NSW Ombudsman

The death of Dean Shillingsworth: Critical challenges in the context of reforms to the child protection system

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

December 2009

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Our logo has two visual graphic elements; the 'blurry square' and the 'magnifying glass' which represents our objectives. As we look at the facts with a magnifying glass, the blurry square becomes sharply defined, and a new colour of clarity is created.

NSW Ombudsman
Level 24, 580 George Street
Sydney NSW 2000

General inquiries: 02 9286 1000
Facsimile: 02 9283 2911

Toll free (outside Sydney metro): 1800 451 524
Tel. typewriter (TTY): 02 9264 8050

Web: www.ombo.nsw.gov.au
Email: nswombo@ombo.nsw.gov.au

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NSW Ombudsman

Level 24 580 George Street
Sydney NSW 2000
Phone 02 9286 1000
Fax 02 9283 2911
Tollfree 1800 451 524
TTY 02 9264 8050
Web www.ombo.nsw.gov.au

December 2009

The Hon Peter Primrose MLC
President
Legislative Council
Parliament House
Sydney NSW 2000

The Hon Richard Torbay MP
Speaker
Legislative Assembly
Parliament House
Sydney NSW 2000

Dear Mr 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 Ministers for Housing and Health 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

Foreword

This report follows my special report to Parliament on 6 October 2009 about the death of Ebony, a seven year old girl who died as a result of starvation and neglect.

Just prior to Ebony's death, the body of a little boy was found in a public reserve in Sydney. The child was subsequently identified as Dean Shillingsworth, and his mother was charged with his murder.

The case became the focus of much media attention and public concern, and along with Ebony's death, became the catalyst for the NSW Government initiating a Special Commission of Inquiry into Child Protection Services in NSW, headed by Justice James Wood AO QC.

At the time of Dean's death, I decided the case warranted investigation by my office. The investigation focused on the actions of the Department of Community Services – now Community Services – and a non-government family support service, in relation to the child and his family.

My investigation was completed in August 2008. The report was provided to the agencies subject to the investigation, to the relevant Minister, and to Justice Wood at that time.

Justice Wood noted in the introduction to his report that the deaths of Ebony and Dean had informed the considerations and recommendations of the inquiry into child protection services. While the inquiry report did not comment on either case because criminal proceedings in relation to both were not finalised at the time, these proceedings are now complete.

As with the death of Ebony, the case of Dean illustrates some of the issues that led the inquiry to recommend strategies for legislative, structural and cultural change in the NSW child protection system.

The cases also highlight some of the critical challenges inherent in the proposed changes. Ebony's death illustrates the need to improve the child protection response by government agencies. This report illustrates why it will also be critical for the non-government sector to be able to identify and respond appropriately to cases involving significant child protection risks. This will be all the more important given the expanded role and responsibilities for the non-government sector in the new child protection system planned for NSW.

Bruce Barbour
Ombudsman

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Chapter 1. Background

On 17 October 2007, the body of a little boy was located in a public reserve in a Sydney suburb. He was later identified as Dean Shillingsworth, aged two years and seven months. The mother told police that the child's death had occurred on 11 October 2007.

Dean's mother was charged with his murder on 20 October 2007. She pleaded guilty to the charge on 18 August 2009.

At the time of Dean's death, my office identified that his death was 'reviewable' under section 35 of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (the Act). Following a review of the records held by the Department of Community Services (DoCS)[1], we decided to investigate DoCS' conduct in relation to the adequacy of the actions taken by the department in responding to concerns about the safety and welfare of Dean and his siblings.

Our investigation was subsequently expanded to include consideration of the actions of a non-government family support service in providing a service to the mother and her children.

The details in this report regarding the conduct of the boy's mother have been taken from documents, and other evidence, provided to us by agencies relating to their involvement with the family. We have made no findings about the mother because that is not our role. Our focus has been solely on the response by involved agencies, based on their evidence of what their staff saw, heard and did.

It is well known that as a consequence of the death of Dean, and that of a girl Ebony, aged seven years, the NSW Government established a Special Commission of Inquiry into Child Protection Services in NSW.

On 24 November 2008, Justice James Wood AO QC, handed down the Inquiry report.

In the introduction to his report, Justice Wood said that as criminal proceedings were underway but not yet finalised in relation to the deaths of the two children, the inquiry would not comment on the two cases. He noted that the deaths of both children had been the subject of comprehensive review by both my office and DoCS and that these reviews *'have informed the considerations and recommendations of the inquiry'*.

In response to Justice Wood's report, the NSW Government developed a five year comprehensive plan to reform child protection in NSW. This plan *Keep them Safe: A shared approach to child wellbeing,* will result in significant changes to the child protection system in NSW.

In summary, the objectives of the plan are to make child protection a 'shared responsibility', with all relevant government agencies having prescribed responsibilities for ensuring the wellbeing of children. DoCS will in future only respond to cases where there is risk of significant harm. Relevant agencies will establish child wellbeing units to assist their staff to determine cases of children at risk that warrant DoCS' intervention. Cases that do not meet the threshold for DoCS' involvement will be handled by the agencies themselves, either through referral to new family referral services established by non-government agencies, or through the resources of the agencies themselves.

This change will be supported by an expansion of early intervention services and a significantly enhanced role for the non-government sector in the provision of services.

The reforms will also be facilitated by legislative change. In April 2009, relevant amendments to the *Children and Young Persons (Care and Protection) Act 1998* were assented by Parliament. At the time of writing, the amendments were pending proclamation.

The changes arising from *Keep them Safe* that are directly relevant to the problems and inadequacies identified through my investigation of this case are discussed in the final section of the report.

1 In July 2009, government agencies in NSW were restructured. DoCS – now Community Services – was merged into the Department of Human Services. As the events the subject of our investigation occurred prior to the restructure, in this report we have referred to the NSW government child protection agency by its former title.

