Community Development and Justice Standing Committee

Red flags, white flag response?

The Department for Child Protection and Family Support's management of a troubled boy with a baby

Report No. 11
March 2016

Legislative Assembly
Parliament of Western Australia

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Presented by

Ms M.M. Quirk, MLA

Laid on the Table of the Legislative Assembly on 17 March 2016

Chair's Foreword

FROM time to time the Community Development and Justice Standing Committee conducts reviews of agencies within its portfolio responsibilities. Such was the case here after the tragic death of a young baby subject to the oversight of the Department for Child Protection and Family Support in February 2014. The circumstances surrounding that death are set out in this report.

Some preliminary inquiries and a hearing were conducted in March 2014. The Committee heard evidence from the then Director General of the Department, Mr Terry Murphy. As a consequence of that evidence, which was less than satisfactory, the Committee resolved to undertake further hearings and seek additional evidence to clarify the incomplete and somewhat dismissive evidence of Mr Murphy.

However, as the young person charged with the unlawful killing of that baby was still to face trial, it was resolved to continue the inquiry once the criminal proceedings had been concluded.

In this context the Committee was grateful to be given permission by the president of the Children's Court, the Honourable Judge Denis Reynolds, to have access to his sentencing remarks. Judge Reynolds is a person of great experience and has seen many complex and difficult cases in the Children's Court. His thoughtful findings are consistent with information the Committee obtained from other sources.

At the outset it is important to note that this review was not about attributing blame and we acknowledge that both individual staff members connected with the case and the agency as a whole will have been (and no doubt remain) deeply affected.

But systemic issues do need closer analysis, and if such a tragedy can be avoided in the future by greater and more targeted allocation of resources, better lines of communication and information sharing and closer partnerships between agencies in complex cases, then the scrutiny is justified.

Approximately 4500 children are currently wards of the state. It is an astonishing number and places an enormous burden on personnel in the Department. The evidence and submission of the Community and Public Sector Union/Civil Service Association indicated that an increasing number of children are, in weasel words, "monitored", which in fact means the opposite.

The final word should come from the mother of the teenager, made in a statement not long before the youth was found guilty of the manslaughter of his baby son:

> *My son now aged 15 is now in prison facing charges for the death of his baby when he was in State care. My son was meant to be supervised when visiting the baby. We do not know what happened… I seriously question the care my son has had by the State in the last four years.*

I am grateful for the contribution of my fellow Committee members in the conduct of this review: Deputy Chair Dr Tony Buti MLA, Mr Mick Murray MLA, Mr Chris Hatton MLA and Ms Libby Mettam MLA. I also thank the Principal Research Officer, Dr Sarah Palmer, and Research Officer, Ms Franchesca Walker, for their professional support of the Committee's work.

MS M.M. QUIRK, MLA
CHAIR

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Ministerial Response

In accordance with Standing Order 277(1) of the Standing Orders of the Legislative Assembly, the Community Development and Justice Standing Committee directs the Parliamentary Secretary representing the Minister for Child Protection to report to the Assembly as to the action, if any, proposed to be taken by the Government with respect to the recommendations of the Committee.

Findings and Recommendations

How a child in State care came to fatally assault his newborn son

The fatal assault of a newborn baby by his teenage father, who was in State care, raised questions about the care and supervision provided by the Department for Child Protection and Family Support. In the course of two hearings with the Department and one with the union representing its staff, the Committee probed the Department's management of the teenager, systemic issues which may have contributed to the tragic incident, and whether any changes to procedures and policies had been implemented.

Purpose of this report

In February 2014, a month-old baby boy died from severe head injuries sustained at Bunbury Regional Hospital a week earlier. The baby's teenage father, who was in State care, pleaded guilty to the manslaughter of the baby and was sentenced to 10 years' detention in March 2015.

Given that the 15-year-old father was in the care of the Department for Child Protection and Family Support (the Department), the Committee sought to establish whether the teenager had been managed appropriately by the Department. Concerns had arisen over the decision to allow the teenager unsupervised access to the baby, given the youth's history of offending and aggressive behaviour. In sentencing the teenager, Children's Court of Western Australia President Judge Denis Reynolds expressed surprise that the teenager's access to the baby had not been conditional and/or supervised.[1]

The Committee was also seeking to understand whether any departmental management or resourcing issues had contributed to the tragic outcome. This followed correspondence to the Committee from the Community and Public Sector Union/Civil Service Association (the Union) which suggested excessive workloads and lack of resources were impacting on the ability of Department case-workers to perform their roles to the level they felt was required.

To this end, the Committee resolved to conduct an agency review hearing with the Department and a separate hearing with the Union. The hearings were held on 25th November 2015 and 23rd November 2015 respectively.

1 From edited transcript of judgment by Judge D.J. Reynolds, 23 March 2015, provided by the Children's Court of Western Australia, 25 September 2015.

The Committee had previously conducted an agency review hearing with the Department in the month following the death of the baby (March 2014). However, as the matter was still before the courts there were restrictions on the information that could be disclosed. Evidence gathered at that hearing, including responses to questions on notice taken during the hearing, is also referred to in this report.

This short report outlines the case and presents conclusions reached by the Committee in regard to:

- the Department's management of the teenager, particularly in relation to impending fatherhood and access to the newborn infant;
- whether systemic issues within the Department contributed to the situation which resulted in the baby being fatally injured;
- whether any changes to Department practices/procedures were implemented as a result of the case.

