NSW Ombudsman

Improving outcomes for children at risk of harm - a case study

A report arising from an investigation into the Department of Community Services and NSW Police following the death of a child

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

DECEMBER 2004

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ISBN 0 7313 1318 6

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December 2004

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 Police 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

Ombudsman

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Foreword

This report should be viewed in the context of our annual report on the reviewable deaths of children and people with disabilities. Our annual report highlights a number of systems issues in relation to the child protection system in NSW.

This report provides a detailed case study of one of the child deaths we reviewed. We decided to investigate this matter because we had significant concerns about the response by DoCS to a number of reports about the risks of harm to the child and his sister. We also had concerns about NSW Police's handling of a number of matters concerning the children.

We have anonymised this report for the protection of the individuals involved but have otherwise left in the details of relevant events. These details are disturbing but unfortunately are necessary for a full appreciation of the issues that were reported to DoCS and NSW Police.

It is important to remember that the care and protection of children is the responsibility of the whole community – starting with parents. The community has invested in a child protection system to provide a safety net for children who are otherwise let down. The case outlined in this report highlights the need to ensure that this system effectively protects those children in need.

Throughout the course of our investigation of this matter, DoCS has advised us of its five year plan to improve child protection in NSW which will be funded by substantial budget increases. This long term plan is undoubtedly a positive step forward. However, in the interim, it is vital that the ongoing risks of harm to children are adequately addressed.

We believe that the protection of children is one of the most important issues that the public must grapple with. Debate on this issue needs to be properly informed about the complex needs of some families and the challenges in building an effective child protection system.

Report following investigation

Background - reviewable death of a three year old boy

On 14 September 2003, a three year old boy was found deceased at the residence of two men, B and C. At around midnight, one of the men, B, called an ambulance. On arrival of the ambulance, B explained that the boy had been vomiting and had had difficulty breathing. B also stated that he had attempted to resuscitate the boy, including using electrical wires to administer electrical shocks to the boy's chest.

The autopsy report prepared for the Coroner states that the cause of the boy's death is undetermined but that recent injuries to the anus and rectum 'consistent with penetration' were found. Both B and C are known to police in relation to child sex offences.

In the course of investigating the circumstances of the boy's death, on 14 September 2003 NSW Police investigators found a videotape at the residence of B and C containing footage of B sexually assaulting the boy's six year old sister. B has been charged and convicted with various offences in relation to sexual assaults on the girl and the video footage.

The girl and boy had been in the care of B for approximately three weeks prior to the boy's death. This involved the two children sleeping at B's residence - a one bedroom flat occupied by B and C. The children's mother would see them daily for short periods in the afternoons after she returned from work.

According to a statement the mother made to police on 14 September 2003, she first met B about six months prior to the boy's death while walking through her local railway station. However, during an interview with police a few days later, B said that he first met the mother only a month before.

The mother states that approximately three weeks prior to the boy's death she bumped into B and C near the railway station. B told her she looked like she needed a break. The mother explained that she was having difficulty in arranging an affordable babysitter and B offered to care for the children for payment. He commenced looking after them that evening.

Three days after B began caring for the children, the girl was sent home from school due to head lice. From this time, until the death of the boy, the girl did not attend school and the boy did not attend his usual day care provider.

The mother says the children were sleeping at B's residence so that she could eradicate the lice from her linen. Teachers at the girl's school say that children sent home due to lice normally return to school the next day. They also state they attempted to speak to the mother on a number of occasions during the girl's three week absence. They say they had difficulty contacting the mother, but were successful during the second week of absence, when the mother advised that the girl was not ready to return to school because of the lice.

The boy's death was notified to the Ombudsman as a reviewable death.

In December 2003, we also received a complaint from a professional who had had involvement with the children. The complaint raised concerns about the response by DoCS and NSW Police to a report that the children had been sexually and physically abused a number of years prior to the boy's death.

In order to carry out our review functions in relation to the boy's death, we requested DoCS to provide all of its records relating to the children.

Following a preliminary review of these records, we decided to conduct an investigation into the response by DoCS and NSW Police to reports about the welfare of the children.

Ombudsman investigation

As part of our investigation, DoCS and NSW Police were required to provide copies of all of their documents relating to any reports received about the welfare of the children and any action they had taken in response to these reports. A number of NSW health services and the Ambulance Service of New South Wales were also required to provide copies of relevant records.

We conducted a comprehensive review of all of the material provided. This review revealed that prior to the boy's death, the children had been brought to the attention of DoCS and NSW Police on a number of occasions.

In October 2004, we provided DoCS and NSW Police with a document containing our provisional findings and recommendations in relation to our investigation (the provisional statement) and invited them to make comments on it.

We received their comments in November 2004 and took them into account in preparing our report on the matter. We consulted with the Minister for Community Services on the report and, in December 2004, we provided DoCS and NSW Police with our final report.

Chronology of events prior to the boy's death

Outlined below is a chronology of the involvement of DoCS and NSW Police with the children and their family prior to the boy's death.

2 June 2000

The first report DoCS received concerning the children was on 2 June 2000. A staff member of a child care centre which the boy had been attending telephoned a DoCS Community Service Centre (CSC H) with concerns about him. The staff member raised the following issues:

- The boy presented as 'startled and stiff' and as though he may be in pain. The child care centre had requested the boy's parents take him to a doctor but the parents claimed that the doctor had said there was nothing wrong with him. The girl also often appeared 'dishevelled'.
- The mother may be having difficulties parenting the boy and she did not appear interested in him.
- The mother had also neglected to pay the child care centre fees, which were in arrears. Because of this, the children may not be able to attend the child care centre in the future.
- The children were residing with their parents at their grandmother's house. The grandmother also supported a number of other relatives. The staff member was concerned about this home environment because it was believed to be loud and there were frequent arguments.
- Some of the parenting decisions of the father were of concern.

The DoCS record of this report notes a history of notifications concerning neglect and domestic violence in relation to the grandmother and her husband.

In response to this report, on the same day, DoCS contacted the father, attended the child care centre and sighted the boy. The next day, the parents took both children to a general practitioner. Following an examination, the doctor advised DoCS that he had no concerns about either child or the parents' response to their medical needs. However, both children were referred to a paediatrician for a full assessment.

The paediatrician also advised DoCS that she had no serious concerns about either child. The paediatrician indicated that the boy only 'scraped through' the developmental test but that she would only be concerned if he failed this test on the next visit. A further appointment was made for both children in July 2000.

On 23 June 2000 a DoCS caseworker observed the children during a home visit to their grandmother's house. The house was considered to be 'a little cluttered', but otherwise in a satisfactory state and the children were observed to interact positively with the parents. Both parents indicated that they were experiencing difficulties in relation to the child care fees, however 'they were working with the childcare [centre] on these issues'.

On 4 July 2000, the mother advised DoCS that the father had left the family home. She had organised child care for both children and stated that the grandmother was also assisting with the care of them. A few days later the mother was advised by the DoCS worker that this case would be closed after the children's further appointment with the paediatrician, depending on the doctor's assessment.

The medical records of the general practitioner who examined the children on 3 June 2000 contain a letter by the paediatrician, dated 30 July 2000. The letter states:

> I ha[ve] not seen these children since I last wrote to you, as I believe they were taken into state care. I have attempted to contact their district officer but to date have not been able to, and will let you know of any further developments.

There are no records on the DoCS file of any contact by the paediatrician with DoCS or vice versa in relation to the outcome of the appointment scheduled for July 2000.

The DoCS file for this matter was closed on 21 July 2000 and the outcome recorded was 'not confirmed'. This outcome indicates that DoCS did not find evidence to substantiate the concerns raised by the report.

5 October 2000

On 5 October 2000, the mother contacted the DoCS caseworker at CSC H, who had dealt with the report made on 2 June 2000. The mother stated that she had had an argument with the grandmother's husband the previous night. He had abused her while the children were at home and told her that she and the children had to move out of the family residence.