Chapter 2.
Our investigation

Our preliminary review of Dean's death was informed by an examination of records provided by the Department of Community Services, NSW Housing, Justice Health, Corrective Services, the Department of Education and Training, NSW Police, Uniting Care Burnside, the Benevolent Society, the Family Law Court, the Sydney South West Area Health Service, the Sydney West Area Health Service, the Hunter England Area Health Service and the Greater Western Area Health Service. We also considered the records of a family support service concerning the mother and her children.

Our review raised questions about the actions of DoCS as they related to the family. Between 2001 and Dean's death, DoCS received 34 risk of harm reports for the toddler and his siblings. Most of these were closed by departmental officers because of competing priorities. None resulted in a comprehensive secondary risk of harm assessment.

Our review also raised questions about the adequacy of the actions taken by a family support service in response to the mother's statements about her son.

Set out below is a summary of our investigation observations, findings and the actions by DoCS and the family support service to address the deficiencies identified through review and investigation of the case.

We provided Justice Wood with advice on the progress of our investigation in the context of his inquiry. A copy of our final report was provided to the Minister for Community Services, the Director General of the Department of Community Services, the head of the family support agency, and to Justice Wood.

2.1 Overview of agency involvement with the family until a year prior to his death

It is not the purpose of this report to discuss all of the aspects of our investigation, particularly those specific to the circumstances of Dean's siblings and extended family. Our focus in this report is Dean, who was the second of three children born to three separate fathers.

For the purpose of providing a context for our observations regarding the involvement of DoCS and the family support service with the family, the following provides a broad overview of the involvement of agencies with the family, prior to the mother of the children approaching the family support service for assistance.

The child's mother describes an unhappy childhood and adolescence. She was 19 years old when her first child, a girl, was born in 2000. After the child's birth, the mother moved a number of times and by December 2001, she and the child were living in refuge accommodation in a regional area.

2001–2004

During the three year period 2001–2004, and prior to the birth of her second child, DoCS received 12 risk of harm reports about the girl.

The first five reports related to an incident of unexplained bruising when she was six months old and living with her mother in the refuge accommodation. A report in 2002 alleged the mother had been physically assaulted by a male friend in the presence of her daughter, with both adults reportedly affected by alcohol at the time. In 2003, the little girl was reported to have witnessed domestic violence between her mother and a male friend. In July 2004, a report alleged that the girl, then aged three years, walked 1–2 kilometres, unaccompanied, from her home to the home of a relative. She reportedly told her relative that she had been hit and kicked by her mother's partner. Police were called and reported to DoCS that the mother and partner had been drinking heavily. In December 2004, the little girl was reported as having witnessed the sexual assault of an adolescent family member.

DoCS' caseworkers had no direct contact with the child or her mother in relation to any of these reports. On two occasions, phone calls to other agencies were made by Helpline staff.

During the period in which these risk of harm reports were made, records indicate that the mother had episodes of heavy drug and alcohol use, and contact with police.

Throughout that time, the mother and her daughter also moved frequently. Records indicate that the family stayed in various crisis refuges or had other temporary accommodation across NSW. They were also accommodated for short periods on a number of occasions with friends and family. As a consequence, reports to DoCS about the little girl were handled by different DoCS offices.

The mother met the man who was to become the father of her second child when she was staying with his mother. At the time she met him, he had an extensive police history. He moved into the mother's home shortly after his release from prison in early 2004. Records show that their relationship was characterised by violence and excessive alcohol and drug use.

2005–2006

The mother's second child, Dean, was born in early 2005. During his short life, Dean was reported to DoCS once before he was born and nine times after his birth. During the same period (2005–2007), his older sister was the subject of a further 11 reports to DoCS. According to departmental records, none of these reports resulted in the department conducting a comprehensive risk assessment.

Initial concerns reported to DoCS prior to the birth of the little boy identified domestic violence and an unsafe home environment as risks for both the little girl and the unborn child. This report was unallocated at the local DoCS office, and closed because of 'current competing priorities', which means there were more urgent cases to attend to with the staff available.

Subsequent reports to DoCS concerned the abusive behaviour of the mother's partner while visiting her in hospital after Dean's birth; the mother leaving the hospital without the baby being discharged and without any formula, clothing or other necessary items; and the physical assault of the mother by her partner while both were intoxicated. These reports were closed by DoCS' local offices due to current competing priorities.

Three more reports were made to DoCS about the children in 2005. The mother was reported to be moody, edgy and withdrawn having escaped domestic violence; and to be homeless on two separate occasions. In relation to one of these reports, Helpline staff arranged and paid for overnight accommodation for the family. All three reports were subsequently closed by the department due to current competing priorities.

In July 2005, the mother was arrested by police in relation to an offence involving the malicious damage of a motorcycle. She was reportedly intoxicated when arrested. Records state that during the arrest she struck a police officer with a closed fist to his face. She was charged in relation to this and other offences and was subsequently convicted and placed on a 12-month good behaviour bond.

By August 2005, the mother and her two children were residing in a refuge. In the following month the mother's partner was again incarcerated. The mother and the children remained homeless, staying in various temporary hostel or emergency accommodation facilities.

In early 2006, the mother's partner was released from gaol and the family reunited, staying at the homes of family and friends.

In February 2006, the little girl was seriously assaulted by a relative. In retaliation, the mother and her partner physically assaulted the relative and, as a consequence, were charged, convicted and incarcerated. They requested DoCS place the children with family members which the department did.

This was the first time DoCS workers had direct person-to-person contact with the mother and her children prior to Dean's death. No comprehensive risk assessment was completed in response to the child's assault. The actions of the mother and her partner were noted by DoCS staff to be 'protective'.

Some weeks later, the mother was released on bail and resumed the care of the children.

Health records indicate that during March 2006, the mother sought assistance for drug, alcohol and anger management issues. DoCS provided her with financial assistance to cover one-off accommodation costs. She failed to attend scheduled appointments and her health file was closed.

