

**COMMUNITY SERVICES COMMISSION  
INQUIRY INTO THE DEATH OF JORDAN DWYER  
AND THE ROLE OF THE DEPARTMENT OF COMMUNITY SERVICES**

**Part 1:**

**The period leading up to and immediately following the discovery of the death of  
Jordan Dwyer**

**1. FINDINGS AND RECOMMENDATIONS**

**2. BACKGROUND**

The following description of events surrounding this matter is drawn largely from the investigation report undertaken by Mr Prasad (see section 3) and from interviews undertaken by the commission with staff from the Coffs Harbour and Tweed Heads offices of the Department of Community Services (DOCS or “the department”).

On Saturday 20 September 1997, a 4 month old baby boy, Jordan Dwyer, was found dead in the back of his mother’s car at Tweed Heads on the far north coast of New South Wales. His mother, Marlene Dwyer had, that day, walked into the Lakeside Christian Centre at Tweed Heads in a distressed state and revealed to the Pastor and others at the centre that she had a dead baby in her car.

The police were called. They in turn contacted the Department of Community Services' statewide Child Protection and Family Crisis Service (CP&FCS) who contacted the Child Protection Casework Specialist (CPCWS) and the Acting Manager from the Tweed Heads Community Services Centre (CSC).

The woman’s other two children (a five year old boy, Jacob, and Jordan’s twin brother, Thomas) were seen with their mother at Tweed Heads Hospital. A s23 notice for a medical examination of the children under the *Child (Care and Protection) Act 1987* was served, the examination undertaken, and the children assumed into the department’s care. They remained in hospital with their mother overnight and were then placed in foster care the following day. Marlene Dwyer was scheduled to Richmond Clinic, Inpatient Psychiatric Unit in Lismore.

Staff at Tweed Heads CSC were informed, on the evening of 20 September 1997 by CP&CFS that a check of the department’s computerised information system (CIS) had revealed that a notification in the name of Jordan Dwyer had been entered at the Coffs Harbour CSC on 27 August 1997, three and a half weeks earlier.

A briefing to this effect was prepared by departmental officers on 22 September and forwarded, through the Director-General of DOCS, Ms Helen Bauer, to the Minister for Community Services, the Hon. Ron Dyer, MLC. At the same time a separate

briefing was prepared for the Minister's parliamentary file. Both briefings informed the Director-General and the Minister that a baby who was previously known to the department had died. While the matter was regarded as tragic, it was not seen as raising any particular concerns. There was some limited media coverage of the baby's death.

On 22 September the CPCWS at Tweed Heads CSC realised the connection between the dead baby and a notification classified as "intake only" which had been received on 15 September at Tweed Heads CSC but not entered on the CIS at that time. The intake officer was asked to fill out a report and enter relevant information onto the CIS, which she did, backdating the date of entry to 15 September.

The notification of 15 September had been from Marlene Dwyer's brother in Victoria who had expressed concern for her well-being and the safety of the children. He contacted DOCS, gave the family name of Drill, but mentioned that the mother also went under the surname of Dwyer. Although both names were given, the CIS was only searched under the name of Drill, and no previous notifications were found. No action was taken in response to the notification on the basis that no address for the family was provided by the brother. Instead, according to the intake officer, Mr Dwyer was advised to contact the police. Mr Dwyer claims he was not advised to do this and that he was left with the impression that the department would attempt to locate his sister and would contact the police.

The intake officer took notes of the phone call, and a subsequent one from Mr Dwyer the next day, but did not enter the information onto the CIS. The result was that the briefing note sent to the Minister and the Director-General on 22 September 1997, which was prepared by the Area Manager of the Far North Coast (FNC) and cleared by the Director, (Operations) Northern, informed them of Jordan's death and of the notification to Coffs Harbour. They were not informed of the notification to Tweed Heads CSC, which, at the time the briefing note was written, was only known by the relevant intake officer and the CPCWS.

The next day the Area Manager for FNC was informed that there had been a notification of the baby some days prior to the police reporting Jordan's death, but that the name given at the time was Drill - hence no connection at the time to the Coffs Harbour notification and no connection at the time the death was first reported. He prepared additional information to update the parliamentary brief and this was faxed to central office on 25 September. He did not update the separate brief for the Director-General or the Minister that had been submitted on 22 September.