The mother stated to the DoCS worker that she would like to move out of the house but that she did not feel it was unsafe, and would remain there until she could secure accommodation from the Department of Housing (DOH). The DoCS worker referred the mother to the DOH and the Domestic Violence Line.

A 'Contact Report' was created which notes that the mother was 'to keep DOCS informed'. This report was added to the children's file as '[the mother] is acting protectively' and the DoCS worker considered that there were no risk or wellbeing issues. The 'Contact Report' was not recorded on DoCS' Client Information System and therefore could only be accessed by viewing the hard copy DoCS file for the children.

30 October 2000

On 31 October 2000, police facsimiled a notification to CSC H concerning risks of harm to the children.

This notification arose from a report that the grandmother had made to police about a domestic violence incident on the afternoon of 30 October 2000. The grandmother alleged that following an argument, her husband, who she claimed is an alcoholic, began to violently smash items in their kitchen. It appears that, other than the grandmother and her husband, only the boy was present, asleep, in the house at the time of this incident. The girl and two children of the grandmother aged 5 and 13 years who were also residing at the home were at a neighbour's house.

When police attended the grandmother's home, her husband agreed to be conveyed to a friend's house. Police also applied for an Apprehended Domestic Violence Order (ADVO) for the protection of all of the residents of the home, including the boy and girl. This order was later granted by consent.

Apart from the domestic violence incident, police reported to DoCS that they considered the grandmother's home was not a suitable residence for children. According to the DoCS summary of this notification, police reported that:

> [t]he front yard and driveway is strewn with rubbish as is the interior…Police did not venture far inside the house due to the overwhelming stench ….DVLO [Domestic Violence Liaison Officer] stated that DoCS should visit the family home as it is extremely dirty and not a suitable [e]nvironment for children to live.

The summary also contains a list of previous reports to DoCS about the grandmother's children in relation to issues of neglect, physical harm and domestic violence. A number of these reports are recorded as being 'confirmed'. This means that DoCS found evidence to substantiate the concerns raised by the reports.

The notification summary recommended that DoCS take the following actions in response to this matter:

> H/v [home visit] sight children
> Full risk assessment
> Supports and referrals as appropriate.

On 31 October 2000, two DoCS staff members attended the grandmother's residence. The record of this visit states:

> the house was in a filthy state cluttered inside and out. Dishes were piled up in the sink there were puddles of liquid on the floor. Half eaten food lay all around the house. The children's bedroom was cluttered with plastic matteress [sic] and other belongings. The bathroom basin was cluttered with stuff. The house had an unusual amount of flies. The[re] was a foul smell through out the house. The eldest child … was sleeping in a part of the lounge room. The floor coverings were filthy covered with dirt and half eaten food. The outside of the house was cluttered with rubbish looked like clothes, furniture, garbage dog food.

The DoCS workers decided that the 'children were at risk and would not be able to reside at the house'. The mother, the boy and the girl were taken to a refuge and, according to DoCS records, were to reside there 'until alternative accommodation through private rental or DOH could be found. [They were] not to reside at [the grandmother's] house. District Officer to write a support letter for DOH for [the mother]'.

The grandmother's two young children were taken to their uncle's house and the grandmother was advised that they were not to return to her place unless it had improved.

On 22 November 2000, a CSC H worker provided a letter of support to the DOH for the mother.

This matter was closed on 18 July 2001. The closure record on the boy's file states that his family 'has been re-notified (12/7/01) [DoCS officer] is now doing a risk assessment. This notification will be recorded as confirmed, referred, closed'. This record indicates that DoCS found evidence to confirm the concerns raised by the report of 31 October 2000 and had referred the matter for further action.

There are no other records on the file of any other action having been taken by DoCS in relation to this matter or that provide information as to whether and/or when the mother found alternative accommodation. However, records relating to a later notification in July 2001 indicate that the mother and the children remained at the refuge until February 2001.

4 December 2000

On 4 December 2000, the grandmother's five year old daughter presented at school with a bruise to the side of her waist. When she was asked by a teacher about this she disclosed that 'her 29 year old sister [the mother] had kicked her on the weekend'. According to police records the injuries were minor and the Joint Investigation Response Team (JIRT) did not investigate the matter because it did not meet their criteria. JIRT is an investigation team comprising both NSW Police and DoCS officers. Allegations of child abuse that may constitute a criminal offence are referred to JIRT to determine whether a joint investigation will be conducted into the matter.

While this report did not specifically concern the welfare of the children, it did raise concerns about the mother's treatment of a child. This would be relevant to any consideration of her capacity to care for her own children.

12 July 2001

In the late evening of 12 July 2001, the DoCS Helpline received a report from a hospital nurse regarding concerns that the boy had been physically abused and that the girl had been sexually abused.

The children and their mother had been staying at the grandmother's house for the past few days as the grandmother was in hospital recovering from a surgical operation. They were at the house with the grandmother's husband, two young children of the grandmother, and a 37 year-old male friend of the grandmother.

When the children and their mother returned to their home on 12 July 2001, the mother's two flatmates noticed bruising on the boy's face. This caused them to call an ambulance, which conveyed them, the children and the mother to the hospital.

According to the DoCS summary of this notification, the nurse who reported the matter stated that there were bruises on the left side of the boy's face around the jaw and upper neck and the right hand side around the jaw line which looked like 'someone has grabbed … [the boy's] face'. The DoCS Helpline worker also spoke to the hospital's treating doctor who stated that there was an additional 'big dark black bruise' on the boy's right ear. The mother had advised the doctor that she did:

> not know how these [bruises] occurred….while at [the grandmother's] house she had left [the boy] unsupervised with [the grandmother's daughter]…. there were times when she had 'no idea' who was with [the children] while at the....house.

The summary also contains a record of a telephone conversation with the hospital social worker who stated that the 'doctor suspects that …[the boy's] injuries are non accidental'.

The hospital medical records for the boy confirm that he presented with the injuries recorded by DoCS as well as a laceration to his forehead and a small bruise to his back. Photographs were taken of the bruises and placed on the file.

The ambulance records document similar injuries to the boy and state:

> pt [patient] conscious, active and well ….Pt has had a hoarse voice, has been irritable and "stand offish", not eating well.

The DoCS summary also states that when the girl was asked by the nurse as to why she was at hospital:

> she pointed at her vulva and said "I have a sore wee wee". [The nurse] was informed by the two flatmates that she has been making statements to them such as "[X] has put his nuts on my wee wee" "I've sucked [X's] nuts'…
>
> The flatmates said that [the girl] was red and inflamed in the vaginal area.

Additionally, according to the social worker:

> [One of t]he flatmate[s] had informed [the mother] that [the girl] had disclosed information regarding [X] three weeks ago. [The mother] admitted to the social worker that she had done nothing with that information although she "doesn't want the children to be abused".
>
> ….
>
> [The girl] described to the doctor urinary frequency and wetting the bed. The urinary analyses suggests urinary tract infection.

The medical records for the girl state:

> / child promptly parted labia with her hands without requiring this specifically
> / no evidence of injury – anus – groin
> / found a blonde-ish ?pubic hair on labia minora, also some other fibres (not hair)
> / no internal examination performed.

Ambulance records state that 'Mum & friends confirm pt's vaginal region is very red, Pt has pain on urination. Pt has also had a rash around her mouth. [On examination] alert …. active and very happy..'.

X was the boyfriend of the mother at the time. He lived with the mother's 20 year-old brother and had looked after the children at various times on his own during the past two months.

The DoCS report notes that in addition to the concerns raised about the abuse of the children, the flatmates had advised the social worker that when they moved into the mother's residence three weeks before:

> the house was in an upheaval, a filthy mess, dirty and untidy. The flatmates have cleaned this up. There is no refrigerator. The flatmates buy food for the children now…. [the mother] is having financial difficulty and [the girl] can not currently attend day care because [the mother] owes them money. The flatmates also informed the social worker that when they moved in the [c]hildren were sleeping in urine soaked sheets.
>
> The Social Worker believes that [the mother] is not capable of looking after the [c]hildren.
>
> …..
>
> The social worker has immense concerns regarding [the mother's] duty of care. She appears emotionally flat according to the social worker.