At some time between April and May 2006, the little girl went to live with her father.

In May, the department received a report that the mother had resumed a relationship with an ex-partner who was a known heroin user. This report was closed because the reporter did not know the mother's address or current whereabouts.

Shortly after, Dean's relatives forcefully took him from his mother, reportedly in response to information about the mother's re-formed relationship and the allegation that both were using heroin.

In July 2006, the mother was convicted of larceny and sentenced to 100 hours Community Service. In August, she was arrested for an outstanding warrant for failing to report as per previous bail conditions.

At the time of her arrest she had neither of her children in her care; however, she was pregnant with her third child. She was sent to Mulawa Detention Centre. She was released from the detention centre in October 2006.

In the months following her release, the mother met regularly with a Probation and Parole officer. The Probation and Parole Service is responsible for the management of offenders within the community. The service aims to reduce the risk of re-offending and to encourage the personal development of offenders. The officer and the mother agreed that she receive counselling for personal issues, and help with anger management. A service plan was put in place.

Following her release, the mother also approached a range of services with the objective of stabilising her life and resuming the care of her children. One of these services was a family support service in Sydney.

The primary focus of this type of service is to support and strengthen families through practical assistance, role modelling, referrals, advocacy and advice. A family support worker started working with the mother in November 2006, and provided her with support until January 2007. Issues addressed by the service expanded over time to include resolution of the family's housing needs, pregnancy and court support. Another worker provided family support to the mother from February 2007 until Dean's death in October 2007.

2.2 Agency contact and family circumstances in the months immediately prior to the boy's death

January – April 2007

In January, the mother resumed the care of her daughter. In the same month, she was also placed on a Good Behaviour Bond for offences committed in 2005.

The family support service wrote a letter in support of the mother's application for housing. Health records show the mother also sought assistance with court preparation in the matter of the assault of her daughter in 2005. She commenced seeing a psychologist in accordance with the plan that she had developed with her Probation and Parole officer. She also initiated Family Law proceedings in relation to her second child who remained living with his grandmother. The mother sought an order for Dean to live with her.

The mother's third child was born in April, and in the same month, she accepted a Department of Housing offer of accommodation. In late April, the mother told the family support worker that she was working on improving her relationship with her six year old daughter – she said her goal was to keep calm and not swear at her. She also told the worker that she had been meeting with the psychologist in relation to her depression and anger management issues and that she hoped to start attending a parenting course. They also discussed the court action aimed at regaining the custody of Dean.

May 2007

In early May, Dean's grandmother sought an order from the Family Court. She wanted the boy to live with her, and to have contact with his mother and father on the conditions that they did not to consume alcohol in the boy's presence and the mother have monthly urinalysis.

Records show that DoCS received a subpoena to produce relevant documents to the Family Court. DoCS declined on the basis that the only documents held by the department contained risk of harm reports, for which production cannot be compelled.

During May the mother had contact with a number of agencies. Her new baby was seen by a child and family nurse on two occasions, with no reported concerns except *'some stress for mum with family court for older child'*. She also had contact with her Probation and Parole officer. The mother was noted to be looking well, to be happy to have her own home, and to be receiving help from the father of her third child. The officer wrote a letter in relation to the Family Court proceedings, noting they had not seen the mother affected by drug or alcohol use.

The family support worker visited the mother during the middle of the month and she too, on the request of the mother, wrote a letter addressed to the Family Court. The letter indicates the family support worker had no concerns about the mother's parenting based on visits *'at least three times a month'* over the past three months.

In late May, the mother attended a court mediation phone conference. Agency records indicate agreement was reached between the mother and Dean's grandmother; and that the mother was happy with the outcome of the conference.

June 2007

In early June, a local court issued interim orders in the Family law matter concerning Dean. By consent it was agreed that Dean would live with his grandmother and that, providing the mother was not using drugs, the boy would spend time with her. The order also provided for regular phone contact.

Around this time, as arranged, the mother had contact with Dean for the first time since May 2006.

During June, records show reduced agency contact with the family. Probation and Parole spoke only once with the mother by phone. The baby health clinic saw the mother and her baby once. The family support service recorded two home visits. The baby's father was present during the first visit. The mother told the family support worker that contact with her son went well and that she was looking forward to his next visit.

July 2007

Dean's second contact visit with his mother occurred in early July. The visit was meant to be for the day, with the child to return to his grandmother's care at 5pm. However, the mother did not return the boy as arranged. In the following days, the grandmother contacted the police and asked them to check on the boy's welfare. Police could not locate the family.

The grandmother then tried to locate Dean herself and this resulted in the mother's relatives calling police. Police records describe the incident as a custody dispute. They attempted to report the incident to DoCS, *'… on phone for over 10 mins, unable to speak to anyone'*. DoCS' records confirm police successfully reported the matter several weeks later. The information was retained at the Helpline as 'information only'.

In mid July, the family support worker became aware that the mother had Dean. During a telephone call, the mother told the worker that she had kept her son back from his last visit and that she had rung her solicitor. The solicitor had told her to return him to the care of his grandmother; however, she had decided to *'wait for the Magistrate's decision'*.

The following day, the Probation and Parole service also became aware of the situation. The mother told the officer that she was aware Dean's grandmother was taking out a recovery order and that she did not know how she would handle a long custody case. She was worried that when the boy's father was released from prison the following month, he would take the boy from the area and stop her getting access. The officer reiterated the solicitor's advice that she should return the child to his grandmother.

Two days later, the mother and Dean, accompanied by the family support worker, attended a young parents' group. The family support worker recorded that the child appeared to be well, enjoying himself, and to be *'very attached to his mother'*.

The following week, the mother attended the baby health clinic and reported she had breached her access conditions by failing to return Dean to his grandmother. In the same week she saw her usual Probation and Parole officer for the last time before her case was re-allocated to another worker.

In late July, the grandmother filed a recovery order with the Court. The matter was listed for hearing in September.