Furthermore, the updated information wrongly stated that the notification to Tweed Heads had been made under a different family name, so that the search of the CIS had not revealed a connection between this notification and the previous one to Coffs Harbour. At this point in time, no-one other than the CPCWS and the intake officer were aware that the notification of 15 September had in fact recorded both Drill and Dwyer as the relevant family names.

The most (but not completely) accurate briefing in relation to the notifications and death of Jordan was therefore contained in the parliamentary briefing folder. However as the information arrived after question time for 25 September had finished, and as parliament would not sit again until 14 October, it was not processed and was not seen by either the Minister or the Director-General.

On Monday 29 September 1997, the Opposition Spokesperson for Community Services, the Hon. Patricia Forsythe, MLC issued a press release stating that there had been notifications of the child to DOCS prior to the notification of his death, and that the department had failed to comply with its own policy in relation to sighting children under one year of age who are subject to notifications.

On radio on 29 September 1997, Ms Forsythe repeated her assertion that the matter had been brought to the department's attention but had not been appropriately handled. The Director-General, on radio on the same day, denied the Opposition Spokeswoman's assertions.

The following day, a senior policy adviser in the Minister's Office accessed the CIS and discovered the connection between the Coffs Harbour notification of 27 August and the notification to Tweed Heads concerning the same child on 15 September. She advised the Minister who immediately wrote to his Director-General, informing her that there had in fact been 2 notifications of Jordan prior to his death, not one as he had previously been advised, and that both notifications had included the name Dwyer. He directed that the matter be subject to a full and immediate investigation by an independent and suitably qualified person.

The Director-General then publicly retracted her claim that there had only been one notification and stated that she had since been informed that there had been a second notification and that an immediate investigation into the matter would be undertaken.

She announced that she had appointed Mr Trevor Barnes, an "employee of the Premier's Department", to undertake the investigation and that it would be completed within a week. It appears that neither the public nor the Minister were informed at the time that Mr Barnes was, and had been for several months, on secondment to the Department of Community Services and working in Ms Bauer's office.

On Wednesday 1 October 1997 media reports revealed that Mr Barnes was no longer conducting the inquiry, following questions raised about his independence. A fresh news release, issued by the department, stated that a former public servant, Mr Vishnu Prasad, would undertake the investigation at the direction of the Director-General with a report to be submitted no later than Friday 8 October 1997.

At this point, the acting Commissioner for Community Services (the commissioner was on leave) wrote to the Minister expressing the view that public confidence may not be satisfied by an investigation carried out on behalf of the Director-General and suggesting that the Minister refer the matter to the commission for a fully independent inquiry.

On 1 October the Minister requested the commission to conduct an independent inquiry under s.83 of the *Community Services (Complaints, Appeals and Monitoring) Act, 1993* to commence immediately following receipt of Mr Prasad's report and to be completed, if possible, by 30 October.

### **3. THE PRASAD INVESTIGATION**

Mr Prasad's investigation was conducted in a very short time-frame and was limited by terms of reference which were designed to establish the facts as quickly as possible. His focus, by necessity, was primarily on the immediate events surrounding the notifications to the department and those directly involved in the precipitating action, or lack thereof.

Mr Prasad was tasked with examining:

- the decision-making processes around the notifications to the department;
- the information available to the department and its analysis in determining the relevant responses, and
- the advice provided to senior management on the matter.

In conducting his investigation, Mr Prasad produced two reports. One dealt with the issues of decision making, information available and analysis of this. The other dealt with the issue of advice to senior management.

The commission received a copy of Mr Prasad's first report on Thursday 9 October. The second report was provided on Thursday 23 October.

### **4. THE COMMISSION'S INQUIRY - APPROACH AND SCOPE**

In undertaking this inquiry, the commission benefited from the work of Mr Prasad, his investigation report and the supporting documentation attached to it.

Extensive additional information was sought and received from the Director-General of the department, Ms Helen Bauer, from whom we received full and prompt cooperation. We also received excellent cooperation from other key people, both inside the department and without, who were involved in this case or its aftermath and who provided written information and were interviewed by telephone and in person.

