NSW Ombudsman

DOCS: CRITICAL ISSUES

Concerns arising from investigations into the Department of Community Services

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

April 2002

NSW Ombudsman

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April 2002

The Hon Meredith Burgmann MLC
President
Legislative Council
Parliament House
SYDNEY NSW 2000

The Hon John Murray MP
Speaker
Legislative Assembly
Parliament House
SYDNEY NSW 2000

Dear Madam President and Mr Speaker,

I submit a report pursuant to s 31 of the *Ombudsman Act 1974*. In accordance with the Act, I have provided the Minister for Community Services with a copy of this report.

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

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Foreword

The Department of Community Services (DoCS) is charged with promoting the safety and welfare of the most vulnerable members of the community — children. The DoCS annual report highlights its core work as including:

- protecting children and young people from risk of harm;
- helping families protect and care for their children;
- providing care and support for children who cannot live with their families;
- supporting homeless children; and
- regulating adoption services.

DoCS officers work with families in crisis. They respond to cries for help from every corner of the state. Single decisions to intervene (or not to intervene) can have far-reaching consequences. There is no question of the commitment of DoCS workers throughout NSW. Every day workers provide real assistance, sometimes in dire and intractable circumstances, to families of every background in rural, regional and urban communities.

I have become increasingly concerned about a number of issues facing DoCS that are impacting on its core work. In my annual report to Parliament last year I flagged that my office had identified a number of systemic issues of concern from the complaints received. Those concerns are now reflected in significant and extensive investigations and other inquiries my officers are conducting into DoCS. This scrutiny is unprecedented, touching almost every area of DoCS operations. My officers are examining:

- DoCS failing to properly investigate allegations of employees abusing children,
- DoCS response to increased reports of child abuse,
- DoCS implementation of recommendations, arising from investigations into child deaths, to reduce risk to children,
- DoCS failing to transfer information between offices concerning children at risk when families move,
- the recruitment and training of foster carers by DoCS, including preventing abuse of children in foster care,
- DoCS failing to notify my office about allegations concerning DoCS employees abusing children, so that its investigations can be properly scrutinised,
- decisions by DoCS about intervening in Family Court proceedings to protect children at risk of harm, and
- DoCS procedures for responding to Freedom of Information (FOI) requests.

Some of our investigations have been finished and others are near completion. In some matters my office has not yet reached a conclusion as information is continuing to be obtained and analysed. The totality of the information to date places a cloud over the effectiveness of DoCS to provide comprehensive protection to children and young people.

The law governing how the Ombudsman works prevents my office from making our investigations and findings public except by way of annual reports and reports to Parliament. By making this report, I am able to provide information to Parliament and the public which will assist to highlight areas of genuine concern about the way DoCS operates.

Central to the work of my office in ensuring scrutiny of DoCS is maintaining a constructive and open relationship. At times my officers have had great difficulty in obtaining relevant information to inform investigations and inquiries. More recently cooperation has increased. In particular, we have spoken to DoCS officers from the vast majority of the 84 community service centres (CSCs). Their concerns are reflected in the decisions by my office to undertake some investigations.

It is clearly in the interest of the public — and in particular children — that rigorous scrutiny of the workings of DoCS continues. Often, complaints can be dealt with informally, for example, by telephone contact with relevant DoCS officers and concerned parents and relatives. The great majority of matters can be dealt with in this way. Some matters where DoCS procedures may contribute to poor outcomes or DoCS systems fail to meet fair and appropriate expectations, will continue to require extensive information gathering and careful analysis.

With considerable public focus on the deaths of particular children who were at risk of harm, it is important that the record reflects the matters where DoCS has carried out a thorough review of what has occurred when a child has died. Some DoCS investigations reviewed by my office have identified all relevant issues, pursued appropriate interventions and made detailed recommendations for further necessary action. However, on occasion this good work by DoCS officers has been thwarted because the recommendations are not acted upon.

The substance of this report details critical issues in the management and performance of DoCS which place the welfare of children and young people at risk.