August 2007

The mother had contact with two agencies during August – the family support service and the agency running the young parents' group. She failed to report or to attend interviews with the Probation and Parole Service and did not have contact with the psychologist who she had been seeing for anger management.

The family support worker visited on 1 August and noted that Dean appeared *'happy and contented to be with his mum'*. She visited the family again two weeks later, and the worker recorded that they covered issues including the pending court case and the mother's strategies for managing her anger, as well as issues specific to the mother's management of her daughter.

In late August, the worker rang the mother to cancel a planned meeting. The mother reported the children had been good and both she and the children were doing well.

The following day the mother attended a local playgroup accompanied by Dean and his baby brother. Two days later, the mother attended a family photo session arranged by the playgroup. Records note the mother was teary during the session. She informed a worker that *'she was feeling upset with [her son] because he reminded her of his father',* and that *[Dean's] father had hurt her a lot in the past'*. The mother agreed for the worker to arrange counselling. An appointment was made for early October.

September 2007

At the beginning of September, police attended a verbal argument between the mother and the father of her third child. According to police records, both had been drinking alcohol *'all afternoon'*. The incident was reported to DoCS as alcohol related domestic violence. At the local DoCS office, the report was forwarded to the early intervention team. The family were assessed for early intervention services through the 'Brighter Futures' program. Due to the family's extensive child protection history, they were determined ineligible for the early intervention program as the risk was too high. The report was referred back to the child protection team, where it was closed three weeks later due to competing priorities.

A week later, the family support worker visited the family for the first time since mid August. The mother told the worker that she was stressed and that her son was acting out and the children were fighting. She agreed to attend a course on managing the children's behaviour.

In late September, the worker sent a letter to the mother's solicitor advising that she had been visiting the mother *'at least three times per month'* and would continue visiting the family for as long as the mother found this useful. She noted the boy appeared to be dressed appropriately and *'appears quite contented with his environment'*.

Soon after, the family support worker visited the mother. The mother was upset and crying and said that she had decided to give Dean back to his grandmother because she was not coping. She gave the family support worker permission to speak with her solicitor and to tell them that she would not be attending Court for the hearing listed for a few days later.

The family support worker returned to her office and rang the solicitor. In a statement, the worker told us that the solicitor agreed to ring the mother. A short time later the family worker rang the mother who said that she had spoken with the solicitor. The mother told the worker that there would be no court; the police *'will come and get* [Dean] *not sure when'*. The worker made three further phone calls to the mother to see how she was. File notes record that the mother was very relieved that *'he is going back'*.

In late September, the mother's new Probation and Parole officer visited her at home. The mother told the officer that she was being supported by the family worker and that everything was going well. When the officer enquired about Dean because he appeared unwell, the mother told the officer that because of death threats by the boy's father, she was returning him to his grandmother's care and had withdrawn from the custody proceedings.

On the same day that the mother saw her probation officer, the Family Court opened its hearing in relation to Dean's custody. The grandmother's solicitor raised concerns about the delay in listing after the application was filed on in July. *'There's a mother with a drug problem who hasn't returned the child. And here we are in September with it before the Court'*. The hearing was nevertheless adjourned upon the request of the grandmother's solicitor, as her client required urgent medical treatment. The Court arranged to expedite the next hearing, and adjourned the matter until 11 October 2007.

October 2007

The mother did not keep her counselling appointment for early October. She told the worker who had organised the counselling appointment that she had decided to return Dean to his grandmother *'because* [the boy's] *father had been released from prison'*. She said she would like to attend counselling sometime in the future.

On the same day, the family support worker visited the mother. She found the mother stressed after *'ringing the Court to see when someone was going to come and get Dean … They have told her it goes back to court on the 18th October. The mother doesn't want to go back to court she just wants her son picked up by police and taken back to his grandmother. My observation is the sooner the better … There was also tension with the mother who was very stressed when* [Dean] *came near her. She just can't stand him. The mother just wanted him gone as soon as possible. Suggestions by the mother were to just take him to DoCS and leave him there …'*

During the visit the mother made a number of calls using the worker's mobile phone. She rang the Family Court to clarify that she did not need to attend court but was unable to establish this. She rang her solicitor, who was not available. She rang the Federal Police to find out whether they would be collecting the boy. They did not know.

According to a statement provided to us by the worker, the worker then suggested the mother telephone the grandmother's solicitor with a view to making an arrangement to hand Dean to his grandmother. The worker said she also '*tried to confirm that* [the mother's suggestion of taking the boy to DoCS] *was really what she wanted to do'*. She also recorded in a file note that was made after Dean's death, that she asked the mother if she felt she may harm him. The mother reportedly said no. According to the worker's notes, the mother decided to take no further action in relation to the boy until she could discuss the situation with her mother.

The day following the visit, the family support worker rang the mother to confirm whether or not she would be attending a picnic arranged for the following week. Other topics were not discussed. The family support service records indicate the family worker did not have any contact with the mother during the next week, as the worker had training.

On 11 October, the Family Law court made an ex parte order authorising police and/or Child Recovery Officers to recover and return the boy to his grandmother.

Police records indicate that Dean died on 11 October 2007 although his body was not found until 17 October.

On 15 October, the family support worker met with her supervisor. The worker raised the concerns she had identified in her contact with the mother almost two weeks prior. The supervisor instructed the worker to contact the mother and visit her immediately. She instructed the worker to take Dean to DoCS if he was still with the mother.

The family support worker rang the mother. The worker recorded in a file note that the mother told her that she had decided to *'wait for the court processes'* for arrangements to be put in place for Dean to be returned to his grandmother. She also did not wish to proceed with the parenting course. The worker recorded the mother said that her son had been good; she wasn't as stressed as she had been; and she was managing. The worker arranged to visit the mother on 22 October.

On 20 October, the mother was charged with the murder of her son.