Initial Response by the DoCS Helpline

Shortly after receiving this notification, the Helpline contacted JIRT, which indicated that they would 'accept the referral and will follow up in the morning'.

The Helpline also arranged for their call out team to attend the hospital to sight the children. During this visit, in the early hours of 13 July 2001, interviews were conducted with the mother, the flatmates and the hospital social worker.

The DoCS record of this visit notes that the social worker repeated her concerns about the care of the children and the mother's 'very flat, non-emotional disposition'. These observations were confirmed by the attending Helpline worker who recorded that it was as though the mother was 'simply shutting down in reaction to the allegations' and that 'it is highly likely that the mother is a victim of abuse herself, and it is highly unlikely that she has ever sought treatment/therapy for this abuse'.

Following discussions with the Helpline worker, the mother agreed to enter into an informal undertaking with DoCS that she would not allow the children to see or have access to X.

The flatmates were also considered to present as:

> strong advocates for the children….
>
> It is clear that both women would be prepared to prevent the mother from allowing access to [X] and would appear to have taken on the parenting role for the two children.
>
> …….
>
> The mother appears unable to react in a positive manner to the needs of the children and if it were the case that [the flatmates] did not reside with the children a removal would have been recommended.

The Helpline recommended that the matter be referred to JIRT, that the mother be contacted later that day, and that a risk assessment in relation to the children be undertaken, including further assessment of the home environment.

Further action by CSC H

In addition to this matter being referred to JIRT, CSC H became involved.

On the basis of the records on the relevant file, there is some difficulty in determining precisely what actions CSC H carried out. However, they appear to have been as follows:

- On 18 July 2001 a home visit was undertaken. It appears that only the boy, the girl and one of the flatmates were present at the time. According to the DoCS record of this visit, the flatmate indicated that X had not been to the house but that she was concerned about the mother's capacity to care for the children, including that she had not been feeding them and that she left them with the flatmates. The flatmate also stated that the day after they had attended the hospital they received an eviction notice and they would therefore be looking for another place to live.

  During the visit the girl repeated the disclosures she had made about X, unprompted, to the DoCS workers.

  The DoCS record of the visit states:

  > [the flatmate] seemed to be somewhat "preoccupied" with her role as 'surrogate mother' regularly reminding caseworkers of her abilities in both parenting and homeskills, house work etc.
  >
  > ……
  >
  > It was becoming clear that both flatmates had hoped to be appointed as primary carers of the [children].

- It appears that CSC H also interviewed the mother, but from available records the date of this is uncertain. Undated handwritten notes indicate that the mother had spoken to the girl about the boy's bruises and the mother believed that her six year old sister was probably responsible for them. The notes state:

  > playing horses with [the children]. bit on ear, then strangled
  >
  > …..
  >
  > Dr(f) }
  >
  > Ambo} I don't think a 6 yr would have done that, marks/bruises too deep.
  >
  > Dr(m)}

- Between 20 and 24 July 2001, there were a number of phone conversations between DoCS and the mother and the flatmates. During this period the relationship between the mother and the flatmates began to deteriorate. The mother stated that she would not be moving into a new house with the flatmates and that she was likely to go to a refuge when they moved out of their house.
- During this period a paramedic from the Ambulance Service and the social worker and a doctor from the hospital each contacted DoCS. All expressed concern about this matter. The paramedic stated that he was of the view that it was very unlikely that the bruising on the boy was caused by a child. The doctor and social worker were critical of DoCS for returning the children to the mother's care. The doctor stated that he believed the children were at risk of further harm.
- During the period from 3 to 13 August 2001, DoCS made a number of unsuccessful attempts to contact the mother by telephone.
- There are no records of any further action by CSC H until after a further notification about the children on 9 September 2001 (this is discussed below).

Response by JIRT

As noted above, this matter was referred to JIRT shortly after it was received by the Helpline.

JIRT accepted DoCS' referral of the girl but not the boy, and therefore its enquiries were primarily directed at the alleged sexual abuse of the girl. Again, on the basis of the relevant records, there is some difficulty in determining precisely what actions JIRT carried out in relation to this matter. However, they appear to have been as follows:

- A home visit was conducted on 19 July 2001 to discuss the sexual abuse allegations with the mother and to arrange an interview with the girl. It appears that during this visit the mother indicated that X had not been to the house since they had been to the hospital. She also claimed that she was unaware of the girl's disclosure regarding X prior to their attendance at the hospital. The mother reiterated that she was unaware of how the boy had sustained the bruising.
- The girl was interviewed on 20 July 2001, during which she made further disclosures regarding X, as follows:

  > Q126 You're sick because of what?
  > ….
  > **A** My wee wee's sore, that's why.
  > Q128 How come---
  > ….
  > **A** Because [X] put his ….. on my wee wee.
  > Q130 Did he? Who's [X]?
  > **A** My mum's boyfriend.
  > Q131 And when did [X] do that?
  > **A** Friday.
  > …
  > **A** And Thursday.

  The girl later described in some detail how these events occurred. She was referred for counselling in relation to these incidents.
- It appears that X was never interviewed. The file notes of CSC H suggest that this was to occur on 4 August 2001. However, there are no records which indicate that this actually happened.
- On 24 July 2001, police made an application to the Local Court for a Personal Apprehended Violence Order (PAVO). The court granted the application on 24 August 2001. The NSW Police record of the order indicates that conditions were imposed which prohibited X from intimidating, stalking, assaulting, molesting, harassing, threatening or interfering with the girl. It appears that the order did not impose further conditions sought by police to prevent X from residing with the girl or going within 500 metres of her residence.
- On 10 and 13 August 2001, JIRT contacted two child care centres which the children had attended. One of these was the child care centre which had notified DoCS of concerns regarding the boy in June 2000. The other child care centre also expressed concerns about the children and in particular their physical care, that they were both 'dirty unkempt smelly' and that the boy was a ''blob' does nothing seems 'spaced out''. They also noted that the children were no longer attending the centre due to outstanding fees, which the centre had contacted debt collectors over.
- The NSW Police case report regarding the police investigation into the sexual assault states that:

  > [The girl] indicated that this [disclosed abuse] occurred at 'his house' but was unable to state when. It is believed that the incident occurred a few days before the notification was received as this is when [the girl] and [the mother] stayed at the POI's [person of interest's] house fore [sic] a few days. It was also this time that [the girl] complained of a sore 'wee wee' and was taken to [hospital].

> Examination results indicate that there was no evidence of vaginal or anus injury, but a blondish pubic hair was found in [the girl's] groin area. No internal examination was performed.
>
> Due to insufficient evidence JIRT will [be] unable to proceed with criminal action

- An assessment report by JIRT for the girl, which appears to have been completed on 13 August 2001, notes:

> there is concern for [the mother's] ability to adequately protect and care for the children in the future. The previous concerns reported of financial difficulties, neglect and domestic violence appear to be unresolved. The concerns raised by child-care staff, the hospital and the current housemates indicate concerns about [the mother's] parenting skills.
>
> 8. RECOMMENDATIONS
>
> A comprehensive home-based assessment, such as, [specialist, multidisciplinary assessments] would be necessary to identify the supports required to ensure the continuity of care with their mother, for these children.
>
> ….A referal [sic] for developmental assessment of [the boy] may be considered due to the concerns raised by the child care staff.
>
> A hand-over meeting to .. CSC [H] for ongoing work with this family.

- JIRT closed this case on 14 August 2001, noting that it was 'confirmed, referred' and that CSC H is 'currently involved re notification on sibling'.

