OmbudsmanSA

Summary Statement of Investigations
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In 2022, I commenced two own initiative investigations following receipt of complaints about the Department for Child Protection (**the department**). While related to different sibling groups, the complaints raised questions about how the department assesses and responds to notifications about children at risk of harm, and in particular its practice of referring notifications to other State authorities[1] pursuant to section 33 of the *Children and Young People (Safety) Act 2017*. Given the similarities in both matters, I decided to merge my findings into one investigation report.

For the purposes of maintaining confidentiality, the individuals in my report were given pseudonyms and the sibling groups are referred to as the Anderson siblings and the Harding siblings. I have also chosen not to detail the nature of the concerns reported to the department in relation to the children.

Under the Children and Young People (Safety) Act, the department is responsible for responding to reports about a child or young person who may be at risk of harm. The Act provides that in responding to these reports, the department can either investigate the circumstances of the child, refer the notification, or decline to take further action if it considers that doing so is unnecessary, or there is an alternative response that more appropriately addresses the risk to the child or young person.

Evidence obtained by my investigation revealed a tragic reality for the Anderson and Harding children, and an increased risk to their welfare over the course of two or more years. Of concern, was the department's inadequate response to this escalated risk and on some occasions, failure to intervene despite requests from State authorities that it do so. Frequently, this appeared to be driven by a lack of departmental resources.

The Anderson siblings

The department received its first Child Abuse Report Line (**CARL**) notification concerning the Anderson family in 2011 and continued to receive notifications in the years following; by 2022 the department had received over 60 notifications. Notifications raised a range of serious concerns about the children's wellbeing and included exposure to violence, substance abuse, neglect, and chronic school absenteeism.

At various times, the Anderson family received support from State authorities and non-government organisations for financial and housing assistance, parenting programs, and education support. Between 2020 and 2022, the department received numerous notifications about the children raising child protection concerns which it referred to another State authority to address.

In 2020, one State authority engaged with the Anderson family wrote to the department identifying risks of concern for the children and said 'I believe this family needs DCP to intervene as there has been no changes even with the support from services'.

[1] A State authority relevantly includes a person who holds an office established by an Act, a public sector agency, South Australia Police, local councils, and non-government organisations contracted to provide services to children and young people and their families for, or on behalf of, the Government of South Australia or local councils.

The department's response was that it did not have the capacity to 'open and work the case'.

Within two months, the department received further notifications about the family and referred these back to the same State authority to manage. Further notifications received after this time about the children included violence, the children's isolation from services and education and a lack of basic care. These notifications were referred to other State authorities for a response.

In 2022, a State authority which had been engaged with the family for some time wrote to the department expressing concern about the 'substantial emotional and psychological harm' suffered by the Anderson children and that the children were 'at significant risk'. Among its concerns, the State authority noted the children's isolation and being withheld from schooling and childcare. The State authority stated its attempts to address child protection concerns had been met with non-engagement from a parent, which placed the children at further risk. The State authority reported that the parent needed 'mandatory involvement'.

In response, the department asked the State authority to continue to work with the family on the basis that it did not have the capacity to 'open the case'.

At the time of notifying of my investigation, the department did not have an open file for any of the Anderson children.

The Harding children

Between August 2021 and June 2022, the Harding siblings were the subject of more than 30 CARL notifications including concern about domestic violence, substance abuse, chronic absenteeism and the impact of parental suicidal ideation on the children.

Over the relevant period there was a sustained and increasing level of severity in the notifications received. Multiple attempts were made by the department to refer incoming notifications to a State authority for a response.

The first referral was not matched to a State authority on the basis that the State authority was 'not well situated to manage the high level of risk' and that a 'statutory response is required'.

The department took no further action at the time.

The department received subsequent notifications and made a second referral to a State authority. During the State authority's assessment process, the children were identified as being at 'extreme' risk. This was screened in for a response by the department but was later closed with no action 'as a result of competing workload pressures'. The referral to the State authority was closed on the grounds that there were 'imminent & serious child safety concerns, safety cannot be maintained'. However, another referral was later accepted.