Following these events, DoCS lodged an application for an emergency care and protection order with the Children's Court for the boy's brother and sister. Both children are now in care until they turn 18.

Chapter 3.
Findings and observations

The focus of our investigation was the adequacy of the actions taken by DoCS in responding to concerns about the safety and welfare of the mother's three children. In relation to the family support service, our focus was the adequacy of the service's actions in providing a family support service to the mother and her children.

3.1 Department of Community Services

3.1.1 DoCS Review

Following Dean's death, DoCS conducted an internal review of the case. The review found that:

> *based on the information known at the time and relative to other priorities, DoCS could not have predicted Dean's death. The response to reports received in the 12 months leading up to his death was consistent with risk assessments when considered alongside other reports in the system. There were however a number of missed opportunities in responses to reports in the past.*

In particular, the review found:

- Issues with the quality of documentation by DoCS staff, including inconsistencies in record keeping and the transfer of information.
- A number of 'missed opportunities' for intervention where recommended responses given to reports warranted a more comprehensive or higher level response. Missed opportunities included reports made at the time of Dean's birth, with the review noting that given the known information at the time, this *'should have combined to create a picture of a higher level of risk'*.
- At times, there was problematic use of language and emphasis placed on information in records, resulting in somewhat misleading information about risks to the children. There were also periods in the case where a level of analysis was lacking.

The review noted that:

> *On the one hand predictability can not be identified and a realistic appreciation of the relative demands in the system does not suggest that DoCS should have done more, especially in recent times, in response to the reports received. On the other hand, pervasive domestic violence is a part of the history and DoCS had much of this information. There are at least three occasions… where the level of violence should have been addressed in both response ratings* [by the Helpline] *and direct field action.*

As a consequence of its review, the department's Child Death Review unit recommended that its review report be provided to relevant senior departmental staff and that an 'in-service' be provided for the Helpline. The unit also recommended the development of a practice review training session for staff, based on the issue identified in the review.

3.1.2 Our investigation

Taking the department's review into account, we made the following overall observations about the department's actions in relation to the family.

In our view, the department's actions, when considered in totality, revealed a continued failure to adequately respond to reports about the risk of harm to the children. The department accepted that there were deficiencies in its actions.

In all, the department received 34 reports about the three children. Twenty-four of these reports were sent to a local DoCS office (Community Service Centre) for further action, or for the information of the Community Service Centre. The Helpline assessed 15 of the reports as indicating a high or medium risk. Despite this, prior to Dean's death, none of these reports resulted in the completion of a comprehensive risk assessment.

Six different Community Service Centres handled the 24 reports that were transferred by the Helpline. Taken together these reports raised concerns about the family's itinerancy, the domestic violence the children were exposed to, and the impact of parental drug and alcohol abuse on them. A number of reports related to abuse or assault. The children were also reported to be neglected. We noted our concern that repeated reports over time about very young children could be closed without comprehensive risk assessment.

In response to our preliminary investigation report, DoCS submitted that the failure of police on two, and possibly three, occasions to make reports following their attendance at domestic violence incidents between the mother and the father of the little boy who died, denied DoCS the opportunity of gaining a more complete and accurate picture of the level of violence in the family. However, had DoCS sought relevant information from police in response to any of the subsequent reports concerning the children, they would have gained the information held by police.

It is relevant here to note our observations about the department's handling of the last report the department received about the children prior to Dean's death.

That report was made to the department in September 2007. It concerned a verbal argument between the mother and her then partner, the third child's father. Police attended and the partner, who had locked the mother and the two older children out of the house, let them back in after being requested to do so by the police. Both adults had been drinking alcohol.

This report was assessed by the Helpline as medium risk and referred to a Community Service Centre for further assessment. There the report was streamed to the early intervention team. That team assessed the family as not eligible for the Brighter Futures Early Intervention program because of the extensive child protection history and high risk. The report was then streamed back to the child protection team, where it was closed because of competing priorities.

In our preliminary report we noted that there is no requirement in such circumstances for these cases to be allocated for further secondary assessment by the child protection team. In response DoCS said that referrals rejected by the Brighter Futures program do receive further assessment. '*However the* [risk of harm] *report is then required to be considered alongside other reports received within the same time period. This is often a difficult and complex process. Incoming reports are considered on the presenting risks (most immediate to less serious) and then against the ability to allocate the matter to available staff*'.

It is significant to note that while DoCS took no action in response to this report because the risk were too high to refer to the early intervention program but too low to warrant comprehensive risk assessment, the family support service *was* working with the family.

In response to our preliminary investigation report, DoCS told of us that in recent years it has put in place a number of strategies that would address many of the deficiencies identify by the review and investigation of this case. For example, a number of strategies have been put in place to improve the handling of risk of harm reports by the Helpline.

The department also told us that certain staff were counselled and others were briefed about their responsibilities when contacted by a member of the public with concerns about the safety of a child or young person. The department also told us of the strategies it has put in place to provide better support to and links with the family support service that dealt with the family.

3.2 The family support service

As noted, our focus in relation to the family support service was the adequacy of the service's actions in providing a family support service to the mother and her children. Family support services provide free voluntary outreach support for families. These services receive funding from DoCS to assist families under stress. In 2007, family support workers had a mandated responsibility under the *Children and Young Persons (Care and Protection) Act 1998* to make a report to DoCS if they have reasonable grounds to suspect that a child was at risk of harm.

As noted, the mother self referred to the service in October 2006 when she said that she was interested in doing a parenting course. After meeting with the service, it was agreed that the focus of support by the service would be supporting the mother in relation to the restoration and registration of her children, and in relation to an AVO against the girl's father. In the months following the commencement of the service, the support provided by the service expanded to include resolution of the family's housing needs, pregnancy and court support.

In our investigation report, we made observations about certain actions of the service, as they related directly or indirectly to the mother and her children, which in our view were inadequate.