Mr Prasad's investigation was a logical starting point for the commission's inquiry. The factual sequence of events as found by Mr Prasad, so far as they are relevant to the performance of the department, have not been contradicted in any significant way by any person interviewed by us or by material sighted by us.

In order to avoid unnecessary duplication and to add value to Mr Prasad's work, the commission determined that the focus of its inquiry should be on looking beyond the findings of fact in his report to ascertain not only *what* went wrong, but *why*, what lessons might be learned and how might the chances of a recurrence be avoided or minimised in the future.

As such, it was felt that further consideration needed to be given to the contextual or environmental issues; the systems, policy and organisational issues that may have played a part in the matter.

This approach was supported by an expert independent advice/opinion obtained by Mr Prasad from Ms Sally Castell-McGregor (formally head of the South Australian Child Protection Agency and an acknowledged child protection expert). A copy of Ms Castell-McGregor's erudite commentary is attached to this report.

Mr Prasad was also assisted by Dr Judy Cashmore (Chairperson of the NSW Child Protection Council), in the course of his investigation. Dr Cashmore provided advice and added comments to those of Ms Castell-McGregor. A copy of her brief but apposite comments are also attached.

In commenting on the actions of the department in relation to the death of Jordan Dwyer, Ms Castell-McGregor observed that:

*"The practice issues I have identified need to be discussed and any resource/training implications addressed. Professionals involved in child protection work in a demanding and stressful context..."* (p.9)

She also observed:

*"(t)he analysis of what happened which is part of any inquiry of this nature must be balanced by an understanding of why (our emphasis) and, most importantly, include constructive suggestions on what can be done to redress any identified system problems".* (p.4)

Dr Cashmore added:

*"systems issues (are) critical and need to be given more weight".* (See attachments 24 and 25B to Prasad report)

Like Mr Prasad's, the commission's report will be presented in two parts: one dealing with events and actions leading up to the discovery of the death of Jordan Dwyer and the immediate aftermath. The other, to be delivered at a later date,

dealing with events and actions subsequent to the death coming to attention, particularly relating to information provided to management, the Minister and the public.

## **5. THE COMMISSION'S INQUIRY - THE QUESTIONS**

It is evident from the Prasad report, and confirmed by our own inquiry that, notwithstanding the scant involvement that departmental officers had with this case, its analysis raises a surprising number of mostly interconnected and sometimes quite complex issues.

First there is the question of exactly what happened at Coffs Harbour and Tweed Heads CSCs?

Secondly, we ask what, if anything, went wrong?

Thirdly, if it is found that the department has erred, why, and what lessons are there in this for future practice?

In looking at these questions, we have not just asked whether proper procedures were followed and whether responsible judgements were made. We have found it necessary to look at the policy and procedural framework in which departmental officers operated. Were procedures clear and unambiguous, and were they the right procedures?

We have also looked at some of the contextual factors; the environment in which officers at all levels are required to work. These factors include, as Ms Castell-McGregor suggests, resource and training issues.

Finally, in relation to all of these matters, were there any failings or shortcomings in the systems of the department, that caused or contributed to any failures identified?

## **6. WHAT HAPPENED - AT COFFS HARBOUR AND TWEED HEADS?**

The summaries below are drawn largely from the Prasad report and its attachments. Where additional information has been provided by another source, this is noted.

### 6.1 Coffs Harbour CSC

During August 1997, Mrs Marlene Dwyer and her 3 boys, one aged 5 years and the others, twins aged about 3 months at that stage, were travelling by car from Victoria to northern NSW/southern Queensland. On 23 August 1997 their car broke down at Woolgoolga, approximately 25km north of Coffs Harbour and they found accommodation in a caravan park while waiting for the car to be repaired.

Residents of the caravan park provided Mrs Dwyer with food and had become concerned with her well-being and that of one of her twin baby boys, Jordan who, they said, looked ill and underfed. On 27 August, they reported him to the Woolgoolga Police, who in turn notified the Coffs Harbour CSC. Information passed onto the department by the police was that, according to the residents who had visited, one of the twins was not being fed or attended to, and had skin hanging off him.

