OmbudsmanSA

Report

Full investigation - *Ombudsman Act 1972*

Complainant	**[Name withheld]**
Department	**Department for Communities and Social Inclusion**
Ombudsman reference	**2012/09285**
Department reference	**13TDCSI/239**
Date complaint received	**14 November 2012**
Issues	**1. Whether the department erred in failing to protect the complainant from X** **2. Whether the department erred in relation to investigating the alleged failure to protect the complainant**

Jurisdiction

The complaint is within the jurisdiction of the Ombudsman under the *Ombudsman Act 1972*.

Investigation

My investigation has involved:

- assessing the information provided by the complainant
- assessing the information provided by the Office of the Guardian for Children and Young People
- seeking a response from the department
- waiting for the department's internal investigation to be completed
- assessing the department's internal investigation report
- seeking and assessing a response from the Department for Education and Child Development
- seeking and assessing information from SYC (formerly the 'Service to Youth Council')
- questioning two former employees of SYC
- providing the department, the Guardian for Children and Young People and the complainant[1] with my provisional report for comment, and considering responses from the department and the Guardian for Children and Young People
- preparing this report.

[1] A current address for the complainant could not be located; accordingly a copy of the provisional report was sent to his last known address (his parent's home).

Standard of proof

The standard of proof I have applied in my investigation and report is on the balance of probabilities. However, in determining whether that standard has been met, in accordance with the High Court's decision in *Briginshaw v Briginshaw* (1938) 60 CLR 336, I have considered the nature of the assertions made and the consequences if they were to be upheld. That decision recognises that greater care is needed in considering the evidence in some cases.[2] It is best summed up in the decision as follows:

> The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issue has been proved … .[3]

Response to my provisional report

The department responded to my provisional report by letter dated 30 September 2014. I address its submissions in the body of this report.

Ms Pam Simmons, the Guardian for Children and Young People, responded by thanking me for undertaking a thorough investigation of the complaint.

The complainant did not respond to my provisional report.

Background

1. This complaint arises from an incident that occurred on 15 September 2011 (**the incident**) whilst the complainant was resident at the then Cavan Training Centre (**CTC**). The complainant was stabbed repeatedly in his back, neck and head with a calligraphy pen by another resident (**X**) during an art class in the Learning Centre at CTC.

2. The complainant was 16 years old and was being held on remand: as such he was a client of the Youth Justice section of the department. I understand that he had been arrested on 31 July 2011 and was initially held in custody at the Magill Training Centre (**MTC**) before being transferred to CTC on 18 August 2011.

3. At the time CTC was used primarily for young men aged 15 to 18 years of age on long-term remand or on a detention order. CTC is now known as the Jonal Drive Campus of the Adelaide Youth Training Centre. The Training Centres are staffed by youth workers and are part of the Youth Justice section of the department. Residents attend school at the Learning Centre in CTC, which is run by the Youth Education Centre (**YEC**) of the Department for Education and Child Development (**DECD**).

4. In light of the fact that the complainant and X were juveniles at the time, I have not identified them in this report. Similarly, this report contains information about X, provided to me by the department, which I do not consider appropriate or necessary to divulge to other parties. As X's identity is known to the complainant among others, I propose to redact such information from copies of the report provided to parties other than the department and the Office of the Guardian for Children and Young People (**OGCYP**). I have highlighted those parts of the report in the copies provided to the department and the OGCYP.

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[2] This decision was applied more recently in *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 110 ALR 449 at pp449-450, per Mason CJ, Brennan, Deane and Gaudron JJ.

[3] *Briginshaw v Briginshaw* at pp361-362, per Dixon J.

5. I am advised that there was a history of tension between the complainant and X prior to the incident, and that the complainant had made it known to departmental officers that he believed X posed a serious risk to his safety.

6. In his complaint to my office, the complainant described the incident as follows:

> On the 15th September 2011 I was in art class. A staff member walked in and said to the teacher 'I have a special delivery for you' and in came [X]. During the class [X] was looking at me and talking to other people saying that he was going to jab me in the face or stab me. At one stage there was no staff member and no teacher as they had walked out. My head was pushed into the table from behind and I felt my head being stabbed with something. It was [X] stabbing me with a calligraphy pen. I tried to fight him off. I felt blood, pain and a burning sensation through my body. Staff restrained [X] and I was taken out.

7. The CCTV footage provided to me shows the complainant seated at a table by himself, working on his project. X is at the side of the room watching his classmates while the teacher is assisting students on the other side of the room. During the class, youth workers enter the classroom to speak to the teacher and then leave the room. X then attacks the complainant.

8. I understand a duress alarm was activated immediately and that youth workers entered the room and restrained X and the complainant. The complainant was then escorted to his room where he was attended to by a nurse while an ambulance was called. Ambulance officers noted the tip of a pen was lodged in the complainant's head. The complainant was then taken to Royal Adelaide Hospital for treatment after which he was returned to CTC.