3.2.1 Focus of the support service

We appreciate that the success of family support services, in part, can be attributed to families identifying their own needs for which they require support. However, this can be problematic if the service does not have an adequate understanding of relevant information. In this regard, we noted that the family support service undertook to support the mother regain the care of her children, without the service having a clear understanding of the family history.

Such an understanding may not have deterred the service from providing the mother with support to regain her children's custody. However, it would have provided a basis for understanding some of the potential risks associated with the mother's changing circumstances, including from having no children in her care to being responsible for three very young children in a relatively short period of time.

3.2.2 Documentation

In many instances, a family support worker will be the professional who has most contact with a family. Because of this, they will often be called upon by their clients or by agencies such as DoCS, to provide written reports or statements about the family that are relevant to decisions concerning children. There is a clear requirement that any report or letter or statement that is written by a family support worker accurately records the relevant facts.

Our investigation indicated that written information provided to agencies by the family support worker was at times inaccurate. Advice to agencies over-stated the level of contact between the family support worker and the family, and conveyed a view that the little boy was more involved in external services than was the case.

In isolation, such inaccuracies and omissions may appear trivial but, in our view, they are not. In each instance we identified, the information was misleading about the level of support the mother was receiving and/or did not provide all relevant information.

On a separate matter relevant to documentation, while the record maintained by the family support worker was quite detailed, there was very little documented information about the children. A number of the home visit records make no mention of the children.

3.2.3 Response to the mother's actions concerning her son

The family support service records tracked the mother's increasingly negative attitude towards Dean which first became evident in September 2007 – eight weeks after she had resumed his care. The worker noted the mother's relief when told the police would collect the little boy, the mother's stress when Dean came near her, and the mother's advice that *'she just can't stand* [Dean]*'* and wanted him gone as soon as possible.

We appreciate that the family support worker formed a view that the mother would not harm her son. We also note that she encouraged the mother to contact her solicitor.

However, in the context of Dean's very young age and the family's history of child protection concerns, the mother's statements were indicative of a potentially harmful situation for the child. In this regard, we also note the worker's own observation that the sooner Dean returned to his grandmother's care, the better.

Given the situation by early October, it was concerning that the worker did not discuss the case with her supervisor until almost two weeks after the relevant events took place, and did not follow-up with the family during that time.

While we acknowledge that the court did not facilitate a prompt resolution of the custody dispute, in our view in the circumstances the worker did not take adequate steps to facilitate the boy's return to his grandmother. We made this observation not on the basis of the events which unfolded, but against the evidence which shows that by early October, the boy was at risk in his mother's care.

3.2.4 Supervision

Following initial orientation, we understand from advice provided by the family support service that family support workers generally receive fortnightly supervision with a coordinator. These sessions involve discussion about each case allocated to the worker – for example the discussion may canvass the number of visits made, issues identified, areas of work, child protection issues, case plans, difficulties and so on. In addition to these sessions, the family support service has an open door policy regarding informal supervision.

During the four months between July and October 2007, the mother's family support worker received formal supervision on four occasions only. When the worker was allocated the family in January 2007, she was new to the service. Although the worker was new, the service had a long history of providing supports to the family.

In relation to the mother, the service knew that she had a history of domestic violence both growing up and in her own relationships, that she had experienced itinerancy and homelessness, and that she had poor anger management which had resulted in her being charged with assault. The service knew that the mother had had periods of significant separation from her two older children – in the case of Dean this was for a period of 11 months. From having only a baby to care for, she quickly went to having three children to look after.

Given this set of circumstances, we would have expected the formal supervision provided to the worker to have been more regular. That it was not was, in our view, problematic and unreasonable.

In response to the tragic circumstances surrounding Dean's death, and the issues raised by our investigation, the family support service told us that it had taken a number of actions to address the issues arising from the agency's handling of matters concerning the family. The service has put in place a range of strategies to improve its supervision of staff, case planning and staff training.

Significantly however, the service also told us that these actions were being taken in the context of a number of challenges currently facing the service, including:

- increased referrals from DoCS for families that do not have an allocated caseworker
- increased referrals of higher risk families
- increased referrals of families who are negotiating the restoration of their children and who are seeking support
- families requiring support services for longer periods because of the complexities of their needs – *'without necessarily there being a risk of harm'*
- difficulties recruiting appropriate staff.

The service also told us that it is not funded to provide services to high risk families; however, it is increasingly dealing with families where the risk is too high for the Brighter Futures program, but not a sufficient priority to ensure a DoCS response.

In response to our final report, DoCS said that *'the Community Services Grants Program through which all family support organisations are funded, is in need of enhancement and reform'*.

3.3 Reform of the child protection system in NSW

In my special report to Parliament on the death of Ebony, I provided a brief overview of the reform of the child protection system in NSW. These reforms are also relevant to the death of Dean and, accordingly, I restate them here.

On 24 November 2008, Mr. James Wood AO QC handed down his report from the Special Commission of Inquiry into Child Protection Services in NSW.

In March 2009, the NSW Government responded to the inquiry by releasing a plan of reform for child protection. *Keep them Safe: A shared approach to child wellbeing* is a five-year plan to change the way in which children and families are supported and protected.

Keep them Safe, supported by amended child protection legislation, will see fundamental changes to the way in which child protection services are designed and delivered in NSW. The cornerstone of the changes is to make child protection a 'shared responsibility'. All relevant government agencies will have prescribed responsibilities for ensuring the wellbeing of children. Child protection will encompass universal services and enhanced early intervention and community based services. The non-government sector will become a more significant partner in the provision of these services.