The intake officer consulted the Assistant Manager who advised that the notification should be entered on the CIS and an intake assessment commenced. Shortly after, a second phone call from the police was received, reporting that the residents of the caravan park had spoken to Mrs Dwyer's five year old about his baby brother, and he had he replied "don't worry about it it's dead." The intake officer immediately relayed this information to the Assistant Manager who requested that she re-contact the police immediately and ask them to attend the caravan park. Failing that, an ambulance should be called.

At the request of the CSC, two police officers, a senior constable and a sergeant visited the family to sight the sick twin and make an assessment of the situation. They found 2 women from St Vincent De Paul (SVDP) visiting, each with a twin in their arms. The police reported back to the CSC that the children "looked fine" and that the 2 SVDP women were visiting. The senior constable reported that he saw no evidence of the mother presenting with a mental illness however, mentioned that she was slightly agitated in recounting an alleged assault that took place in Kempsey a number of days earlier.

The CSC contacted SVDP to obtain an independent view of the situation. One of the SVDP visitors was spoken to and advised that there was no evidence of abuse or inability of Mrs Dwyer to care for the children, and that with the twins appeared quite healthy and not crying, although slightly small.

On the basis of this information, the case was closed by Coffs Harbour CSC at the intake stage and did not involve a field response and sighting of the baby. (See Prasad report, p.13)

## 6.2 Tweed Heads CSC

Mrs Dwyer left Woolgoolga caravan park a day on 29 August 1997 and continued north with her 3 children, intent on locating their father, Scott Drill. She ran into him in a supermarket at Murwillumbah on 12 September 1997, reportedly threatened to kill him, and told him that one of the babies was already dead. Only one of the twins and Jacob were with her at the time.

Mr Drill then contacted his sister, who in turn rang Mrs Dwyer's sister on 14 September, expressing concerns about the well-being of Mrs Dwyer and her

children. This information was relayed to Mrs Dwyer's brother, who telephoned the Murwillumbah police station. He was told by the police to contact the department, which he attempted to do - unsuccessfully as it was a Sunday. He rang again on Monday 15 September and spoke with an intake officer about his concerns for his sister and her family.

In the course of this conversation, he reportedly gave the name of Drill as the children's family name, Marlene Dwyer as their mother's name, and details of her car number plate and bank account. He mentioned that his sister suffered from slight depression and anxiousness, had broken up with the children's father during her pregnancy with the twins and was obsessive about him. Mr Dwyer detailed Mrs Dwyer's encounter with Mr Drill in the supermarket when she had threatened to kill him, herself and the children, and had claimed that one twin was already dead.

The intake officer took notes of this conversation and then discussed the matter with the CPCWS who apparently advised that, with no address there was little the department could do and that Mr Dwyer should contact the police. A check of the CIS under the name of Drill did not reveal any previous contact with the department.

The matter was treated as "intake only" and no immediate entry was made to the CIS. According to the intake officer, Mr Dwyer rang back the next day and was told to contact the police and list his sister and her children as missing persons. Mr Dwyer states that he contacted Tweed Heads CSC a number of times over the 15 and 16 September. He claims he was not told at any stage to contact the police. He asked to be kept informed and was told that his name and number would be placed on file and he would be kept up to date with any developments. He says he was left with the impression that the department would follow up and would contact the police.

A record of these conversations was not entered onto the CIS as a notification. According to the intake officer she did not get around to this because of other calls and matters left over from the previous day.

On 20 September the police notified the department of the death of a baby. Departmental officers attended the Tweed Heads hospital where the family had been taken and it was confirmed that the mother's name was Dwyer. A check of the CIS that day revealed the Coffs Harbour notification of 27 August. A briefing in relation to the death and the previous notification to Coffs Harbour was prepared and forwarded to the Director-General and the Minister on 22 September. At the same time, a briefing was prepared for the Minister's parliamentary folder.

The investigating police officer contacted the Tweed Heads CPCWS on 22 September to check whether the department had any information on the family. It was at this point that the CPCWS made the connection with the Drill case which she had discussed with the intake officer on 15 September. She spoke to the intake officer

who wrote up her notes and entered them onto the CIS on 23 September, but backdated the entry to 15 September.