Background

On 24th February 2014, a month-old baby boy died at Princess Margaret Hospital from severe head injuries sustained at Bunbury Regional Hospital a week earlier. The 16-year-old mother of the baby had entered the room at the Bunbury hospital to find the baby's 15-year-old father holding the infant, which was not breathing and had a visible critical head injury.

The baby had been born six weeks prematurely and needed to remain in hospital until he was strong enough to be discharged. The injuries to the baby occurred two days before the baby was due to be discharged into the care of his teenage parents. As a result, the baby was taken into State care and put on life support at Princess Margaret Hospital in Perth.

The baby's young father, who was also in the care of the Department, was initially charged with aggravated grievous bodily harm, but following the baby's death and a post-mortem examination this was substituted with a murder charge.[2]

In an interview with police the youth said he had accidentally knocked the baby's head against a door frame, but this was not consistent with medical and forensic evidence. While the youth has not given any further account of what occurred in the hospital room, Judge Reynolds found that the fatal injuries were the direct result of at least two

2 The youth appeared in court on the murder charge on 1 April 2014; Banks. A., ''Confused' teen faces charge of killing son', *The West Australian*, 2 April 2014, p15.

separate and deliberate physical actions in which the baby's head was struck with a hard object or propelled into a hard surface.[3]

Just prior to the trial in February 2015, agreement was reached that the youth would plead guilty to manslaughter.[4] He was sentenced to 10 years' detention on 23 March 2015 and will be eligible for a supervised release order after serving half of that term.

The youth had a tumultuous personal history. He was in State care between the ages of 6 and 10, and then again from the age of 12. He had been subjected to neglect, exposure to substance abuse, violence, transience and instability.[5]

A statement made by the mother of the youth (provided originally to the Royal Commission into Institutional Responses to Child Sexual Abuse) indicates that the youth was taken into care because of his mother's abuse of alcohol and drugs.

The youth's mother had suffered a series of tragic events. She was sent to a mission at the age of eight due to her parents' alcohol abuse, where she was sexually abused. She also turned to alcohol to try to forget the abuse. Her use of alcohol and drugs apparently increased after the death of her partner of 20 years and the loss of her house. She and her four adult children were still homeless at the time of the statement.[6]

At the time of the baby's birth, the youth was the subject of a conditional release order[7] for possession of cannabis, bodily harm to a person, and burglary. Prior offences included aggravated robbery, stealing of a motor vehicle, damage with intent to harm, doing an act which resulted in harm, and doing an act which resulted in bodily harm.[8]

Just prior to the birth, he began living with the expectant mother and her family in Bunbury (although the judge's comments note that the couple separated a week after the birth). The youth's case-worker was still based in Cannington, apparently because the youth had only recently moved to Bunbury.[9]

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3 From edited transcript of judgment by Judge D.J. Reynolds, 23 March 2015, provided by the Children's Court of Western Australia, 25 September 2015.

4 *ibid*.

5 *ibid.*

6 Closed correspondence, Daydawn Advocacy Centre, 8 December 2015.

7 A conditional release order allows offenders to go about their daily lives under certain conditions. It can only be imposed on an offender if there are reasonable grounds for expecting the offender will not reoffend during the term of the order, or the offender does not need supervising by a Community Corrections Officer.

8 From edited transcript of judgment by Judge D.J. Reynolds, 23 March 2015, provided by the Children's Court of Western Australia, 25 September 2015.

9 Ms Emma White, Director General, Department for Child Protection and Family Support, *Transcript of Evidence*, 25 November 2015, p2.

Concerns around the management of the case

Unsupervised access to the newborn baby

A key concern in regard to the management of the youth centred on whether he should have been allowed unsupervised access to his newborn baby. Given the youth's history, Judge Reynolds was surprised that this had been allowed, also commenting that the youth's capacity to exercise proper judgement was "distorted".[10]

The youth's mother also stated that he was "meant to be supervised when visiting the baby" and did not understand what had happened.[11]

In the November 2015 hearing with the Department, the Committee suggested that "alarm bells" should have been ringing in regard to the teenager's circumstances and behaviour, alerting the Department to the possibility, or perhaps inevitability, of such a tragic outcome. Those circumstances included the identification by the Department of the need for the youth to take part in formal anger management counselling.

The Committee queried what factors in addition to the boy's age, prior offences and personal history would have been needed for the Department to consider that he should not have unsupervised access to the child.

Department Director General Emma White agreed that there were alarm bells, which was why the Department had become involved in the case. However, she implied that the judge's comments could only be made with the benefit of hindsight.[12] There were gaps in their knowledge of the youth and their assessment of him was a "work in progress".

> *… at the time the information we had, without doubt, pointed to vulnerabilities and risks that this young parent was facing, and the newly born child; that is why we were involved. We were involved in a very intensive planning process with those young parents and their extended family because we considered at the time there were risk factors, to a degree… From the information that we had available at that time, there was nothing to suggest that this young father had ever harmed a child or made any threats to harm a child. He certainly had a range of issues that you have outlined but with regard to contact with a child within a hospital environment, and based on the information we were being given by hospital staff and from our own*

10 From edited transcript of judgment by Judge D.J. Reynolds, 23 March 2015, provided by the Children's Court of Western Australia, 25 September 2015.

11 Closed submission, Daydawn Advocacy Centre, 8 December 2015.

12 Ms Emma White, Director General, Department for Child Protection and Family Support, *Transcript of Evidence*, 25 November 2015, p7.