The main components of reform outlined in the Government's *Keep them Safe* include:

- A change to the mandatory reporting threshold, with mandatory reports to DoCS required only where there is a 'risk of significant harm'.
- Relevant agencies – NSW Health; Department of Education and Training; NSW Police Force; and the Department of Human Services (covering Juvenile Justice, Housing and Ageing, Disability and Home Care) – will establish 'Child Wellbeing Units'. The Units will provide advice to mandatory reporters regarding whether concerns constitute 'significant harm' and should be reported to DoCS and possible service responses where there is risk but not one of significant harm. In the latter cases, agencies will be responsible for referral of families and children to appropriate support services, or for providing assistance to them directly or in conjunction with another agency or agencies. Child Wellbeing Units will be established in October 2009, and will become fully operational on the first school day of 2010.
- Family Referral Services managed by non-government organisations, will be established to provide referral services to link children at risk and their families to appropriate services. These services will be trialed in three locations for a 12 month period from January 2010.

- There will be an increase in services available to families and children, including universal services and early intervention and community based services. The NSW Government has committed $750 million over the next five years for systems and new services to implement *Keep them Safe*. In addition to $170 million allocated to systems changes such as the establishment of Child Wellbeing Units and RIRS, there will be:
  - $114 million for prevention and early intervention services
  - $25 million for services for Aboriginal children and young people
  - $58 million for acute services, including intensive family preservation services
  - $220 million for out-of-home care.
- The capacity for information exchange between relevant agencies working with children at risk and their families will be improved. The *Children Legislation Amendment (Wood Inquiry Recommendations) Act 2009* allows for a greater exchange of information between government agencies and non-government organisations, where information relates to the safety, welfare or wellbeing of a child or young person.
- There will be a focus over the next five years on building the service capacity of the non-government sector. 40% of the increased funding allocated to the implementation of *Keep them Safe* will be directed to non-government organisations.
- There will also be significant change within DoCS, to assist the department's revised role in dealing with cases of significant harm. All DoCS CSCs will be subject to a 'quality review', that will examine CSC leadership and team management, support systems, compliance with policies and procedures and culture. DoCS' information management technology, caseworker guidance and supervision and professional development processes will also be enhanced through a range of specific initiatives.

3.4 Reforms in the context of our investigation

In his introduction to the report of the inquiry, Mr Wood said the report would not comment on the two cases that prompted the Inquiry, as criminal proceedings relating to the deaths of the children were not yet finalised. He noted that the deaths of both children had been the subject of comprehensive review by both my office and DoCS, and that these reviews *'have informed the considerations and recommendations of the Inquiry'*.

In addition to providing the inquiry with our review and investigation work relating to Dean and his family, my office made a number of submissions. The submissions were relevant to the issues we identified in examining agency responses, and were further based on observations informed by our broader work on child protection matters.

Set out below are three of the critical issues we raised to the inquiry that are particularly relevant to our investigation, related recommendations arising from the inquiry, and the response of the NSW Government.

3.4.1 Effective response to reports of risk of harm

Research highlights that children's exposure to domestic violence, parental alcohol abuse and neglect may have long-term emotional, developmental and behavioural impacts on them. A consistent issue raised by this office has been the capacity of DoCS to respond effectively to children who were the subject of reports of risk of harm. In our submission to the inquiry on assessment and early intervention and prevention, we noted this issue to be one of the greatest challenges for New South Wales in achieving a strong child protection system.

Our investigation of the circumstances of Dean and his siblings demonstrates the challenges associated with a child protection system struggling with high and competing demands. Between 2001 and Dean's death in 2007, DoCS received 34 risk of harm reports in relation to the family, 10 of which concerned Dean. Most of these reports were closed by departmental officers because of competing priorities. None resulted in a comprehensive secondary risk of harm assessment.

In considering assessments and response, the inquiry into child protection services found that demand for child protection services was being met for only a fraction of the children reported, and that families were excluded from intervention or service provision because of the prioritisation of high risk cases needing urgent intervention. The inquiry noted that for those reports assessed by DoCS, *'many assessments lack a holistic approach, lack rigour and do not take advantage of the expertise or information of others'*.[2]

As described above, the inquiry's primary response to these issues was the creation of different pathways for children at risk of harm, with the aim of increasing capacity by making child protection the collective responsibility of the whole of government and of the community. Keep them Safe is the plan to implement these changes.

2 Hon. James Wood AO QC, Report of the Special Commission of Inquiry into child protective services in NSW. November 2008, p.376.

3.4.2 Expanding service capacity and the role of non-government agencies

In our submission to the inquiry about assessment and early intervention and prevention, we supported the need to adopt a different system for responding to risk of harm reports, and agreed that this could be achieved in part through service expansion and a greater role for the non-government sector in provision of such services. We noted however, that there would be particular service and cultural challenges for the non-government organisations.

A particular and immediate challenge would be recruiting and retaining sufficient numbers of adequately qualified staff. We also observed that given the greater involvement of non-government agencies, such as the family support service involved with Dean and his family, such services will increasingly be required to move from a strong support and family strength focus to one which could involve the provision of evidence to DoCS where cases may meet a statutory threshold. This may be a difficult cultural shift.

The final report of the inquiry outlined a child protection system comprising integrated universal, secondary and tertiary services, with universal and secondary services being delivered by the non-government sectors and state agencies. DoCS would be the provider of last resort. Part of the inquiry's vision was for a workforce strategy, which would take into account the recruitment needs of NGOs and funding for related infrastructure.

Keep them Safe subsequently gave significant focus to strengthening partnerships across the community services sector, based on a five-year plan for workforce development and cultural change within the sector.

As noted above, 40% – approximately $300M – of the increased funding allocated to the implementation of *Keep them Safe* will be directed to non-government organisations. Funds will provide for additional places in the Brighter Futures program; Family Referral Services; intensive family preservation and intensive Aboriginal and other family based services; other prevention and early intervention services and out-of-home-care.

It is nevertheless significant to note that the 2008 review of the Community Services Grants Program did not result in any increase in funding for services provided through the program. This includes the family support service that was involved with Dean and his family – and all other family support services across NSW.

Such services provide a range of local prevention and early intervention services and are not funded to provide crisis services. While it can be reasonably anticipated that the planned changes to the child protection system will result in an increase in the number of families with children at risk being referred to these services, their capacity to respond is in question given their reported difficulties meeting current service demand.

