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Investigation regarding the Department of Human Services Child Protection program (Loddon Mallee Region)

October 2011

Whistleblowers Protection Act 2001

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Letter to the Legislative Council and the Legislative Assembly

To

The Honourable the President of the Legislative Council

and

The Honourable the Speaker of the Legislative Assembly

Pursuant to section 103 of the *Whistleblowers Protection Act 2001*, I present to Parliament my report of an investigation regarding the Department of Human Services Child Protection Program (Loddon Mallee Region).

John R Taylor
ACTING OMBUDSMAN

24 October 2011

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Section 22A of The Whistleblowers Protection Act 2001

1. This report is made pursuant to section 103 of the *Whistleblowers Protection Act 2001* (the Act). Section 22A of the Act allows me to disclose, in such a report, particulars likely to lead to the identification of a person against whom a protected disclosure has been made if I determine it is in the public interest to do so and if I set out in the report the reasons why I have reached that determination.

2. In this report I am dealing with a disclosure concerning practices in the Loddon Mallee Region of the Department of Human Services. The disclosure did not include any names of particular individuals which the person who made the disclosure considered were responsible for the actions referred to in the disclosure. Instead that person considered that those actions arose from decisions made by 'managers' and 'senior managers … with the support of the Regional Director'.

3. Having considered the four matters referred to in section 22A(2), I have determined that, to the extent those descriptions identify persons against whom a protected disclosure has been made, it is in the public interest to identify a number of the subjects of the protected disclosure in this matter by disclosing the following particulars: their general position titles, occupation and working roles of those persons. I have made this determination for the following reasons.

4. I consider that it is in the public interest for the minimal level of identification, referred to above, of the individuals concerned to be identified in this report as, without doing so, it would not be possible to make a meaningful report pursuant to section 103 of the Act regarding this disclosure. I consider that it is necessary to make a report to the Parliament regarding the issues raised by this disclosure as the disclosure and the investigation of that disclosure reveal serious and significant failures of the department to provide safety and well-being to Victoria's most vulnerable children caused by deliberate policy decisions of certain of the subjects to reduce the number of child protection reports that are investigated.

5. I do not consider that this public interest can be satisfied by any means other than by identifying the subjects of the disclosure; confidentiality being not appropriate as it is, in the instances in this report, inconsistent with the identified public interest.

Executive summary

Failure to ensure the safety of children

6. This is the fourth report that I have prepared in two years regarding the serious concerns that I have about the performance of Victoria's child protection system.[1] I have also consistently expressed my concerns in my annual reports to Parliament.

This is the fourth report that I have prepared in two years regarding the serious concerns that I have about the performance of Victoria's child protection system.

7. I am, again, compelled to present a report regarding the failure of the Department of Human Services (the department) to ensure the safety and well-being of some of Victoria's most vulnerable children.

8. This investigation, initiated by a whistleblower, has identified:
   - failures to protect children at risk
   - the pursuit of numerical targets overshadowing the interests of children
   - a practice of providing the minimum possible response to child protection reports that can be justified
   - poor record-keeping.

I am, again, compelled to present a report regarding the failure of the Department of Human Services to ensure the safety and well-being of some Victoria's most vulnerable children.

9. In this investigation I have identified reports regarding children at risk in the Loddon Mallee Region which have not been investigated by the department despite the circumstances involving:
   - parents assaulting each other while holding their very young children
   - children living in disturbing and chaotic environments
   - professionals reporting a parent's drug use to be 'so severe that she cannot parent her children or attend to their needs'
   - children disclosing to their teachers that they had been physically assaulted

1 Victorian Ombudsman: *Own Motion Investigation into the Department of Human Services Child Protection Program* (November 2009); *Own Motion investigation into Child Protection – Out of Home Care* (May 2010); and *Investigation into the failure of agencies to manage registered sex offenders* (February 2011).

- a father acknowledging he had previously accessed child pornography
- children observed behaving in a sexualised manner
- counsellors reporting that a father's violence was escalating
- allegations that children were being threatened with a knife by their sibling
- young children being left in the care of a fourteen year old sibling for several days
- lengthy histories of reports relating to the well-being and safety of children from credible sources.

10. Consequently I referred the circumstances of 59 children identified during my investigation to the department for reconsideration as I considered the safety of these children could not be assured. The department reopened the cases of 50 children which were closed and took other action to address my concerns in the other nine.

I referred the circumstances of 59 children identified during my investigation to the department as I considered the safety of these children could not be assured.

11. I consider the failure to investigate these reports to be a consequence of an intentional policy decision by the Bendigo office of the Loddon Mallee Region of the department to reduce the number of child protection reports that it investigates. Despite receiving more reports in 2010-11 than the previous year, the region conducted less than three quarters of the number of investigations.

Despite receiving more reports in 2010-11 than the previous year, the region conducted less than three quarters of the number of investigations.

12. The Secretary and other executive staff of the department were informed of this policy shift and briefed that the number of investigations conducted by the region would be 'reduced significantly'. Regional managers were not aware of any systematic auditing or review by the department of the handling of reports following this policy shift.

13. In response to my draft report, the Secretary stated:

> Viewed individually, they [the 59 referred cases] all raise issues of potential harm to children and are indicative of cases assessed in intake on a daily basis across Victoria. One of the most difficult challenges for child protection is to assess all cases and establish which constitute the most serious and imminent risk.

Examples of such serious cases in Loddon Mallee Region that were investigated include:

- a report about a one year old infant whose mother was the victim of family violence. When the mother attempted to flee the father, who had a mental illness, he threatened to murder her
- a report about a registered sex offender who had the sole care of his two children
- a report that a mother of three children had stabbed the children's father was also investigated
- a report on a sibling group of six children, including an infant, whose mother was incarcerated and whose father was about to be arrested leaving the children without a caregiver.

14. I believe a practice has developed where the drive to meet numerical targets has overshadowed the interest of children despite evidence that they may be at risk. The managers deny this, however I consider that the evidence speaks for itself.

I believe a practice has developed where the drive to meet numerical targets has overshadowed the interest of children despite evidence that they may be at risk.

15. Many of the above examples may have been avoided if the lessons from my previous three reports had been learnt. This includes the first recommendation of my 2009 report which was for independent scrutiny of the thresholds applied by the department when deciding which reports to investigate.

16. I have also identified evidence of the misrepresentation of data regarding the number of children allocated to child protection workers. For example, I have established that children remained allocated to one child protection worker absent on long term leave.

I have also identified evidence of the misrepresentation of data regarding the number of children allocated to child protection workers.

The disclosure

17. In June 2011 I received a disclosure from a whistleblower regarding the operations of the child protection program in the Loddon Mallee Region[2] of the Department of Human Services (the department). The disclosure alleged the region was misrepresenting the number of children not allocated to a child protection worker by:

    - directing intake staff not to accept cases for further investigation

2 The Loddon Mallee Region has its head office in Bendigo.

- closing cases without adequate assessment
- allocating child protection cases to supervisors, managers and specialist staff.

18. The disclosure further alleged that these practices led to children being subjected to multiple reports to the department due to the failure to properly assess and respond appropriately to the initial report.

19. The disclosure associated these practices with the work of the Specialist Intervention Team[3] which had been brought into the region over the last 18 months to assist it to deal with its workload. However my investigation has not substantiated the allegations concerning this Team.

20. I concluded that the disclosure satisfied the requirements for a public interest disclosure because it tended to show conduct which involved a substantial risk to public health or safety and/or conduct that amounted to a breach of public trust.

Children without a child protection worker

21. The number of children not allocated to a child protection worker has received considerable attention since my 2009 report through media coverage, parliamentary debate and public hearings conducted by the Standing Committee on Finance and Public Administration. In addition, in February 2011 the Government commenced an inquiry into child protection called Protecting Victoria's Vulnerable Children Inquiry, to develop recommendations to reduce the incidence and negative impact of child neglect and abuse in Victoria.

22. There has been a substantial reduction in the proportion of children not allocated to a caseworker across the department generally and the Loddon Mallee Region (the region) particularly. The region's percentage of children not allocated to a child protection worker fell from 27.3 per cent on 30 June 2010 to 1.4 per cent in April 2011 before rising again to 5.5 per cent on 29 July 2011. State-wide the rate fell from 16.1 per cent on 30 June 2010 to 8.3 per cent on 29 July 2011.

Reducing the percentage of reports investigated

23. My investigation has ascertained that one element of the region's strategy to reduce the number of children without an allocated child protection worker was to investigate fewer reports. In March 2010

3 An initiative that arose from a recommendation in my 2009 report *Own motion investigation into the Department of Human Services Child Protection Program*.

the region briefed the Secretary and other senior executives of the department of its intention to 'significantly' reduce the proportion of reports it investigated.

One element of the region's strategy to reduce the number of children without an allocated child protection worker was to investigate fewer reports.

24. The percentage of reports investigated by the region has fallen from 32 per cent in 2009-10 to 22 per cent in 2010-11. Despite receiving 551 more reports in 2010-11, it conducted less than three-quarters as many investigations.

Inappropriate closure of reports

25. Witnesses described concerted efforts by managers in the child protection program to close large numbers of reports within a short period of time, often on a single day, to reduce the number of children on the awaiting allocation lists. This practice was described as 'culling' the case lists of staff.

26. Data for cases closed during 2010-11 demonstrated that there were a number of days where an unusually high number of cases were closed. The largest number of cases closed on any one day was 90 on 28 June 2011. This is in contrast to an average of 22.7 cases closed per day throughout the year.

27. File examinations by my officers found many cases which I consider were closed prematurely by regional managers. A number of these cases were closed during the last few days of June 2011. Because of the department's use of snapshot data when reporting on the number of children not allocated a child protection worker in its 2009-10 Annual Report, I am not surprised that the significant closure activity during that period led to a complaint that the region was attempting to misrepresent its performance.

File examinations found many cases which I consider were closed prematurely by regional managers.

28. I am also concerned at the poor standard of record-keeping exhibited in the files reviewed during my investigation. Many cases did not contain a detailed analysis regarding why an investigation was not considered necessary.

I am also concerned at the poor standard of record-keeping exhibited in the files reviewed.

29. The Secretary responded that:

> I have acknowledged that the closure of many of the cases brought to my attention was premature however [*sic*] do not accept that this was caused by either the region's pursuit of numerical targets or influenced by a practice of minimal intervention.

Allocation of children to staff on leave

30. Several witnesses referred to two specific instances involving the allocation of children to staff who were on extended leave.

31. My investigation confirmed one instance where children remained allocated to a child protection worker who was on extended leave. Fourteen cases remained allocated to this officer for more than two months after they commenced leave.

Children remained allocated to a child protection worker who was on extended leave.

32. A number of witnesses stated at interview that they believed cases had been allocated to supervisors, managers and specialist staff in order to reduce the number of children who appeared not to have an allocated child protection worker.

33. I identified one example of a specialist officer managing cases which their role would not ordinarily require them to do. While the officer agreed to assist the region by managing a number of previously unallocated cases, the officer considered they were subsequently assigned more children than the officer felt able to provide an appropriate level of service to.

34. I have made six recommendations including that the department undertakes an audit program in each region to review the appropriateness of decision making by intake units. The Secretary has accepted all of my recommendations.

Introduction

The disclosure

35. In June 2011 I received a disclosure from an anonymous whistleblower regarding the operations of the child protection program in the Loddon Mallee Region of the department based in Bendigo. The disclosure alleged the region was misrepresenting the number of children not allocated to a child protection worker by:
    - directing intake staff not to accept cases for further investigation
    - closing cases without adequate assessment
    - allocating child protection cases to supervisors, managers and specialist staff.
36. The disclosure further alleged that these practices led to children being subjected to multiple reports to the department due to the failure to properly assess and respond appropriately to the initial report.
37. The disclosure associated these practices with the work of the Specialist Intervention Team which had been brought into the region over the last 18 months to assist it to deal with its workload.
38. I concluded that the disclosure satisfied the requirements for a public interest disclosure because it tended to show conduct which involved a substantial risk to public health or safety and/or conduct that amounted to a breach of public trust.

Department of Human Services child protection program

39. The department operates the child protection program within the legislative framework of the *Children, Youth and Families Act 2005*. The program is delivered through eight regions: Barwon – South Western, Gippsland, Grampians, Hume, Loddon Mallee, Eastern Metropolitan, North West Metropolitan and Southern Metropolitan. An After Hours Emergency Child Protection Service also operates within the program.
40. The department can receive reports from any person concerning the welfare of children. These reports can either relate to 'a significant concern for the well-being of a child' or a belief '…. on reasonable grounds that a child is in need of protection'.
41. In 2010-11 the department received a total of 55,721 reports regarding 'a significant concern for the well-being of a child' or a belief '…. on reasonable grounds that a child is in need of protection'. This was an increase of 7, 292 from the previous year.

42. A report received by the department is initially considered by the relevant region's intake unit during business hours or by the After Hours Emergency Child Protection Service outside business hours.