9. X was charged with and subsequently convicted of Aggravated Assault with Offensive Weapon and sentenced to twelve months imprisonment which he served in the Yatala Labour Prison, having reached 18 years of age.

10. The department advises that following the assault, incident reports were completed by youth workers and by YEC staff. A meeting was also held at CTC with Youth Justice and YEC management and staff in relation to the incident and a briefing was provided to the Director of Youth Justice on 15 September 2011. The complainant was placed on a Safety Plan and an At-Risk Plan.

11. In October 2011 the complainant contacted the OGCYP and advised he still felt unsafe, and that he believed an investigation should be undertaken into how and why the department had failed to keep him safe. An advocate from the OGCYP contacted the department on behalf of the complainant.

12. I am advised that the department informed the OGCYP that it would commence an investigation into the matter. However, some eight months later they were informed that an investigation by the department's Special Investigation Unit had not in fact commenced and that Youth Justice would now do a 'desktop investigation'. I understand that this did not occur either.

13. On 14 November 2012, the OGCYP lodged a complaint against the department with my office on behalf of the complainant, who at the time was still in custody at CTC. The complaint comprised two issues: firstly, that the department erred in failing to protect the complainant from X; and secondly, that the department erred in failing to investigate the alleged failure to protect the complainant. The complainant included the following details:
    - that the department was aware of the risk X posed to the complainant

- that the department should not have transferred the complainant from MTC to CTC where X was a resident
- that the complainant had been told by the department that he would not have contact with X
- that the complainant should not have been placed in the same class as X
- the complainant would like to know who made the mistakes in failing to keep him safe; he believes that it is important for the department to know where it failed so this sort of thing does not happen to others
- the complainant would like to have the failure acknowledged by the department and would like a formal apology from whomever was at fault.

14. By letter dated 12 December 2012, my predecessor notified the department that he had decided to conduct a preliminary investigation of the complaint. He requested a report addressing the two issues and copies of any documents relevant to the matter. He also requested information from the OGCYP.

15. I am advised that on 27 December 2012 the Director of Youth Justice referred the matter to the department's Care Concern Investigations section (**CCI**) for what was identified as a 'Serious Care Concern Investigation'.

16. My office received a response to my request for information and supporting documents from the OGCYP by letter dated 7 January 2013.

17. By letter dated 8 February 2013 the department responded to my request for information. In addition to a report responding to specific questions raised by my predecessor, Ms Joslene Mazel, the Chief Executive of the department, advised the following:
    - at the time of the incident Youth Justice was part of the Families SA division of the former Department for Families and Communities (**DFC**)
    - as a result of the Machinery of Government (**MOG**) changes in October 2011 [which came into effect on 1 January 2012], Families SA was transferred to DECD
    - however, the Youth Justice section transferred to the newly-formed department (formerly known as DFC)
    - the department's CCI was formed following the MOG changes
    - at the time of the incident, reports of incidents of harm to clients were made to Families SA's Child Abuse Report Line (**CARL**)
    - Youth Justice made a report to CARL in relation to the incident on 19 September 2011. A decision was made by Families SA not to refer the matter to the (then) Special Investigations Unit (**SIU**)
    - the matter was referred to the department's CCI in December 2012 'given the previous non-referral by Families SA of the matter to the SIU' [and following notification of this investigation]
    - CCI made a determination that the incident warranted further investigation
    - an investigation report from the CCI (**the CCI Report**) 'is expected at the end of February 2013'
    - CCI had requested certain information and documentation which it retained at the time of Ms Mazel's letter; that this impeded Youth Justice's information gathering for the purpose of responding to Ombudsman SA; and that CCI had advised that any interference with the investigation process should be avoided until the investigation is complete.

18. In light of the fact that the department was now undertaking an investigation of the matter, my predecessor decided to put my office's investigation on hold. The CCI Report was not, however, completed by February 2013; and over the following 12 months, I was informed a number of times that the investigation remained ongoing. I

am advised by the department that 'as the investigation progressed, the complexity of the investigation increased as did the number of enquiries which needed to be conducted by CCI…' I understand the CCI report was completed on 23 December 2013. Following advice that it had been completed, I obtained a copy under summons dated 13 March 2014.

19. On 19 March 2014, the department provided a copy of its report along with 72 documents provided by Youth Justice to CCI; a copy of the CCTV footage showing the incident; and copies of photographs of the complainant's injuries sustained as a result of the incident. The CCI investigation appears to have been comprehensive and included interviews of key staff involved in the management of X and the complainant. Much of the evidence in this report is derived from the CCI Report.

20. The Investigating Officer concluded in the CCI Report that there had been a deficit in the quality of care provided to the complainant, and stated 'It is for the delegate to decide on a finding following consideration of this report.' I am advised that on 21 February 2014, Ms Mazel decided on a finding of a Deficit in the Quality of Care Substantiated. Ms Mazel directed that an Action Plan be developed to implement strategies to address the issues which resulted in the deficit in care. The department has developed and provided me with a copy of the Action Plan.