Scrutinising DoCS — the role of the Ombudsman

The Ombudsman deals with complaints about most government departments and public sector agencies including DoCS. We receive complaints, investigate conduct and make recommendations. The Community Services Commission previously dealt with many DoCS complaints about child protection and out of home care functions. While that was the case, the Ombudsman, in accordance with the relevant legislation, was not permitted to deal with these issues. However, legal advice from the Crown Solicitor has resulted in much of DoCS work being regarded as outside the Commission's jurisdiction. Since January 2001 the Ombudsman has therefore received and dealt with complaints of this type.

From May 1999 the Ombudsman has also been responsible for overseeing DoCS (and other agencies) systems for protecting children and for responding to allegations of child abuse made against employees.

The Ombudsman can now look into the majority of DoCS work including:

- DoCS handling of child abuse allegations and convictions against its employees, including foster carers;
- DoCS handling of child abuse allegations against employees of other agencies;
- DoCS handling of applications under the *Freedom of Information Act*;
- DoCS conduct when exercising its statutory child protection and out of home care powers; and
- the work of joint investigation response teams, that comprise DoCS officers and police.

There are certain DoCS matters which we cannot, or generally do not, look at:

- We do not generally question the decisions of DoCS child protection experts, unless their conclusions are so unreasonable that no reasonable person could have reached them. We do closely examine the inquiries made by those persons and the information considered in reaching a decision. We also look at what action is taken to implement the decision.
- We cannot review the conduct of departmental officers in proceedings before a court. This includes proceedings in the Children's Court and Family Court.

Issues about DoCS and other agencies are generally raised with the Ombudsman by people making a complaint. DoCS has no obligation to advise us of any complaints it receives, other than allegations of child abuse against DoCS employees. Nor is DoCS obliged to report to the Ombudsman on issues or concerns about its procedures or systems raised by DoCS employees.

Where appropriate, complaints about DoCS (and all other agencies) are resolved quickly and informally with the assistance of Ombudsman officers. We will generally encourage complainants to first approach DoCS with their complaint.

Where a complaint to us indicates that an investigation by DoCS is required, we will generally expect DoCS to do so — well and thoroughly. We may monitor the progress of the investigation and assess the adequacy of the final report. We also monitor changes which are recommended following an investigation.

Sometimes, complaints will allege serious wrong conduct that requires in-depth investigation by Ombudsman officers. Sometimes a complaint or series of complaints also indicates a systems issue which requires an 'own motion' Ombudsman investigation — that is to say, investigation into conduct which no one has specifically complained about, but which needs to be carefully scrutinised.

In conducting an investigation the Ombudsman can:

- require DoCS to provide detailed information and relevant documents,
- use Royal Commission powers to question DoCS officers and obtain sworn evidence,
- interview DoCS officers,
- enter DoCS offices and inspect documents and files, and
- audit DoCS files.

At the end of an investigation, the Ombudsman may recommend that changes be considered to improve the way DoCS performs its core work of child protection. Every recommendation is the subject of consultation with DoCS and the Minister for Community Services. If the recommendation is unworkable, every opportunity is provided for this to be communicated and other solutions canvassed. Those recommendations then become the responsibility of DoCS management to consider and, if accepted, to implement.

In addition, the Ombudsman is responsible for oversight of employment related child protection. All child abuse allegations against DoCS employees (and other agencies) must be notified to the Ombudsman. We scrutinise the systems in place for preventing child abuse by employees of DoCS. We examine how DoCS handles and responds to child abuse allegations and convictions against its employees. We conduct audits of practices and systems and review policies and procedures. We closely monitor the investigation of child abuse allegations against employees and the management of those employees.

Critical issues

1 Core work

Responding to increased reports of child abuse

Since December 2000 anyone who has a concern about the welfare of a child first contacts DoCS centralised Helpline. These calls about a child's welfare are called reports. Since that time, the number of reports received by DoCS of children at risk of harm has increased dramatically.

