COMMUNITY DEVELOPMENT AND JUSTICE STANDING COMMITTEE

Eleventh Report — "Red flags, white flag response? The Department for Child Protection and Family Support's management of a troubled boy with a baby" — Tabling

MS M.M. QUIRK (Girrawheen) [10.09 am]: I present for tabling the eleventh report of the Community Development and Justice Standing Committee, titled "Red flags, white flag response? The Department for Child Protection and Family Support's management of a troubled boy with a baby".

[See paper 3957.]

Ms M.M. QUIRK: In February 2014, a month-old baby 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 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 committee sought to establish whether the teenager had been managed appropriately by the department.

In looking at this issue, I thank committee research staff Dr Sarah Palmer and Ms Franchesca Walker for their diligence, insight and equanimity, which always contributed to our deliberations. I pass on my gratitude to committee members, the member for Armadale, Dr Tony Buti; the member for Collie–Preston, Mr Mick Murray; the member for Balcatta, Mr Chris Hatton; and the member for Vasse, Ms Libby Mettam. Their respectful and robust commitment to the matters in hand was appreciated.

The youth who is the subject of this review had a tumultuous personal history. He was in state care between the ages of six and 10, and then again from the age of 12. He had been subjected to neglect, exposure to substance abuse, violence, transience and instability. Concerns arose 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, the President of the Children's Court of Western Australia, Judge Denis Reynolds, expressed surprise that the teenager's access to the baby had not been conditional or supervised. The committee also sought 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 of WA that suggested excessive workloads and a lack of resources were impacting on the ability of departmental caseworkers to perform their roles to the level they felt was required. The committee concluded that there were multiple red flags warranting only supervised hospital visits by the teenager, but as we now know this did not occur. More than likely this was due to a lack of staff and resources rather than a conscious decision to allow unsupervised access. One of the most telling facts about this case was that despite the teenager being identified as in need of targeted anger management counselling prior to the birth of his child, this had not taken place and unsupervised visits still occurred. Compounding the level of acceptable risk was the fact that a caseworker in Cannington still had responsibility for the young man even after he had been in Bunbury for some time, yet another caseworker in Bunbury had supervision of the rest of the family.

The committee's eleventh report, "Red flags, white flag response? The Department for Child Protection and Family Support's management of a troubled boy with a baby", makes seven findings and two recommendations. Concurrent with the agency review by the committee, the Ombudsman also performed, under his statutory role, a child death review. This occurs when a child dies while in the care of the CEO of the department. It is the statutory duty of the Ombudsman to perform such a review. At the time of the hearing with the Department for Child Protection and Family Support in November 2015, the department's director general said that the Ombudsman's review had not been completed. On completion of the review, the department received a letter outlining the Ombudsman's recommendations to improve public administration to prevent or reduce child deaths. As the individual case reviews are provided only to the relevant agency, the committee did not have access to the Ombudsman's review. But from time to time the Ombudsman's findings over the previous year are published in the annual report. The most recent Ombudsman's report identified a number of issues related to public administration that were particularly relevant to the case the committee was looking at. These included that the department was not adequately meeting policies and procedures related to the management and timeliness of case allocation; the department was not conducting safety and wellbeing assessments in a sufficiently timely manner; the department was not adequately meeting policies and procedures in pre-birth planning; the department was not providing sufficient case management supervision to ensure timely action in regard to pre-birth planning; and the department was not adequately meeting policies and procedures relating to post-birth safety planning. Although it is not possible to identify individual cases from the annual report, it is true to say that the issues canvassed, together with the findings, are consistent with the committee's observations in this particular inquiry.

The committee began its inquiry in March 2014, in the weeks after the death of the baby. However, because of ongoing criminal proceedings, the inquiry was deferred until the conclusion of the teenager's trial. Having been granted access to the judge's sentencing comments about the case, the committee held a second hearing in

November 2015. A hearing was also conducted with the Community and Public Sector Union–Civil Service Association of WA after the committee received a letter from the organisation outlining concerns about systemic issues within the department that may have contributed to the tragic outcome in the Bunbury case. Throughout the committee's agency review, and within the report, the committee was conscious to ensure that blame was not apportioned to individuals for the tragic incident. The committee is acutely mindful that the staff involved, and indeed the whole agency, would have been deeply affected by the event. However, in the interests of ensuring such a situation is not repeated, the committee felt bound to investigate concerns that the department is struggling to cope with a high volume of cases and that this impacts on its capacity to monitor and supervise children in care.