Whether the department erred in failing to protect the complainant from X

21. In his complaint to my office, the complainant submitted that the department had been made aware that X posed a risk to him prior to the incident and, accordingly, that the department should have done more to protect him from X.

22. In particular, the complainant alleged that:
    - while he was at MTC, he was advised that he may be moved to CTC. He told staff that had received death threats from X and that other residents had told him that X was going to stab him. He was told by Youth Justice staff that X was in lockdown and would not be coming out so he was not a risk
    - when he moved to CTC, other residents told him that X was saying he was going to stab him. The complainant informed staff of this and told them that he needed to be separated from X. Staff at CTC told him he would not be put in any classes with X when he came out of lockdown.

The complainant informed the department that X had threatened him

23. In his oral evidence provided to the CCI, the complainant submitted that:
    - he had received threats from X whilst he was residing at his home address prior to detention, as well as during his stay at MTC and at CTC
    - when he was at CTC he didn't want to go to school because another resident had told him X was going to 'get him'
    - prior to the incident, X had approached him in the Learning Centre on two occasions, and abused him from outside the recreational area
    - prior to the incident he had told 'all the workers' that he was getting threats from X, including Red Cross staff, MTC and CTC Senior Shift Officers and Supervisors, and the Manager at MTC
    - he had told YEC staff and youth workers that X had approached him at the Learning Centre
    - he had told unit staff that X had yelled abuse at him whilst in the recreational area.

24. The department has confirmed that Youth Justice was aware that the complainant held concerns about X. Indeed, the following evidence, taken from the CCI Report and

attached documents and from the department's submission to me dated 8 February 2013, supports the complainant's assertion that he informed departmental staff that X posed a risk to him:

- at the time of the complainant's arrest and admission to MTC, it was noted on his MTC admission form that the complainant had been involved in several incidents with fellow MTC residents in the past, including X. Further, the complainant stated to MTC staff that there was tension between himself and X in particular. In the MTC Initial Screening Tool, it was noted that 'staff need to be vigilant around resident [X] whenever [the complainant] is near due to ongoing issues'
- by letter dated 27 September 2010, the complainant's lawyer advised MTC that his client had been assaulted by another resident shortly after he was remanded in custody in July of that year. MTC was advised that the complainant felt intimidated and threatened by X and 'believes strongly' that X was the reason why he was assaulted. The department responded by stating it had no records of the complainant being assaulted and that X was not moved to CTC as a result of any assault. There is no indication that departmental staff spoke to the complainant about his concerns at this point
- a case note dated 18 August 2011 (generated by MTC staff) refers to concerns raised by the complainant about his potential transfer to CTC, and indicates that the complainant identified X and several other residents as posing a potential risk to his safety
- as a result of this, the complainant was accommodated in a different unit from X at CTC
- on the transfer of the complainant to CTC on 18 August 2011, an email of the same date from Ms Jo-Anne Pritchard, the Client Services Supervisor of CTC, to a number of departmental staff stated:

> Information from MTC… Apparently [X] told another resident in CTC that he wants to bash [the complainant] which got back to [the complainant] and [the complainant] has also told MTC staff that [X]'s mother has been sending… a co offender text messages saying they are going to get [the complainant] when he gets out.. this is all around prior offending that they were all involved in and [X] took most of the rap for apparently…

  This email does not appear to have been sent to any YEC staff.
- it was noted in a Health Centre assessment of the complainant dated 19 August 2011 that X 'co offended with [the complainant] and according to [the complainant] there is tension between these two boys'
- the CCI Report states that from the date of his transfer, the complainant voiced concerns for his safety at CTC. It states that departmental records indicate that the complainant had reported to centre staff and external agency staff that he was concerned about the actions of other residents, including X, whom he believed wanted to harm him. Further, it states that this was documented in case notes on C3MS (the electronic case management system) and noted in 'Resident Running Sheets'. For example, the following was noted on a Resident Running Sheet on 22 August 2011:

> [The complainant] spoke with the centre nurse who in turn spoke to staff about his serious concerns for his safety at Jonal Drive Campus… he had been receiving death threats from [X]… He is also concerned about his safety around [3 other residents]. [The complainant's] main concern is attending school where he may come in contact with these residents. SSO informed. Information logged.

- On 5 September 2011 it was noted in the Custodial Management Status (**CMS**) meeting minutes[4] that the complainant had been receiving 'verbal threats from

[4] CMS meetings are held fortnightly at CTC, include health, education and Youth Justice staff, and enable information about resident progress, behavioural issues and educational issues to be exchanged.

boys' and that there were 'concerns for his safety'. I note this meeting was attended by one YEC staff member and that the minutes were distributed to the meeting participants.