The State authority began to engage with some members of the family and continued to accept new referrals resulting from incoming notifications. Whilst new and significant referrals were accepted by the State authority, it was noted that there had been a lack of engagement by the family, who had only been sighted three times over a three-month period. The family was described as being isolated from services and the children were chronically absent from school.

In one day, multiple notifications were received reporting new and existing concerns. At this time, the department was advised that the State authority was ceasing its involvement due to lack of engagement with the family.

Prior to my Office contacting the department, the department had never opened an investigation file for any of the children.

My investigation identified that in many instances, the department inappropriately referred notifications in relation to the Anderson and Harding siblings to other State authorities, having failed to adequately consider:

- relevant child protection history
- a clear deterioration in the children's living environment and an escalation in reported child protection concerns
- a demonstrated inability by other State authorities to address previous child protection concerns
- the fact that other State authorities lacked comparable statutory power to address the identified child protection concerns
- repeated requests from State authorities for department intervention.

My investigation also identified other areas of concern, including:

- a failure to 'screen in' notifications identifying serious risks to a child
- a failure to follow up on referred notifications that had not been responded to
- department policy requiring the department to close a notification without further action when the notification had been referred to a State authority but subsequently declined; of significant concern was that this practice applied even for a notification declined by a State authority on account of the identified risk to a child being 'too high' for it to manage.

Evidence revealed multiple instances where a State authority identified an increasing risk to the children, and requested statutory intervention, but due to a lack of capacity the department referred these notifications back to the same State authority to manage.

During my investigation, the department informed my Office about several initiatives undertaken to improve the department's response to notifications of children at risk of harm. The department noted its current review and implementation of up to 34 recommendations stemming from multiple reviews and inquiries conducted into the department in the last 12 months, several of which relate to the assessment, prioritisation and investigation of notifications.

I also met with staff of the department and Department for Human Services to discuss recent improvements to the allocation of intensive support services, in large part managed by the Department for Human Services.

Despite these changes, there appeared to remain a gap in the department's oversight of children and young people at risk of harm. Specifically, I consider this to be the case with children and young people who are considered as being at too high a risk for a State authority to engage with (or to continue to engage with), but at the same time, assessed as not being sufficiently at risk to warrant investigation by the department. This seemingly results in children and young people who have been identified as being at high risk being left without any direct oversight or intervention.

My investigation acknowledged an intentional shift by the department toward early intervention in an attempt to reduce the necessity of child removal; referral of a matter to a State authority that can provide intensive family services supports this shift. However, to refer a notification, the department must have formed the view that a State authority can more appropriately deal with the matter. In circumstances, such as those identified in my report, where a State authority expresses that the risk to a child or young person is too high, or cannot be sufficiently mitigated through its engagement, it is not reasonable for the department to maintain the view that a State authority can more appropriately deal with the matter. My investigation concluded that, in these circumstances, the department should be responsible for reassessing the risk to the child and providing an appropriate response. This

is all the more because the current legislation provides the department with statutory authority to require a parent, guardian or other person to undergo certain assessments, undertake random drug and alcohol testing, or undertake a rehabilitation program, whereas other state authorities do not possess these powers.

My investigation revealed a widely adopted practice in which the department appears to refer notifications about at-risk children without forming a reasonable belief that said State authority is the more appropriate agency to address the risk to the child. By acting in this manner, it is my view that the department has acted contrary to the Children and Young People (Safety) Act by failing to ensure that the protection of children and young people from harm is its paramount consideration.[2]

To address the errors identified in my report, I recommended the following:

Recommendation 1
The department amend its Outcome Codes Procedure to ensure that where the department has attempted to refer a notification to a State authority, and that authority rejects the referral for any reason, the notification must be reassessed by the department for alternative response (not closed without further action).

Recommendation 2
The department amend the Manual of Practice to include timeframes for referrals of CARL notifications under section 33 of the Act, specifically when a referral must be accepted by a State authority, or an alternative response considered in the event a response is not received.