3.4.3 Information exchange and risk assessment

Our investigation illustrates the critical importance of effective information exchange and interagency coordination between government and non-government sectors with child protection responsibilities.

Dean's family was very itinerant and engaged at various times with a range of non-government and government services including NSW Police and NSW Health. Six different DoCS' Community Service Centres handled risk of harm reports about Dean and/or his siblings over a six year period. At times, information was not relayed, or not relayed effectively, within DoCS or to another agency dealing with the family.

The family support service's failure to obtain information from, or pass on information to DoCS, at any stage, represents a fundamental weakness in practice.

In the context of a much broader mandate of agencies involved in child protection cases, the child protection inquiry recommended that the *Children and Young Persons (Care and Protection) Act 1998* should be amended to permit the exchange of information between human services and justice agencies, and between such agencies and the non-government sector, where the exchange relates to the safety, welfare and well-being of a child or young person. The inquiry agreed with the principles we enunciated in our submission on interagency coordination, that areas such as serious and chronic neglect, parental substance abuse, serious mental health issues and high risk domestic violence matters, were particularly suitable for coordinated cross-agency work.

In line with commitments made in *'Keep them Safe'*, in May 2009, the Government introduced and passed changes to the care legislation to reflect this recommendation. These changes have the potential to improve the exchange of information between government agencies and non-government organisations, where information relates to the safety, welfare or wellbeing of a child or young person.

However, it will be critical that timely and sufficiently detailed information is shared between the Child Wellbeing Units, between the Child Wellbeing Units and DoCS, and between the proposed Family Referral Services, the Wellbeing Units and DoCS. While the details of these arrangements are still being finalised, we have expressed concerns about early planning failing to recognise the need for all these agencies to have access to information about previous child protection reports to assist them to make informed assessment and referral decisions.

It is also important to recognise that the formal arrangements being developed in relation to information exchange present only part of the challenge. Both the government and non-government agencies alike need to appreciate that effective child protection practice is contingent on agencies understanding the need to be proactive in obtaining information from other agencies and in passing it on. From our review of child protection practice over a number of years we have seen an emphasis on the risks associated with the disclosure of confidential information at the expense of recognising the very significant child protection risks which can arise from the failure to pass on vital information. Therefore, while the recent legislative amendments represent an opportunity to improve practice in relation to the exchange of information, we believe this will not occur without a corresponding cultural shift that promotes information exchange as part of good child protection practice.

Chapter 4. Conclusion

In my special report relating to the death of Ebony, I raised some particular challenges inherent in the planned changes to the child protection system, and my view that these challenges must be understood and acknowledged if they are to be overcome. Similarly, it is important to consider the issues raised in my investigation relating to Dean and his family, in the context of broader system changes.

A critical issue will be how the varied components of the new multi-faceted system will be implemented.

The child protection inquiry envisaged a revitalised system drawing on the provision of an array of universal and targeted services, delivered by non-government and state agencies. At the centre of these services would sit Child Wellbeing Units, which would work with DoCS as a provider of 'last resort' for those children at risk of significant harm, and with the Regional Intake and Referral Services – now to be known as Family Referral Services – and early intervention services for children otherwise at risk. Through the Wellbeing Units and referral services, vulnerable children and families would be linked with appropriate early supports and services.

The expanded role of non-government agencies has the potential of making the system more responsive to the needs of children at the local level, and of ensuring that more families receive timely and appropriate support.

However, while the Child Wellbeing Units are in the process of being established in 2009 and fully operational by early 2010, the Family Referral Services will be initially trialed in only three areas for a 12-month period from January 2010. The expansion of Brighter Futures – the early intervention program currently catering to around 6,000 families each year – will be limited in the first instance in capacity to assist only an additional 200 families by mid 2010. The Government has committed to examining further enhancements following an evaluation of Brighter Futures in 2010. As I noted in my report about Ebony, in establishing Child Wellbeing Units without the support of a statewide Family Referral Service system, and without having significantly expanded early intervention services, there is a potential risk relating to the capacity of responsible agencies to either directly provide, or arrange for, adequate support to vulnerable families across all areas of the State.

My investigation into the death of Dean also illustrates some of the particular difficulties faced by non-government agencies in responding to children at risk of harm.

Greater involvement of non-government agencies in responding to children at risk is clearly appropriate and has the potential to deliver more effective and holistic services. To achieve this potential, however, it will be essential for government, with the sector at large, to develop an effective plan for capacity building. The non-government sector will not have a Child Wellbeing Unit. Services will be expected to effectively identify statutory cases, and for many of these families, provide direct assistance in the short-term or throughout the statutory process. For those cases that do not meet the statutory threshold, it is envisaged that non-government agencies will be responsible for the provision and organisation of the supports required for the child and their family. This is a significant expectation to place on an already stretched sector.

As I stated in my report concerning Ebony, the reformed child protection system will not only need good coordination and information exchange, but will not function in its absence.

My investigation into the death of Dean illustrates the importance of putting in place a robust information exchange regime that ensures not only the capacity to exchange information legally – but that what is exchanged is adequate and timely and made available to the relevant agencies, whether government or non-government. The work of my office has demonstrated very clearly the risks inherent in responding to child protection concerns with only partial information, making it impossible to conduct a proper holistic risk assessment.

The reform strategy adopted by the NSW Government represents substantial change in the child protection system, and the way in which the community as a whole work to ensure the wellbeing of vulnerable children. It is an unprecedented change, and it is critical that the risks to its success are discussed, monitored and responded to, and the results carefully evaluated.

NSW Ombudsman
Level 24, 580 George Street
Sydney NSW 2000

General inquiries: 02 9286 1000
Facsimile: 02 9283 2911

Toll free (outside Sydney metro): 1800 451 524
Tel. typewriter (TTY): 02 9264 8050

Web: www.ombo.nsw.gov.au

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