43. At intake the department is required to assess whether there are well-being and/or safety concerns for the child and the level of risk of harm to the child. The assessment undertaken by departmental intake staff may involve:

    - a detailed discussion with the person making the report
    - a search of the department's client database (CRIS) to determine if there has been any prior departmental involvement with the child
    - contact with relevant professionals such as doctors, teachers, Victoria Police and maternal and child health nurses
    - consultation and case conferences with senior departmental workers, specialist staff or relevant professionals.

44. On the basis of the information gathered at the intake phase the department will determine whether the report relates to 'wellbeing' or 'safety' issues.

45. If the department considers the report has identified significant concerns for the 'wellbeing' of the child it may refer the report to a Child and Family Information Referral Support Teams (Child FIRST). Child FIRST is a community based referral service that assesses the needs of children and families and then arranges for local support services to provide them with support and assistance.

46. This arrangement provides an alternative response for those reports where the risk to the child is not considered significant enough to warrant a departmental investigation.

47. However if the department considers the report concerns a child's safety, it is considered a 'protective intervention report' and an investigation must be conducted 'as soon as practicable', as required by section 205 of the Children, Youth and Families Act. The report will then be transferred to another unit within the region's child protection program for investigation.

48. An investigation may lead to the department making a Protection Application to the Children's Court if it considers the child to be in need of protection. The Children's Court can issue a range of Protection Orders. Some orders transfer the custody or guardianship of children from the parent to the department; others allow the department to monitor children while they remain in their parents' care.

Ongoing concerns regarding the child protection program

49. I have consistently expressed concerns regarding the child protection program in my annual reports to Parliament. In the past two years I have also tabled two parliamentary reports[4] regarding the department's management of the program and a further report regarding the joint responsibilities of Victoria Police, Corrections Victoria and the department in relation to registered sex offenders.[5] I have also reported on my concerns regarding the conditions in which young people are held in custody.[6]

50. Complaints to my office regarding child protection increased by 32 per cent in 2010-11 compared to 2009-10. I received more complaints regarding the Loddon Mallee Region than any other rural region.

51. Complainants have raised concerns regarding:
    - the thoroughness of investigations
    - the administration of court orders
    - access arrangements for children in care
    - screening of carers
    - abuse of children in care
    - delays in providing support and assistance to families and carers
    - poor communication by departmental staff.

52. Many of these complaints reflect the themes identified in my previous reports and demonstrate the need for sustained efforts to improve the effectiveness of the child protection system.

2006 investigation in Loddon Mallee Region

53. In my 2006 Annual Report[7] I described an investigation I conducted in early 2006 into allegations about the Loddon Mallee Region's child protection program. The current investigation has identified several issues that are similar to those dealt with in my previous investigation.

54. My earlier investigation also arose from information received from whistleblowers. During that investigation I received evidence regarding:
    - failures to thoroughly investigate and intervene in cases where children were at risk

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4 Victorian Ombudsman, *Own Motion investigation into the Department of Human Services Child Protection Program* (November 2009) and *Own Motion investigation into Child Protection – Out of home care* (May 2010).

5 Victorian Ombudsman, *Whistleblowers Protection Act 2001 - Investigation into the failure of agencies to manage registered sex offenders* (February 2011).

6 Victorian Ombudsman, *Whistleblowers Protection Act 2001 – Investigation into conditions at the Melbourne Youth Justice Precinct* (October 2010).

7 *Ombudsman Victoria 2006 Annual Report*, pages 20-21.

- failures to follow established procedures and case practice standards
- manipulation of key performance indicators.

55. My 2006 investigation also included a review of 34 cases concerning 57 children who were reported to the regional child protection program. In 26 cases involving 47 children, I was concerned that the region may not have responded appropriately to children at risk. The department responded promptly to my concerns about these individual cases and significant action was taken in several cases.

2009 investigation of the state-wide child protection program

56. On 25 November 2009 I tabled a report concerning an *Own Motion Investigation into the Department of Human Services Child Protection Program*. My report identified a wide range of concerns regarding the operation of the department's state-wide child protection program and I made 42 recommendations.

57. My 2009 investigation dealt with several matters that I have also addressed in this current investigation. I concluded that:

    - the actual number of children who were not allocated to a child protection worker in official departmental statistics was under-reported[8]
    - the threshold of risk to children considered acceptable by the department was inconsistent and varied according to the availability of resources and the geographical location of the child concerned[9]
    - there were many instances where the department had failed to intervene with children whose circumstances required it[10]
    - workload pressures had hampered the ability of departmental staff to appropriately consider 'cumulative harm' as required by the Children, Youth and Families Act[11]
    - there was insufficient independent scrutiny of the department's decision making processes, particular in relation to the consistency of thresholds for intervention applied across the state[12]
    - the department's reliance on 'snapshot'[13] data was problematic[14]

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8 Victorian Ombudsman, *Own Motion investigation into the Department of Human Services Child Protection Program* (November 2009), page 42.

9 ibid, page 29.

10 ibid, page 9.

11 ibid, page 44.

12 ibid, page 45.

13 Data extracted at a fixed point of time.

14 Victorian Ombudsman, *Own Motion investigation into the Department of Human Services Child Protection Program* (November 2009), page 113.

- the department's structure and broad range of responsibilities created inherent conflicts of interest[15]
- important statutory obligations and internal practices standards were not being complied with.[16]

58. The evidence obtained in my 2009 investigation demonstrated that variations in regional capacity and resources determined the quality of the response provided to many children reported to the department. I was concerned that:

> … the threshold of risk to children tolerated by the department varies across regions due to their variable capacity to respond. In my opinion it is unacceptable that the geographic location of a child should dictate the degree of risk to their safety that is considered tolerable.[17]

59. I also expressed concern regarding the perverse influence of key performance measures on child protection practices and noted:

> It appears that the drive to meet performance measures influences the risk threshold tolerated by the department. The cases examined in my investigation highlight a tendency toward minimal intervention based on superficial risk assessments. This practice is dangerous and in my opinion there is a risk of poor outcomes for children.[18]

60. I also identified that the department had failed to provide government with accurate and up-to-date information regarding the number of children who did not have an allocated child protection worker. I therefore recommended that the department publish data regarding the number of children not allocated to a child protection worker in its annual report, in addition to providing the Minister with monthly briefings on the matter.

15 ibid, page 16.

16 ibid, page 80.

17 ibid, page 42.

18 ibid, page 43.

The investigation

Investigation methodology

61. In investigating this matter, my officers:
    - examined files relating to 79 children known to the region
    - interviewed child protection workers, supervisors, managers and other staff from the Loddon Mallee Region
    - interviewed members of the Specialist Intervention Team
    - analysed statistical data from the child protection database
    - examined leave records for Loddon Mallee child protection staff
    - reviewed email records of departmental officers
    - interviewed representatives of Victoria Police and community service organisations
    - made a number of enquiries with the department, St Luke's Anglicare and Victoria Police
    - referred the circumstances of 59 children to the department for reconsideration.
62. All witnesses who were interviewed were offered the opportunity to be legally represented or to be accompanied by a support person. They were also provided with written information regarding their obligations and entitlements under the *Whistleblowers Protection Act 2001*.
63. In the course of the investigation, 22 formal interviews were conducted on oath or affirmation with witnesses, all of whom attended voluntarily. One witness requested, and was permitted, to be legally represented.

Children without a child protection worker

64. The number of children not allocated to a child protection worker has received considerable attention since my 2009 report through media coverage, parliamentary debate and public hearings conducted by the Standing Committee on Finance and Public Administration.

65. Owing to my concern that the child protection system required greater transparency and accountability, my 2009 *Own Motion Investigation into the Department of Human Services Child Protection Program* recommended that the department:

> Report on unallocated client data for each region and state-wide in its annual report and to the Minister on a monthly basis.

66. However I cautioned against the use of 'snapshot' data as:

> … it is problematic when data is frequently captured as a 'snapshot'. A snapshot does not allow for problems to be identified and addressed which may not have been apparent on the particular day a snapshot was taken.[19]

67. Despite my comments the data included in the department's 2010 annual report was a 'snapshot' of the number of unallocated cases on 30 June 2010.

Children not allocated to child protection workers

68. The department's 2009-10 annual report stated that 16.1 per cent of children involved with child protection across the state were not allocated to a child protection worker as at 30 June 2010. This compares with 22.6 per cent at 19 June 2009 as reported in my 2009 report.20 The department's performance target is for less than 5 per cent of children to be without an allocated child protection worker.

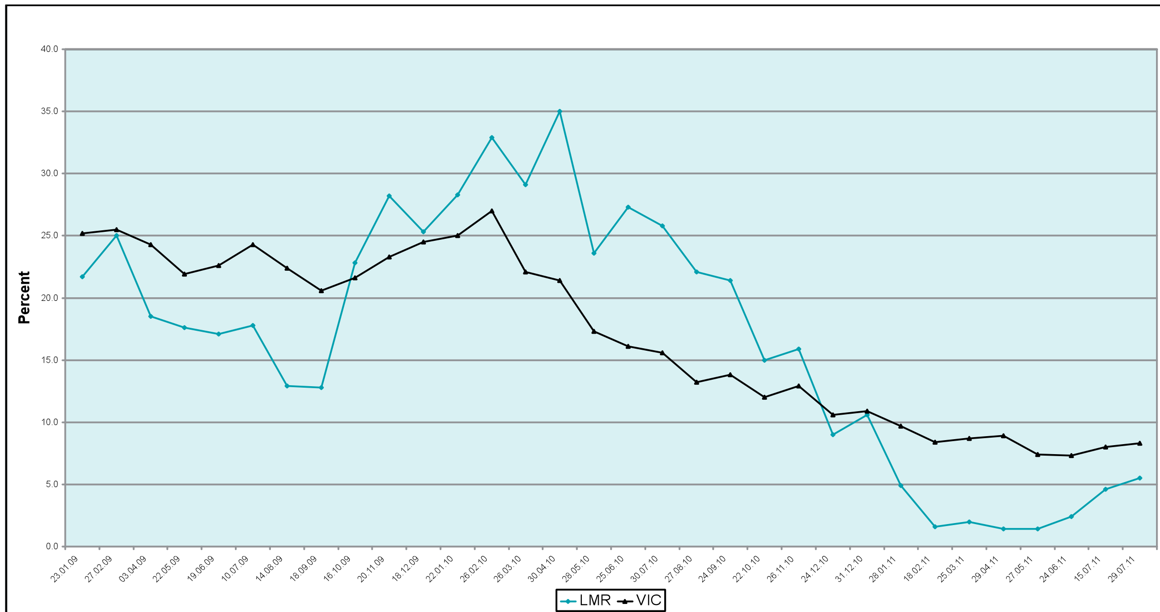
69. The Loddon Mallee Region had the highest proportion of unallocated children in the state at 27.3 per cent on 30 June 2010. By comparison, other regions had rates ranging from 5.6 per cent in Barwon-South West to Gippsland at 24.5 per cent.

19 ibid, page 125.

20 ibid, page 9.

70. More recent monthly data shows the proportion of children without an allocated child protection worker has fallen significantly across the department generally and the Loddon Mallee Region in particular as shown below:

Figure 1: Percent of unallocated cases for London Mallee Region (LMR) and state-wide – 23 January 2009 to 29 July 2011



71. The region's rate of unallocated children fell to a low of 1.4 per cent in April and May 2011. Nearing the end of the financial year the proportion was 2.4 per cent on 24 June 2011, before rising again to 5.5 per cent on 29 July 2011.

72. In response to my draft report, the Secretary stated:

> The results of this focus on case allocation are significant. As at July 2011 an additional 1,734 children (statewide) had an allocated worker, compared to 1 July 2009.
>
> Despite these improvements, a number of children still do not have an allocated case manager (960 on 30 June 2011). This is due to a significant increase in reports. The number of reports received in 2010-11 was 55,631, a 15.1 per cent increase on the 48,429 reports received in 2009-10.

The region's strategy to reduce the number of children not allocated to a child protection worker

73. Several witnesses interviewed during my investigation spoke of the priority given by the region to reducing the number of children who are not allocated to a child protection worker. Various witnesses said:

> Management has been quite clear in telling us that we're number one in the State for unallocated cases.

> They've got it down to whatever it may be now and they're jumping up and down about, saying how good, that is.
>
> There is certainly that pressure on us now that we need to try to maintain the unallocated list.
>
> … at the moment there's a push we don't have unallocated on our lists at all.

74. A senior regional manager, Manager A, described the development of a concerted strategy to address the issue in late 2010 and early 2011. Manager A explained that the impetus for the strategy arose from concerns that they held regarding the state of the child protection program upon their return from extended leave in October 2009. The Manager's concerns included:

    - high numbers of staff vacancies
    - poor retention of staff
    - large number of staff on temporary employment arrangements
    - poor compliance with departmental requirements for staff supervision
    - poor case practice and decision making.

75. Another regional manager, Manager B, stated in response to my draft report that:

    > When I commenced my position with the Department of Human Services, Loddon Mallee Region (LMR) Child Protection Program in April 2010, I found that the Program had:
    >
    > 1. Significant number of cases waiting for allocation;
    > 2. Significant staffing instability at both the management and case carrying level;
    > 3. A staff group that had no confidence in prior managers in Child Protection (including the prior Child Protection Manager) to deal with workload and work force issues;
    > 4. Multiple complaints from services and families about the lack of response from the Program, in that their children were not being allocated a Child Protection Worker;
    > 5. Unsafe work practices;
    > 6. A lack of systems for the monitoring or reporting of workload;
    > 7. Poor levels of supervision by Team Leaders and Unit Managers to Child Protection Workers; and
    > 8. Compromised levels of staff practice within the program.