> *observations and otherwise at that point in time, we had nothing to suggest that those vulnerabilities and risks would result in what has been a very heinous and tragic situation that he perpetrated.*[13]

Ms White said that about 80 per cent of the families the Department worked with had experienced some form of domestic violence, about 60 per cent had drug and alcohol issues and almost half had mental health issues. Hence, the risk factors in the youth's case were not particularly unusual. However, she said there was no evidence that this had desensitised staff to the potential risks.[14]

Ms White said that despite efforts to engage with the youth in the past, the Department had not been successful in making a difference. It was only in the few weeks prior to the baby's birth that the youth had become more receptive to Department support, completing a drug and alcohol program and agreeing to participate in an anger management program.

The Department submits that its inability to keep track of the youth in the previous years led to missing information "that you would ideally like at your fingertips" in making decisions about his ability to care for an infant.[15]

> *… with a young person who, despite every effort, is not engaging or sharing those aspects of their life with the professionals who make the assessment – looking back is the opportunity, very sadly, when you actually put some of that information together, and we did not have that opportunity at the time.*[16]

Finding 1

The Department for Child Protection and Family Support was unable to make a fully informed decision about whether the youth should have unsupervised access to his newborn infant, due to incomplete information.

Recommendation 1

Where there is insufficient information about a case and there is potential for a dangerous outcome, the Department for Child Protection and Family Support should take a precautionary approach.

However, the Committee is not convinced that the youth's attendance at the hospital following the birth of the baby was appropriately managed by the Department. A table of activities associated with the case provided by the Department at the request of the

13 Ms Emma White, Director General, Department for Child Protection and Family Support, *Transcript of Evidence*, 25 November 2015, p8.
14 *ibid*.
15 *ibid.,* p9.
16 *Ibid.,* pp9-10.

Committee (see Appendix 3) reveals that on 30 January 2014, the teenager was involved in a physical altercation with his mother inside the hospital. Four days later, there was discussion between the Department staff and the hospital about the father only being permitted to visit during the day.[17] It could be argued that hospital staff were given the supervisory role by default.

On 4 February 2014, the correspondence states that the hospital "re-confirmed" that the father was only permitted to visit between 8am and 8pm (excluding the rest period between 12pm and 2.30pm) and that "he should not attend the hospital if he was feeling upset". The Department concurred, but noted that "there was no requirement for the father to be supervised during these visits".[18]

The Committee postulates that the level of monitoring by the Department would not have enabled it to meet the hospital's requirement that the teenager not visit the hospital if he was upset.

The Department was patently aware of the risk posed by the father. An entry in the table of activities for 5 February 2016 notes a discussion between the case team leader and the district director, in which they agreed "there is risk in the case and the Department's ongoing assessment and planning with regards to the baby's safety and wellbeing is required. Whilst the baby is in hospital and the maternal family are engaged there is sufficient safety for the baby."[19]

Sadly, this proved not to be the case. In the Committee's view, the fact that the teenager had already been involved in an altercation at the hospital and had a history of aggression (his enrolment by the Department in an anger management course was recognition of this) should have meant he was not left unsupervised.

The Committee concurs with Judge Reynolds' comment that it was surprising that the teenager's access to the baby had not been supervised. It had been conditional, but meeting the conditions imposed by the hospital could not be guaranteed.

While the Department cites the benefit of hindsight as having influenced the judge's comments, it seems clear that there were enough indicators of risk to warrant supervision well before the baby was assaulted.

Finding 2

Despite the Department for Child Protection and Family Support having enough evidence of potential risk to justify supervised visits, it allowed the teenager to visit his baby without supervision.

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17 Ms Emma White, Director General, Department for Child Protection and Family Support, Letter (Attachment 1), 2 February 2016.

18 *ibid.*

19 *ibid.*

Level of engagement with the youth

The Department has indicated that in the (approximately) two years from when the youth was taken into State care in 2011, he had approximately four (foster care) placements and other placements that he chose but which were not necessarily endorsed by the Department.[20]

The Department said that quarterly reviews were always completed and the youth participated in his annual reviews in person, with extended family present. Ms White said efforts to maintain contact with him were "reasonable and persistent from the time he came into care".[21]

Correspondence from the Department indicates that from 2011 to 2013, staff met with the youth approximately 40 times. Between April and July 2013, his whereabouts were unknown to the Department.[22]

Table 1: Number of attempted and successful contacts between Department staff and the teenager

Year	Contacts in person	Attempted contacts	Attempted home visits	Phone calls	Attempted phone calls	Phone calls to carer	Letters
2011	Approx. 22			6	2		2
2012	8		3	1	3	1	
2013	Approx. 10	7		1	2	1	

However, Ms White said during the second hearing in November 2015 that the couple (the teenage father and his partner) were "highly mobile" and the Department was "having a great deal of trouble catching up and engaging with them".[23] They did not know until three weeks before the baby's assault that the youth was living in Bunbury.