Despite the recommendations of the Helpline and JIRT that a home based risk assessment of the family be undertaken, there are no records of any further action by either CSC H or JIRT.

9 September 2001

The DoCS Helpline was notified of further concerns about the children by NSW Police on 9 September 2001.

Early on the morning of 9 September 2001, police received a report from a neighbour of the mother in relation to the children. The neighbour reported that the children had been left with a 14 year old boy from 9 am on 8 September 2001 at the mother's rented flat, which she had moved into only two weeks before. The neighbour had seen the 14 year old leave the premises at 1 am on the morning of 9 September 2001, before the mother had returned home. The neighbour had checked the premises and could see the two children locked inside asleep.

Police attended the flat and were let inside by the landlord, who lived next door. The NSW Police record of this incident states:

> Police entered the unit to find it in a total state of filth and disarray. There was garbage all over the floor including bread crusts and dirty nappies. There was no fridge in the kitchen and the only food evident was a few tins of spaghetti in a cupboard. There were clothes all over the unit and there was a strong smell of urine. The victims were found in one of the bedrooms. [The girl] was found asleep on a mattress fully clothed. She had a doona covering her though no pillow. [The boy] was found on the floor fully clothed also however he had no blankets to cover him and his clothing was saturated….
>
> [The girl] also stated that she is often left alone with her younger brother and they put themselves to bed.

Police conveyed the children to the hospital for assessment and immediately notified DoCS of the situation.

The DoCS records for this matter do not include any reference to the girl's comment to police that she is often left alone with the boy. They state that:

> [The] Dr … advised that [the] children presented to be in good health and that there appears to be no medical/health concerns.
>
> ……
>
> The girl told police on way to hospital that [X] puts his nuts on her wee wee. There is a recent report in this regard which is being investigated by JIRT...

There is no record of this further disclosure by the girl on the relevant NSW Police record.

Medical records from the hospital for the girl (which were not on the relevant DoCS file) state that she repeated the same sentence about X to the examining doctor. The medical record also states:

> Expressed my concern that I have not fully exposed [sic] the children and wondered whether forensic examination is necessary. Was told [by the DoCS worker] that the comments [the girl] made about [X] have been made before and are under investigation.

A further entry on the record states that the girl was complaining of 'wee-wee pains'.

At the time these further disclosures were made by the girl, JIRT had completed its investigation into the disclosures she made in July 2001 and had closed its file on the matter. There are no records to indicate that information regarding these further disclosures was ever referred to JIRT.

Initial response by the DoCS Helpline

In response to this report, the Helpline took immediate action to temporarily place the children in the care of DoCS and arranged a temporary foster carer for 9 September 2001.

The mother made a '000' call about the children at 6.30am on 9 September 2001 and was referred to the DoCS Helpline. She advised the Helpline that she had left for work at 8.30am on the morning of 8 September 2001 for work. She claimed that she was working in a 'Call Centre' for the rest of the evening but was unable to provide details of the employer. The Helpline worker queried the mother as to whether she was aware of the risks of leaving a 14 year-old boy to care for children aged 18 months and 4 years. According to the Helpline worker, the mother responded '"no, what is wrong with that?" and that '"it was only for 2 days"'. DoCS records also indicate that the 14 year old boy had a history of reports to DoCS, including for un-medicated 'ADHD' and '[b]ehaviours at school and violence towards other peers'.

The mother was advised that, due to concerns about the risks of harm to the children, DoCS had temporarily assumed the care of them.

The Helpline referred the matter to a CSC (CSC J) to continue with 'assessing safety/risks/parenting/and child minding arrangements for s/children', to consider 'other action and/or services as deemed appropriate' and to 'contact [the mother] Monday 10/09/2001'.

Further action by CSCs

On 10 September 2001, the mother attended CSC H and was interviewed by one of the caseworkers who had dealt with the notification in July 2001.

During this interview, the mother advised that after moving out of the premises in August 2001 which she had shared with the two flatmates, she stayed in a YWCA for a week and 'different places'. She claimed that before the 14 year-old babysitter had arrived, her flat was 'spotless'. She was unable to explain how it had become so dirty but had begun tidying it up once she returned home. The caseworker advised the mother that CSC J would now be dealing with the matter and that she would have to speak to them.

The relevant DoCS file contains a letter dated 10 September 2001 from the Manager Casework, at CSC J, to the Local Court advising that the mother had been interviewed at CSC J that day and an inspection of her home had been conducted. The letter further states that resulting 'from the investigation of the matter' no further court action would be undertaken and the children were to be returned to the mother's care on the following grounds:

- [The mother] acknowledging the inappropriateness of placing children in the care of a youth.
- [The mother] agreeing to exercise better judgement when arranging care for her children.
- [The mother] locating appropriate bedding and resources for the home.
- [The mother] placing the children into Temporary Care for 7 days, to enable her to locate bedding and resources for the children.

  Further assistance will be afforded the family where necessary.

The mother signed a voluntary temporary care agreement, starting from 10 September 2001, placing the children in foster care arranged by DoCS for up to seven days. It is unclear precisely how many days the children were in foster care. However, a contract for 'Temporary Foster Care' between the foster care providers and CSC J states that the expected duration of the placement was for two days.

As noted above, the Helpline referred this matter to CSC J for further assessment of the 'safety/risks/parenting/and child minding arrangements for .. children' and to consider 'other action and/or services as deemed appropriate'. However, the case was closed on 22 November 2001 under the 'Priority One' policy on the basis that the matter was unallocated for four weeks and 'no additional or further concerns [were] notified within the month'.

May 2003

In May 2003, the DoCS Helpline received three further reports concerning the children.

Reports relating to an incident on 7 May 2003

The first two reports followed an altercation on 7 May 2003 between the mother and her then flatmate, S, while they were driving to pick the children up from day care and school. The mother called the police later in the evening, claiming that while in the car S began to verbally abuse her. She alleged that as she attempted to alight from the vehicle at a red light, S grabbed her around the neck and put her in a headlock. The mother claimed to have suffered minor injuries from this assault.

In response to this report, police attended the mother's residence to arrest S and later interviewed him. During his interview, S claimed that the assault took place because he was trying to prevent the mother from damaging his car. He also claimed that they had been arguing about the mother's failure to care for the children, including that she had left home the previous night without feeding them, that she had neglected them for most of the year and that she was rarely at home. S stated that he did a lot of the caring of the children.

A charge of assault was initially laid by police against S but was later withdrawn because there was no reasonable prospect of conviction. An application for an Interim ADVO for the protection of the mother was made by police but declined by a magistrate.

On the morning of 8 May 2003, the mother contacted the DoCS Helpline with regard to the safety of the children. According to the mother, S had 'been caring for the children and was transporting them to school and so forth'. She reported her concerns about the altercation with S the day before and claimed that S had also 'kicked [the boy] in the leg last Tuesday 06/05/2003' and that he had drug and alcohol abuse issues. The mother requested that DoCS locate alternative accommodation for S. However, after the role of DoCS was explained to the mother, she stated that she no longer required assistance as S had been charged and removed from her residence.

This phone call was not considered by the Helpline to evidence any risk of harm to the children. However, it was still recorded on the DoCS information system because 'there are similar concerns raised where the Mother is alleged to leave the children in other people's care'.

On 8 May 2003, police also facsimiled a report to the DoCS Helpline outlining the alleged assault by S on the mother. Police also expressed concerns over the state of the mother's residence, which they had sighted when arresting S. In particular, the police report stated that the place was 'extremely untidy and dirty'. When asked to further elaborate on this by the Helpline, police reported that:

- floors had things all over them (dirt, plastic)
- clothes piled waiste [sic] high in the one room police could see. [S] said that was mums room.
- bags & boxes all piled up.
- house filthy.

The Helpline assessed this information as requiring a 'Level 2 response' and recommended transferring the file to CSC H for a 'secondary risk assessment, supports and/or referrals to support the children'. A Level 2 response requires DoCS to respond within 72 hours of referral to the CSC or JIRT, due to serious safety concerns[1].