76. My investigators located a memorandum from the Regional Director to senior departmental executives, and copied to the Secretary, dated 3 March 2010 which sets out the region's strategy to reduce the number of children not allocated to a child protection worker. Manager A confirmed at interview that they had prepared the memorandum.

77. The strategy incorporated:

- recruitment to vacant positions including attracting staff from New Zealand
- utilising flexible employment practices to retain experienced staff
- analysing the proportion of reports proceeding to investigation
- increasing the range of placement options for children in out of home care
- contracting cases to Community Services Organisations
- short term after-hours and weekend work to review cases and complete administrative tasks required to close cases
- the appointment of a Strategic Reform Quality and Planning Manager
- requesting assistance from the department's Specialist Intervention Team.

78. Other initiatives implemented by the region included encouraging final year social work students to undertake fieldwork placements within the region. The region attracted 18 students in 2010 and subsequently 11 were recruited to positions in the program after completing their studies. The region supported these students by appointing a Student Placement and Recruitment Coordinator to coordinate and support the initiative. Overall, 17 additional child protection workers were recruited in 2010-11.

79. The region was also allocated a Principal Practitioner position to provide expert consultation, training and advice to child protection staff. The Principal Practitioner commenced in February 2011.

80. In response to my draft report, Manager A stated:

> … when I returned from leave in October 2009…I became aware of very concerning problems within the workforce: there was an extremely high number of job vacancies, poor retention rates, nearly half of the frontline staff were on fixed term contracts, supervision compliance was poor and intensive work was clearly required to improve performance. This was the context for the February 2010 [*sic*] memorandum and led to the significant improvements in performance documented in 2010-11. The reduction in the unallocated rate was the product of intensive, concerted hard work and I believe it will result in the improved delivery of services and the reduction of risks to vulnerable children – which is our core work.

81. However, despite these assertions, my investigation very quickly identified a significant number of cases of concern as the following chapter illustrates.

Failure to ensure the safety of children

82. Overall I considered that many of the reports examined by my officers had been closed prematurely without sufficient assurance that the children concerned were safe. Consequently I referred the circumstances of 59 children to the department for reconsideration.

83. The department accepted that further action was required to ensure the safety of all of these children. New reports were opened for 50 children whose files had previously been closed and further action was taken to address my concerns for nine children with open cases.

84. In some cases I examined, the risk was acknowledged; however no investigation occurred due to workload issues or the expiry of the department's internal timelines for responding to reports. I also identified cases which were inappropriately referred to family support services where I considered a departmental investigation was warranted.

85. Risk assessments were often inadequately documented and internal processes were not complied with. These poor practices were particularly prevalent on days when large numbers of cases were closed. It is not surprising therefore that some staff became suspicious that the achievement of internal performance measures had supplanted the careful consideration of children's circumstances as the region's priority. Manager B stated that 'no staff member raised with me any concern about this, and the first that I became aware of the apparent concern was through this investigation'.

Assessment of child protection reports

Setting higher thresholds for investigation

86. The whistleblower disclosure alleged that the region had set a cap on the proportion of reports that could progress to investigation. The cap was allegedly imposed to minimise the number of children who were on the region's unallocated list. In my 2009 *Own motion investigation into the Department of Human Services Child Protection Program*, managers in other regions stated that they had been pressured to apply caps to the number of reports that would be investigated.[21]

87. I did not locate any evidence of a specific 'cap' being placed on the proportion of reports being investigated in the Loddon Mallee Region. However all witnesses agreed that there has been a rise in the threshold, frequently referred to as the 'bar', for deciding which reports should be investigated.

88. A reduction in the number of reports investigated by the region was an explicit element of the region's strategy. The Regional Director's memorandum to the Secretary in March 2010 addressed the proportion of reports being investigated by the region:

> LMR's[22] Further Action rate reached a high of 40.8% in December 2009. In January 2010, it had dropped back to 30.4%. The region is

21 ibid, page 34

22 Loddon Mallee Region

> aware that such rates are unsustainable and that these need to be reduced significantly.

89. In response to my draft report Manager A stated:

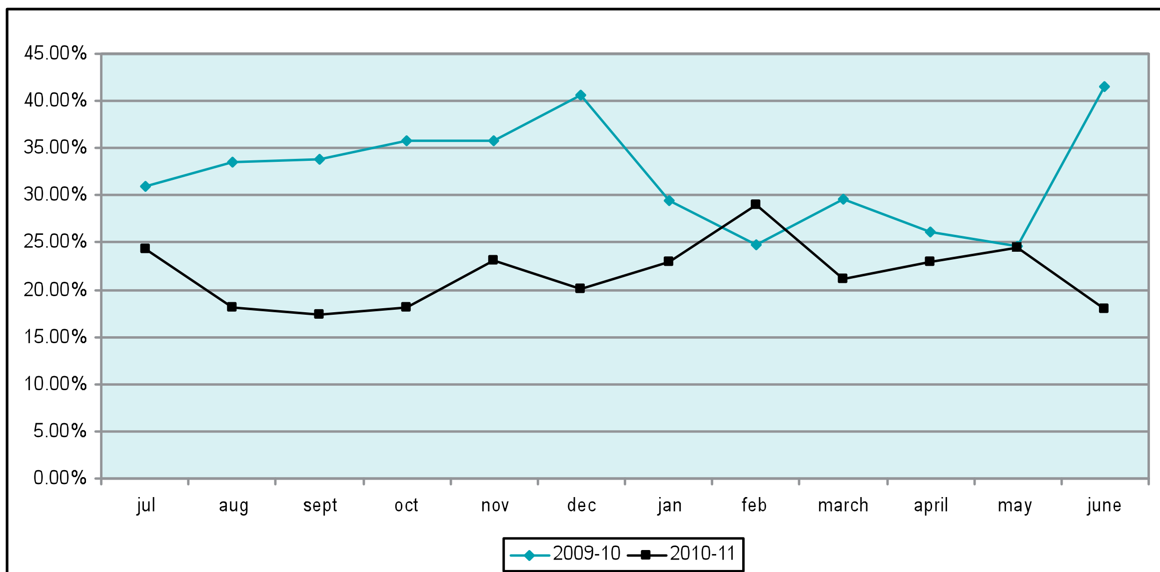
> I ask that you ... acknowledge the fundamental tension that exists between demand and capacity and that the investigation rate is one way at the front end that demand and capacity is managed. In my time as Manager ... our region has never directed or encouraged child protection workers to refrain from proceeding to investigation where a child is believed to be at risk of significant harm.

90. Manager B stated:

> This [point] is correct, however, it neglects to mention that the region's strategy included a number of other related activities, of which investigation threshold were [*sic*] only one.

91. The implementation of the strategy led to a reduction in the proportion of reports investigated by the region in 2010-11 compared to 2009-10 as illustrated below:

Figure 2: Percentage of child protection reports investigated in the Loddon Mallee Region from 2009-10 and 2010-11



92. Despite the overall number of reports to the region increasing by slightly more than 10 per cent from 5,287 in 2009-10 to 5,838 in 2010-11, the number of investigations conducted fell by approximately 26 per cent from 1,708 to 1,262. The cases reviewed by my investigation demonstrate that this reduction in the number of investigations led to children being left at risk of harm.

93. In response to my draft report Manager A stated:

> Stating that the number of investigations conducted fell by 26% is not what the graph [Figure 2] depicts overall. Although there is a stark difference between the proportion of reports investigated in June 2010 and June 2011 ... overall the rates show much less variation

throughout 2010-11 than in 2009-10. Between the months of January and May 2010 and 2011, the difference is not significant and certainly is not 'widening'. The percentage of reports being investigated is identical in the months of May 2010 and May 2011.

94. It is correct that a similar proportion of investigations were conducted in the months of January to May in both 2009-10 and 2010-11. However Manager A has limited their comparisons to the periods following the region's implementation of its new approach to the investigation of reports. That approach involved a substantial reduction in the number of investigations being undertaken from January 2010 onwards which continued into 2011.

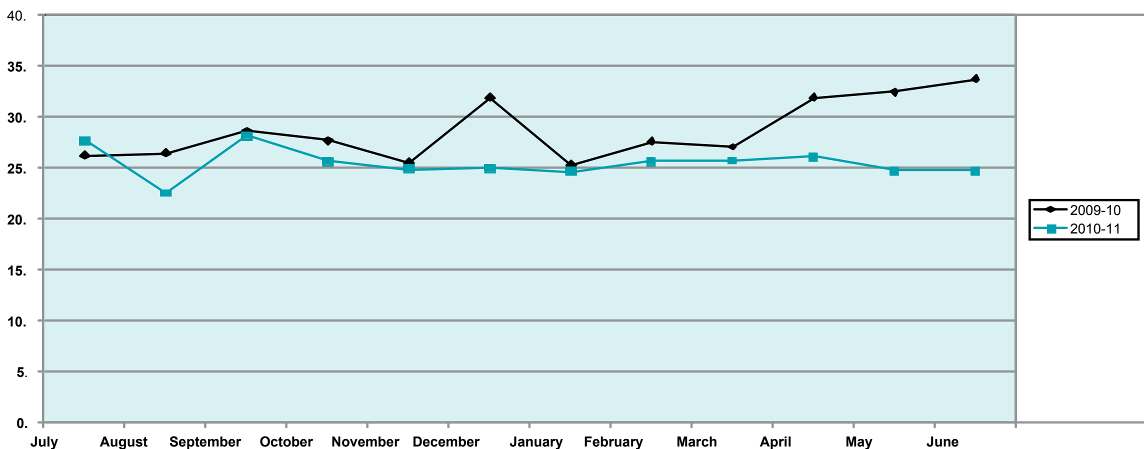
95. Manager B stated:

> This [the reduction in the number of reports investigated] is correct, however it does not capture the other potential outcomes for families reported to the Program being other referral activity that is undertaken to ensure that vulnerable children, youth and families are provided an appropriate community services when a report is received. Despite the perceived reduction in reports that are investigated, the LMR Child Protection Program still investigates children at risk.

96. However the region's failure to adequately address the needs of many children has been demonstrated by the department's decision to take further action in relation to all of the 59 children for whose safety I was concerned.

97. State-wide the proportion of reports investigated by the department during 2010-11 was also lower than in 2009-10. In light of the consequences of the shift in the investigation rates in the Loddon Mallee Region, I am concerned that the state-wide reduction in investigation rates may be leading to similar unsatisfactory outcomes for children. The following graph illustrates a reduction in the proportion of reports investigated state-wide in 2010-11 compared to 2009-10:

Figure 3: State-wide percentage of child protection reports investigated from 2009-10 and 2010-11



98. Senior managers within the Loddon Mallee Region stated that the tightening of thresholds for investigation was necessary for the region to cope with its workload.

99. Manager B stated at interview on 31 August 2011 that:

> Just because a child is brought into child protection does not ensure their safety, the safety is afforded when we have good staff that are supported and positions are filled and we can allocate those children to a case manager and afford them good supervision which wasn't the case when I came into the region.

100. The Manager further stated that the previous approach was not sustainable and the higher threshold was necessary to ensure the region's workload was manageable with the available resources. Manager B said:

> … we have needed to really look strongly at the sorts of numbers of children that we can bring into the program to provide a targeted quality service for, we're not an unfunded, infinite resourced, environment. We only have a set number of staff to provide a set number of services to certain children…I just can't keep bringing children in that I can't deliver a service to.

101. The capacity of the region to maintain its previous rate of investigations is a state-wide issue. In February 2011 I received advice from the Secretary in relation to the department's implementation of my 2009 recommendations, that:

> With a continued growth in reports, the investigation rate is likely to come under further pressure as the capacity of the child protection program to investigate reports is finite.

102. The Secretary also stated:

> While resources for child protection have increased so too has demand and I contend the department has continued to improve performance and respond to demand within the available resource base.
>
> The increase in reports to child protection in 2010-11 has resulted in an increase (in real numbers) of investigations and Court Orders while the number of children with an allocated case manager has also increased.

103. The Regional Director stated at interview on 1 September 2011 that the additional funding provided to the program has not kept pace with the increasing demand on the program over time:

> Governments of both persuasions have added numbers of staff in but in actual number terms they are not big numbers really, they wouldn't equate to anything like say a ten per cent increase in notifications [reports], not a ten per cent increase in the workforce …

Consequences of the higher threshold

104. Reducing the proportion of reports that are investigated in an environment where the overall number of reports is rising carries significant risk that vulnerable children may be left in unsafe circumstances.

105. Witnesses expressed concern that many reports that identified serious risk to children were not being investigated. Manager B said that '[a]t no point in my time as Manager have staff or managers expressed any concerns to me about any identified risk to children that were not being investigated and/or being appropriately responded to by the Program'.

106. My review of departmental files supported the concerns of these witnesses. Many files contained little evidence of a comprehensive assessment of the children's needs and appeared to include only the minimal enquiries necessary to justify a decision to close the case.