25. The CCI Report summarises how the complainant's concerns were recorded by the department from his admission to MTC up until the incident:

> A review of Departmental records indicates that [the complainant] had reported concerns about his safety on no less than ten occasions in the months prior to the incident on 15 September 2011. His concerns were reported at his initial entry to MTC, in log entries at MTC, at his transfer to Jonal Drive Campus, his admission to Jonal Drive Campus, to Jonal Drive Campus Health Centre staff, to visiting Service to Youth (SYC) and Red Cross staff, to his solicitor, Ms Lana Chester and was noted [sic] in his Unit Bravo Resident Running sheets the Unit Bravo log book, Custodial Management Status minutes of 5 September 2011 and on his C3MS file.

26. Based on the above evidence, I am satisfied that the complainant informed departmental staff on a number of occasions that his safety would be at risk if he had contact with X. It is also clear that these concerns were documented and taken seriously, if only to the extent that the department ensured that the complainant and X were not accommodated together at CTC.

X's behaviour prior to the incident

27. I understand that X had been remanded in custody at various times since he was 12 years old. He turned 18 years old on 27 July 2011.

28. The CCI Report indicates that leading up to the incident, X was known by CTC staff to be of risk to other residents:

[redacted]

[redacted]

36. Indeed, it does not appear that the department recorded the complainant's concerns on any of the documentation produced for X. This is despite the fact that the escalation of X's behavioural problems occurred around the same time that the complainant was voicing his concerns.

The decision to move the complainant to CTC

37. The complainant submits that he should not have been moved to CTC given that X was resident there and that he had made the department know of the threats X had made.

38. The department has advised that the decision to move the complainant from MTC to CTC was based on 'clearly established operational transfer criteria and procedure'. MTC was utilised for boys aged 14 years and younger and 15 year old boys who were in police custody and short term remand, whereas CTC accommodated all boys aged 15 years-plus on detention order and on long term demand. The complainant was aged 16 years and 2 months at the time of the transfer; had been on remand since 31 July 2011; and was facing charges that were likely to result in a detention order.

39. On this basis it was clearly appropriate that the complainant was moved to CTC. I consider the risk to the complainant could have been managed while he and X resided at the same training centre, although, as noted below, I consider it failed to do so.

Threats to the complainant by departmental officers

40. I have also considered whether Youth Justice staff made 'threats' to the complainant whilst he was at MTC, that he would be sent to CTC. I note that the complainant did not make these allegations to my office nor, it appears to the OGCYP or the CCI. During the course of my investigation, I discovered a file note of a meeting between the complainant and two case workers employed by SYC[5] dated 17 August 2011 which records the following:

> …In regards to accommodation, [X] was worried because workers at Magill kept threatening him with saying 'we will send you to Cavan' and he worried as there are many guys who have threatened to hurt him physically who are Cavan at the moment and he is worried that once he goes there he will get bashed and he would just be transferred back to Magill anyway…

41. I was unable to contact the complainant to ask him about the file note; and one of the case workers present at the meeting was unable to recall to my office anything about it. The other case worker told my investigating officer that she does recall the complainant telling her that staff at MTC made threats to send him to CTC as a way to make his behaviour improve. The case worker was of the view that this was in no way connected with the complainant's transfer to CTC. She said the transfer was going to happen anyway and the decision to move him was not made by those allegedly making the threats.

42. Allegations of Youth Justice staff engaging in conduct of this nature are extremely concerning. However, in light of the passage of time since this occurred, the fact that it was not raised by the complainant and I was not able to question the complainant about this issue, and the hearsay nature of the evidence before me, I decline to make a formal finding in relation to this issue.

The placement of X in the art class

43. The CCI Report explains that the allocation of students to classes was generally a process of consultation, via an early morning meeting each day, between the Senior Shift Supervisor at CTC and the Youth Education Centre Principal or Deputy Principal. Directly before class, a YEC Daily Team Meeting would be held where the Principal or Deputy Principal would then advise staff of student attendance and related issues.

44. However, it is not entirely clear how X came to be placed in the art class on 15 September 2011. In its submission to me dated 8 February 2013, the department advised:

> The decision to place [the complainant] and [X] in an education class together was made by the Acting Principal of the Education Centre at the time….

[5] A 'community not-for-profit organisation centred on employment, training and youth services' at http://syc.net.au/.

45. This is supported by the Training Centre Manager Report completed by Ms Julia Lamont, following the incident. Ms Lamont's report states that X should not have been placed in the class and that the decision was made by the Deputy Principal, despite the fact that YEC had been informed about the risks previously.

46. Mr Steve Roche, Acting Duty Supervisor at CTC, gave evidence that he recollected that X had been taken to the Learning Centre in the morning as part of his re-integration plan; that there had not been a place for him in an alternative class; and that the YEC Deputy Principal, Mr Graham Clark, had decided to place him in the art class.