Report of 17 May 2003

On 17 May 2003, the DoCS Helpline received a further report about the children from an anonymous neighbour. The DoCS record of this states:

> On 13 April, 2003, [the girl] was playing at the reporter's home with the reporter's four year old niece…. On 14 May, the reporter's niece spontaneously disclosed to her mother "[The girl] was really rude mummy, she said let's go and kiss [S's] penis". The reporter was then informed of what her niece had said.
>
> [The girl] has previously told the reporter about an incident that occurred prior to the family residing [at the current residence]. [The girl] said that her mother's former partner grabbed [the boy] around his neck and held him against a wall. The reporter expressed a view that [the girl] appears old for her age and does a lot of the caring of [the boy].
>
> The reporter indicated that the mother's flat mate, [S], has the primary care of both children for extended periods…..A number of neighbours independently of each other have suspected that [the mother] is a prostitute and that [S] is her 'pimp'….
>
> The reporter said that [the boy] appears to have some kind of delay and the children appear neglected and often are wearing grubby clothing.
>
> The reporter is aware of another incident which occurred approximately six months ago. An ex-partner of the mother arrived and attempted [to] force [the mother] and the children into a car. [S] apparently intervened and became angry and screamed at the mother's ex-partner, you have really scare[d] [the girl], go away you psycho. A physical altercation then occurred between the two men resulting in police attending. The reporter said that [the girl] told her a story about being really scarred [sic] when her mother's ex-boyfriend attempted to force them into a car.

In relation to the incident that occurred six months prior, the NSW Police 'COPS' contains a record of an altercation between S and an ex-partner of the mother outside her premises on 23 November 2002. This record states that the mother did not witness the altercation and it makes no reference to the presence of the children. No action was taken by police in relation to the matter due to the conflicting versions of events provided by the two involved parties. It is unclear whether this is the incident to which the anonymous neighbour refers.

1 See pages 45-47 of our *Reviewable Deaths Annual Report 2003-2004* for a further explanation of initial risk of harm assessments.

The DoCS record of the notification of 17 May 2003 states:

> the anonymous reporter was assessed to be highly credible and provided information which indicates these children are at extreme risk of harm… the alleged perpetrator has the primary care of the children for extended periods, despite the mother alleging he is physically abusing them. There is a nee[d] for urgent intervention to ensure the safety of these children, with a need to consider action in the Children's Court'
>
> ….
>
> … . a stage 2, level 2 was deemed appropriate given the severity of alleged concerns and vulnerability of the children.

The record indicates that the matter was referred to CSC H to follow up on this action.

DoCS response to reports received in May 2003

Again, despite initial assessments of these matters indicating that the children were at 'extreme risk of harm' and that a secondary risk assessment was required, on 13 September 2003, the day before the boy's death, DoCS closed the file relating to the reports in May 2003. The closure occurred under the 'Priority One' policy, on the basis that the matters were unable to be allocated due to staff shortages and other cases having higher priority.

Action taken by DOCS and NSW Police following the boy's death

As noted above, NSW Police laid a number of charges against B in relation to the sexual assault of the girl. B pleaded guilty to these offences and has been sentenced to 16 years imprisonment. NSW Police has advised us that the investigation into the circumstances of the boy's death is ongoing.

On 14 September 2003, the DoCS Helpline removed the girl from the care of the mother and placed her into foster care. The next day CSC H made an application to the Children's Court for an emergency order to place the girl in its care for 14 days pending further investigation of her situation. This application was granted on 16 September 2003 for three days only, until 19 September 2003. A summary of the court outcome on the DoCS file for the girl states:

> Magistrate strongly suggested that this matter should come back before him, and raised option of care application rather than an extension of [emergency order].
>
> Dept to urgently assess placement options – in particular uncle and grandparents.

For the purposes of this assessment, on 17 September 2003, DoCS made a request to NSW Police for a criminal record check in respect of the girl's uncle.

On 19 September 2003, the Children's Court heard a further application by DoCS for an interim order allocating parental responsibility of the girl to DoCS and for an assessment order, to allow the Children's Court to assess the mother's capacity to care for the girl. According to a report by a DoCS manager dated 22 September 2003, the court was advised in the course of these proceedings that the criminal record check on the uncle was not complete.

The assessment order application was adjourned to 16 October 2003. The application for the interim care order was denied. However, the Children's Court made an alternative interim order, placing the girl under the supervision of DoCS and requiring the mother to accept a number of undertakings. These included undertakings by the mother to accept the supervision and reasonable directions of DoCS; to reside at the premises of her brother; and not to leave the girl with any person not approved by DoCS.

The girl was returned to her mother to reside at her uncle's house on 20 September 2003. DoCS visited the uncle's residence and observed it to be a 'reasonable and adequate environment'.

On 22 September 2003, NSW Police advised DoCS that the criminal record check on the uncle indicated that he was a suspect in December 1998 in relation to downloading child pornography from the internet. Further advice provided by NSW Police on 25 September 2003 indicated that several months after these suspicions arose, police examined the uncle's computer and found no evidence of any pornographic material.

DoCS conducted an interview with the uncle on 29 September 2003. This interview also raised concerns about him, in particular, that he indicated a reluctance to advise DoCS or the Children's Court of any breach by the mother of the undertakings she had accepted in relation to the care of the girl.

As part of its supervision of the girl, DoCS commenced weekly home visits to her residence. A number of other agencies and service providers have also been providing assistance and support to the family. This includes:

- weekly counselling sessions for the girl regarding the sexual assault upon her and her brother's death;
- regular medical checks of the girl;
- counselling for the mother for the loss of her son, the sexual assault upon the girl and for a sexual assault she suffered as a child; and
- assistance from a community family support service.

From 20 October until 6 November 2003, DoCS conducted a secondary risk of harm assessment of the girl. This involved a number of interviews with and observations of the girl, the mother, the father and professionals involved with the girl. The assessment concluded that the girl was highly likely to suffer further serious harm in the future.

On 6 November 2003 the Children's Court granted the assessment order application. The report prepared by the Children's Court Clinic on 1 December 2003 in accordance with this order recommends that DoCS:

> remain actively involved with [the girl] and her mother for the next two years and that they monitor [the mother's] parenting of [the girl] and her ability to protect [the girl] from further harm.

We have been advised by the Children's Court that legal proceedings in respect of the care of the girl have not yet been finalised. A draft care plan on the DoCS file for the girl indicates that DoCS is proposing that parental responsibility be given to the Minister but that the girl be placed with the mother in accordance with a number of undertakings.

Findings and observations

In light of the chronology of events outlined above, we have significant concerns about the handling by DoCS and NSW Police of reported welfare and child protection issues regarding the children prior to 14 September 2003.

The Department of Community Services

The chronology above outlines an extensive history of involvement by DoCS with the children's family prior to the boy's death. To assist in our discussion about this involvement, the following significant points are noted:

- The first report received by DoCS regarding the welfare of the children was in June 2000. This report raised the following issues in relation to the family:
  - — the health and development of the boy;
  - — neglect of the children and concerns about the parenting capacity of the mother and father;
  - — financial difficulties;
  - — concerns about the home environment of the children at the grandmother's house; and
  - — a history of neglect and domestic violence in relation to the grandmother's family.

In response to this report DoCS contacted the father and, subsequently, the children were examined by a general practitioner and a pediatrician. DoCS also undertook a home visit, during which an inspection of the grandmother's home and observations of the children with their parents were conducted. Following this visit and receipt of advice from the doctors that they had no concerns about the children, the matter was recorded as being 'unconfirmed' and closed. However, it appears that DoCS did not follow up on a further proposed assessment of the children by the pediatrician in July 2000.

- A further report was received by DoCS in October 2000. This report raised concerns about:

  — domestic violence by the grandmother's husband; and

  — the home environment of the grandmother's house in which the children were living - police reported that the house was not a fit residence for children.