Case study 1:

A report was received on 4 May 2011 alleging that a father struck his partner to the head and face. Their three children, aged from 4 months to 12 years of age, were at home although not in the same room. The mother sustained injuries but would not make a statement to police due to her fear of her partner, nor would she accept the assistance of a support service.

The initial assessment of the report was that the children's safety was unknown. Later follow up with police established that the children's mother did not follow through with an application for an Intervention Order. The children's school did not have any serious concerns for the children nor did a Maternal and Child Health Nurse.

However the department did not undertake any checks with the New South Wales Department of Community Services despite the family living on the border. Contrary to departmental standards, no consultation occurred with a Specialist Infant Protective Worker.

I was concerned that the assessment of risk to the children was limited and incomplete in light of the mother's refusal to either accept assistance or apply for an Intervention Order.

I referred the circumstances of these children to the department for reconsideration. I was subsequently advised that their case had been re-opened for the department to make further enquiries.

107. This practice of minimal intervention and assessment was characterised by a child protection worker with more than 10 years experience as:

> We have a really dangerous mindset happening - how do we close it? You then seek the information to confirm your bias.

108. Several examples provided by witnesses or identified by my case reviews involved children who were being exposed to chronically unstable and neglectful circumstances over lengthy periods of time. I asked the

Secretary to review the circumstances of the following child to ensure she was being appropriately protected.

Case study 2:

> In May 2011 police reported concerns regarding a six year old female child. Her mother had been seen extremely intoxicated and police were concerned she would be unable to care for the child due to her level of intoxication.
>
> There had been 13 previous reports regarding domestic violence between the child's parents, mental health concerns for the mother, allegations that the mother exposed the child to possible sexual offenders and parental drug and alcohol misuse. There was also a concern about the mother's inappropriate discipline of the child.
>
> A review of the child's file identified that the risk of cumulative harm had not been adequately considered by the department.
>
> The Secretary subsequently advised me that a new report had been opened and the child's circumstances would be investigated.

Managing the risk

109. The region's approach to reducing the number of reports that are investigated was not matched by having robust strategies in place to monitor the risks inherent in this approach. In response to my draft report Manager B stated:

> I do not agree with this statement. We have various systems in place to monitor, on a regular basis, the implementation of the strategy. This includes my supervision of the Unit Managers who run the units, a daily monitoring of the CRT [Corporate Reporting Tool] system, and the implementation of the Workload Monitoring Review Panel.

The Manager said:

> I also disagree that we are implementing a policy of minimal intervention and assessment.

110. Manager B said that there are limited means by which to understand the consequences for children whose circumstances are now no longer investigated. While complaints, child death reviews and incident reports provide some feedback to managers, the region has no systematic process in place for reviewing the quality of decision making in its Intake Unit. Manager B was asked:

> Question: How do you measure or judge the impact that's having on children reported that are no longer investigated, or can you measure that?
>
> Answer: No we can't. We don't have any resourcing to sort of measure that decision making that would happen in our intake where the decision is made not to bring a child into the child protection system or refer a child to Child FIRST.

111. The department also has no means by which it can identify the proportion of reports that it receives which are not investigated due to resource constraints. Manager B agreed that this absence of data hindered their ability to understand the level of unmet demand within the child protection system:

> It would certainly be useful I think in terms of understanding unmet need and I think to continue those conversations for regions to be able to negotiate with the division and subsequently through the funding line to government about what we need.

112. Manager A stated at interview on 1 September 2011 that, after reviewing the cases referred to the department by my office, they now believed that a review of decision making in the intake phase is required. The Manager said:

> The process that I am looking to put in place is around independent random audit of those cases that haven't gone through to investigation over a twelve month period because I think we need to look back that far and do a really rigorous analysis of all those cases … and look at what are the trends and themes coming through here and what's that about.

113. Manager A subsequently wrote to my office following the interview stating:

> During my interview of 1 September 2011 with you, I mentioned some Loddon Mallee Region (LMR) Child Protection Reports which had not proceeded to protective investigation. These Reports had recently been brought to my attention by the Children Youth & Families Division. In my interview with you I explained that the Child Protection Manager […] and the Regional Principal Practitioner […] and I had reviewed these closed Reports and had formed a view that they should have proceeded to Investigation, given the nature of the protective concerns and other relevant factors.
>
> I also explained that following the review of these Reports, I had initiated a request for an audit. I confirm that I met with the Director of the Specialist Intervention Team (SIT), Service Delivery & Performance Division on the morning of 1 September 2011 to request that SIT undertake an 'end to end' business analysis of the operations of LMR's Intake function to ensure that the threshold for risk for children is applied consistently and appropriately. I followed up this meeting with a formal request by email and a project brief has subsequently been developed by SIT and the business analysis will commence shortly. I expect that this will decrease the risk of Reports not proceeding to investigation when the initial information obtained at Intake indicates that they should.

'Repeat' reports to child protection

114. A 'repeat' or multiple report is where a child has previously been subject to a report to the department. The department receives many 'repeat' reports regarding vulnerable children and families.

115. Data provided by the Loddon Mallee Region indicates that it has one of the highest rates of 'repeat' reports in the state:

Table 1: Number and percentage of 'repeat' reports to child protection by region and state-wide in 2010

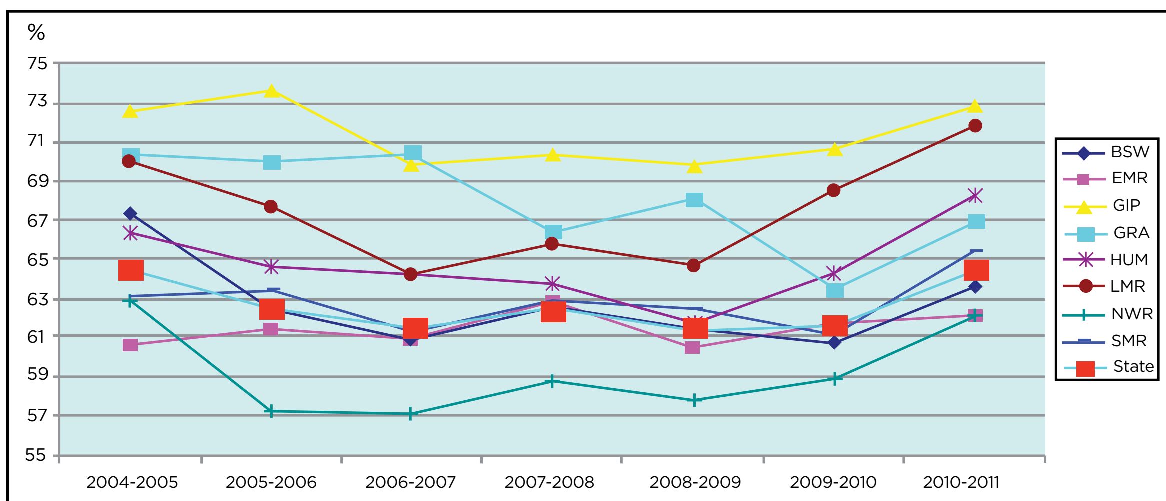
Region	Number of reports	Repeat reports	% repeats
Gippsland	4 585	3 338	72.8
Loddon	**5 132**	**3 605**	**70.2**
Hume	3 504	2 315	66.1
Grampians	2 803	1 825	65.1
Southern Metropolitan	11 867	7 461	62.9
Barwon-South Western	3 103	1 948	62.8
Eastern Metropolitan	5 890	3 565	60.5
North & West Metropolitan	13 746	8 243	60
State-wide totals	50 630	32 300	63.8

116. Manager A stated that:

> ... there is a high rate of 'repeat' reports from family members (compared with mandatory reporters such as police) in our region. Further work needs to be done to understand this unique feature which is likely to be related to demographic and socio-economic factors in Loddon Mallee Region. However, it is unlikely to change in the short term and does not point to any inherent problem in the delivery of services.

117. The following figure demonstrates that the number of 'repeat' reports has increased across the state in the last two years.

Figure 4: Percentage of 'repeat' reports by region and state-wide from 2004-05 to 2010-11



118. In response to my draft report, the Secretary stated:

> The most 'first' reports are received for infants and very young children, 10,224 under three years in 2010-11. Therefore where chronic or relapsing family characteristics are present, these children may be brought to the attention of child protection a number of times until the age of 17 years. The department is undertaking considerable analysis of children reported multiple times. In 2009-10, 29,826 reports were repeat reports. In this year, 13,077 children were reported for the third or more time in their lifetime (to date). Of these, 5,206 children (39.8 per cent) were investigated in that year and 2,970 substantiated (including 1,232 where a Protection Application was issued). This highlights the number of children subject to repeat reports and that intervention rates with these children are higher than annual intervention rates.

119. Several staff expressed frustration that many of these children could have been effectively assisted by a more comprehensive response to initial reports. As two said:

> Well, you know, if you close 100 and 30 come back in, that's 70 that haven't come back in, and that means they're probably doing OK.

> It's a bit of a common - bit of a common black humour at the office that most of the time if you walk up to the intake board you'll know the majority of families at any time … they just keep coming back.

120. The following cases illustrate this issue. In the case study 4, the closure was predicated in part on the assumption that further reports would be received should the child remain at risk of harm.

Case study 3:

The department received a report about a two month old child in March 2011. The report was in relation to violence between the infant's mother and the mother's partner.

The department had previously been involved with the mother when she was an adolescent. The mother has an intellectual disability and a history of significant substance misuse, criminal behaviour and placing her personal safety at risk. She was classified as a 'high risk adolescent' during her own involvement with the department.

The Intake Unit identified that it appeared that the infant had not been seen by a Maternal Child Health Nurse since birth. There were concerns about violence between the mother and her partner, as well as ongoing substance misuse by the mother, who has a history of not cooperating with support services.

The file was closed in July 2011 on the basis that the child's mother was cooperating with support services.

After I referred this matter to the Secretary a further investigation was conducted and, following a violent incident where the mother was assaulted, the child was removed from her care.

Case study 4:

A report was received on 11 June 2011 alleging that the parents of four children under 14 years of age had recently separated, following many years of domestic violence.

It was alleged that the oldest sibling had recently become threatening towards his mother and siblings and he regularly threatened them with a knife. The reporter believed the children had previously sustained injuries such as a black eye from their older sibling and that this could be verified through hospital records.

On 11 June 2011 a team leader reviewed the information and decided that contact should be made with the children's schools and Child FIRST to gather information regarding the family. The team leader also directed that contact be made with the mother to discuss support that may be available to her and a possible referral to Child FIRST.

On 28 June 2011 a manager completed a case note as follows:

> Due to competing work demands, this case had been unable to be followed up since the report was [received] on 11/6. The reporter has raised some concerning allegations however has also reported there are allegedly other professionals involved with this family who would report to CP [Child Protection] if they had concerns for the children. Whilst not dismissing the reporter's concerns, there appears insufficient information to suggest the children are at an unacceptable level of risk…Case to close.

121. I was concerned in this latter case study that the department did not contact the children's schools or follow up with the hospital to ascertain if the children had sustained injuries. I asked the department to reconsider the child's circumstances and was subsequently advised a new report had been opened and follow up would be undertaken with a view to referring the family to Child FIRST.

122. I note that the department's Child Protection Practice Manual includes detailed advice regarding the management of 'repeat' reports. The advice establishes as standard practice that:

> Where Child Protection has received two reports in a 12 month period that have not been investigated, irrespective of classification, any subsequent report in that 12 month period must be investigated unless the Intake Unit manager reviews the case and assesses an investigation is not warranted.
>
> If an investigation is not warranted, the Intake Unit manager should record an explicit rationale for this decision on the electronic client file.
>
> If the Intake Unit manager has had previous involvement or contact with the case, it is preferable that another unit manager undertakes the case review wherever possible.

123. I consider the requirement for a comprehensive review of ‘repeat’ reports, with a bias toward investigation, to be a prudent approach. Review by a different manager also ensures that another perspective is brought to a matter and avoids placing the initial decision maker in a situation where they are required to consider the appropriateness of their own decisions.

124. In response to my draft report, the Secretary stated:

> I agree that the current practice standard is prudent. The department intends to maintain this procedure and proposes to strengthen the advice that the review be undertaken by a manager not presently involved in the original decision not to investigate.

125. Many of the case studies examined in my investigation involve ‘repeat’ reports. There was little evidence of compliance with the above departmental requirements in these cases. In many instances the reviews conducted by managers lacked detail and were also conducted by a manager who had previously been involved in a case:

Case study 5:

On 9 March 2010 a report was received that a mother had assaulted her partner while he was holding their seven month old child in his arms. The police subsequently advised that the children’s mother admitted hitting the father however no injuries to the child had been observed. It was also reported that the mother has applied for an Intervention Order.

While the file indicated that follow up was to occur with a Maternal and Child Health Nurse, the mother and a Specialist Infant Protective Worker, there are no further notes on the file prior to the case being closed. On 18 March 2010 a manager noted that the probability of harm was unlikely as the parents had separated and no injuries to the child had been observed. The manager noted that ‘given the length of time that has elapsed since the incident, it would appear irrelevant to ask the mother to attend for a medical check’.