47. However, other oral evidence provided to CCI is not so clear as to who was responsible for X attending the art class. Mr Clark gave evidence that he could not recall how X was placed in the class. The teacher of the art class, Mr Daniel Zaccagnini gave evidence that he could not recall if X had been scheduled to attend the class, and that it may have been an elective lesson that he had chosen to attend. One of the youth workers present at the time of the incident, Mr Jason Prosser, stated that he thought X had joined the class about ten minutes after it had started and had been escorted in by another youth worker. He also thought he could have been attending it as an elective class.

48. I also note that Mr Zaccagnini gave evidence that the art room is more like a workshop than a normal classroom, as it contains sharp objects and electrical equipment such as the spray gun. X's BMP at that stage prevented him from being placed in workshops.

49. CCI sought documentation in relation to the placement of X into the art class, but the department advised that the attendance sheets could not be located following the closure of MTC.

50. Based on this evidence, and on balance, I am unable to make a finding as to how X came to be placed in the art class.

51. In response to the complainant's allegation that when X was brought into the class room, the relevant staff member said 'I have a special delivery for you', the department submitted that it 'strongly contests any suggestion that staff were involved in orchestrating the incident'. There appears to be no evidence supporting such a finding.

Who was aware of potential issues between X and the complainant?

52. The evidence is also inconsistent as to which staff (YEC and Youth Justice) had been informed about X's behavioural issues and specifically about the complainant's concerns with him. In its submission to me dated 8 February 2013, the department advised:

> …There is evidence that the Acting Principal was informed by YJ [Youth Justice] that [the complainant] and [X] should be kept separate…

53. Mr Roche gave evidence to the CCI that:
- it was 'well known across the centre' that the two residents needed to be kept apart
- this had been mentioned in a number of meetings prior to the incident
- the complainant had reported to him in the days prior to the incident that he had been placed in classes with X, despite being told previously that this would not happen
- he spoke with Mr Clark in the days prior to the incident and had been reassured that the two young men would not be placed in the same class together.

54. By contrast, the oral evidence of YEC staff does not acknowledge that information about X was passed to them. Mr Clark gave evidence to the CCI that:
    - he was unable to recall whether the Learning Centre staff were aware of the issues
    - there were weekly meeting held between CTC staff and YEC staff at which issues or concerns were discussed, but he was unable to recall the content of these meetings
    - he could not recall that there were discussions about separating the complainant and X
    - the CTC procedure to inform YEC staff of any separation of residents involved a weekly 'Medical Information' form. Mr Clark did not recall the complainant and X being identified on this list. CCI was unable to locate any Medical Information forms.

55. Mr Zaccagnini gave evidence to the CCI that he was unaware of any issues regarding the complainant and X. He stated he had not been made aware of a BMP for X or that there were any risks associated with having him in his class. He stated that if the Learning Centre was aware there was a threat to a student, they would be instantly separated and that this had occurred with other young people.

56. Similarly, the two youth workers in attendance on the day of the incident gave evidence that they were unaware that any issues existed between the complainant and X.

Sharing information

57. It appears that issues concerning residents, including potential risks, were passed between staff primarily through the use of BMPs, Risk and Behavioural Plans, and CMS meetings.[6]

58. The CCI Report states that information would be shared between education centre staff, client services staff and the unit supervisors through regular CMS meetings. At these meetings, the progress of residents and other potential issues (such as the safety concerns of the complainant) would be discussed.

59. However, the CCI Report found that:

> …No information was received that Youth Justice or YEC staff had received minutes of CMS meetings or had access to them. Information was obtained that at the time of the incident there was no clear and consistent process for the distribution of the minutes or the outcomes of these meeting to appropriate staff (both Youth Justice and YEC) that had contact with the two men within the centre…

60. In relation to the BMP developed for X, the CCI Report noted that 'no information was obtained to indicate that the BMP was distributed to Learning Centre staff or that Learning Staff were involved in its development.' I have no evidence before me as to who was provided with copies of X's Risk and Behavioural Plan either.

61. Further, as noted previously, neither the BMP nor the Risk and Behavioural Plan drew a connection between X and the complainant, despite the complainant's concerns being recorded elsewhere.

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[6] I note that matters were also recorded on the Resident Running Sheets and the C3MS.

Conclusion

62. Based on the evidence referred to above I am of the view that the department failed to adequately protect the complainant from a very real risk. It is my view that:
    - the fact that X posed a risk to the complainant was known by the department: the complainant had repeatedly told staff about threats made to him by X and X's behaviour leading up to the incident indicated he was volatile
    - in light of the above, X should not have been placed in a class with the complainant
    - X should not have been placed in a class in the art room which is arguably akin to a workshop
    - the complainant was a juvenile in the care of the department at the time, and his safety was the responsibility of the department. Indeed, security issues within the CTC were properly the responsibility of the department (not DECD which was providing education services on the campus)
    - the department failed to ensure that information concerning the risk posed to the complainant was made known to all relevant staff (Youth Justice and YEC staff). Even if the risk was not quantifiable, the department failed the complainant by not disseminating the concerns held about X's behavior and the complainant's concerns about X to relevant staff
    - the department erred in relation to its management of X by failing to draw a connection between X and the complainant's concerns about X (for example, the complainant's concerns about X were not documented in X's BMP and Risk and Behavioural Plan)
    - the department failed to treat the complainant's concerns with sufficient seriousness
    - the department erred in failing to implement a strategy to ensure the complainant had no contact with X.