Staff at the Helpline carry out an initial assessment of the information provided to determine what, if any, action is required. If staff at the Helpline decide that the child has been abused or is believed to be at risk of harm and may be in need of care and protection, the report is referred on to a Community Service Centre (CSC) or a Joint Investigation Response Team (JIRT). CSCs are the local offices of DoCS. JIRTs are made up of DoCS workers and police officers and deal with matters where there may be criminal conduct in the reported abuse. If a JIRT determines there is no criminal conduct to pursue, it refers the matter to a CSC to deal with the child protection concerns.

CSCs are dealing with a significantly increased volume of work. When a report is received by a CSC, it is assessed and prioritised by a local manager against the other work the office is already dealing with. Where possible, matters are allocated to a DoCS caseworker for action.

During a visit to one CSC in December 2001, we were told it had 170–180 unallocated child protection cases including seven matters where a child had been assessed as being at immediate risk of harm. This meant no action was being taken on seven cases of children assessed by DoCS staff as being at immediate risk, plus some 160–170 cases where action had been assessed as necessary but of lesser priority.

A manager at another CSC we visited in January 2002 told us they generally received around 200 reports a month and closed approximately 130 cases a month which had been assessed as warranting some sort of response but on which no action was taken due to other work commitments. This is consistent with existing DoCS 'Priority One' procedures.

While not a comprehensive assessment of workloads across DoCS, this snap-shot demonstrates the tremendous pressure of work CSCs are dealing with due to the increased number of reports.

Clearly, those responsible for the management of DoCS need to have accurate and comprehensive information about what is happening across all CSCs, to know how many reports are closed under the 'Priority One' procedures and what is in the reports.

However, when we asked DoCS how it is monitoring the impact of the increased number of reports on individual CSCs, Central Office said: 'Area directors will receive some data on the numbers of reports received by CSCs but the monitoring and review of work at each CSC is a role of the managers and area staff'.

Central Office has also told us that its client database, the Client Information System (CIS), 'does not provide centralised data for unallocated work' and that:

> DoCS does not have any category of work that is 'unassigned' or 'unallocated'. Caseworker time is provided according to the priorities of a particular client and current DoCS policies for each response category. This means that there is no data centrally on the status of unassigned work.

Managers in CSCs have told us that they keep figures on unallocated cases and provide them to their Area office (Areas). However, none of the managers we interviewed was clear about what then happened to those figures and none had received feedback from their Areas or Central Office.

There has been considerable public debate and media scrutiny about how DoCS is dealing with the large increase in the number of reports about child welfare being received by the Helpline. Our concern is that DoCS does not appear to have mechanisms in place to know with any degree of certainty how many reports have been acted on, how many cases remain unallocated and how many have been closed under DoCS 'Priority One' procedures. This is an area of inquiry we are currently pursuing with DoCS.

Failure to comply with obligations to notify allegations of child abuse against its employees

Since May 1999, DoCS has been required to notify allegations of child abuse and convictions against its employees to the Ombudsman within 30 days of becoming aware of them. We have investigated DoCS consistent delay in forwarding their notifications to us. Approximately half of the notifications we have received from DoCS since May 1999 have been outside the 30 day period, with nearly a quarter of matters taking over nine months to notify. We are also concerned DoCS may not be reporting all allegations of abuse.

Failing to notify us about these allegations, or late notification, means that DoCS investigations are not subject to appropriate scrutiny as required by Parliament.

Foster carers

Children requiring out of home care have often been removed from their families because of abuse or neglect. They should be placed in a caring and safe environment, away from the abusive behaviour to which they were exposed. Foster care placements should provide such an environment.

Our examination of a number of notifications alleging abuse of children in DoCS foster care led us to investigate the adequacy of DoCS practices concerning the recruitment, training and support of foster carers, and its investigation of child abuse allegations against foster carers.

We have found that not all DoCS foster carers were authorised to provide out of home care prior to the placement of children. Some foster carers did not receive any training in managing children with challenging behaviours. Matching the needs of the children and young people with the skills of the foster carers did not appear to be a primary consideration in some out of home care placements. In addition, there is evidence that DoCS monitoring and support of foster carers was intermittent and unplanned. In three cases we looked at in detail there was very little evidence of regular home visits by DoCS to ascertain how the placements were progressing. Case plans did not reflect the key principles of participation and self-determination of families, carers and the child or young person.