On 29 March 2010 another report from a professional reporter alleged that the mother wished to resume a relationship with the child’s father and was attempting to change the Intervention Order to enable contact with him. Allegations had also come to light that the father had broken the child’s arm some months ago. On 30 March 2010 a Maternal and Child Health Nurse confirmed the child had sustained a broken arm some months ago however the department was not able to confirm how the injury occurred.

On 18 April 2010 a manager noted that urgent contact was required with the police and the mother. Police were contacted on 22 April 2010 and the mother on 4 May 2010 when she agreed to a referral to Child FIRST.

On 10 May 2010 another report was received. The report raised concerns about the mother’s new partner being violent and exposing his children to serious domestic violence. Child FIRST accepted the referral of the family.

> On 12 May 2010 the department was contacted by a dispute resolution worker about the parents allegedly assaulting each other and the mother recently attempting suicide.
>
> On 18 May 2010 a decision was made by a Specialist Infant Protective Worker that the case should be investigated. This decision took almost two months despite serious concerns being raised about the children's safety.
>
> On 25 May 2010 a visit was conducted. The case notes on file were not completed.
>
> The case was closed on 22 December 2010 on the basis that Family Law Court (FLC) action was underway and the parents were handing the children over for access in a public place. The file notes that the mother was accepting assistance from a domestic violence support worker. The file also records concerns that the father had attempted to run the children's mother over in a car, no details are recorded in the closure summary.
>
> Since this case was closed there have been a number of reports received however none have been investigated. The allegations have included emotional abuse, a violent incident between the mother and her partner and that one of the children had a bleeding vagina.

126. The file relating to the above case study demonstrates little regard to the department's policy for the management of 'repeat' reports. There is no detailed review of the children's circumstances recorded in the final report reviewed during my investigation and I consider the rationale for not investigating the report to be superficial. There was no evidence that the bias toward investigating 'repeat' reports was implemented in this case. The department has reconsidered the matter at my request and commenced an investigation into the children's circumstances.

Child protection referrals to Child FIRST

127. Reports identifying significant concerns for a child's well-being, which the department does not consider to require investigation, may be referred to a Child FIRST program operated by a Community Service Organisation. St Luke's Anglicare (St Luke's) operates the Child FIRST program which accepts referrals from the region's Bendigo office.

128. There was an increase in the number of referrals to St Luke's Child FIRST program in 2010-11. Data provided by St Luke's also demonstrated an increase in the number of referrals from the department that were not accepted.

Table 2: Referrals to St Luke's Anglicare Child FIRST from the Loddon Mallee Region Child Protection Program from 2008-09 to 2010-11

Year	Total referrals	Referrals from the department	Referrals from the department not accepted
2008–09	503	155	2
2009–10	506	141	7
2010–11	551	216	12

129. Senior staff from St Luke's stated that cases may not be accepted because they … 'require a Child protection investigation and should not be diverted to family services at this initial stage'.

130. While these witnesses considered that the department's referrals to Child FIRST over the longer term had been appropriate, they had noted a change in the complexity of cases referred to Child FIRST over the past twelve months.

131. In response to my draft report, Manager A stated:

> … the increase in referrals from the region between 2009-10 and 2010-11 is proportionate with the growth in the number of Child Protection reports during that period. The increase in the number of referrals from the region that were rejected by Child FIRST is not statistically significant. In 2009-10, the percentage was 4.9% and in 2010-11 it was 5.5%.

132. The Secretary stated:

> Where it was assessed that children and families would benefit from a family support service, referrals were made to Child FIRST with those referrals increasing by 53 per cent from 141 in 2009-10 to 216 in 2010-11.

133. The following case was provided to my officers as an example of an inappropriate referral to Child FIRST:

Case study 6:

On 9 June 2011 the department received a family violence report from Victoria Police regarding a family with four children aged between two and 15 years. The report described an incident where the mother and father of the children had started to argue after the father attended an appointment with his counsellor. As the mother was bending down to pick her two year old son up, the father kicked her in the shin. The mother has kicked him back and the father then retaliated by kicking the mother in the groin.

The department attempted to refer the family to Child FIRST on 21 June 2011 however the referral was not accepted due to the young age of the children and concern about the father's escalating violent behaviour. It was recommended the department investigate further.

On 8 July 2011 another report was opened with the same details as the previous report.

There was no follow up conducted by the department until 19 July 2011 when an intake worker contacted a counsellor involved with the children. On the 22 July 2011 an attempt to contact the parents was made and a letter was sent to them on 27 July 2011 requesting they contact the department.

On 1 August 2011 another report from police was received. The report stated that the father had assaulted the mother while holding his two year old son during the incident. The police advised the department that they had successfully applied for an Intervention Order and the father was subsequently removed from the home.

The assessment following this report stated:

> The harm consequences are assessed as serious given the ongoing nature of the Family Violence, and the children [*sic*] exposure to this … The harm probability is assessed as highly likely … Further assessment is required to establish the children's immediate and future safety, stability and development.

However a further referral was made to Child FIRST without an investigation being conducted.

On 4 August 2011 Child FIRST advised the department that the referral would not be accepted and asked that the department investigate further.

On 8 August 2011 another report was received from a counselling service that had seen the father. The service raised serious concerns that the father been successful in having the conditions on the Intervention Order changed to allow phone contact with the mother. The service stated of the father, 'We are most concerned about what appears to be a significant lack of insight … He has expressed no remorse and appears to regard his behaviour as justifiable'. The service requested that child protection remain involved in the case.

On 12 August 2011 an intake worker sent the service an email stating that the report would be closed and asked that the service monitor the situation and re-report should they become aware of further concerns. A similar letter was sent to the children's mother.

On 16 August 2011 the region's Principal Practitioner was consulted leading to a decision to conduct a further investigation of the report.

As at 29 August 2011 the case was still awaiting allocation to a child protection worker and no investigation had been started.

Despite the children being exposed to and involved in at least two violent incidents between the parents no investigation had commenced almost three months after the initial report.

I made enquiries with the department regarding the progress of this matter due to the lengthy delay in investigating the report. I was subsequently advised that the first visit to the family was conducted on 6 September 2011.

134. St Luke's and departmental witnesses also described recent changes to how referrals to Child FIRST have been managed. Several witnesses said that accepted practice has been for the department to keep the child's case open until Child FIRST has accepted a referral. Child FIRST's acceptance would be confirmed after a staff member had visited the family with a community based child protection worker.

135. This practice allows for the department to meet its obligation under the *Child Protection and Integrated Family Services State-Wide agreement (Shell Agreement)* 2010 that:

> When a referral is not assessed as requiring a family service case work response, community based child and family services may provide advice to child protection. Child protection will consider and plan an appropriate response for the family, giving regard to the child's safety, stability and developmental needs.

136. A review of departmental files confirmed that in some recent cases the department had closed the child's case prior to Child FIRST visiting the family and confirming that it would accept the referral. For example:

Case study 7:

The department finalised an involvement with six children less than 12 years of age on 17 June 2011. The case had been closed at intake with the statement:

> Parents relationship appears to be characterised by ongoing family violence which is being addressed by regional referral to Child FIRST.
>
> Case to close with Child FIRST conducting a joint home visit to the family with the CBCPW [Community Based Child Protection Worker] to encourage the family to engage with the service.

The children had previously been subject to protective orders due to their exposure to violence between the parents. At that time the children also presented with injuries. A number of previous investigations by the department also related to the children having contact with a number of different registered sex offenders.

A further report was received on 24 June 2011 following police attendance at the family home due to an incident of violence. The report noted that 'Police determined that risk of future violence to be likely'. The mother and children entered refuge accommodation.

The case was closed on 28 June 2011 with a notation on file that the Community Based Child Protection Worker would conduct a joint home visit on 30 June 2011.

137. I was concerned that the department's response to this report was inadequate in light of the family's history. For example, no contact was made with the children's school during the intake phase. I was also

concerned that the report was closed prematurely as the department did not wait to confirm that the mother was willing to co-operate with Child FIRST.

Case study 7 continued:

Another report was subsequently received on 4 July 2011 alleging that:

- the children had been exposed to a violent incident and the mother and children had been moved to a refuge by police
- the matter was heard at court and the mother attempted to have Intervention Order proceedings against the father ceased
- the mother had been sighted with black eyes
- the children had been hit with belts in the past and were scared of their father
- the father had been threatening the children
- the father had allowed a known sex offender to reside in the house
- there were alcoholics living with the children.

A child protection worker assessed the harm consequences to the children as serious and that exposure to harm was highly likely in the future given the long history of child protection involvement.

The team leader directed that the Community Based Child Protection Worker be contacted regarding the home visit that had been scheduled for 30 June 2011 and the case be closed on the basis that the Community Based Child Protection Worker believed Family Services can monitor the family.

138. I was concerned that police were not contacted to gain further information about the family violence incident and allegations regarding a sex offender having contact with the children. I note that the Community Based Child Protection Worker stated the family services worker had not yet engaged with the family other than having an initial meeting.

139. My office asked the department to reconsider the circumstances of these children. This led to the department opening a new report and commencing an investigation into their safety.

Conclusions - assessment of child protection reports

140. The evidence obtained from witnesses and my review of departmental files raises very similar issues to those identified by my 2009 Own motion investigation into the Department of Human Services Child Protection Program.

141. The number of children whose circumstances I consider received only a superficial assessment, and the apparent tendency within the region toward the minimum possible intervention that can be justified, suggests

a practice within the region where the safety and well-being of the children is being compromised. I am concerned that the drive to meet numerical targets has overshadowed the interests of children despite evidence that they may be at risk.

142. That practice is, in my view, the result of strategies implemented in the region and across the state to reduce the number of children who are not allocated to a child protection worker. In essence, this could be seen as an exercise in keeping the numbers down, to the detriment of the children involved.

143. The region implemented a strategy one element of which was an intentional reduction in the proportion of reports which it investigated. Given the implications for the safety and well-being of vulnerable children, I would have expected much greater care to have been taken to understand the consequences of re-positioning the responsiveness of the child protection program to reports of child abuse. However in my view the region failed to adequately mitigate the inherent risks in its strategy.

144. It was the responsibility of managers in the region to identify and manage the risks that accompanied the region's strategy. While Manager A's plan to commission a systematic review of the region's decision-making is a positive step, such measures should have been incorporated into the region's strategy from the outset.

145. I note that this minimisation strategy was well known within the department. The Secretary and other executives were briefed that the region intended to reduce 'significantly' the proportion of reports it investigated.

146. My 2009 report gave prominence to the need to scrutinise the thresholds being applied to the investigation of reports. In that report I recommended that:

> The department:
>
> Establish arrangements for the ongoing independent scrutiny of the department's decision-making regarding reports with particular attention to:
>
> a. how the urgency of reports is categorised
>
> b. the consistency of thresholds applied across the regions
>
> c. the appropriateness of the thresholds applied by the department in its decision-making.

147. In response to my draft report, the Secretary stated:

> The department takes the risk assessment of reports of abuse and neglect of children very seriously and has taken significant steps to improve capacity at the point of report to identify and manage appropriately those reports that upon investigation result in substantiation of significant issues.
>
> The department has undertaken a significant work program for the purpose of reforming intake and improving decision making,

> including intake processes and thresholds as well as regional reviews and audits.
>
> The audit and review activity has involved the mapping of the processes in all nine intake rooms, visits to other jurisdictions, the development of more centralised options and once concluded will have involved the analysis of the department's response to more than 2,000 reports.
>
> A review of Loddon Mallee Region intake decision making commenced in September 2011 and involves analysis of service provision for families reported to child protection in Loddon Mallee Region. The analysis involves a review of approximately 600 reports received over a 12 month period to July 2011 with a focus on reviewing decision making and threshold management.
>
> As a result of the activity, the department is considering options for significant reform of intake in 2012 that may lead to a statewide intake model.

148. While the department has begun to implement this recommendation made in 2009, my investigation found no evidence of any systematic approach to validating the appropriateness of the Loddon Mallee Region's threshold for intervention. Had my recommendation been implemented the department may have identified and remedied the unintended consequences of the region's strategy.

149. Although the investigation of this disclosure has examined the specific circumstances in the Loddon Mallee Region, I am concerned that other regions may be implementing similar practices.

150. The number of children not allocated to a child protection worker and the department's performance against its timeliness measures are measures of the department's capacity to respond to demand. However the evidence obtained in this investigation shows that, to some extent, the region's response to unmet demand was to re-define whether the circumstances of children reported to it required investigating. The unmet needs of those children are not reflected in the department's performance measures. Improved measurement of unmet demand would provide the department with better information on which to plan its deployment of the Specialist Intervention Team and provide advice to government regarding resource requirements.

151. In response to my draft report, Manager A stated:

> The staff and managers within my region work tirelessly and with dedication to protect vulnerable children. On my own behalf and on behalf of those I manage I fundamentally deny the existence of a culture of compromising child safety and wellbeing. I deny the existence of any desire to manipulate data and maintain that the reduction in our region's unallocated rate was a genuine improvement and the result of hard work.
>
> There has been a genuine reduction in the number of children who are not allocated a child protection worker. This has led to improvements in the delivery of services and the management of risk.