The youth's mother questioned the care her son had had, asserting that it was after being taken into State care that he stopped attending school, earned a criminal record, became a father before the age of 16 and ended up on a manslaughter charge.[24]

Given the Director General's recognition that the level of engagement was less than optimal and that this had resulted in missing information which would have otherwise

20 Ms Emma White, Executive Director of Country Services, Department for Child Protection and Family Support, *Transcript of Evidence*, 17 March 2014, p10.
21 *ibid.*, p6
22 Mr Terry Murphy, Director General, Department for Child Protection and Family Support, Letter, 22 March 2014.
23 Ms Emma White, Director General, Department for Child Protection and Family Support, *Transcript of Evidence*, 25 November 2015, p2.
24 Closed submission, Daydawn Advocacy Centre, 8 December 2015.

aided in the assessment of the boy's suitability as a parent, sufficient contact is a critical issue.

The Committee acknowledges the difficulty of keeping track of a youngster who is highly transient and who may not want to be found. Nevertheless, the Department has a duty of care to a child in its protection and should review its methods for maintaining contact.

Finding 3

The transient nature of the youth's lifestyle stretched the Department's resources, making it difficult to fully engage with him and understand the complexity of his case.

Recommendation 2

The Department for Child Protection and Family Support should review its methods of maintaining contact with highly vulnerable and transient youth to ensure that every possible avenue for contact is pursued. It should direct sufficient resources to monitoring the location of particularly troubled children.

The Cannington case-worker continued to manage the youth's case after the Department became aware that he had moved to Bunbury to live with his partner and her family.

Ms White said it was appropriate for the Cannington case-worker to continue to manage the youth rather than transferring the case to Bunbury, given the short timeframe. She said the Department would generally look for a period of stability within the new location before making a transfer.[25]

The level of attention and care in the weeks before the birth appears to have been quite intensive, with the Department attempting to compress a lot of pre-birth planning and assessment into a short period. The time constraint was exacerbated by the premature birth of the baby.

Ms White said that the type of contact with the youth at this stage included direct conversations about his hopes and fears in regard to becoming a parent.

> *There were several meetings in person and I believe some telephone calls in the assessment and planning. We were not only directly talking with him about that, but bringing him, his partner – the mother – and extended family around the table as a family unit to do that risk assessment and planning work. What needed to happen by way of*

25 Ms Emma White, Director General, Department for Child Protection and Family Support, *Transcript of Evidence*, 25 November 2015, p2.

> *referrals to anger management, for example, was done by Bunbury staff on behalf of Cannington…*[26]

There were also meetings between Department staff and staff at Bunbury Regional Hospital, and Ms White maintains that the level of consultation was adequate.

> *Generally two hospital personnel were at those planning meetings in person. There were also daily email exchanges; there were daily phone calls between our staff and the hospital's staff…. We know of 33 interactions where … midwives and other staff had made direct observations with regard to parenting and observations with the parents' interaction with the young infant. That is the sort of level of engagement.*[27]

It is somewhat difficult to ascertain from the table of activities provided by the Department exactly how much time was devoted to the teenager's case prior to the baby's death. The table shows only two instances of meetings involving the father (on 28 January 2014 and 4 February 2014).[28] When further clarification was sought it was suggested that the youth may have been present at meetings along with his partner, even though this was not explicitly detailed in the case notes.[29] The actual duration of the meetings and telephone contact was unspecified.

While the baby was assigned a Bunbury-based case-worker, the teenager's case was being co-worked – that is, the original Cannington-based case-worker was managing the case remotely with input from a Bunbury case-worker. This is apparently not an unusual situation, given that many of the Department's clients regularly move between districts.

However, according to the Union it requires constant communication between the co-workers to make it work well, adding to the workload. The work was also not clearly split between the workers, meaning that two workers may expend more hours on a case than would a single worker.[30]

The Committee was told that district staff work collaboratively on cases and therefore a range of staff – not just the case-worker – will work with the family concerned. The Committee is unable to assess the extent to which the case-worker being based in

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26 Ms Emma White, Director General, Department for Child Protection and Family Support, *Transcript of Evidence*, 25 November 2015, p10.

27 *ibid*., p13.

28 Ms Emma White, Director General, Department for Child Protection and Family Support, Letter (Attachment 1), 2 February 2016.

29 Ms Andrea Walsh, Manager, Executive Services, Office of the Director General, Department for Child Protection and Family Support, Email, 26 February 2016.

30 Ms Rikki Hendon, Branch Assistant Secretary, Community and Public Sector Union/Civil Service Association, *Transcript of Evidence*, 23 November 2015, p6.

Cannington might have impacted the management of the case. Given the very short timeframe for working with the couple before the baby was born, perhaps the Bunbury team should have been better resourced.

Ms White said that in retrospect the Department could have provided more support and guidance for staff about the needs of adolescent parents so that they were better equipped to help the young couple. This was something that had since been implemented (see below).

Systemic issues

The Bunbury tragedy brought forth concerns that what occurred might have been symptomatic of deeper, systemic problems within the Department.

The Union said that the child protection system was under immense pressure and was inadequately resourced, creating an environment in which employees were forced into situations "inherent with unacceptably high levels of risk" which significantly hindered the management of children at risk.[31]

Inadequate resources/excessive workload impacted on the completion of safety and wellbeing assessments, decisions about bringing children into care, the number of cases being monitored remotely and the amount of contact between parents and children when a child was first taken into care.[32]

Could the failure to maintain regular and meaningful contact with the youth have been due to under-resourced and over-worked staff?

Was it the case that staff did not receive the support they needed to be able to make a thorough and timely risk assessment? Complex cases, of which the Committee was told the Department has many, require considered and measured assessment. Evidence from the Union suggests that the pressures of workload did not allow this.