Opinion

In light of the above, I consider that, in failing to effectively manage the risk that X posed to the complainant, the department acted in a manner that was wrong within the meaning of section 25(1)(g) of the Ombudsman Act.

Further action

63. In its response to my office dated 8 February 2013, the department advised that a new agreement between the department and DECD:

> …now stipulates in clear terms that DCSI, YJ [the Youth Justice section of the department] has jurisdiction in all areas of the campus including the Education Centre, when matters relate to the AYTC campus safety and security… and YJ staff are responsible for the management of all young persons' security and behavioural responses.

64. Further, the CCI Report noted that the department has implemented a range of improvements in communication and information exchange processes since the incident, including:
    - weekly At Risk and Intelligence Group meetings involving a multidisciplinary team plus Community Youth Justice/Psychological Services
    - Behavioural Support Officer have a one hour hand over each day between 2pm and 3pm to ensure all essential information is communicated
    - C3MS reports access for all staff to place alerts and read
    - duty supervisors now provide handover information which is disseminated at shift changeover

- resident unit transfer documents include any essential information that needs to be transferred to staff
- weekly accommodation unit team meetings and weekly Behavioural Support Officers team meetings provide an opportunity for information exchange and updating of issues for clients
- daily morning briefing with all key Managers and Supervisors to discuss that day and the previous day's occurrences.
- Behavioural Support Officers attend YEC debrief to ensure information sharing across the centre.

65. These procedural improvements are reflected in an Action Plan produced by the department following the completion of the CCI Report. In addition, I understand:
    - it has been decided that the YEC Deputy Principal will attend a section of the At Risk and Intelligence Group meetings to discuss high profile residents and the workshop approval process
    - the Action Plan has been updated to include the following improvements:
        - the Duty Manager provides daily overview to all the management team and Supervisors of current Assessment, Care and Teamwork plans, incidents and relevant information that occurred over the previous 24 hours
        - a Security Information Reporting process has been developed to allow all staff to report any security or intelligence issues in a way that can be recorded and used to assess and manage resident risk
    - A further two initiatives are under development:
        - scoping the possibility of Health and Youth Education Centre staff located at the AYTC having access to C3MS (client case management tool) to allow greater information sharing and quicker access to relevant client information
        - a MOAA is being developed with SAPOL around the sharing of information.

66. I acknowledge that the department has initiated these changes to ensure better communication of risk factors within the Training Centres. I understand that one of the complainant's concerns in lodging his complaint was to ensure the mistakes made are not repeated in the future.

67. The complainant also submitted in his original complaint to the department and in his complaint to this office, that he would like an acknowledgment and an apology from the department in relation to its failings.

68. I understand that in response to an application under the Freedom of Information Act 1991, the department has provided a redacted version of the CCI Report. I do not consider that this amounts to a formal acknowledgment by the department of its failings. Although the Investigation Officer found that there had been a deficit in the quality of care provided to the complainant, he writes that 'It is for the delegate to decide on a finding following consideration of this report'. It is my understanding that the department has not communicated to the complainant in any other way since the CCI investigation was completed.

69. In light of my view that the department acted in a manner that was wrong, and in light of the seriousness of the matter, I consider that the department should communicate with the complainant in relation to the incident and its failings, and apologise.

Recommendation

To remedy the above error, I recommend under section 25(2) of the Ombudsman Act that the department:

- acknowledge its failings and provide a written apology to the complainant

- favourably consider any claim for compensation by the complainant.

In its response to my provisional report, the department advised:
- that a letter of regret to the complainant had been prepared in respect of the incident
- that it had contacted lawyers believed to act on behalf of the complainant, and that 'any claim for compensation against the Department would be considered by SAICORP, as the Department's insurer.'

In accordance with section 25(4) of the Ombudsman Act the department should report to me by **8 December 2014** on what steps have been taken to give effect to the recommendations above; including:
- providing a copy of the letter sent to the complainant
- the status of any compensation claim.

In the event that no action has been taken, reason(s) for the inaction should be provided.

Whether the department erred in relation to investigating the alleged failure to protect the complainant

70. The second aspect of the complaint is whether the department erred in relation to investigating how and why the incident occurred.

71. By way of background, it is important to understand the history of the investigations sections of DFC, DECD and the department. Prior to the MOG changes, investigations relating to care concerns of DFC clients were conducted by the SIU. I understand in January 2012 the SIU split in two so that Families SA (now part of DECD) and the newly formed department both had their own investigation teams. I am advised that the department's team changed its name to the CCI in or around April 2012.