> I reject the notion that the region responded to unmet demand by redefining risk. The region responded to increased demand through a concerted workforce strategy which included recruitment and retention initiatives, creating capacity by ensuring appropriate case closures and making good use of the department's Specialist Intervention Team. I consider these measures must be acknowledged… – there is simply no basis for a conclusion that the region's only response to demand was to increase the threshold for investigation.

152. Manager B stated:

> I strongly refute the allegation that we are compromising the safety of vulnerable children.
>
> All Child Protection staff and managers have operational imperatives and performance indicators that we are accountable for. The preliminary conclusions fail to acknowledge the established funding to regional Child Protection Programs. We have established funding for a limited number of Child Protection practitioners, which means I am unable to employ staff outside of the Program's financial capacity.
>
> There was no cynical exercise in keeping numbers down, and we did not act to the detriment of vulnerable children.
>
> I believe we did identity and manage the risks.
>
> I do not agree that we were re-defining the circumstances of children. We were instead improving our understanding of our client group, with the resources we had available, to best support a service response to vulnerable children and families.

153. In response to my draft report, the Secretary stated:

> I strongly disagree, however, that case allocation is about the pursuit of a numerical target … and that the regional strategy was developed for that purpose. The allocation of a case manager to a child is fundamental and necessary to support good child protection practice.
>
> As at 10 July 2009 Loddon Mallee Region had 17.8 per cent of clients awaiting allocation increasing to a high of 36.5 per cent in February 2010 and reducing to 25.8 per cent in July 2010. During this period, the number of children without an allocated case manager was significant and unacceptably high. As a result, the region developed a strategy to enable as many children as possible had [sic] a dedicated case manager and to ensure that this was achieved in a sustainable fashion.
>
> The regional strategy was a balanced approach to improve allocation and to understand better the factors influencing regional workloads. In your 2009 investigation, you state in paragraph 24 'the effect of a child protection system stretched beyond its capacity can manifest itself in poor case practice'. Loddon Mallee Region identified this as a problem.
>
> The strategy, described in the memorandum, was designed to support the region to 'work toward' the target of 5 per cent

> unallocated … and to reverse the 'upward trend'. I do not agree that the brief describes a strategy committed to a numerical target at the expense of the interests of children. The allocation of cases can only be seen in the best interests of children.
>
> In 2010-11, the region's investigation rate did reduce to 21.6 per cent against the statewide rate of 25.4% and was a contributing factor to the regions improved capacity to allocate existing clients. The region sought to balance the number of workers able to work with children considered at highest risk with resources available to undertake new investigations.

154. However, the Secretary's response and the perceptions of senior managers are not consistent with the case studies included in this report; the demonstrable reduction in the number of reports investigated; or the evidence received from experienced child protection workers.

    The Secretary's comment that the regional strategy was not developed to pursue a numerical target is also inconsistent with the March 2010 memorandum provided to her by the region regarding its strategy. The purpose of that memorandum was to:

> … detail the strategies underway to work towards the target of 5% unallocated rate by September 2010.

Recommendations

I recommend that the department:

Recommendation 1

Review its procedures for assessing 'repeat' reports to ensure they receive comprehensive assessment by a manager not currently involved in the decision not to investigate.

Department's response:

The department accepts this recommendation.

I recommend that the department:

Recommendation 2

Implement an ongoing audit program in each region to review the appropriateness of decision making by intake units.

Department's response:

The department accepts this recommendation.

I recommend that the department:

Recommendation 3

The department develop strategies for systematically collecting data regarding unmet demand.

Department's response:

> The department accepts this recommendation in principle and will await the outcome of the Protecting Victoria's Vulnerable Children Inquiry to inform the response to this recommendation.

Closure of reports

155. Several witnesses expressed concern that a large number of reports had been closed by the region without all of the processes required by the department's Child Protection Practice Manual having been completed. It was alleged that these closures had been completed by both local managers and the Specialist Intervention Support Team.

156. File examinations by my officers found several cases which I consider were closed prematurely by managers. There were also multiple examples where the reasons for not investigating a report were poorly documented with little evidence of a considered assessment regarding the level of risk to the child. However my investigation did not substantiate the allegations regarding inappropriate case closures by the Specialist Intervention Team.

Inadequate documentation of risk assessments

157. The minimum expected practice prior to a report being closed, either with or without an investigation having occurred, is for the child protection worker to document their assessment and consult their supervisor.

158. Each case is required to have a closure summary. The department's Child Protection Practice Manual states that:

> Arguably the two most significant documents within a case record are the intake record and the case closure summary.[23]

159. The case closure summary and case closure screen in the department's CRIS database should include the following information, as appropriate:

    - an overview of child protection involvement, including original protective concerns
    - brief summary of child protection involvement in chronological order and indicating significant documents and reports, for example, Temporary Assessment Order reports, protection application report and/or disposition report, assessment reports, medical reports

23 Protecting Victoria's Children – Child Protection Practice Manual. Advice no: 1527 Case closure actions and tasks, page 1.

- rationale for decisions such as substantiation and level of risk
- how the protective concerns have been addressed
- the rationale for case closure
- any risk that could reoccur and actions required
- closure plan (referrals, information and advice provided)
- the views of other professionals if relevant
- family views, if relevant
- dates of any relevant endorsements provided.

160. The department also has additional requirements for the closure of cases involving high risk infants.[24] High risk infants are defined as children under two years of age where any of the following factors are present and the severity and cumulative impact of these factors is affecting the child's safety and development:

- parental substance and alcohol abuse
- family violence
- parental mental illness
- intellectual disability
- parent/carer under 20 years or under 20 years at birth of child
- lack of willingness or ability to prioritise child's needs above own
- rejection or scapegoating of child by the parent
- harsh, inconsistent discipline, neglect or abuse
- inadequate supervision or emotional enmeshment
- single parenting/multiple partners
- inadequate antenatal care.

161. The standards for responding to reports regarding high risk infants include:

> Where a child under two years is the subject of a report and any of the high risk factors are evident, practitioners must consult the regional specialist infant protective practitioner or high risk infant manager to inform the course of action.
>
> For all reports on children under two years where any of the high risk factors are evident, Child Protection practitioners must contact the hospital where the child was born to obtain relevant information regarding antenatal and postnatal care.

162. My officers reviewed a selection of cases closed during 2010-11 with particular reference to the key intake documents and case closure summaries recorded on all child protection files. The documents reviewed were frequently of a poor standard. Several examples were

24 Protecting Victoria's Children – Child Protection Practice Manual. Advice no: 1012 High Risk infants (HRI) – practice requirements

noted where the required sections of these documents were not completed including those detailing the health and welfare needs for the children concerned. Important details such as cultural issues and the need for interpreters when dealing with the family were also left blank, despite this information being known to the department.

163. Of greater concern were instances where the required risk assessment fields including 'intake outcome decision' and 'priority urgency' were left blank. In some instances it was difficult to understand the basis for the department's decision not to investigate the report. For example:

Case study 8:

A report was received on 23 August 2010 regarding a 16 year old female with departmental history around her mental health, her parent's alcohol and drug use and her exposure to domestic violence. The report raised concerns that she was suffering from drug induced psychosis, was associating with high risk adults and being exposed to her parent's alcohol and drug use and violence. The intake worker states that the 'harm consequences is [*sic*] assessed as concerning'.

No further notes outlining any follow up were evident. No risk assessment was completed and notes stated 'risk and needs analysis is not completed as approved by PSM'[25].

On 27 August 2010 a Unit Manager endorsed the closure of the case with no further action. No follow up had been conducted to inform the department's assessment.

The regional Child Protection (CP) Manager, was shown the case documentation at interview and he stated that he would have expected the document to have been completed. He also stated he did not give any authorisation for the risk and needs analysis not to be completed. It was his view that the case required additional assessment than was demonstrated by the case notes.

My office requested the department re-consider the circumstances of this young person. I was subsequently informed that new reports have been opened regarding both the young person concerned, who is now aged 17, and her 16 year old sibling.

Finalising cases for closure

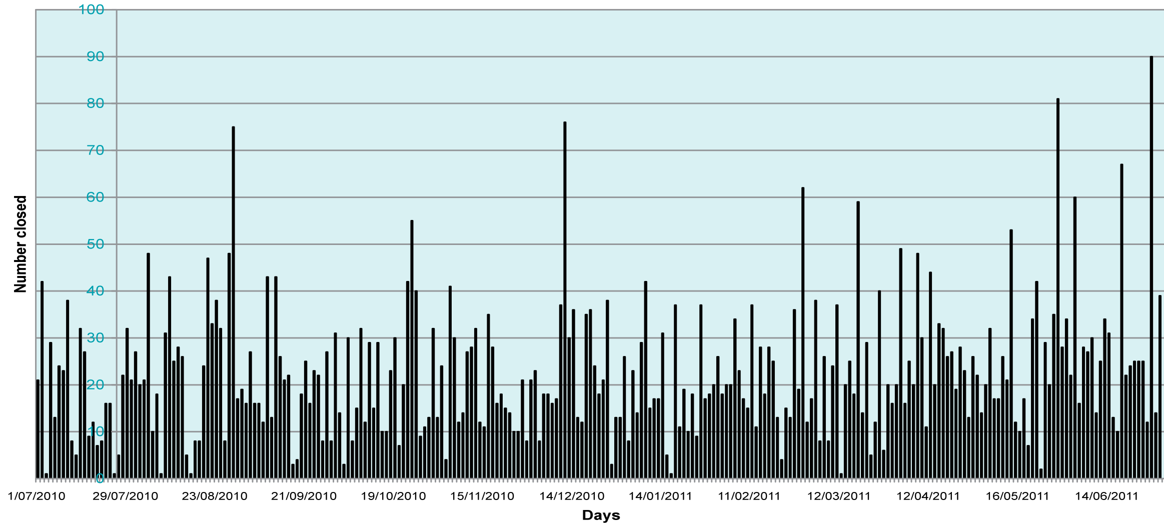
164. Witnesses described concerted efforts by managers in the child protection program to close large numbers of reports within a short period of time, usually on one day, to reduce the number of children on the awaiting allocation lists. This practice was described as 'culling' the case lists of staff.

165. Data for cases closed during 2010-11 demonstrated that there were a number of days where unusually high numbers of cases were closed.

25 PSM - Acronym commonly used by departmental staff to refer to the regional Protective Services Manager / Child Protection Manager.

The largest number of cases closed on any one day was 90 on 28 June 2011. This contrasts with an average of 22.7 cases closed per day throughout the year. The following graph illustrates the peak closure dates:

Figure 7: Closures per day in 2010-11 financial year



166. An increase in closure activity is apparent particularly during the lead up to the end of the 2010-11 financial year when data for the department's annual report was required. Senior officers denied this closure activity was motivated by a concern to make a favourable impression within the department or improve the region's performance in the department's annual report.

167. Both Manager A and Manager B maintain that there was no agenda or direction in the region to close cases without proper regard to the circumstances of the children concerned. Manager B stated:

> I don't really like the word cull. I am certainly aware that there are managers that do turn their minds, as they should, to the times when the lists in their units need to be looked at. So certainly there are examples in our intake unit of our intake unit manager proactively looking at lists and looking at opportunities to resolve particular intake reports, having a really concerted effort on that. Which is necessary from time to time with influxing numbers and different demands on any day, as part of their work agenda, that they need to also attend to their lists. I am also aware of other units like Bendigo North that have really proactive approaches to that, where they call them blitz days, where all staff can be, as best as possible, be free of client contact to spend the day trying to work through their files to do the administrative requirements to resolve or transfer particular cases.

168. In response to my draft report, Manager A stated:

> Child Protection involvement can only continue for the period it is legally mandated. Just as intervention and support is our responsibility, so is ceasing our involvement when protective

> concerns have been addressed. Resolving cases in closure phase is an important part of managing the program. Sometimes this work requires concerted focus.

169. Manager A referred to efforts to close number of cases which were in the 'closure phase' and could be easily resolved by finalising outstanding tasks. Manager A stated at interview:

> Having a concerted effort over a period of a few days or a couple of days, or even over a weekend, where people have said that they might want to do some overtime, that in itself is not a concerning practice. Because sometimes people are just so bogged down, for example in the investigations or the case management work that they're doing, that they can't see the wood for the trees. And if you say, right this is the effort that we're going to put in now into working to resolve these cases that are in closure phase, then that is absolutely a, its unfortunate that it has to be done in that way, but that is an absolutely legitimate activity …

170. In response to my draft report, the Secretary stated:

> Concentrated closure activity frequently occurs in busy intake units, and other areas of the child protection program, in all regions, on specific days and particularly in school holidays, when the number of reports temporarily decrease, allowing attention to be given to the timely resolution of cases identified for closure.

171. However the cases reviewed during my investigation demonstrate that children's cases were closed during these periods of intensive activity without sufficient attention to detail. A number of these cases were closed during the last few days of June 2011. For example:

Case study 9:

A teacher reported to the department on 9 March 2011 that a 14 year old young person had a large bruise to her arm. The young person had told the teacher that her father had hit her and then refused to provide further information.

