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Department for Child Protection (2020/00827)

This investigation arose out of a complaint by a member of the public. In early 2020, the complainant gave birth to her first child (**the child**). Prior to and in the days following the birth, the department received notifications expressing concern about the complainant's capacity to safely care for the child. In response to the notifications, the department developed and implemented two successive safety plans which placed the child in the care of their father, four days after the child's birth. At that point, the complainant was no longer in a relationship with the child's father. When the complainant approached Ombudsman SA, she did not know where the child was as the father had limited contact with her, contrary to conditions of the second safety plan.

The department's Manual of Practice provides that safety plans are collaboratively developed agreements between the department and parents, guardians or caregivers. Safety plans aim to address safety concerns for a child or young person, and are preferred, where possible, to formal statutory action by the department.

In this matter, the Ombudsman concluded that the department had not collaboratively developed the safety plans with the complainant. Rather, the Ombudsman considered that the department had developed the plans separately with the father and presented them to the complainant for agreement. There was no information to suggest that the complainant was able to contribute to the terms of the safety plans, or that the department meaningfully sought her input in this process.

The complainant also initially refused to sign the safety plans. Where this occurs, the department is required to consider alternative responses, such as statutory removal. It did not appear that the department responded to the complainant's refusal or advised her of other options, as required by the Manual of Practice. In response to the Ombudsman, the department explained that it did not consider statutory removal to be necessary as the father had made 'an assertion of his parenthood'. In the Ombudsman's view, the department's justification was not compelling, as refusal by one parent ought to have been sufficient to consider alternative arrangements.

Finally, the Ombudsman concluded that the complainant had been particularly vulnerable in the circumstances, and that it was necessary for the department to consider whether she needed independent, professional support while the safety plans were being developed and implemented. This appeared to have been available at the time, and appeared to have been considered by the department in the early stages of its response to the notifications. While the department was not required by legislation or policy to provide such support, the Ombudsman concluded that it was appropriate given the complainant's vulnerability, the outcomes of the safety plans, and the lack of collaboration between the department and the complainant.

Having regard to each of the factors above, the Ombudsman concluded that the department had acted in a manner that amounted to error when it developed and implemented the safety plans. In forming this conclusion, the Ombudsman had regard to the United Nations Convention on the Rights of the Child and the obligation to ensure that a child is not separated from their parents except where competent authorities, subject to judicial review, determine that doing so is in the child's best interest. As a safety plan is not subject to judicial or internal review under the *Children and Young People (Safety) Act 2017*, the Ombudsman

concluded that the complainant's ordinary judicial review rights had been bypassed and the department had acted in a manner that was inconsistent with the Convention.

The Ombudsman made three recommendations in the interest of improving departmental practice and avoiding recurrence of the errors identified in the investigation.