The committee's short report outlines the case and presents the conclusions it reached about the Department for Child Protection and Family Support's management of the teenager, particularly in relation to impending fatherhood and access to the newborn infant, and whether systemic issues within the department contributed to the situation that resulted in the baby being fatally injured and whether any changes to departmental practices and procedures were implemented as a result of that case.

Although the committee was principally focussed on the individual case, evidence was adduced more generally of widespread systemic issues. Much of this is only alluded to in the report; however, I commend anyone who is interested to look at the submissions and transcript of evidence that is publicly available on the committee's website.

In concluding, I will refer to the broader issues that were elicited. I mention these because the tragic incident in Bunbury is a symptom of a system under immense pressure in which inadequate resourcing has created an environment of uncertainty and staff are forced into situations that have an inherently unacceptable high level of risk. Those factors include some reluctance by DCPFS staff to bring children into care placements partly because there are too few foster carers prepared to look after those children and also because of staffing and resourcing levels. Even the processing of applications to become foster carers takes longer than it should. The support and backup of foster parents is sub-optimal, which again is resource related. Kids in this situation are invariably categorised as "monitored". I regard this word as a weasel word because, in reality, it is the opposite—they are in fact not monitored. An implication of monitored cases is that they are not counted in the case load numbers. However, the responsibility for those cases remains with a caseworker even if there is not the time allocated for careful, let alone any, supervision. It also became apparent that an increasing number of caseworkers report being distressed and upset because they feel as though they should be doing something different, something more, to progress those cases in their charge and to protect those children. The union told the committee that a lot of this is about resourcing; there are simply not enough child protection workers to go around. They feel immense pressure and they are carrying out very significant workloads because of that.

The number of children entering care continues to grow, so do the demands on workers in the Department for Child Protection and Family Support. In fact, since 2006 the number has more than doubled. When the effects of the workforce renewal policy, targeted voluntary separations and efficiency dividends are factored in, it is not surprising that the system struggles to cope with an increase in demand. This overly simplistic measure of case load fails to take into account the complexity and intensity of the cases, and the capacity of the caseworker. Disturbingly we were told that team leaders are requested to check that allocations are correct. The team leader reallocates the cases from the caseworker list to the monitored list so that the casework allocation does not go over 15 cases. Once the data collection has been completed, the case is reallocated back to the staff member.

Members, as we reflect on a system that is overextended and under stress, it is hard to be optimistic about the future of those who are in state care. I admire the work done by our child protection workers, and it is admirable that they prevail and persist, often at personal cost to their own health and wellbeing. With the number of children in state care having doubled in the last decade, it is easy for those in close contact with kids at risk to become desensitised, and we must all guard against this. The death of this baby should serve as a catalyst for renewing our resolve and recommitting to breaking the cycle of dysfunction.

The title of the report refers to red flags and a white flag. The red flags are the risk factors that should act to alert us to be vigilant and mindful. As we all know, the white flag is an internationally recognized protective sign of truce or ceasefire, and request for negotiation. The white flag is also used to symbolise surrender. Persons carrying or waving a white flag are not to be fired upon, and nor are they allowed to open fire. In this context, the overwhelming number of cases, the complexity of many cases, and the stretched resources, may lead some within the system to capitulate or surrender. Likewise, we should not shoot the messenger. Those working in the department need to communicate to their supervisors the challenges they are facing with their workloads and unacceptable risks, without fear of repercussion. We need to value their work and commitment.

I conclude with a quote from Dietrich Bonhoeffer, who, with more brevity, summarises the challenges for us all —

The test of the morality of a society is what it does for its children.

MS L. METTAM (Vasse) [10.23 am]: I would like to take the opportunity to comment on the findings of this report from the Community Development and Justice Standing Committee. This report covers a very tragic event. The fatal assault of any child by their parent is abhorrent, and in this particular tragic case it is even more terrible because it occurred from a teenage father who had a tumultuous background, which is why he was in state care.

One of the key factors that faced the committee was correspondence from the Community and Public Sector Union–Civil Service Association that suggested that excessive workloads and lack of resources were impacting upon the ability of department caseworkers to perform their roles to the level they felt was required. The union said that the child protection system was under immense pressure and was inadequately resourced, which created an environment in which employees were forced into situations inherent with unacceptably high levels of risk, and which significantly hindered the management of children at risk. The union said also that inadequate resources and 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. However, the committee states in finding 4 of its report that although systemic issues, such as inadequate resources and excessive workloads, may have contributed to the outcome in the Bunbury case, a direct link is not evident.