On the day the report was received the protective worker noted:

> Based on the information provided there are concerns for the child's physical and emotional health given allegations of physical abuse.

The department contacted the Sexual Offences and Child Abuse Unit on 10 March 2011 and was advised that police did not intend to take any action.

On 10 March 2011 the case was closed at intake with the following rationale:

> This is the first report on this YP [Young Person]. At this time there is no evidence that physical abuse is ongoing in the home and the reporter has been unable to elicit specific information about the current bruise. File to close …

Three months later a second report was received when the 14 year old told her teacher that she had been caring for two of her younger siblings (aged two years and nine years) for five days while her parents had travelled to Melbourne with one of her siblings for medical treatment. The 14 year old stated that she had left the 10 year old at home to care for her two year old sibling so that she could attend school. The young person also stated that her parents may remain in Melbourne for up to two weeks.

Child protection subsequently confirmed that the children had been left home alone for a number of days and that there had been concerns in the past regarding this practice. While a child protection worker spoke with the oldest child, the intake report makes no reference to any contact with either parent.

The case was closed on 29 June 2011 with a referral to be made to Child FIRST.

Case study 10:

A report was made to the department in May 2011 regarding four children between the ages of six and 15 years. The report alleged that the eight year old child had disclosed that she had been raped by a family friend some years earlier. It was unclear why the child was speaking about the incident at that time.

The department referred the matter to police who met with the parents. The parents claimed that they had no knowledge of the alleged rape and arrangements were made for the parents to speak with the child and then re-contact police. The alleged perpetrator was described as 'undesirable' by police and it was confirmed that the parents had allowed the child to have sleepovers at his home. The case was closed at the intake phase.

A month later a second report was received alleging that the children were physically neglected, had lice and were dirty. The report alleged that the mother abused alcohol and drove while intoxicated with the children in the car.

The risk assessment completed stated:

> The likelihood of serious harm is concerning and it appears that [the] children are not being supervised appropriately… They are at risk of emotional [and] psychological harm due to parents lack of ability to protect and care…appropriately. [Their] physical safety is also at risk due to the parents actions.

On 21 June 2011 the team leader recommended that police be contacted regarding the alleged concerns regarding drink driving, the children's school be contacted regarding their presentation and the parents be contacted to discuss support services.

None of these actions were completed and on 27 June 2011 the file states:

> Police had recent involvement with this family and noted no sig [significant] concerns for these children in their parent/s

> care. Case to close with a letter to the parents re concerns/nfa [no further action] decision and contact details for services.
>
> The 'recent' involvement of police appears to have been in respect to the rape allegations. Due to my concern that the safety of these children had not been ascertained by the department, my officers asked that the report be re-considered.

172. The department opened new reports regarding both of the above cases after I requested that the children's circumstances be re-considered. The department is investigating both reports.

173. During my investigation I also obtained an exchange of emails between senior staff at the Bendigo office showing a concerted effort to close cases and allocate from the unallocated case lists on 17 June 2011. Sixty seven cases were closed on that day.

174. The exchange of emails canvassed which cases would be allocated to child protection workers following these closures and suggested that this decision be based on which families had the largest number of children. There is no reference in these emails regarding the need to consider the relative levels of risk for those children who were awaiting allocation to a child protection worker.

Specialist Intervention Support Team

175. In my 2009 report on my *Own Motion Investigation into the Department of Human Services Child Protection Program* I recommended that the department assign responsibility for monitoring regional performance to an executive officer who has responsibility to implement a corporate response when regional performance does not meet minimum state-wide standards. My recommendation was designed to address the inconsistent response between regions that arose due to variations in capacity across the state.

176. The Specialist Intervention Team (SIT) was established in response to my recommendation and the Secretary informed me that:

> The SIT has been funded as part of the Government's 2009 boost to child protection services. It will provide direct assistance to regions experiencing operational challenges and have a significant focus on partnering with regional management and staff to support operational capacity building, and improve sustainability and performance across the state.

177. Prior to formal Specialist Intervention Team operations commencing in September 2011 the department had made some ad hoc deployments to assist the Loddon Mallee Region to manage its workload.

178. The Specialist Intervention Team was formally deployed to the region upon its formation in September 2010 and representatives remained in the region until February 2011.

179. Witnesses spoke positively regarding the contribution of the Specialist Intervention Team in assisting regional staff to conduct investigations,

reviewing cases to establish whether they could be closed or alternatively required further action and coaching regional staff regarding how they could fulfil their roles more effectively.

180. Some witnesses expressed concern that cases had been closed by the Specialist Intervention Team without meeting the requirements of the Child Protection Practice Manual. However none were able to provide any specific examples of such cases. A review of regional files did not locate any examples of inappropriate case closures involving the Specialist Intervention Team.

Conclusions - closure of reports

181. The concerted effort to close a large numbers of cases on a single day raises similar concerns to those expressed earlier in this report. In many of the cases reviewed I have been concerned at the superficiality of the assessment undertaken when considering the circumstances of children involved.

182. I am not surprised that the significant increase in closure activity immediately prior to the end of the financial year has led to suspicions by staff that an effort was made to misrepresent the region's performance. Many of the cases I have referred to in this report were closed during the final days of the 2010-11 financial year. However there is also a correlation between the increase in closures in May and June 2011 and a higher number of reports received in these months.

183. In response, the Secretary stated:

> The assertion in the draft report that the high number of case closures in the Loddon Mallee Region on 28 June 2011 was to impact end of financial year performance reporting is incorrect. Ninety cases were closed on this day. Eighty-seven were cases in intake phase. Intake reports are not included in the count of allocated or awaiting cases and had no bearing on the allocation performance measure.

184. I have not concluded that this closure activity was designed to misrepresent financial year performance reporting although I can understand why some staff interpreted this activity in this manner. However the closure of large numbers of reports in the intake phase ensured that they did not progress to investigation and therefore require allocation. This practice was consistent with the region's strategy of reducing the number of reports investigated.

185. In my view, the proper consideration of reports should generally lead to relatively consistent rates of case closures. Sudden peaks in such activity should be avoided in order to ensure managers and staff remain focussed on the circumstances of individual children concerned rather than creating a climate where the closure of cases becomes an end in itself.

186. In response to my draft report Manager A stated that:

> … 'closure days' related to cases where only discrete activities were required to close files … closure for the sake of closure was not

> acceptable and I was not aware of any instance of the premature closure of files.

187. Manager B stated:

> I strongly disagree that there was any "concerted" effort on the part of managers to close cases on the same day or period, or that "peaks" in case closures reflect such an effort. It is not uncommon that managers will dedicate organisational time to reviewing work load with their units and making decisions regarding cases with their staff. As such, it is possible that such activity may appear to be "concentrated" on any given organisational day, as such activity would produce results. This approach by managers is proactive, and is aimed at supporting client outcomes and to ensure safe work environments for the staff with safe and manageable workloads.

188. I am also concerned at the poor standard of record keeping exhibited in the files reviewed during my investigation. Many cases did not contain a detailed analysis regarding why an investigation was not considered necessary. This contributes to the view that, at times, consideration of some cases was at best superficial.

189. Inadequately documented risk assessments create practical consequences for departmental officers due to the high rate of 'repeat' reports received by the department. Assessment information needs to be readily accessible to child protection workers who may need to make decisions regarding how new reports ought to be responded to. Good record-keeping is also an important element for ensuring proper accountability for decision making.

Recommendations – closure of reports

I recommend that the department:

Recommendation 4

Reinforce the requirement to fully document risk assessments and rationales for each case closure.

Department's response:

> The department accepts this recommendation and will re-issue practice advice to the workforce and support through regional briefings to staff.

Manipulation of allocation data

190. Children's cases are transferred between child protection workers as they progress through the various phases of the department's intervention or because the allocated child protection worker resigns, takes extended leave or transfers to another position.

191. The allocation of cases within teams is the responsibility of team leaders under the general direction of their unit manager. The regional Child Protection Manager has overall management responsibility for the performance of the program.

192. Senior staff explained that the number of cases that any child protection worker may have allocated to them at any one time is based on the judgement of their supervisor, taking into account the experience of the staff member and the complexity of the cases allocated to them.

193. However witnesses alleged that senior managers at times increased the number of children allocated to a child protection worker by:
    - allocating cases to staff who were absent on long term leave
    - pressuring supervisors, managers and specialists to allocate cases to themselves.

194. My investigation found examples of these practices occurring in the region.

Allocation to staff on leave

195. In one instance a supervisor stated at interview that they believed their manager had suggested that cases remain allocated to a child protection worker who was on extended leave. The witness stated that they were uncomfortable with the suggestion and did not act upon it.

196. However my officers confirmed another instance where children did remain allocated to a child protection worker who was on extended leave. Fourteen children remained allocated to the child protection worker for more than two months after they commenced extended leave on 11 May 2011. A sibling group of two was re-allocated from the child protection worker on CRIS on 12 July 2011 while the remaining cases were re-allocated on 19 July 2011.

197. In response to my draft report, Manager B stated:

> … due to the situation, the Unit Manager initially was not given clear advice about when [the child protection worker] would return to work. The Program therefore was unable to immediately reallocate the cases allocated to [the child protection worker]. When it became apparent that [the child protection worker's] return to work was going to be delayed, [the child protection worker's] cases were reallocated.

198. The Secretary stated:

> The department does not reallocate cases when a worker is temporarily unavailable as it is not in the best interests of children

> and young people. The worker had 27 children (nine families) allocated at the time [the child protection worker] commenced [unplanned] leave.
>
> On 16 May 2011, 13 children were reassigned. On 12 July 2011, a further two children were reassigned and on 19 July 2011, the remaining 12 children were reassigned. Prior to reassignment, all cases were actively responded to by other staff as required.
>
> Reallocation of the cases occurred progressively as the duration of the worker's absence became clearer and allocation capacity became available. Any misrepresentation of the case allocation data was unintended and would have made minimal difference to the region's performance.

Allocation to supervisors, managers and specialists

199. A number of witnesses stated that they believed cases had been allocated to supervisors, managers and specialist staff in order to reduce the number of children who appeared not to have an allocated child protection worker.

200. One supervisor recounted experiencing pressure to allocate cases to themself in 2010 stating:

> … I don't think its fair, because you're not case managing … the staff members would be doing tasks … Its just hiding numbers and its not fair. It's not fair to the families either.

201. Several witnesses referred to a former specialist officer carrying a caseload despite the role not being intended to incorporate casework functions. My officers obtained a copy of the position description for this role which does not include any reference to carrying a case-load of allocated children.

202. My officers reviewed snapshot data for a number of dates and found that the specialist officer was allocated in the range of 16–24 children during the latter half of 2010.

203. At interview, Manager B stated that there were some supervisors, specialists and managers in the region who had volunteered to have cases allocated to them because they had long term relationships with the families concerned.

204. The Manager stated that the specialist had agreed to manage a number of children with whom they were familiar through their role. Manager B further stated that these allocations would have had a minimal impact on the overall proportion of children reported on the CRIS database as not allocated to a child protection worker.

205. The specialist, who has now left the department, was interviewed by my investigators and asked about their caseload. The specialist stated that they had attended a meeting in approximately May 2010 where supervisors and managers were asked to contribute to the region's strategy to reduce the number of unallocated cases.

206. The specialist confirmed that they had agreed to be allocated a number of cases; however the specialist had only expected this to involve five or six families. The specialist stated to my investigators that they had considerable difficulty providing the children and families they were allocated with the service that they required:

> I felt at times that some of the cases were very very complex and I felt that in my role I couldn't do them justice, that they really should have been case managed on a daily basis and that's what I found very hard to do.

207. The specialist also stated that they had raised concerns with their supervisor, Manager B, regarding their capacity to manage the children assigned to them however Manager B 'just felt that I could do the job'. The specialist added that the children assigned to them were allocated to other staff prior to their leaving the department.

208. In response to my draft report Manager B stated:

> The [specialist] requested that [they] manage these cases until they were able to be allocated to a Child Protection Worker, as [they] had a relationship with the children involved. [The specialist] volunteered to manage these cases as they were all vulnerable … children with whom [the specialist] was working in relation to [their specialist role].
>
> Throughout the period I supervised [the specialist] and supervised these cases. At no point did [the specialist] raise concerns with me about [their] capacity to manage the children assigned to [them] as an established manager within the program.

209. The Secretary stated:

> Consistent with the need to prioritise the safety and wellbeing of children and young people, I consider it is essential for senior managers to have the option to allocate cases to specialist practitioners and managers as the need arises.
>
> These staff are amongst our most experienced practitioners and bring considerable expertise to cases that might otherwise be unallocated. The proposed reform of the operating model for child protection currently subject to an enterprise bargaining process will see all specialist staff assigned responsibility for the case management of children commensurate with other duties.

Conclusions – manipulation of allocation data

210. My investigation has found evidence that cases remained allocated to a staff member on long term leave and that some supervisors and managers felt pressured to carry caseloads outside the normal duties of their position.

211. While the evidence does not indicate a widespread manipulation of data through these practices, it does suggest that the reduction of the number of unallocated children became, in some instances, an end in itself rather than an indicator of the quality of service being provided by the department.