We recently sought a notification from DoCS, after it had failed to provide one, about the death of a young child several months after being placed in the care of DoCS foster carers. The foster mother has been charged with the murder of the child.

It is clear from the reports of the Coroner, the police and DoCS own internal review that DoCS failed to adequately assess the suitability of the foster carers in that :

- the foster carers had been rejected as foster care applicants in another state,
- the foster carers had not completed the departmental training and assessment procedures and were not approved foster carers,
- the referee checks were inadequate,
- the deceased child had been admitted to hospital on three occasions whilst in the foster carers' care and the doctors from the hospital had raised concerns with DoCS about the suitability of the foster mother as a carer.

This case highlights the deficiencies in DoCS management of its foster care program. It is an extreme example of what can happen when the recruitment and supervision of foster carers lacks the level of rigour required to protect children, in need of out of home care, from further abuse or neglect.

Licensing of child care centres

DoCS is the licensing authority for child care centres. Each centre is required to have an authorised supervisor and a licensee approved by DoCS.

DoCS processes in relation to approving and withdrawing the approval of an authorised supervisor are unclear. We have reviewed cases where DoCS has withdrawn its approval for an authorised supervisor but has been unable to provide its policies and procedures concerning this process.

In one case DoCS advised the child care centre that it had withdrawn its approval of an existing authorised supervisor as a result of allegations of child abuse made against her. DoCS advised the centre that its licence and funding might be revoked if the authorised supervisor continued to have contact with children. The supervisor left the centre. DoCS then allowed the centre to operate without an authorised supervisor for at least a further 12 months. This meant the centre was unlicensed for that period. DoCS provided inconsistent information to us about its processes in this regard and gave inadequate information to the child care centre about how to deal with the situation.

DoCS and the Family Court

It is not uncommon for reports to be made to DoCS concerning the abuse of children where there are also proceedings before the Family Court. DoCS may on occasion need to involve itself in such proceedings to prevent further abuse of a child.

We have looked at DoCS procedures for making decisions whether or not to join Family Court proceedings and the adequacy of guidance to its officers about the circumstances in which it is appropriate to join such proceedings. We have found both to be inadequate. It is currently unclear

what information is needed to make the decisions, who is to be consulted, who the final decision maker is or the time within which such a decision should be made.

In one case we have investigated, DoCS had confirmed sexual abuse of a six-year-old boy by his father, who was applying for a residence order from the Family Court. Despite repeated requests by the boy's mother, with whom the child was living, and a sexual assault counsellor working with the family, DoCS delayed making a decision about whether or not to join the proceedings. The court ordered interim unsupervised contact for three weeks between the child and his father. DoCS officers told us they were highly distressed by this order and felt DoCS had failed the child.

Delays in processing Freedom of Information applications

We have initiated an investigation into DoCS processing of FOI applications after considering information which suggested statutory deadlines were not being met in a significant number of applications, and that the delays and the backlog were serious.

Material provided by DoCS suggests there are considerable problems. It appears that some of the issues are:

- a large increase in the number of applications,
- a shortfall in staff,
- centralisation of FOI processing,
- the time involved in dealing with external reviews,
- the impact of the *Privacy and Personal Information Protection Act* and the *Children and Young Persons (Care and Protection) Act*,
- processing of applications on behalf of the Department of Ageing Disability and Home Care, and
- difficulties in locating documents.

DoCS has a number of strategies in place to tackle the problems. We are assessing the adequacy of these strategies and have also made some procedural suggestions to improve DoCS FOI processes.

Inadequate investigation of allegations of child abuse made against employees

The investigation of child abuse allegations is part of the core business of DoCS. It is therefore of significant concern that five of the investigations we are conducting are into apparent failures by DoCS to properly investigate child abuse allegations.

One of our investigations relates to the failure of DoCS to properly investigate allegations that a senior DoCS staff member abused his children. A particular focus of our investigation is the apparent failure by DoCS to carry out an appropriate assessment of the potential risks relating to the staff member's employment.