In cases such as this, hindsight is a wonderful thing, and it is easy, if not desirable, to affix blame on the failings of a department. However, as the committee found, there is no direct link to any systemic failure by the department in this case. This report illustrates the tremendous pressures placed on a department that is dealing with a transient and highly mobile population. Correspondence from the department indicates that from 2011 to 2013, staff met with the youth approximately 40 times, and between April and July 2013 his whereabouts were unknown to the department. It indicates also that the father and his partner were highly mobile, and the department was having a great deal of difficulty catching up and engaging with them. The department did not know until three weeks before the baby's death that the youth was living in Bunbury.

I would like to thank my fellow committee members—the chair of the committee, the member for Girrawheen, and the members for Armadale, Balcatta and Collie–Preston—for their work on this report. I also give special thanks to the committee staff—Dr Sarah Palmer, principal research officer, and Ms Franchesca Walker, research officer—for the great work they have done on this report. Thank you.

MR C.D. HATTON (Balcatta) [10.27 am]: Within its role and portfolio responsibility, the Community Development and Justice Standing Committee set about investigating the circumstances surrounding the death of a young baby and the involvement of an agency—in this case the Department for Child Protection and Family Support. This case goes back to February 2014 when the department had oversight of the case. However, it is important to note that the review was not about blaming any one individual or identity, whether it be a whole department such as DCPFS, and the leadership and staff of that department, or even the hospital administration or hospital staff at the location of the baby's death.

It is clear the baby's death was caused solely by the action of the father, and the father had been sentenced and is serving time for that offence. As we all know, when tragic events such as this occur, there is often a history of previous events and circumstances. There is often a dysfunctional family history. There is often some history of contact with the police and the law. There is often a complex web of dysfunction underlying the event. Issues are often brought to the attention of departments, in this case the Department for Child Protection and Family Support. In this case, there certainly was a background of family history and dysfunction to be considered, monitored and managed. The father had a criminal record and DCPFS had a case support and monitoring system in place for the father. Therefore, given that departmental interventions and practices were in place, the committee decided to find out more about those interventions and procedures, and the monitoring of the case.

As I have stated, the committee did not set about to blame. It set its focus on identifying those mechanisms and procedures that would best be adopted to prevent a tragic event such as this from occurring again. The Department for Child Protection and Family Support has a pivotal role in supporting the welfare of children and young people who are wards of the state. Some 4 500 children are currently wards of the state. It is a huge, but necessary, task to monitor the lives of young people in need. I personally praise the leadership and staff of the department for the difficult role that they perform to help young people. However, given that huge task of monitoring across our geographically huge state, we need to look at whether procedures can be better applied or administered, and whether there can be surety that everything possible is being done to minimise, and indeed prevent, tragic events such as this.

It should be noted that the committee was informed that 80 per cent of the families that the department works with have experienced some form of domestic violence; about 60 per cent have drug and alcohol issues; and almost half have mental health issues. Hence the risk factors in the youth's case were not particularly unusual. Child protection and family support is problematic and difficult, and it is managed with protocols.

The committee today tables seven findings and two recommendations. Findings 1, 2 and 3 essentially note that the department was unable to make fully informed decisions about the father's unsupervised or supervised access to the newborn infant due to incomplete information. However, although there was some evidence of potential risk to justify supervised visits, the teenager father was allowed to visit his baby without supervision. It appears, as evidenced in finding 3, that some of the inability to get information about the father was due to the difficulty of keeping track of this highly transient young person who may not really have wanted to be found. In effect, it is acknowledged that this scenario, this case, presents a constant pressure on departmental resources and the procedural ability to engage with individuals across the state. The complexities are vast and a challenge. Findings 4 to 7 indicate that systemic issues such as inadequate resources and excessive workloads may have contributed to this case, but a direct link is not evident. However, attention is brought forward by the committee to the relationship between the level of staffing and the capacity to monitor. Finding 6 indicates a positive implementation undertaken by the department to provide staff with more guidance in supporting adolescent parents and parents to be.

The committee has made two recommendations in this tragic case of an infant death. Recommendation 1 states —

> 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.

Recommendation 2 states —

> 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.

In conclusion, this review certainly had an element of emotion attached to it, as anyone would understand in the case of a tragic death of a baby and the circumstances around it. I would like to commend my fellow committee members for remaining focused and working together to arrive at the findings and recommendations to be put forward for better outcomes for children in need.