In evidence to the Committee, Ms White said that a review of the case had established that both the Cannington and the Bunbury case-workers had appropriate case-loads at the time of the incident. Other senior staff involved in the pre-birth planning were also expending time and effort to help support the management of the case. Excessive workload was not identified as an issue.[33]

31 Ms Rikki Hendon, Branch Assistant Secretary, Community and Public Sector Union/Civil Service Association, *Transcript of Evidence*, 23 November 2015, p2.

32 *ibid*.

33 Ms Emma White, Director General, Department for Child Protection and Family Support, *Transcript of Evidence*, 25 November 2015, p20.

Nevertheless, the Bunbury office had a higher workload than it does at present, and changes had been made to the team structures to improve the workflow of the office, according to Ms White.

In 2007 the Department implemented a Strategy for Caseload Management (SCLM) to ensure that no more than 15 cases could be allocated to a full-time case-worker, except in exceptional situations where the maximum could be increased to 18. A workload management tool measures the intensity and complexity of work to inform the appropriate allocation of cases.[34]

However, the Union's branch assistant secretary Rikki Hendon had concerns about how effectively and how often that lens was applied.

> *I do think, in fairness, that for a period of time that was effective. I still think it is effective for individuals if it is implemented properly, but somewhere along the line the resourcing has stopped flowing through to the Department to match the number of children in the Department's care. That has put pressure on making that effective.*[35]

According to the Union, in 2015 there was an average of 122.2 case-workers with more than 15 cases, which the Union regarded as "much more than exceptional".[36]

Additionally, a case-load of less than 15 could be too much depending on the intensity and complexity of the cases. Hence, while the teenager's Cannington case-worker had a workload of approximately 14 cases at the time of the incident,[37] it may have been too many depending on the nature of the cases.[38]

The caseload limit of 15 was allegedly managed by reallocating cases from the case-worker to the Monitored List, which consists of children who have an open case with the Department but do not have an allocated case-worker.

Once data collection had been completed, the case was reallocated to the staff member. "This is what we hear from our members, and it is certainly not an isolated comment; it is a very regular comment."[39]

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34 Ms Rikki Hendon, Branch Assistant Secretary, Community and Public Sector Union/Civil Service Association, Letter, 21 October 2015.

35 Ms Rikki Hendon, Branch Assistant Secretary, Community and Public Sector Union/Civil Service Association, *Transcript of Evidence*, 23 November 2015, p7.

36 *ibid.*, p9.

37 Ms Emma White, Director General, Department for Child Protection and Family Support, Letter, 2 February 2016.

38 Ms Rikki Hendon, Branch Assistant Secretary, Community and Public Sector Union/Civil Service Association, *Transcript of Evidence*, 23 November 2015, p4.

39 *ibid.,* pp9-10.

The Department had never received any evidence of this, although it knew the issue had been raised by Union members.[40]

Ms Hendon said that the monitoring of cases on the Monitored List was often "a very distant monitoring";[41] with no active involvement over a period of time it was likely that cases would get worse.

> *It is a cycle. These children have no regular contact even though in report after report it finds that kids want more contact with staff when in care. One team leader in the past 12 months had over 57 cases on the monitored list. That is 57 cases the team leader has had to juggle or have a little bit of an oversight into; cannot actively work it because they are also trying to manage a team full of people also carrying full cases.* [42]

The Union had been told of cases which staff clearly felt should have been allocated to a case-worker that were instead allocated to the Monitored List. Staff said that police and health workers also believed the children in question should have been taken into care.

A lack of foster placements and delays in the processing of applications was also raised.

> *We certainly have had conversations with a number of our members who have given us instances when they have wanted to bring a child into care. They have had pretty significant evidence that that child is at significant risk or is being abused, and the determination is, no, that child cannot be taken into care. The only explanation our members give us for that is that they are under resource pressure, that there is either nowhere to put the child because there are not enough placements, that the placements are full of other children or that there is just too great a workload. That is actually a quite common theme that we have had come through to us from our membership.*[43]

According to Ms Hendon, when foster carers took on a child they were not always given the necessary support and assistance, especially if the child was on the Monitored List.[44]

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40 Ms Cheryl Barnett, Executive Director, Metropolitan Services, Department for Child Protection and Family Support, *Transcript of Evidence*, 25 November 2015, p18.

41 Ms Rikki Hendon, Branch Assistant Secretary, Community and Public Sector Union/Civil Service Association, *Transcript of Evidence*, 23 November 2015, p3.

42 *ibid.*, p5.

43 *ibid.*, p8.

44 *ibid.*, p10.

The Union said that while the Department claimed that the resources allocated to it through the Budget each year were based on demand, the demand model was not keeping up with actual demand. The number of child-in-care cases had doubled since 2006.[45]

The Union has presented convincing evidence of resourcing and workload issues within the Department, which could be indirectly linked to the Bunbury case. It is possible that excessive workload meant that the monitoring of the teenager in the period from 2011 was not as good as it could have been, even though the Department maintains that the case-worker's workload was manageable.

It is also possible that there were too few staff in the Bunbury office to manage such a complex case. The fact that the Department has restructured the office arguably supports this view.

Having the case split between case-workers in Cannington and Bunbury was probably also unhelpful. It may have resulted in the teenage father receiving less attention than the mother and baby.

While the links to this particular case may be difficult to prove, the Committee acknowledges that the systemic issues raised by Department staff warrant further investigation.