Other investigations we have underway concern the adequacy of DoCS investigations into allegations of child abuse against:

- two child care workers,
- a council employee, and
- a foster carer who was also a former DoCS caseworker.

Child protection and disciplinary investigations

When allegations of child abuse are made against DoCS employees, the practice of DoCS is to conduct separate child protection and disciplinary investigations. There is a question as to whether it is necessary for DoCS to conduct such separate investigations. However, if separate investigations

are to be conducted, then it is essential to coordinate them. This would mean that there is no unnecessary duplication of investigative steps and that each investigation would make relevant information available to the other.

In one such case we found that DoCS had failed to coordinate its investigations. DoCS did not have a procedure in place to manage the concurrent investigations, failed to ensure that regular contact was maintained between those involved in the investigations, and failed to ensure this contact was documented.

Risk assessments

Risk assessment and risk management are essential components of any investigation by DoCS, whether in the course of general child protection work or in response to allegations of child abuse against a DoCS employee.

Risk assessments in child protection work

When a report about a child being at risk is sent from the Helpline to a CSC and allocated to a caseworker, DoCS guidelines require the worker to conduct an assessment of the risks to the child. This should be done by gathering and assessing information about the child's circumstances. This risk should also be documented to show the factors considered in reaching the decision.

Risk assessments are not always being completed at CSCs in the course of general child protection work in accordance with DoCS guidelines.

On many of the files we have examined, there is no documentation with respect to the process or outcome of risk assessment. It is therefore unclear whether a risk assessment has not been carried out or has been conducted but not documented. Neither situation is satisfactory.

DoCS has now introduced a new risk assessment framework which includes the addition of new screens on the CIS. It also made a considerable investment in training all staff in the new framework. DoCS believes the new format will improve its casework practice.

However, from the evidence we have seen, even under the earlier procedures, adequate risk assessments in any format were not being completed in the majority of cases. We have suggested to DoCS that it needs to address this issue as a matter of urgency if its new policy is to have any impact on practice.

Employee risk assessments

DoCS has also failed to undertake full risk assessments of employees of other agencies when there have been allegations of child abuse made against them. One particular area of concern is the practice of interviewing the alleged victim of abuse but not always interviewing the employee alleged to have engaged in abuse of the child. The failure to interview employees about allegations against them means that DoCS does not have an opportunity to gather information from the employee that can be used in a risk assessment.

Another concern is the failure of DoCS to undertake comprehensive risk assessments arising from allegations of child abuse against its own employees. For example, in one matter, DoCS investigated allegations of child abuse against a foster carer. However, the department only considered the allegations concerning abuse of foster children, initially failing to identify and assess the potential risk to the carer's own children.

2 Internal operations

Poor record keeping practices

In virtually all of our contacts with DoCS, it has been evident that record keeping practices are extremely poor with:

- no centralised or unified records management system,
- casework files which are hard to follow and contain inadequate records,
- documents out of chronological order,
- no or inadequate file notes about decisions or actions,
- no or inadequate notes of important meetings,and
- no or inadequate notes of telephone conversations.

In a number of child protection and out of home care files we have examined it has been difficult to identify essential information such as the child's current address or the name of their carer. On occasion records have been lost.

DoCS has no consistent file keeping practices. Ad hoc record keeping practices have been developed in different CSCs. Some offices have developed useful templates and checklists, but these are confined to a particular office unless a worker takes the ideas with them when they move to another office. Local initiatives have replaced any central guidance about such matters.

DoCs appears to have no standard case file format and Community Service Centres appear to have developed their own systems, even including different types of physical files. As files are often transferred between offices when families move, this means CSCs have a varied selection of lever arch files and paper files from other offices with assorted filing and reference systems.