  As a result of this report, a more extensive history of reports regarding neglect, physical harm and domestic violence in relation to the grandmother also came to light.

  On initial assessment of this report, CSC H recommended a home visit; that the children be sighted; a full risk assessment; and supports and referrals as appropriate.

  In accordance with this recommendation, DoCS workers visited the home. This visit confirmed the concerns of police about the state of the premises. The mother and the children were taken to a refuge until alternative accommodation could be found and a letter of support to the DOH was provided. It appears that a full risk assessment, as recommended, was not undertaken. Following receipt of a further notification about the family, the file for this particular matter was closed in July 2001, with a notation that DoCS was 'now doing a risk assessment' on the family.

- The report received by the DoCS Helpline in July 2001 raised the following significant concerns about the children:

  — physical abuse of the boy either by the mother or other persons with whom the boy may have been left;

  — sexual abuse of the girl by the mother's boyfriend and the mother's failure to take action when she was informed about the girl's disclosure about the abuse three weeks prior to DoCS being notified;

  — the mother's neglect of the children and her capacity to care for them. This included concerns about the state of the children's residence; that the mother's flatmates were primarily caring for the children; and that the children had been left with the mother's boyfriend who had allegedly sexually assaulted the girl; and

  — the mother's financial difficulties.

  The initial response to this report by the DoCS Helpline call out team was to sight the children at the hospital. As a result of this action, the call out team member prepared a report noting that the mother was likely to have been a victim of abuse and that, were it not for her flatmates, a removal of the children would have been recommended. They recommended that the matter be referred to JIRT and that a risk assessment of the children be undertaken, including a further risk assessment of the home environment.

  CSC H workers subsequently visited the home. However, the mother was not present at the time and there is no evidence of a home-based risk assessment being undertaken. Additionally, at this time DoCS was informed that the mother had been issued an eviction notice. The mother subsequently advised that she would not be moving into a new residence with the flatmates.

JIRT interviewed the girl about the alleged sexual abuse, resulting in a Personal Apprehended Violence Order being obtained for her. Enquiries by JIRT with two child care centres also confirmed concerns about the neglect of the children and the mother's financial difficulties and raised further concerns about the boy's development.

JIRT expressed significant concerns about the mother's parenting capacity and recommended that CSC H undertake a specialist and 'comprehensive home-based assessment' to identify the supports required for the family. However, there is no evidence to suggest that this recommendation was implemented.

- On 9 September 2001, the DoCS Helpline received a further report about the children, which raised the following concerns:
  — the mother had left the children in the care of a 14 year-old boy for two days. This again raised serious issues as to the mother's decision making capacity in relation to whom she entrusted the children with. These concerns were exacerbated by reports on the DoCS information system regarding violence by the 14 year old;

  — the state of the children's premises was again reported to be a serious issue; and

  — continued disclosures of sexual abuse by the girl.

  The Helpline responded to this report immediately by temporarily assuming the care of the children and arranging foster care. The matter was then referred to CSC J to continue with assessing 'safety/risks/parenting/and child minding arrangements' and to consider other services as deemed appropriate.

  However, following an interview with the mother the next day, a decision was made to return the children to her on the basis that she made a number of undertakings. The undertakings included that the children would remain in foster care for a few days until the mother located appropriate household items. The undertakings did not involve the provision of any support or other intervention by DoCS to address the risks raised by the report.

  There is no evidence to suggest that further follow up or assessment of the family was undertaken or that further services were provided. The case was closed in November 2001, under the Priority One policy, on the basis that it had been unallocated for four weeks and no further reports about the children had been received within the month.

- In May 2003, three further reports were received by DoCS about the children. These were made over 18 months after the previous report in September 2001. However, they raised a number of issues that had previously been reported. For example:

  — domestic violence;

  — concerns about the state of the children's residence;

  — neglect of the children by the mother and in particular leaving the care of the children to others – in this case S;

  — concerns about the mother's decisions in relation to whom she left the children with – the mother had reported that S had been abusing them and a neighbour raised concerns that the girl may have been sexually abused by S; and

  — concerns about the delayed development of the boy.

> In respect of these reports, the DoCS Helpline assessed that the children were at 'extreme risk of harm' and that there was a need 'for urgent intervention' to ensure the safety of the children. It recommended a 'secondary risk assessment, supports and/or referrals to support the children'. It appears that these recommendations were not implemented. The matter was closed in September 2003 under the Priority One policy due to staff shortages and other cases having higher priority.

The chronology of events outlined above indicates that between June 2000 and May 2003, DoCS received seven reports directly concerning the children. These reports, particularly from July 2001, provided evidence of persistent risks of harm to the children due to the mother's neglect, including concerns about the state of the children's residence, the mother leaving the care of the children to others and her poor decision making in relation to whom she left the children with. These risks were compounded by a history of intergenerational neglect and domestic violence, and the likelihood that the mother had been a victim of abuse herself, as identified by the Helpline call out team in July 2001. They were the same risks that ultimately resulted in the children being left to the care of B and seriously harmed in September 2003.

On initial assessment, intake staff at the CSC level (for the earlier reports) and at the Helpline (for reports received from July 2001) accurately identified the risks to the children. Appropriate recommendations were also made that follow up action be taken by the relevant CSCs. For example, in response to the reports in October 2000, July 2001, September 2001 and May 2003, intake staff recommended that comprehensive risk assessments be conducted so that necessary supports, referrals and interventions could be provided to ensure the safety and wellbeing of the children. In response to the July 2001 report, JIRT specifically recommended a specialised and 'comprehensive home-based assessment …. to identify the supports required to ensure the continuity of care'.

In a number of cases, DoCS also provided crisis responses to the reports. In October 2000, the family was taken to a refuge; in July 2001 the DoCS Helpline call out team visited the hospital to sight the children and, a few days later, CSC H undertook a home visit while the mother was absent; and in September 2001 the children were removed from the mother for a number of days.

However, prior to the boy's death, there is no evidence to indicate that DoCS took appropriate action to avert the persistent risks of harm to the children. For example, prior to 14 September 2003, there is no evidence to suggest that DoCS provided appropriate supports, referrals and/or interventions to the family to address the chronic risks to the children. Nor is there any evidence that a comprehensive risk assessment of the family was undertaken to identify what services and intervention were required to address the ongoing concerns raised by the growing number of reports about them.

In contrast, following the boy's death, DoCS initiated a number of actions for the ongoing protection of the girl. This included commencing proceedings in the Children's Court which resulted in the girl being placed under the supervision of DoCS and an assessment being conducted by the Children's Court Clinic; undertaking a comprehensive secondary risk of harm assessment of the girl; and the provision of a number of support services by other agencies.

On 22 November 2001 and 13 September 2003, DoCS made decisions not to take further action, closing its files in accordance with its Priority One policy.

According to DoCS, the purpose of this policy is to assist casework managers in ensuring that 'cases of highest risk receive a prioritised response'. The policy was last updated in February 2002. This version of the policy states:

> Prioritisation should be conducted with reference to the risk assessment framework, the Interagency Guidelines and consultation with relevant staff.
>
> Unallocated work is Child and Family casework, which meets our business criteria, but cannot be responded to because of insufficient resourcing and the order of priorities may be designated as unallocated. The decision to not allocate work may be implemented at any stage of assessment or investigation following the initial assessment at DoCS Helpline.

> .....
>
> [Decisions as to whether casework is to be allocated] need to take into account the risk level and response timeframes in the Required Action Plan (RAP) as well as risk levels identified through any assessments conducted through the CSC or JIRT.

The decision in November 2001 to close the children's case arising from the report in September 2001 under the Priority One policy was made on the basis that the matter was unallocated for four weeks and 'no additional or further concerns [were] notified within the month'.

