OmbudsmanSA

STATEMENT ON INVESTIGATION

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Outcome of investigation into the actions of the Department for Child Protection (the department) – manner in which the department responded to a young person's case was wrong.

The Deputy Ombudsman has concluded an investigation concerning the manner in which the department responded to a particular young person's case.

The complainant described the young person as having special needs due to several medical concerns. The complainant explained that they had personally made notifications to the department for several years with serious concerns about the safety and welfare of the young person in the family home however, the department had failed to take any action. The complainant's concerns relate to, among other things, the young person having been continually exposed to domestic violence and drug use in the family home.

The complainant made a formal complaint to the department in late 2017 relating to the failure to take action. The complainant was dissatisfied with the department's outcome letter which advised that the department was 'unable' to respond to the young person's case at that time. The complainant then made a complaint to the Ombudsman.

In this investigation, the Deputy Ombudsman noted that:

- the department has records of an extensive history of notifications made over numerous years about the young person's safety and welfare in the home. The notifications predominantly relate to exposure to domestic violence and drug use.
- many of the notifications were assessed by the department as meeting the threshold for requiring a child protection response. However, those matters were closed by the department using the 'Closed No Action' closure code on the basis that the department did not have the capacity to respond to the concerns.
- the department's outcome letter advised the complainant that:
    - the department was 'unable to respond' to the young person's case at the time
    - the young person's case had been referred to the Child Wellbeing Program which requires voluntary participation by the young person and their family
    - the relevant district office of the department had fortnightly meetings with the Child Wellbeing Team. If the Child Wellbeing Program determined that it was unable to support the young person, the department would be informed of this through the fortnightly meetings and would consider alternative options to provide support to the young person.
- at the time the department's outcome letter was written and sent to the complainant, a child protection intake was open (**the open intake**) and had been assessed as requiring a child protection response. Eight separate notifiers contacted the department about the same concerns which were of a serious nature and alleged violence against the young person

- the open intake was eventually closed in August 2019 as Closed No Action
- the department's file illustrated that, at the time of the department's outcome letter, the Child Wellbeing Program was not engaged with the young person and had not been for some time and the department had not considered alternative options to provide support to the young person.

Outcome

The Deputy Ombudsman was mindful that:

- section19(1) of the *Children's Protection Act 1993* (the relevant Act at the time) provided that the open intake required an assessment or investigation by the department. The department's relevant policy also reflected this.
- the open intake related to serious concerns of violence against the young person
- the department's outcome letter indicated a reliance on the Child Wellbeing Program being engaged with the young person at the time however, there was no such engagement at that time.

The Deputy Ombudsman formed the view that, among other things, the department's outcome letter was incorrect in that the department was not 'unable' to respond to the young person's case and and instead the department was required to take action, and in that the Child Wellbeing Program was not engaged at the time. The Deputy Ombudsman also took into account that the department was aware of the extensive child protection history, aware of an escalation in concerns, aware that it had continued to take no action in relation to concerns relating to the young person over many years and aware of the young person's added vulnerability due to their disability.

The Deputy Ombudsman's final view was that the manner in which the department responded to the young person's case was wrong within the meaning of section 25(1)(g) of the Ombudsman Act.

To remedy the error, the Deputy Ombudsman recommended that the department take action in relation to any intake currently open concerning the young person. If no intake was currently open, the Deputy Ombudsman recommended that the department re-open the most recently closed intake. The Deputy Ombudsman also recommended that the department apologises to the complainant for the incorrect advice provided in its outcome letter.

The agency has accepted the Deputy Ombudsman's views and recommendations and has already commenced taking action to implement the recommendations.