Recommendation 3
The department implement a function within the department's systems to prompt follow up by the department in circumstances where it has not received a response from a State authority to referral of a CARL notification.

Recommendation 4
That the department amend the Manual of Practice to require that if, following a referral of a notification to a State authority and the subsequent escalation of a matter through the regional Partnership meetings, a State authority forms the view that risk to a child or young person is too high and cannot be sufficiently mitigated, the Department for Child Protection must open an investigation file and conduct a safety assessment for the relevant child or young person.

[2] *Children and Young People (Safety) Act 2017* s 5.

Recommendation 5
That the department amend the Manual of Practice to require that if, following an attempted referral of a notification to a State authority, the notification is declined on the basis that the risk to a child or young person is too high and cannot be sufficiently mitigated, the Department for Child Protection must open an investigation file and conduct a safety assessment for the relevant child or young person.

In response to my revised recommendations, the department accepted all five recommendations in principle, submitting:

> Having considered your five tentative recommendations, the Department for Child Protection (the department) can advise that while we accept the recommendations in-principle, and certainly acknowledge their intent, there are constraints across the broad child protection system that will inhibit our capacity to action the recommendations in full in their current form.
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> As we have discussed, over some time now, there has been an upward trend in child protection notifications in this state over the past few years. To illustrate the quantum of the demand in 2021 – 2022 FY; in round terms 80,000 reports were received by the department. In excess of 34,000 of these reports were screened in for a child protection response. Over 25,000 were actioned by the child protection system in South Australia (inclusive of DCP, DHS and other government and non-government State authorities) however notably, over 9000 matters did not receive a service due to an inability of the service system to allocate or respond.
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> As you are aware, child protection jurisdictions across Australia are all challenged by the same issues, which primarily relate to increased demand; and a shortfall in the available services to meet such demand.
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> We appreciate and acknowledge that the broad child protection system is required to keep evolving and reforming to ensure children at risk and those who have been harmed receive the intervention they require. However, the pattern of increasing volume and associated complexity means that if the department were obliged to allocate and investigate those matters to a State authority that have not been accepted (due to either the capacity of the State authority or their assessment regarding risk) this may well have the unintended consequent [sic] of meaning that other matters of equal risk, or indeed higher risk, would not be actioned. The department is required to use professional judgement and discretion every day when matters are referred for a DCP response and some of the recommendations below limit that discretion and potentially increase the danger for other children.
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> That said, the department is committed to reassessing all screened in child protection matter[s] when the broader system is not in a position to respond, however, we do need to be transparent about the fact that there will be occasions when a matter is closed without further action, or not proceeded with because of the gap between demand and the available services.

In response to recommendation 4, the department recognised that staff of the Department of Human Services have the same skillset as departmental staff and have the capability to respond to families and children experiencing high risk. The department also noted the Department of Human Services currently undertakes a different risk assessment to the department. The department stated that developing a single safety and risk assessment 'is considered a critical first step before we can consider prioritising work between agencies'.

While I am pleased with the department's acceptance of my recommendations and acknowledge the department's feedback in relation to implementation of these recommendations, I note with concern the department's submission that implementation of my recommendations will 'potentially increase the danger for other children'. Ultimately, it is a matter for the department to determine how to appropriately implement my recommendations and address the administrative issues that have been identified in a manner that ensures its compliance with its legislative obligations and reduces the risk of harm to children. Further, while I recognise that development around risk assessment will occur in the future, I reiterate that, in the meantime, it is crucial these high-risk matters are not left without oversight.

My recommendations seek to hold the department accountable to assessing matters where a State authority has expressed that there is a known risk of harm to a child or young person, the risk is high, and that the risk cannot be mitigated through the State authority's engagement. I recognise the current resourcing constraints on the department and the broader child protection system, and that it is for the department to allocate resources to protecting children at greatest risk of harm. However, to continue a practice whereby these high-risk matters go without investigation and further assessment of risk by the department, given its legislative responsibility to protect children at risk of harm, is unacceptable.