While no further reports were received from September 2001 to November 2001, at the time this matter was closed, DoCS did not have any evidence to suggest that the risks highlighted by earlier reports had subsided. In the 17 months prior to November 2001, DoCS had received four reports about the children. All of these reports raised significant concerns about the mother's neglect of the children and her parenting capacity. In July 2001 and September 2001, DoCS was alerted to serious risks of harm in relation to the mother leaving the care of the children to others. In one case, reported in July 2001, this may have left the girl exposed to sexual abuse by X. In another, reported in September 2001, a 14 year-old babysitter had left the children locked in their home alone. DoCS decided to close this later case despite the fact that no risk assessment had been undertaken and that it was unaware of the circumstances of the children at the time of the closure.

In September 2003, a decision was made to close the cases initiated by the three reports received in May 2003. While these reports were received over 18 months after the previous report, they presented similar risks. For example, concerns were raised about the state of the residence – a risk factor that had previously resulted in the children's placement with their mother in a women's refuge. DoCS was also advised that S had been providing the primary care of the children, despite the mother reporting that he had been abusive to them. The anonymous neighbour also observed that the girl did a lot of the caring of the boy and reported an incident that raised concerns that she may be being sexually abused by S. There was also evidence to suggest that the boy may have been physically abused by the mother's former partner and that the boy was developmentally delayed.

In response to these issues, the initial assessment officer at the Helpline indicated that the 'children are at extreme risk of harm' and that '[t]here is a need for urgent intervention to ensure the safety of these children, with a need to consider action in the Children's Court'. However, the three reports were closed the day before the boy's death, on the basis that they were unable to be allocated due to staff shortages and because of other cases having higher priority. This was despite the absence of any action by DoCS to determine whether the reported risks had abated.

Our broader concerns about DoCS' Priority One policy, and its risk assessments and handling of reports concerning neglect, are discussed in detail in our annual report on the review of child deaths[2].

Following the boy's death, DoCS briefed the Minister, the Honorable Carmel Tebbutt MLC, on its prior involvement with the children's family. This included the provision of a 'Case Summary Report Following an Extraordinary Matter' dated 16 September 2003, which outlines the previous notifications DoCS had received about the children and its response to these. In relation to the DoCS response, the report states:

- DoCS practice has been consistent with policy and procedures. A number of child protection reports during 2003 were closed under the case closure policy.
- While there has been child protection concerns for the children, including [the mother] making inappropriate care arrangements for the children, there was no ability to anticipate [the boy's] death.

2 See page 49 for our discussion on the Priority One policy and page 53 for discussion concerning neglect.

In our view, DoCS' involvement with the children's family prior to the boy's death, when examined in totality, reveals a continual failure to adequately respond to reports about the risks of harm to the children. The mounting number of these reports from June 2000 until May 2003 alerted DoCS to the persistent nature of these risks. Despite identification of these concerns by intake and Helpline staff at the initial assessment stages, DoCS failed to take adequate steps to protect the children from the ongoing dangers they were facing. In this office's view, this failure by DoCS was unreasonable. Had appropriate action been taken, a different outcome may have resulted for the children.

This failure was the result of a myriad of decisions during a period expanding over three years. For this reason, we have not focussed on the specific conduct or inaction of the numerous individuals who had involvement with the family. Our investigation reveals an overall failing by DoCS to adequately protect the children from serious harm.

However, the broader focus of our investigation is not intended to suggest that the decisions and actions of individual officers involved with the family did not play a significant role in the outcome of this matter. Rather, the failings revealed by our investigation highlight the need for a further examination of the conduct of relevant officers so that appropriate managerial and remedial action, including training and education, can be taken. Given that DoCS has the ultimate responsibility for implementing such action, we believe it is appropriate for this further examination to be carried out by DoCS.

For this reason, we recommended to DoCS that it undertake a review of its involvement with the family prior to the boy's death with a view to implementing measures to address the deficiencies in its handling of reports about the children. We indicated that this review should include a consideration of:

- the adequacy of DoCS' record keeping in relation to its involvement with the family and any action to address problems in this regard; and
- whether any managerial or remedial action is required in relation to the conduct or decisions of individual DoCS officers who handled reports about the family.

Response by the Department of Community Services to our concerns

The DoCS response to the concerns we have raised in relation to this matter is set out, in full, below:

> Thank you for your statement of provisional findings and recommendations of 21 October 2004 on which you invited DoCS to comment prior to the report being finalised.
>
> The death of any child is a tragic event and has devastating consequences for the family and professionals involved in the case. DoCS treats the death of any child coming within its areas of responsibility as a most serious incident. It is one from which we must maximise the learning available so as to minimise risk to those children who are in our child protection system and those who are still to come.
>
> The draft investigation report makes a number of observations about the adequacy of the child protection system and the decisions of various staff at the time of [this] case. DoCS does not contest the facts in the provisional report. However, we are concerned about some conclusions that have been drawn from the facts.
>
> <u>The context in which the NSW child protection system operates</u>
>
> Reviewing the death of a child occurs with the benefit of hindsight and with the outcomes of the case known. Where such a review is conducted in isolation from the context within which the various decisions were taken, the reviewer may still find clues as to systemic changes that may be necessary for the future. However, where the reviewer wishes to make comment about the decisions made by the agency or individual officers, then the context within which those decisions were made becomes crucial. When examining our own cases, DoCS considers it essential to contextualise the individual case against the workload and realities of day-to-day child protection work.

The key contentious issues in this case in 2003 revolve around the decisions to close the case without allocating it to a caseworker for a full secondary risk of harm assessment.

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 the growth of child protection reports these figures can well be understood. In 1989/99, there were 72,762 reports concerning 50,181 children and in 2001/02, DoCS received 159,643 reports concerning 84,965 children. These issues were also extensively canvassed in the report of the Inquiry by the Social Issues Committee of the NSW Legislative Council in 2002 entitled "Inquiry into the Child Protection Services". Under such pressures staff could only attend to the most urgent 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 Blueprint is consistent with the bulk of the recommendations in the draft Ombudsman's Annual Report to Parliament: reviewable child deaths.

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 resourcing situation in … CSC [H] in September 2003 was therefore essentially the same as that existing at the time of the various inquiries and reports mentioned above.

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.

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.

While acknowledging that proposed improvements to the NSW Child Protection System may have impacted on decisions or actions in this particular case, it would be misleading to suggest that such changes would in fact prevent all deaths of children. Such reforms can only improve the life outcomes for the majority of children in the system.

Decisions of various DoCS' officers made in the … case

With a view to identifying any concerns or learning arising from the tragedy of [the boy's] death, DoCS examined the [children's] case in full shortly after his death. Information available to DoCS at the time indicated that staff at … CSC H had a number of matters on hand where safety concerns for other children were apparently higher than those for the … children. This was, unfortunately, the case over a period of time.

DoCS' examination of the case confirmed adherence to relevant policies by staff. DoCS has no information to suggest that the decision-making or conduct of officers require examination beyond that which has already occurred. Our assessment is that, while the eventual outcome was indeed tragic, the decisions by staff were made in good faith, in line with the resources available and departmental policies were appropriately applied. DoCS did not identify any individual failings and no further information has come to light that would suggest this assessment needs to be revisited.

In the above context, it is worth re-stating that [if] cases arise that present clear evidence that officer/s may have operated outside the boundaries of the law, policies or procedures, DoCS will investigate and take any subsequent appropriate action.

DoCS notes your statement on page 1 of the investigation report that you do "not purport to comment on the conduct of individual employees". However, the conclusion in the draft report that "a different outcome may have resulted for

> the … children" remains of concern. This comment infers that [the boy's] death and [the girl's] sexual assault would not have occurred if DoCS had responded differently. This is the inference that DoCS' staff have drawn from the report.
>
> DoCS contends that there is no way to predict outcomes that may have arisen from different fact situations – this can only be a matter of broad speculation. The statement about a different outcome is not supported by any objective evidence. DoCS considers both the facts of the case and a considerable body of international research support its position on this point.
>
> While DoCS does not support the conclusions you have drawn in the … investigation, this in no way diminishes our interest in the systems issues arising from this case. DoCS will continue to address the systems issues raised by the Ombudsman in the effort to improve outcomes for children in the NSW Child Protection System.