72. The department advised in its letter to my office dated 8 February 2013 that it responded to the incident in accordance with the relevant policy at the time and, in particular, that it took the following action:
    - reported the incident to the Families SA Child Abuse Report Line (CARL)
    - contacted SAPOL (and that a criminal process followed)
    - incident reports were completed by relevant staff
    - the CTC manager conducted an incident response meeting
    - alerts were created on C3MS
    - the complainant was placed on a Safety Plan.

73. The department submits that Families SA did not refer the matter for investigation:

> In September 2011, the reporting of incidents of harm to clients (in the care of DCSI) were directed to the Families SA's Child Abuse Report Line (CARL). Families SA, Crisis Response Unit (CRU) then assesses all calls made to determine the required response level.
>
> A CRU response options was a referral to the (then) Special Investigations Unit (SIU) where cases are assessed if DCSI has potentially failed to provide appropriate care or where there is an allegation of assault against a staff member.
>
> YJ made a report to CARL in relation to this assault on 19 September 2011. I am advised that a decision was made by Families SA not to refer the matter to the SIU for further investigation.

74. In a letter to me dated 25 August 2014, Mr Tony Harrison, the Chief Executive of DECD, advised that an 'Extra-Familial Intake Report' was recorded by the Crisis Response Unit (**CRU**) on 16 September 2011. That report provides that a 'Notification Referral' (now known as a Care Concern Referral) 'has not been raised for the Special Investigations Unit as there is no information suggesting that there was negligence on part of the Cavan staff.' An outcome of 'Closed at Intake' was recorded by CRU on 16 September 2011.

75. It appears that whilst Youth Justice referred the matter to CARL, no information was provided in relation to the complainant's concerns about X prior to the incident and little about the pattern of X's behaviour (the 'Extra-Familial Intake Report' does note that the assault was the second perpetrated by X in the past 2 months). In my view, had the referral included concerns about the level of care provided to the complainant by staff (as opposed to simply a referral of an incident involving two residents), the matter would have been formally referred to the SIU by CARL and in all likelihood an investigation would have ensued.

76. That said, based on the evidence before me which I set out below, it appears the matter did in fact reach the SIU in 2012.

77. The complainant made his complaint known to the department through the OGCYP in December 2011. Following several conversations with officers at the OGCYP, the complainant advised one of them on 30 November 2011 that he wished the OGCYP to advocate on his behalf to recommend that Youth Justice require 'an independent body to make a full inquiry into the circumstances that resulted in him being stabbed'. Ms Simmons, conveyed this to Ms Jackie Bray, the Director of Youth Justice, in a telephone conversation on 13 December 2011.

78. The OGCYP has provided me with copies of documents which shed light on the subsequent history of the complaint:
    - the OGCYP file note dated 13 December 2011 records that Ms Bray advised Ms Simmons that the incident had been referred to the SIU
    - the file note also indicates that Ms Simmons stated she would offer to the complainant that he can either make a complaint to the department (through the Customer Relations Unit) and an internal investigation would be done, or make a complaint to the Ombudsman. Ms Bray agreed that 'either a departmental review or an Ombudsman investigation should be taken as she is concerned about what failed in protecting [the complainant] on that day'
    - on 13 December 2011 Ms Bray forwarded Ms Simmons an email from Ms Denise Brine of the department indicating that she had spoken with Mr Rohan Crawford of the SIU and that 'they were ready to proceed with an investigation'. Ms Brine's email stated 'I understood they were ready to start the process. Will follow up with Rohan or Catherine tomorrow where they are at.' Ms Bray advised Ms Simmons 'We will continue to check with SIU'
    - a file note dated 5 March 2012 records a conversation between Ms Amanda Shaw, Senior Advocate at the OGCYP, and Ms Bernie McGinnes, the Acting Director of Youth Justice. Ms Shaw's note records that the purpose of her phone call was to 'follow up on the current status of the internal review regarding the incident… ' Ms McGinnes undertook to look into the matter
    - Ms Shaw emailed Ms McGinnes on 27 March 2012 seeking an update 'regarding the internal review' of the matter. Ms McGinnes replied by email dated 28 March 2012 stating she would telephone Ms Shaw to discuss, and stating that 'recommended actions arising from the review now form part of the response to not only that incident but also the current escape…'
    - Ms Shaw and Ms McGinnes spoke on 3 April 2012, and Ms Shaw's file note records:

  - Ms McGinnes stated that the recommendations from the review process following the unrelated escape of multiple residents from CTC apply in this circumstance
  - Ms McGinnes confirmed that a specific review of the incident has not been undertaken, but that a 'desktop' review will be undertaken now
  - this contradicts information provided in Ms Brine's email that SIU was undertaking an investigation into the incident and indicates that the Youth Justice Directorate has no knowledge of the progress of the investigation.
- on 21 May 2012 Ms Shaw emailed Mr Crawford, the Principal Investigator of the SIU, seeking an outcome of the investigation. Mr Crawford responded that 'The report is still being prepared. We will forward an outcome when it is completed…'
- Ms Shaw again requested the report on 13 June 2012 and Mr Crawford replied that 'The completed report is on my desk for vetting and then it needs to be approved by CE…'
- following another request by Ms Shaw on 17 July 2012, Mr Kym McIntosh replied on behalf of Mr Crawford stating he was in the process of doing a further edit on the report and expects it will be completed in the next week
- a file note prepared by Ms Shaw on 28 August 2012 indicates that she spoke to Mr Crawford in person about the matter. Mr Crawford indicated that the matter he had been referring to did not involve X and that the CCI had not been investigating the incident. Ms Shaw asked why an investigation had not taken place, and Mr Crawford undertook to follow this up
- in an email dated 7 September 2012 to Ms Shaw, Mr Crawford advised that 'It appears the matter was reported to CARL but it wasn't raised as a Care Concern… from the notes it appears that the Principal in the Education Centre Mr Graham Clark placed them in class together even though he was aware of the risk of them being together. Concerns involving the principal would not be investigated by CCI… but fall under DECD Investigations. The matter I was thinking of was another incident…'

79. In a letter to Ms Bray dated 10 September 2012, Ms Simmons set out this history and concluded:

> In summary, there has been no investigation of this serious incident and therefore no reflection or review of required changes in practice or procedure. We will no longer pursue an independent investigation but will assist [the complainant] with a complaint if he requests it.

80. In its response to my provisional report, the department provided the following by way of explanation as to why an investigation was not carried out:

> …At the time of the incident, and the subsequent referral to CARL, there was not a clear consolidated history or assessment of [the complainant's] concerns in respect of X. The information was recorded in a variety of documents across Cavan and Magill Training Centres and the details did not become apparent until the review and consolidation of documents during the CCI investigation. Improvements in case recording and information sharing have been implemented since the incident…
>
> …Whilst SIU may have been aware of the incident when or shortly after it occurred and when CCI spoke with OGCYP about the incident on 28 August 2012, the preceding history of [the complainant's] concerns about X had not been raised with SIU and therefore did not initiate a Serious Care Concern Investigation. As stated, once a clearer picture of the context of the incident was apparent, the matter was referred to CCI and the matter was thoroughly investigated.

81. In my view, this response in fact identifies failings on the part of the department; and it erred in failing to collate or assess the history of the complainant's concerns about X, and in failing to pass that information onto CARL.

82. In light of the above evidence, I have drawn the following conclusions:
    - I accept that a report was made to CARL by the department in September 2011. I note the department's submission that 'a decision was made by Families SA not to refer the matter to the SIU'. However, it appears this was because the department did not report any potential failing by Youth Justice staff but rather presented the matter as a 'one-off' incident between residents
    - as noted above, I am of the view that the department erred in failing to collate or assess the history of the complainant's concerns about X, and in failing to pass that information onto CARL
    - nevertheless, the evidence before me indicates that the matter was brought to the attention of the SIU and, further, that the SIU were ready to commence an investigation in December 2011
    - it is not at all clear to me what happened to the pending investigation. I note Mr Crawford's explanation to OGCYP that the error was considered to have been made by a DECD employee and consequently was a matter for the DECD investigation team
    - I consider the matter was serious and should have been investigated; this is evident given the findings contained in the CCI Report and this report. In fact it almost beggars belief that the department failed to investigate how a juvenile in its care came to be assaulted in a context where the department had been alerted to a risk of that nature. A SAPOL investigation was not sufficient in these circumstances
    - further, the matter should have been investigated by the department, given that it occurred within a Training Centre and the complainant, a juvenile, was in the department's care at the time. I do not accept it was reasonable at any time to consider it was DECD's responsibility to investigate the matter
    - it appears the department confused the complainant's matter with another matter, and in doing so provided misleading information to OGCYP as to the status of the 'investigation'
    - upon realising the confusion, the department made no attempt to follow up as to whether DECD were investigating the incident. This is unacceptable given the seriousness of the matter.

83. I acknowledge the following factors:
    - I speculate that the MOG changes may have contributed to the confusion surrounding the matter
    - the department commenced an investigation, albeit immediately upon being notified of my office's investigation
    - I understand that CCI now independently have access to and check Families SA reports (C3 Reports) on a weekly basis to check whether there is any matter that falls within its purview.

84. Nevertheless, I am of the view that the department:
    - erred in failing to report the relevant context of the assault to CARL (that is, the possibility that the department had failed to provide the complainant adequate care)
    - erred in failing to investigate the incident in response to the complainant's and the OGCYP's requests
    - failed to handle the OGCYP's enquiries about the investigation in a satisfactory manner, with due regard to the importance of the matter and the role of the OGCYP.

Opinion

In light of the above, I consider that, in failing to initially investigate the incident and in its handling of OGCYP's enquiries as to the status of the matter, the department acted in a manner that was wrong within the meaning of section 25(1)(g) of the Ombudsman Act.

Megan Philpot
ACTING SA OMBUDSMAN

8 October 2014