Finding 4

Systemic issues, such as inadequate resources and excessive workloads, may have contributed to the outcome in the Bunbury case, although a direct link is not evident. These issues may have impacted on the Department's ability to: keep track of the teenager; mobilise the necessary resources to support the young couple immediately before and after the baby was born; manage the case from Bunbury; provide supervision for the youth when in the presence of the baby.

45 Ms Rikki Hendon, Branch Assistant Secretary, Community and Public Sector Union/Civil Service Association, *Transcript of Evidence*, 23 November 2015, p5.

BOX 1[46]

Child Death Reviews

When a child in the care of the CEO of the Department for Child Protection and Family Services dies, a Child Death Review is undertaken by the Ombudsman.

At the time of the hearing with the Department in November 2015, the Ombudsman's review had apparently not been completed. However, in subsequent correspondence the Department director general indicated that all reviews had been finalised by mid January 2016.

On completion of the review, the Department receives a letter outlining the Ombudsman's recommendations for ways to improve public administration to prevent or reduce child deaths. The Department is required to provide the Ombudsman with six-monthly updates on its implementation of the recommendations.

While the individual case reviews are provided only to the relevant agency, the Ombudsman reports from time to time on patterns and trends which emerge from the reviews as a whole.

A summary of the findings of its reviews is also provided in its annual report. The most recent report (2014-15) identified a number of issues related to public administration which are particularly relevant to the case in question, including:

Not adequately meeting policies and procedures relating to management and timeliness of case allocation.

Not conducting Safety and Wellbeing Assessments in a sufficiently timely manner.

Not adequately meeting policies and procedures in relation to pre-birth planning.

Not providing sufficient case management supervision to ensure timely action in regard to pre-birth planning.

Not adequately meeting policies and procedures relating to post-birth safety planning.

Changes implemented

During the first hearing with the Department (in March 2014), the director general at the time Terry Murphy indicated there was no intention to change any of the relevant child protection or pre-birth planning policies or practices as a result of the incident.[47]

46 Information sourced from Ombudsman Western Australia, Annual Report 2014-15, pp47-84. Accessed from: http://www.ombudsman.wa.gov.au/Publications/Documents/annualreports/2015/Ombudsman-Western-Australia-Annual-Report-2014-15.pdf

47 Mr Terry Murphy, Director General, Department for Child Protection and Family Support, *Transcript of Evidence,* 17 March 2014, p9.

However, during the more recent hearing the current director general said that her predecessor did not have all of the evidence before him at the time and formal review processes had not commenced.[48]

Mr Murphy had not visited the Bunbury office or completed a review of the incident when he declared that the Department's duty of care "is quite sound". This conclusion was based on "a range of recorded material that does satisfy us that no policies and procedures were contradicted and that there was no negligent behaviour".[49]

Finding 5

The former director general of the Department for Child Protection and Family Support, who was in the position at the time of the incident, asserted that no procedures or policies had been breached, even though staff had not been interviewed and a review completed.

Ms White said that some changes had been implemented as the result of the formal review, which had since been completed, and there were a few more to come.

A review of policies and procedures with regard to children in care who will become parents before the age of 18 had been undertaken. As a result changes had been made to provide staff with more instruction and guidance about what they needed to do to give more practical and educational support to young parents and parents-to-be.

A review of the statewide pre-birth protocol – which determines when the Department becomes involved in partnerships with other departments and services (e.g. the Department of Health) and what needs to occur for young parents or mothers at risk in the weeks before birth – revealed that the protocols needed to be localised in some of the regional locations.[50]

A localised protocol was under development with Bunbury Regional Hospital. However, it would only be relevant to that district. The Bilateral Schedule – Interagency Collaborative Processes for when an unborn or newborn baby is identified as at risk of abuse and/or neglect is apparently in place,[51] although staff said they were only able to find a draft bilateral protocol from 2013 on the Department intranet.[52]

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48 Ms Emma White, Director General, Department for Child Protection and Family Support, *Transcript of Evidence*, 25 November 2015, p20.

49 Mr Terry Murphy, Director General, Department for Child Protection and Family Support, *Transcript of Evidence,* 17 March 2014, p11.

50 Ms Emma White, Director General, Department for Child Protection and Family Support, *Transcript of Evidence*, 25 November 2015, pp3-4.

51 Ms Andrea Walsh, Manager, Executive Services, Office of the Director General, Department for Child Protection and Family Support, Email, 26 February 2016.

52 Ms Rikki Hendon, Branch Assistant Secretary, Community and Public Sector Union/Civil Service Association, Letter, 22 January 2016.

Finding 6

Changes implemented by the Department for Child Protection and Family Support to provide staff with more guidance in supporting adolescent parents/parents-to-be are a positive development.

Finding 7

There is a direct nexus between the level of staffing resources and the capacity to monitor and supervise. Staffing at a sustainable level, along with appropriate practices, would help to prevent a similar death from occurring.

MS M.M. QUIRK, MLA
CHAIR

Appendix One

Committee's functions and powers

The functions of the Committee are to review and report to the Assembly on: -

a) the outcomes and administration of the departments within the Committee's portfolio responsibilities;

b) annual reports of government departments laid on the Table of the House;

c) the adequacy of legislation and regulations within its jurisdiction; and

d) any matters referred to it by the Assembly including a bill, motion, petition, vote or expenditure, other financial matter, report or paper.