212. In the specialist's case, this officer considered they were unable to provide the service required by the children assigned to them. In the case of children allocated to the child protection worker on extended leave, 14 children were left without an active child protection worker for more than two months.

213. Manager B stated:

> I strongly refute the allegation that we were manipulating data. There was never any pressure on staff to allocate cases to themselves. Nor was there a practice within the Program to allocate cases to staff on extended leave … [the specialist] did not raise these concerns or issues with me whilst I was supervising [the specialist] on these cases. In the case of [the child protection worker], the children concerned were allocated to a Child Protection Worker as soon as we became aware that [the child protection worker] would not be returning to work.

214. The Manager also said:

> I also strongly deny that there was a practice of allocating cases to staff who were absent on long term leave.

215. The Regional Director stated:

> While acknowledging the many flaws in day to day decision making as described in the report, it is a highly speculative conclusion to argue that the region's motive for case closure is little more than cynical data manipulation.
>
> Given the widely acknowledged resource constraints in all child protection systems, it is not possible to keep adding cases to workers unless there is some regular removal of cases where effective actions in responding to safety have been completed.
>
> The purpose of intake practice and case closure is to ensure that finite resources are allocated to cases most in need. Clearly good processes and careful judgement are necessary to decide which cases are the highest priority and when cases can be safely closed.
>
> This is not data manipulation. In my 14 years as a regional officer, I can say unequivocally that annual reports do not motivate regional managers and staff and in any event do not become available to the public for months after the end of the financial year.
>
> I accept the view that some workers may see this as an exercise in data manipulation, the fact remains that case closure at the correct stage is a legitimate action to manage demand appropriately.

Recommendation – manipulation of allocation data

I recommend that the department:

Recommendation 5

Audit the allocation of cases in the Loddon Mallee Region to specialists, supervisors and managers to ensure that all allocations represent the provision of a bona-fide case work service.

Department's response

> The department accepts this recommendation and advised that it has audited the allocation of cases to these staff classifications and advised that as at 1 July 2011 no cases were currently allocated to specialist workers.

Child Death Reviews

Previous concerns

216. The Child Death Review system examines the deaths of children who were clients of the department within the 12 months preceding their deaths.[26] In 2010 the department notified the Office of the Child Safety Commissioner of 29 child deaths that met this criterion.[27]

217. In my November 2009 report into the Department of Human Services Child Protection Program, I noted concerns regarding the effectiveness of Victoria's Child Death Review system. In particular I was concerned that there were a number of deaths of children who were known to the department that had not been subject to the review process.

218. A gap has emerged since the introduction of the Children, Youth and Families Act. This Act permits the department to receive reports regarding un-born children so that assistance and support can be provided to pregnant women to reduce the likelihood that the child, when born, will be at risk of harm.

219. In my earlier report I referred to a previous matter involving a still born child whose death was not reported to the Child Safety Commissioner for the purposes of a child death enquiry. The department did not accept my recommendation that such cases should be reviewed in order to provide the department with the opportunity to review the practice and effectiveness of its intervention with unborn children.

How the Child Death Review process operates

220. The *Child Wellbeing and Safety Act 2005* requires the department to advise the Child Safety Commissioner of the death of each Victorian child who was a child protection client at the time of death or had been a client within 12 months prior to his or her death. All deaths regardless of the cause are required to be reported.

221. When the Child Safety Commissioner receives notification from the department about the death of a child, he is required to record the death on the Child Death Register held within the Inquiry and Review Unit (the unit) of his office. The unit then undertakes a review into each death as required by the Child Wellbeing and Safety Act. The object of each review is:

> ... to promote ongoing and continuous improvement and innovation in policies and practices relating to child safety and protection.

222. The unit produces reports on its review and a draft copy is forwarded to the department and other stakeholders for comment. The report is then finalised and forwarded to the Victorian Child Death Review Committee.

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26 http://www.ocsc.vic.gov.au/vcdrc/index.htm downloaded on 5 September 2011.

27 *Annual Report of inquiries into the deaths of children known to Child Protection 2011*. Victorian Child Death Review Committee, June 2011 pxi.

223. The Victorian Child Death Review Committee (the Committee) is an independent ministerial advisory body which considers the findings provided by the Child Safety Commissioner on a case by case basis and determines whether any recommendations for action are required.

224. The Committee provides an annual report to the Minister for Community Services outlining the inquiries reported to it during the previous year and the recommendations made in respect to each inquiry.

A gap in the Child Death Review system

225. In this investigation I identified a case which will not be subject to the child death review process despite the family of the infant concerned having been subject to 10 previous child protection reports.

Case study 11:

In 2010 the department referred a family with young children to a Community Services Organisation. The children's mother was pregnant at the time of the referral.

The children had been subject to previous reports to the department. None of the reports had proceeded beyond the intake stage.

A further report was received regarding the circumstances of the children who were residing with the mother and her partner. The report included allegations that:

- there was garbage all over the bedroom floor
- dirty nappies were "everywhere"
- adults were smoking cigarettes inside
- the children were inappropriately clothed.

The department was also aware that the mother was pregnant at the time of the report. The report was closed on the basis that the '… parent's relationship is acrimonious and issues are FLC [Family Law Court]'.

The mother subsequently gave birth however the infant died a couple of months later. Police who attended the home at the time of the infant's death reported that the house was 'putrid' with food scraps and cigarette butts throughout the house, a steamer on the stove had mould an inch thick and the remains of a fish and chips meal from a week prior were ground into the carpet. Beside the mother's bed, where the infant had passed away, there was a pile of dirty nappies, chicken bones and cigarette butts.

A category one incident report was completed following the infant's death.[28] The incident report stated that the infant was 'not currently, or previously, on a Child Protection Order, and the siblings did not have current Child Protection involvement'. While the incident report did state that the infant had been co-sleeping with his mother, it

28 Category one incidents include the most serious incidents involving departmental clients and must be reported to the Minister.

made no reference to the home environment as detailed by the reporter nor did it provide an accurate history of the department's involvement with the family.

The department closed the April 2011 report in the intake phase without conducting an investigation. I referred this case to the department for review and was informed on 17 August 2011 that the department would open a new report and investigate.

226. The infant and their siblings were living in appalling circumstances. The following photograph taken by police demonstrates the unacceptable conditions which these children were living in. In this photograph a baby's bottle is on the floor next to the bed in which the infant passed away. The baby's bottle is surrounded by clutter including cigarette butts, chicken bones and a soiled nappy. Even after police reported these conditions to the department no action was taken until I referred the matter to the Secretary.

Figure 8.

Floor immediately beside the bed where the infant passed away

227. As the infant was not born at the time of the previous report to the department, they were not regarded as a 'child protection client' within the meaning of Child Wellbeing and Safety Act, therefore the death will not be subject to the child death review process. This is despite the siblings having been the subject of 10 reports to the department and the last of these having been made while the mother was pregnant.

228. In response to my draft report, the Secretary stated:

> The infant referred to … was not at any time the subject of a report to child protection either before or following birth therefore was not in scope for review within current legislative provisions.

Conclusions

229. I am concerned that the death of the infant referred to above will not be subject to the child death review process. This is despite the lengthy history of the department's intervention with the family; the department's knowledge that the mother was pregnant at the time of the last report; and the death of the infant in disturbing circumstances.

230. The absence of a mechanism to review the department's response to a family with whom it has had extensive involvement is a lost opportunity to improve child protection practices. In my view this is a shortcoming in the current system of external scrutiny in the child protection system.

Recommendation – Child Death Reviews

I recommend the Minister for Community Services consider:

Recommendation 6

Introducing amendments to the Child Wellbeing and Safety Act to broaden the circumstances in which a child death review is conducted.

Department's response:

The department accepts this recommendation. The Secretary stated that:

> The government has a policy commitment to enable review of all children found to have died from circumstances of abuse and neglect and who were not previously known to child protection. As such I confirm acceptance of Recommendation 6.

Summary of recommendations

I recommend that the department:

Recommendation 1

Review its procedures for assessing 'repeat' reports to ensure they receive comprehensive assessment by a manager not currently involved in the decision not to investigate.

Department's response:

The department accepts this recommendation.

I recommend that the department:

Recommendation 2

Implement an ongoing audit program in each region to review the appropriateness of decision making by intake units.

Department's response:

The department accepts this recommendation.

I recommend that the department:

Recommendation 3

The department develop strategies for systematically collecting data regarding unmet demand.

Department's response:

The department accepts this recommendation in principle and will await the outcome of the Protecting Victoria's Vulnerable Children Inquiry to inform the response to this recommendation.

I recommend that the department:

Recommendation 4

Reinforce the requirement to fully document risk assessments and rationales for each case closure.

Department's response:

The department accepts this recommendation and will re-issue practice advice to the workforce and support through regional briefings to staff.

I recommend that the department:

Recommendation 5

Audit the allocation of cases in the Loddon Mallee Region to specialists, supervisors and managers to ensure that all allocations represent the provision of a bona-fide case work service.

Department's response

> The department accepts this recommendation and advised that it has audited the allocation of cases to these staff classifications and advised that as at 1 July 2011 no cases were currently allocated to specialist workers.

I recommend that the Minister for Community Services consider:

Recommendation 6

Introducing amendments to the Child Wellbeing and Safety Act to broaden the circumstances in which a child death review is conducted.

Department's response:

The department accepts this recommendation. The Secretary stated that:

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Ombudsman's Reports 2004-11

2011

Investigation into the Office of Police Integrity's handling of a complaint
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SafeStreets Documents - Investigations into Victoria Police's Handling of Freedom of Information request
September 2011

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Investigation into an allegation about Victoria Police crime statistics
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Whistleblowers Protection Act 2001 Investigation into the improper release of autopsy information by a Victorian Institute of Forensic Medicine employee
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Ombudsman investigation – Assault of a Disability Services client by Department of Human Services staff
March 2011

The Brotherhood – Risks associated with secretive organisations
March 2011

Ombudsman investigation into the probity of The Hotel Windsor redevelopment
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Whistleblowers Protection Act 2001 Investigation into the failure of agencies to manage registered sex offenders
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Whistleblowers Protection Act 2001 Investigation into allegations of improper conduct by a councillor at the Hume City Council
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Ombudsman's recommendations second report on their implementation
October 2010

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October 2010

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Ombudsman investigation into the probity of the Kew Residential Services and St Kilda Triangle developments
June 2010

Own motion investigation into Child Protection – out of home care
May 2010

Report of an investigation into Local Government Victoria's response to the Inspectors of Municipal Administration's report on the City of Ballarat
April 2010

Whistleblowers Protection Act 2001 Investigation into the disclosure of information by a councillor of the City of Casey
March 2010

Ombudsman's recommendations – Report on their implementation
February 2010

2009

Investigation into the handling of drug exhibits at the Victoria Police Forensic Services Centre
December 2009

Own motion investigation into the Department of Human Services – Child Protection Program
November 2009

Own motion investigation into the tendering and contracting of information and technology services within Victoria Police
November 2009

Brookland Greens Estate – Investigation into methane gas leaks
October 2009

A report of investigations into the City of Port Phillip
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An investigation into the Transport Accident Commission's and the Victorian WorkCover Authority's administrative processes for medical practitioner billing
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Whistleblowers Protection Act 2001 Conflict of interest and abuse of power by a building inspector at Brimbank City Council
June 2009

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May 2009

Investigation into corporate governance at Moorabool Shire Council
April 2009

Crime statistics and police numbers
March 2009

2008

Whistleblowers Protection Act 2001 Report of an investigation into issues at Bayside Health
October 2008

Probity controls in public hospitals for the procurement of non-clinical goods and services
August 2008

Investigation into contraband entering a prison and related issues
June 2008

Conflict of interest in local government
March 2008

Conflict of interest in the public sector
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2007

Investigation into VicRoads' driver licensing arrangements
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Investigation into the disclosure of electronic communications addressed to the Member for Evelyn and related matters
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Investigation into the use of excessive force at the Melbourne Custody Centre
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Investigation into the Office of Housing's tender process for the cleaning and gardening maintenance contract – CNG 2007
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Investigation into a disclosure about WorkSafe's and Victoria Police's handling of a bullying and harassment complaint
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Own motion investigation into the policies and procedures of the planning department at the City of Greater Geelong
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Review of the Freedom of Information Act 1982
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Investigation into parking infringement notices issued by Melbourne City Council
April 2006

Improving responses to allegations involving sexual assault
March 2006

2005

Investigation into the handling, storage and transfer of prisoner property in Victorian prisons
December 2005

Whistleblowers Protection Act 2001 Ombudsman's guidelines
October 2005

Own motion investigation into VicRoads registration practices
June 2005

Complaint handling guide for the Victorian Public Sector 2005
May 2005

Review of the Freedom of Information Act 1982 Discussion paper
May 2005

Review of complaint handling in Victorian universities
May 2005

Investigation into the conduct of council officers in the administration of the Shire of Melton
March 2005

Discussion paper on improving responses to sexual abuse allegations
February 2005

2004

Essendon Rental Housing Co-operative (ERHC)
December 2004

Complaint about the Medical Practitioners Board of Victoria
December 2004

Ceja task force drug related corruption – second interim report of Ombudsman Victoria
June 2004