DR A.D. BUTI (Armadale) [10.34 am]: I also rise to talk on the Community Development and Justice Standing Committee report titled "Red flags, white flag response? The Department for Child Protection and Family Support's management of a troubled boy with a baby". Of course, this is a tragic scenario that the committee was investigating. Before I go on, I would just like to thank my fellow committee members, with the committee led by the chair, the member for Girrawheen, who always chairs our meetings in a manner that allows us to get maximum information from those appearing before us. I also thank my fellow committee members: the member for Vasse, the member for Balcatta and the member for Collie–Preston. Also, as all people who sit on committees know, we cannot do this work and the reports cannot be produced without the outstanding efforts of the committee staff, in this case Dr Sarah Palmer, principal research officer, and Ms Franchesca Walker, research officer. I thank them immensely for the efforts they continue to make in supporting our committee.

I do not need to go through the history of this tragic story, because my fellow committee members have already done so, but I just want to make some general statements and then maybe some more specific statements. We have a crisis in Western Australia in regard to child care. There is a crisis in Australia in respect of child care. The chair, in her foreword to this report, stated that there are approximately 4 500 children currently wards of the state, and that is an incredible demand on the department. Without making a political statement, I think it is obvious that the department is under great strain and staff are unable to cope with the demands upon them, and it has probably always been thus. I think we need to look at the issue of state care, and although it is a controversial issue, we need to look at the balance between foster care and more permanent placements in adoption, but that is a debate to be had on another occasion. If a child is in state care, the department, which basically represents the state, actually becomes the parent of the child—it sits in loco parentis to the child. It has a guardianship responsibility and it also has a responsibility to ensure that the child under its care is safe and does not come into harm's way. In the situation being discussed here, the baby who was killed was not as far as I can recollect under the care of the state, but the father who committed the tragic action that led to the death of this child was in state care. I think it is not too much of a logical step to say that if the state has the obligation to ensure someone under its care is out of harm's way and does not end up in harm, it also would have the responsibility to ensure that the child does not do something that would be detrimental to their life, and of course killing their own child and ending up in prison is not an action that is in the best interests of a person in the department's care. The state has an immense responsibility, and as a result of that immense responsibility, the workers in this department are under immense pressure and stresses.

As was mentioned, there were submissions from and hearings with the union, and, as this committee has quite clearly stated, we were not trying to blame anyone in particular for this tragic scenario. But the union made quite clear in its submission that this is a department whose members are under incredible stress. It may be argued that that is the union pushing its perspective—of course it is—but we just have to speak to people who work in this

department—management, executive management and staff members—and they will tell us the stresses they are under. Page 10 of the report deals with systemic issues, and that is where the union presented its case in respect of the resources allocated to its workers. In this case, as the member for Balcatta mentioned, this particular individual was difficult to monitor because he had a substantially transient lifestyle. One of the things surprising to the committee was that it was recommended that the father engage in an anger management program. It was highlighted and detected that he had problems controlling his anger but he was allowed unsupervised access to his baby without first undergoing the anger management program, and I think that is a failure of the department—a major failing of the department. The union discussed the allocation of cases to each staff member. Page 11 of the report states —

> … 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, it may have been too many depending on the nature of the cases.

As this individual had a quite mobile, transient existence, maybe being responsible for 14 cases was just too much. Because the department is saying that a case load of 15 is normal does not mean that that is best practice, and we should be considering best practice when someone has responsibility for the care of wards of the state. Finding 4 of the report states —

> 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.

This suggests that the committee could not find a direct cause between the lack of resources and the death of this baby. Comments have been made that the alleged inadequate resources and excessive workloads did not cause the death of the baby. Of course we cannot find a direct link causing the death of the child, but let us turn it the other way. If there were sufficient resources and the workloads were not excessive, the death may have been prevented. Although not having enough resources does not cause the death, it does not mean that, as a result of that, a person is going to kill someone, but if there are sufficient resources and proper decisions are made, the death may have been prevented. Given the history of this case and the characteristics and personality of the individual involved, if there was sufficient time to ensure that the proper decisions were made and the father undertook an anger management program, this 16 or 17-year-old individual would not have been allowed to have unsupervised access to his baby. If he was not allowed to have unsupervised access to the baby, the death would not have taken place. It did not cause the death, because the department obviously did not tell the father to kill the child, but it could have been prevented. That is what we have to look at. That is why recommendation 1 was made, which suggests taking a precautionary approach. It states —

> 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.

Given the fact that there was trouble maintaining contact with the father, the decision should not have been made to allow him unsupervised access. If the department had taken a precautionary approach until he had undertaken the anger management program and it was satisfied that his anger management issues were under control, he should not have been given unsupervised access to his child. If he did not have unsupervised access to his child, this situation would have been prevented.