At the commencement of each Parliament and as often thereafter as the Speaker considers necessary, the Speaker will determine and table a schedule showing the portfolio responsibilities for each committee. Annual reports of government departments and authorities tabled in the Assembly will stand referred to the relevant committee for any inquiry the committee may make.

Whenever a committee receives or determines for itself fresh or amended terms of reference, the committee will forward them to each standing and select committee of the Assembly and Joint Committee of the Assembly and Council. The Speaker will announce them to the Assembly at the next opportunity and arrange for them to be placed on the notice boards of the Assembly.

Appendix Two

Hearings

Date	Name	Position	Organisation
17 March 2014	Mr Terry Murphy	Director General	Department for Child Protection and Family Support
	Ms Emma White	Executive Director, Country Services	
23 November 2015	Ms Rikki Hendon	Branch Assistant Secretary	Community and Public Sector Union/Civil Service Association
	Ms Linda Goncalves	Community and Campaigns Organiser	
25 November 2015	Ms Emma White	Director General	Department for Child Protection and Family Support
	Ms Kay Benham	Executive Director, Policy and Learning	
	Ms Cheryl Barnett	Executive Director, Metropolitan Services	

Appendix Three

Table of activities undertaken by Department for Child Protection and Family Services staff in relation to the case

Attachment 1

Casework activities undertaken in relation to the baby

23.12.2013	Referral for pre-birth planning intaked by Bunbury district
20.01.2014	Co-worker sought for the father.
21.01.14	Baby born prematurely at 34 weeks. Cannington Office advises Bunbury Office that background information on the father has been sent in response to Bunbury's request for information sent on 20 January 2014.
22.01.14	Email from Cannington Office to Bunbury Office requesting co-worker given due date for birth on 05.03.14.
23.01.14	Bunbury Office advised Cannington Office of the premature birth on 21.01.14. Case allocated to Bunbury caseworker. Meeting with the baby's mother and grandparents organised for 24.01.2014. Emails exchanged between Bunbury and Cannington offices regarding co-worker, case history and planned signs of safety meeting on 28.01.2014.
24.01.15	Case manager gathered relevant information to inform the signs of safety mapping including requesting information from WA Police regarding the baby's mother and father. Initial Signs of Safety Mapping completed by the Departmental Case Manager in Bunbury with the mother, Maternal Grandmother, another Department Child Protection Worker and Bunbury Regional Hospital Signs of Safety Mapping undertaken to assess the risks to the baby and to identify the protective factors that would mitigate the risks including the role of extended family in keeping the baby safe. Case manager provided advice by email to senior district management regard the next signs of safety mapping on 28.01.14. Email from case manager requesting assistance from another colleague to co-facilitate signs of safety meeting on 28.01.14.
28.01.14	Second Signs of Safety Mapping with the mother, father, Paternal Grandmother, Maternal Grandmother, Bunbury Regional Hospital and CPFS. No concerns were raised by the hospital staff regarding the care of the baby, both parents were noted as attentive and responsive to the baby. The plan was to refer mother and baby to Best Beginnings and link the father to appropriate services. Email to case manager from Bunbury Regional Hospital with information about the mother of the baby requested under s.23 of the Act. Case manager received information from WA Police regarding contact with the baby's mother and father. as requested under s.23 of the Act. Email received by case manager from Country Health Service regarding the baby as requested under s.23 of the Act.

29.01.14	Email from case manager to Cannington case manager with notes from second mapping and highlighting possible new co-worker from Bunbury in care for children team. Case manager organised taxi to transport the mother to and from hospital to allow the baby to breast-feed.
30.01.14	Email from CPFS Crisis Care Unit to inform Bunbury that there was a physical altercation between and his mother outside the lifts at the hospital.
31.01.14	Case plan review filed regarding consult between Team Leader and case worker filed. Internal mapping between Team Leader case worker and other CPFS Bunbury staff to confirm case direction. Emails from case worker to Bunbury Hospital requesting additional information regarding the altercation.
03.02.14	Initial Inquiry Outcome Report written and approved. Discussion between Team Leader and Bunbury Hospital about the father only being permitted to visit during the day. Meeting arranged with the baby's mother and father for 04.02.14. Email to Team Leader from case worker [Cannington] regarding financial support for the father.
04.02.14	Email to Bunbury Hospital requesting information about the baby pursuant to s.23 of the Act. Meeting with CPFS, Bunbury Hospital, Community Mental health, the baby's mother and father at Bunbury Hospital to consider safety needs for the baby. Hospital staff did not raise any concerns in relation to the couple's parenting. The Hospital re-confirmed that the father was only permitted to visit between 8am and 8pm (but not during the rest period from 12.00pm to 2.30pm) and he should not attend the hospital if he was feeling upset. The Department was in agreeance with this action. There was no requirement for the father to be supervised during these visits. Aboriginal Liaison Officers were present at this meeting and an Aboriginal worker to support engagement with the South West Aboriginal Medical Service (emotional and well-being service). The father was linked in with Centrecare and Relationships Australia for counselling in relation to his behaviours. Email from Bunbury office to Cannington office advising of the meeting with the father and that Bunbury is meeting with him regularly.
05.02.14	Discussion between Team Leader and District Director South West to consider safety needs for the baby to be discharged. Agreed there is risk in the case and the Departments ongoing assessment and planning with regards to the baby's safety and wellbeing is required. Whilst the baby is in hospital and the maternal family are engaged there is sufficient safety for the baby. Given the mother and extended family's cooperation and support it was assessed child centred family support and Best Beginnings could proceed.