The nature of DoCS work means it is essential caseworkers are equipped with up to date and accurate information concerning the families they are dealing with. In relation to some of the files we have examined, it would be impossible for a worker unfamiliar with a case to gain essential information rapidly from the casework file. Caseworkers frequently have to respond urgently to changing situations; however, the current record keeping practices of DoCS mean that workers may not have all known information when required to make serious decisions in potentially life threatening situations. This has implications for staff safety when entering the home of a family they are unfamiliar with, as well as for the quality of the decisions that can be made in such circumstances.

DoCS has acknowledged its poor record keeping practices. In March 2002, in answer to our criticism that it had failed to provide all the documents we had required in an investigation, DoCS said:

> As previously identified by the Ombudsman in other matters DoCS record keeping practices are deficient, something we acknowledge. Thus when we have not produced documents, be it on this or other occasions, it is **not** deliberately failing to comply but rather inadequate record keeping practices. [Emphasis in the original].

Following our criticism, DoCS recently issued a bulletin to staff summarising their obligations in relation to record keeping.

DoCS needs to ensure it now follows through with the necessary action to rectify the acknowledged deficiencies.

Client Information System

The CIS is DoCS client database. It has screens to record a range of activities including details of reports, risk assessments and case plans.

There are significant problems with the CIS. In April 2002, in a refreshingly frank but bleak assessment of the CIS, Central Office detailed the problems which included:

- The current CIS is so poor that it is a disincentive for staff to use the system and thereby record in a central location critical and serious information.
- The lack of information makes it almost impossible for DoCS management to plan. It is very difficult for management to obtain an overall view of the organisation's workloads, trends and problem areas from the current system.
- Extra work: the users perceive the system generally as a burden which contributes little assistance to the primary task.
- Limited management of information. Extracting information from the system is a very difficult and time-consuming process.
- Data will continue to be held in different repositories — as it is now — and cannot be retrieved in a useful form.
- Inability to provide statistics/information at short notice from system.

DoCS had been aware for some time of the inadequacies of the CIS, having commenced an earlier project which we understand was intended to deliver a new data base to coincide with the enactment of the *Children and Young Persons (Care and Protection) Act 1998*. This project was unsuccessful. The delays in upgrading or replacing the system have contributed to the chaotic state of DoCS records.

Central Office told us that in September 2001 it developed business cases for a new client database and an electronic document management system for DoCS and the Department of Ageing, Disability and Home Care. DoCS asked Treasury for funding to replace its current systems.

Treasury has approved funding for the new client database and a tender process is currently being concluded. Central Office states the new client system is due for release in 2003 and should allow for extra functionality to support staff to record information and for managers to monitor.

DoCS has informed us that an electronic document management system was not approved by Treasury and it is now dependent on 'the implementation of shared services across the Department of Community Services, Department of Housing and Department of Ageing, Disability and Home Care'.

Clearly a user friendly, efficient and comprehensive client data base which provides centralised management information is essential for the effective operation of DoCS.

Transfer of client files between community services centres

It is well known that children of families known to DoCS who move around are at increased risk. A number of the children known to DoCS and who have died had moved around with their families before the child's death.

Cases are allocated to a particular CSC depending on where the child is living. When DoCS becomes aware that a child has moved, DoCS procedures require that the casework file should be transferred to the new CSC within 21 days.

To determine the adequacy of DoCS procedures for managing this transfer process, we conducted an audit of files transferred during a specified period at a range of CSCs. We also conducted interviews with relevant CSC managers to find out their experience of how the system works in practice.

The audit revealed that DoCS transfer policy is not being complied with in the majority of CSCs. Most files were not transferred within the 21day timeframe. The files were not compiled according to DoCS guidelines and did not contain appropriate documentation to ensure a seamless transfer of casework.

All of the managers we interviewed spoke of the need for a meeting or teleconference to hand over a file. The reality appeared to be that pressure of work precluded this from happening and on many occasions an exchange of e-mails substituted for a handover meeting. This means caseworkers have no formal introduction to a family and are reliant on information on the file, which is often poorly documented. It also means other service providers involved with the family have no opportunity to discuss their involvement.

When a family moves, stringent processes should be in place to ensure that casework continues with the family where there are concerns about the children. To date the evidence we have seen leaves us with grave concerns about the adequacy of DoCS practices in this area.