Our comments on the response by the Department of Community Services

This response from DoCS did not satisfactorily address our concerns about this matter.

The response indicates that in order to identify:

> any concerns or learning arising from the tragedy of [the boy's] death, DoCS examined the [children's] case in full shortly after his death. Information available to DoCS at the time indicated that staff at … CSC H had a number of matters on hand where safety concerns for other children were apparently higher than those for the … children. This was, unfortunately, the case over a period of time.

However, DoCS did not provide any details to this office as to the information available to it at the time of this examination, which indicates that CSC H 'had a number of matters on hand where safety concerns for other children were apparently higher than those for the … children'.

Additionally, CSC H was not the only CSC that was involved with the family. CSC J was responsible for dealing with the notification made on 9 September 2001. This notification raised significant concerns about the mother's capacity to care for her children – particularly when, by this time, DoCS had already received a number of reports raising similar issues. CSC J closed this case in November 2001 under the 'Priority One' policy on the basis that the matter was unallocated for four weeks and 'no additional or further concerns [were] notified within the month'. The DoCS response did not address this aspect of its involvement with the children.

DoCS' response also expresses concern about our comment that 'a different outcome may have resulted for the … children'. According to DoCS, this is because it infers that '[the boy's] death and [the girl's] sexual assault would not have occurred if DoCS had responded differently'. DoCS also contends that there 'is no way to predict outcomes that may have arisen from different fact situations – this can only be a matter of broad speculation'.

We wish to emphasise that at no stage have we suggested that, had DoCS taken appropriate action in response to the reported risks of harm to the children, that the boy's death and the sexual assault of the girl would with certainty have been prevented. Our view is that a different outcome *may* have resulted had DoCS taken adequate steps to protect the children.

Nor have we suggested that DoCS should have predicted the precise outcomes that eventuated for the children. However, on the basis of the numerous reports received about the risks of harm to the children, it should have been clear to DoCS that, without significant intervention, the children would continue to be at risk of harm, including neglect and/or abuse.

For the above reasons, we maintain the view that the failure by DoCS to take adequate steps to protect the children from the ongoing dangers they were facing was unreasonable.

The evidence available to this office does not suggest that decisions by individual officers involved in this matter were not made in good faith. However, individual decisions are likely to have played a role in DoCS' failure to adequately protect the children from serious harm. For this reason we again recommended to DoCS that a further examination of the conduct and decisions of relevant officers be undertaken by DoCS.

The purpose of this examination would be to ensure that appropriate managerial and remedial action, including training and education, can be taken.

Further response by the Department of Community Services

Following our consultation with the Minister for Community Services on our report in relation to this matter, DoCS provided us with a further response to our concerns.

This response advises that DoCS' review of this matter shortly after the boy's death primarily focused on the involvement of CSC H with the children in 2003, rather than its decisions and casework in 2000 and 2001. In light of our continued concerns about DoCS' involvement with the children in 2000 and 2001, DoCS advises that it will be conducting a full review of its actions at these times. This review will be examining:

- the full extent and case history of DoCS' involvement with the … children in 2000 and 2001
- the resultant casework decisions against policy and procedures as they existed at various points in time
- any concerns or learning arising from the case and recommendations for practice, systems or procedural improvement.

DoCS states that appropriate action will be taken if any evidence arises that suggests that any officers may have operated outside the boundaries of the law, policies or procedures.

DoCS also provided a summary of contextual information regarding the workload capacity of CSC H in 2003. This included the following information:

- From May to July 2003, the [CSC H response] team had five caseworkers, of which two were within their first two months of temporary employment.
- One caseworker was involved with a high profile ongoing matter up until September 2003 which was taking up 75% of her time, involving court ordered contact 3 days a week.
- Due to comparative inexperience of the other teams, the response team was also carrying a number of ongoing and court matters (it would not ordinarily have responsibility for these), during this time.
- With leave entitlements and staff movements there were regular occasions when only two caseworkers were available on the response team.
- From December 2002 to October 2003 an average of only 20% of all cases were able to be allocated at [CSC H].
- From December 2002 to October 2003 (note for one month aggregated data are unavailable), [CSC H] averaged 18 level 1[3] reports per month, the bulk of which were allocated. It also averaged 49 level 2 reports per month over this time. The allocation rate of level 2 reports ranged between 10% and 39% with an average of 23%. These allocation rates are generally consistent with those in CSCs across DoCS prior to any resource enhancements from the 5 year funding package.

  In effect this meant that at [CSC H] matters which may be prioritised as a medium response (level 2) were very often difficult to allocate, due to the need to deal with level 1 reports and the capacity of caseworkers to take on more work. Matters of a more serious concern within the level 2 response were kept open in the hope that it might be possible to allocate them at a later date within the Priority One policy.

The response states that in relation to DoCS' involvement with the children in 2003 'it would seem more productive to see whether we could: (i) apply the new (trial) Case Closure Policy principles to the facts of the case, and (ii) conduct a peer review as per the New Zealand model (essentially a practice review)'.

3 A Level 1 report requires DoCS to respond within 24 hours of referral to the CSC or JIRT

NSW Police

Our concerns about NSW Police's involvement in this matter relate primarily to its investigation of the alleged sexual abuse of the girl and NSW Police's referral of information about the children to DoCS.

We are concerned that there was a lack of rigour by police in investigating the alleged sexual abuse of the girl by X that was reported to JIRT in July 2001 and, in particular, that:

- A hospital doctor who examined the girl stated that they found what appeared to be a pubic hair in the girl's vagina. However, it appears that no DNA or other analysis was carried out on this. While such evidence may not be definitive in proving a sexual assault, it was clearly relevant.
- The NSW Police record for this matter indicates that no internal examination of the girl was undertaken. Additionally, it appears that no consideration was given to obtaining DNA swabs from the girl or her clothing, which may have provided evidence of the sexual assault. The reasons for this are uncertain - particularly in light of the identification of what appeared to be a pubic hair by the hospital doctor.

We are also concerned that there have been failings in adequately recording and referring important information obtained by NSW Police in respect of the children. In this regard, the following points are noteworthy:

- The DoCS records in relation to the report on 9 September 2001 indicate that the girl made a further disclosure of sexual abuse by X to police at that time. However, there is no reference to this on the relevant NSW Police record and there is no indication that this information was provided by police to JIRT.
- The NSW Police record of the police attendance at the children's residence on 9 September 2001 indicates that the girl stated that she is 'often left alone with her younger brother and they put themselves to bed'. However, there is no reference to this statement in the DoCS records relating to this incident. This would clearly be important information for DoCS to consider when responding to the risk of harm report.

We recommended that NSW Police undertake a review of the above matters. We recommended that, in carrying out this review, NSW Police should consider whether any strategies are required to ensure that any identified failings by NSW Police are not repeated in the future and whether any managerial or other remedial action in respect of individual officers is required.

NSW Police has advised us that the Child Protection and Sex Crimes Squad will be conducting a review of the issues we have raised. NSW Police anticipates that this review will be completed by 18 December 2004 and will advise us as to the outcome in due course.

Recommendations

The Department of Community Services

We have recommended that DoCS advise us of the outcome of its review of its involvement with the children in 2000 and 2001, including any action taken as a result of the review.

In relation to its interactions with the children in 2003, we have recommended that DoCS advise us as to the outcome of the:

- Application of the new trial case closure policy principles to the facts of the case, and
- Peer review.

We have asked DoCS to provide us with this advice by 28 February 2005.

NSW Police

We have recommended that NSW Police advise us of the outcome of the review by the Child Protection and Sex Crimes Squad by 18 December 2004.