10.02.14	The Department was working towards the baby going home with his family when discharge from the hospital was determined appropriate by medical staff. In preparation for discharge the Department wrote to the mother outlining what needs to happen to provide for the baby's safety at home. Email from Bunbury Hospital to the Department advising that the mother is seeking financial assistance for baby items in preparation for discharge to the maternal grandmothers house in Bunbury.
13.02.14	Email from a senior Social Worker at Bunbury Hospital to the Bunbury case worker advising that they will refer to Best Beginnings service. Case worker acknowledged this course of action.
15.02.14	The baby's mother was admitted to the hospital to learn mother crafting skills to assist her in her parenting of the baby on discharge from the hospital.
14.02.14	Hospital notes sent to case worker covering period 27.01.14 - 04.02.14.
16.02.14	Interaction Report completed by Crisis Care Unit and sent to Bunbury case manager regarding the baby being severely injured.
17.02.14	Email from Bunbury Team Leader to relevant case workers regarding the baby's injuries and the father being arrested. Bunbury Team Leader made a referral to Crisis Care Unit made in case of out of hours contact by family. Crisis Care Unit completed the case plan review associated with the baby's injuries and sent it to the case worker and Team Leader. Move to Initial Inquiries. Initial Inquiries Outcome Report sent to case worker and Team Leader. Move to Safety and Wellbeing Assessment. Crisis Care Unit sent the Safety and Wellbeing Assessment Outcome report to the Bunbury case worker and Team Leader . Child brought into the care of the CEO pursuant to s.37 of the Act. Email to case worker and Team Leader from Princess Margaret Hospital advising of new PMH case worker. Email to Team Leader Bunbury from Team Leader Cannington advising they are aware of events. Email from PMH to the Bunbury Team Leader regarding visitation by family members. Email from PMH for consent to examine the baby. Medical consent for examination form signed and sent to PMH by Bunbury Team Leader Emails exchanged with the PMH about a serious injury planning meeting. Serious injury planning meeting held which made determinations about medical care of the baby. Information about the baby's injuries provided to the Department. Discussion between case worker and Major crime.

	Email to Cannington Team Leader from Bunbury Team Leader regarding outcome of Serious Injury Planning Meeting with PMH held earlier. Email to Bunbury Team Leader containing press release and media reports. Telephone call between Department of Corrective Services and Bunbury Team Leader to advise that the father has been referred to appropriate counselling services. Corrective Services agreed to keep the Department updated regarding the father's well-being and progress.
18.02.14	Telephone conversations with Maternal Grandfather and case worker. Case notes written and filed. Email from Bunbury Team Leader to District Director and Executive Director regarding progressing a care and protection application. Email to Team Leader Bunbury by District Director to proceed with filing a care and protection application and affidavit Email from Bunbury Team Leader to District Director with update. Email from Cannington Aboriginal Practice Leader to CPFS case workers and team Leaders regarding cultural advice associated with contact. Home visit conducted by case worker to maternal Grandmother. Case notes written and on file. Meeting with the mother and Bunbury case worker, Team Leader and PMH Social Work at PMH. Application for Care and Protection Order (Time Limited) and supporting affidavit prepared by case worker and sent to Legal Services. Team Leader Responsible Parenting and YFEW Team provided background information of their involvement with the mother and their knowledge of the mother and fathers relationship. Email exchange between Bunbury Team Lader and Crisis Care Unit. Email exchange between Bunbury Team leader and Cannington regarding contact by family at PMH.
19.02.14	Submission for Termination of Life Support prepared. Genogram prepared. Care and protection application filed in Perth Children's Court Email from Bunbury Team Leader to District Director about letters advising the parents that Care and Protection Order's had been lodged being served. Meeting with the mother involving the Team Leader, case manager, Hospital staff and maternal grandparents to inform them of medical advice to turn off life support for the baby.

20.02.14	Financial assistance provided to the mother . Email to major Crime by Bunbury Team Leader. Email exchange between Bunbury Team Leader and Cannington Office. File note regarding meeting with Ms and grandparents on 19.02.14. Email to PMH by Bunbury Team Leader regarding paperwork for registering the baby's birth. Email from Bunbury Team Leader to PMH requesting if the mother has made any decisions and other matters. Emails between PMH and Department regarding possible family meeting on 21.02.14. Case Manager had telephone contact with the mother who said she was feeling better and discussed a visit by CPFS officers and family members who could visit. Case Manager had telephone conversation with the mother where she requested that family members not visit the baby without her being present. Email exchange between Bunbury Team Leader and Legal Services regarding the serving of papers being difficult due to the mother's location being unknown. Email exchange between case worker and PMH. Visit to the father at Banksia Hill by Cannington case worker Email from Team Leader Cannington to Bunbury Team Leader and case worker about meeting with the family and contact visits at PMH
21.02.14	Email from Bunbury case worker to Crisis Care Unit regarding Court proceedings and ruling that the parents should decide if life support should be withdrawn. Medical report from PMH to Bunbury Team leader. Email exchange between Cannington and Bunbury regarding contact by family with the baby. Email exchange between Cannington and Bunbury regarding possible conflict between maternal and paternal extended family.
23.02.14	PMH contacted Crisis Care Unit to advise that the baby's health was worsening and he was not expected to survive long; noting that the mother was with the baby and extended maternal family. Case note to all case workers and filed. Crisis Care Unit attended to offer support.