Lack of knowledge about policies and procedures

DoCS internal intranet, Business Help, is the directory for the department's policies and procedures. We understand there are 40 Business Help topics and 200 policies and procedures. Given this amount of information, there appears to be a lack of clarity in how staff use Business Help and how management ensures staff refer to Business Help for up to date information. Staff have told us of difficulties in navigating through the intranet and of policies 'changing almost weekly'.

On occasion there appear to be significant gaps in advice we are given by Central Office about current policies and procedures and the actual practice of staff in CSCs, the Helpline and JIRTs. The reasons for this appear to include poor standards of staff supervision, poor communication throughout DoCS and inadequate staff training.

Administrative problems

The level of supervision and support provided to CSCs appears to be restricted due to the structure of DoCS.

DoCS operates through its Central Office in Ashfield, eight area offices, 16 network offices and 84 CSCs. The number of Areas has been reduced from 16 to eight in DoCS current 'transformation' process. DoCS geographically largest area, Western, covers 26 CSCs in locations including Albury, Broken Hill, Deniliquin, Lithgow, Walgett and Cootamundra.

We have been told that some managers can spend 10 out of 12 days out of the Area office travelling. In our experience, this means senior managers with significant responsibilities are hard to contact and are often unable to deal with matters when they are contacted because they are away from their own office and do not have the necessary information with them.

There also appear to be significant difficulties in disseminating information between Central Office and Areas, and between Areas and CSCs. We have experienced frustration ourselves when making inquiries with DoCS. Generally staff in CSCs provide prompt and helpful information about matters they are dealing with. However, as soon as we require information collectively from a CSC, an Area and Central Office, the process becomes cumbersome and time consuming.

There is evidence DoCS itself experiences the same problems. For example, DoCS Legal Services Branch at Central Office has made significant efforts to disseminate information through Areas to front line staff about their obligations to record certain decisions in writing and to provide written advice about appeals. Despite persistent attempts, it would seem these efforts have been largely unsuccessful.

At a very practical level, we have observed particular difficulties resulting from the lack of administrative support in CSCs. This means caseworkers photocopy bulky documents, including entire files, type court reports, create files and undertake many basic administrative tasks. While it is not unusual to find public servants doing most of their own word processing and administrative tasks, it is not an efficient or effective use of scarce resources to require front line caseworkers to complete most of their own basic office tasks.

The inevitable consequence is that essential administration is not done, understandably as it is given a lower priority than taking urgent action to protect children. Files are not made, maintained or stored efficiently. Time is wasted locating files and sorting through information on ill-kept files. Vital information which needs to be found urgently is hard to locate, if it has been recorded at all.

Conclusions

DoCS is the lead agency in protecting children and young people. The community rightly expects it to perform core work to a very high standard. It is not enough that DoCS officers are committed and well-intentioned. Without the right systems, records and support, appropriate child protection interventions become as much a matter of good luck as good management.

This report demonstrates the clear link between poor internal processes and ineffective DoCS interventions on the ground. For example, poor record keeping means poor communications between DoCS officers, and between community service centres, area offices and Central Office. An inadequate computer system means incomplete information which nobbles management's efforts to plan work across DoCS. Lack of administrative support means a reduced capacity to meet community calls for child protection.

Since the Ombudsman has been the primary oversight agency for DoCS, we have seen movement towards recognising and addressing deficient practices. For example, DoCS has established a Systems Improvement Group this year to capture and implement recommendations arising from internal reviews. Provided that Group functions effectively, it should improve the ability of DoCS to learn from errors.

The Ombudsman is well placed to have a whole-of-organisation perspective of DoCS. Our ongoing investigations will result in recommendations which, if implemented, should improve the operation of DoCS and as a consequence, child protection within the community.

DoCS must not only demonstrate a willingness to respond constructively to our recommendations. DoCS must also respond to heightened community concerns about how it protects children and young people. DoCS response to increased scrutiny needs to be pro-active and creative, and not merely a reaction to issues that arise from complaint to complaint, or media report to media report.