non-attendance at school jeopardises future development, and subsequently recommended that section 23 of the Children and Young Persons (Care and Protection) Act be amended to include habitual non-attendance at school as a risk circumstance. The NSW Government has adopted this recommendation.

In addition, the Government also recognised the critical importance of the Home School Liaison Program in reducing the number of children at risk of poor educational progress because of habitual non-attendance at school, and in *Keep them Safe*, committed to employment of an additional 25 Home School Liaison officers by 2010.

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## Chapter 12.

# Conclusion

Over the next few years, Justice Wood's inquiry and the NSW Government's acceptance of the vast majority of the inquiry's recommendations will lead to a vastly changed child protection system in this State.

With any significant change there are always risks and challenges. The proposed changes to the child protection system in NSW are no exception. In order to manage these risks, it is constructive to consider some of the potential issues that may arise in the reform environment.

A critical issue will be how the varied components of the new multi-faceted system will be implemented. The inquiry envisaged a revitalised system drawing on adequate provision of an array of universal and targeted services, delivered by non-government and State agencies. At the centre of these services would sit Child Wellbeing Units, which would work with DoCS as a provider of 'last resort' for those children at risk of significant harm, and with the Regional Intake and Referral Services and Early Intervention Services for children otherwise at risk.

The expanded role of a range of government and non-government agencies has the potential of making these agencies more responsive to the needs of children at the local level, and of ensuring that more families receive timely and appropriate support.

However, while the Child Wellbeing Units will be established in 2009 and fully operational by early 2010, the Regional Intake and Referral Services will be initially trialed in three areas for a 12-month period from January 2010. Following evaluation of these trials, the Government currently plans to establish the services across the State by the end of 2011.

The expansion of Brighter Futures, the primary avenue for early intervention, will be limited in the first instance to enabling the program to cater to an additional 200 families by mid 2010. Brighter Futures currently assists around 6,000 children each year. The Government has committed to examining further enhancements following an evaluation of Brighter Futures in 2010. Sustained health home visiting services for vulnerable teenage mothers is also a longer-term strategy, substantially commencing between 2010 and 2011.

In establishing Child Wellbeing Units across the State without the support of a statewide Regional Intake and Referral system, and without having significantly expanded early intervention services, there is potential risk relating to the capacity of responsible agencies to be able to either directly provide, or arrange for, adequate support to vulnerable families across all areas of the State.

The case of Ebony and her sisters also exemplifies the critical importance of effective information exchange and interagency coordination. Under the reforms, the child protection system will not only need good coordination and information exchange, but will not function in its absence. How the provisions in the legislation relating to information exchange are put into practice – especially in relation to exchange between the Child Wellbeing Units, and between these Units and DoCS and the RIRS – will be critical to the effective functioning of the new system. The planning which is underway in relation to these issues is of vital importance, as will be evaluation of the results of these plans following their implementation.

It is also important to recognise that legislative and structural change will provide the clear framework for better collaboration, but there must also be significant cultural shift to put the principles underpinning the government's plan into action.

The new child protection system also relies upon an expanded range of agencies to make difficult, but sound, decisions and assessments around how notifications to DoCS should be treated and what response to child protection concerns should be provided. In the early stages there will be a period where skills are being developed by agencies that have not had a significant hands-on role in child protection. Whether these shifts in responsibility improve the child protection system, and how quickly any improvement occurs will be dependent on the plans developed, and the availability of resources to meet the needs of vulnerable children and their families.

As the changes recommended by the inquiry and the subsequent reform strategy adopted by the NSW Government represent substantial change, it will be critical that the risks to success are monitored and responded to, and the results evaluated.

It is also important to remember that Ebony's death was a major catalyst for this changed landscape of child protection in NSW. There can be no greater impetus to succeed than the safety and wellbeing of our vulnerable children.





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