## 7. WHAT WENT WRONG? - THE PRASAD FINDINGS

In summary, Mr Prasad found that:

- A notification to Tweed Heads CSC was made on 15/16 September 1997 by Mrs Dwyer's brother, expressing concern for her well-being and that of her children; on advice from the Child Protection Specialist, the notification was not acted on (on the basis that no address was provided) and was classified as "intake only"; a search of the CIS under the name of Dwyer was not undertaken until 22 September, which revealed the Coffs Harbour notification of 27 August; and the notification of 15/16 September was not entered onto the CIS until 23 September, 3 days after the department had been notified of Jordan's death.
- The death of Jordan Dwyer could not have been prevented by actions of the Tweed Heads CSC even if the CSC had made an appropriate response to the notification (presumably on the basis that preliminary autopsy reports had revealed that Jordan was probably already dead by this time). He noted, however, that on-going problems for Mrs Dwyer and her surviving children could have been resolved earlier had an appropriate response been made.
- The notification in relation to Jordan Dwyer made to Coffs Harbour CSC on 27 August 1997, represented the only opportunity the department had of intervening to save Jordan Dwyer's life although, since the actual time and cause of death was not known when his report was written (and is still not known by us), it is not possible to say that intervention at this stage, no matter how appropriate, would have prevented his death.
- Following that notification, appropriate procedures in relation to entering the information onto the CIS and informing supervisory staff were followed.
- However, insufficient information was collected on which to base the decision to close the case at the intake stage; correct procedure was not followed as to the requirement for a DOCS officer to sight the baby or for the CSC to obtain appropriate professional advice was not met; and the decision to close the case at intake stage demonstrated poor professional judgement.

- The involvement of police officers in responding to notifications of babies under 12 months and making mental health assessments is an inappropriate interpretation of the Interagency Guidelines for Child Protection Intervention.

In making these findings, Mr Prasad clearly paid regard to the comments of Ms Castell-McGregor and Dr Cashmore, and their commentaries (attached) are commended.

Mr Prasad made a number of **recommendations**, including that DOCS:

- review and reissue statements around policy and practice in relation to babies under 12 months;
- improve the design of CIS entry screens;
- undertake disciplinary inquiries into the actions of relevant staff involved in handling the notifications at Coffs Harbour and Tweed Heads CSCs;
- establish why those directly involved at Tweed Heads CSC did not have appropriate supervision and support at the time;
- immediately dispense with the services of any temporary staff at Tweed Heads CSC who were involved in handling the notifications.

Mr Prasad's findings and recommendations in relation to his second report will be dealt with in the second part of the commission's report.

## 8. DEPARTMENTAL POLICIES AND PROCEDURES

In order to evaluate Mr Prasad's findings, it is necessary to look at what policies and procedures govern the actions of officers in these situations. Policies and procedures are the central guide for staff in undertaking the department's work and responding appropriately. They are particularly crucial in an organisation that is large, dispersed and whose primary work is often, by its nature and of necessity, crisis driven and can involve life and death issues.

### 8.1 The policy and procedural framework for child protection work

The policy and procedural framework for child protection work is complex and involves a multiplicity of laws, policies, policy manuals, guidelines and departmental memoranda.

The legislative mandates for the department's Child Protection and Family Support activities are contained in the *Child (Care and Protection) Act 1987* and the *Community Welfare Act 1987*.

Another overarching document is the *Interagency Guidelines for Child Protection Intervention*, issued by the NSW Child Protection Council with the endorsement of the Premier and all relevant departmental Chief Executive Officers in February 1997, following a major review in the context of criticisms of interagency cooperation by the Police Royal Commission. These guidelines detail the roles and responsibilities of various agencies in child protection and how they should work with each other.

The basic departmental document governing this area is the *Child Protection: procedures for recognising, notifying and responding to child abuse and neglect*.

This document was issued in March 1997, and is aimed at DOCS staff and those in funded, contracted or licensed services. It is intended to dovetail with the Interagency Guidelines, and to provide specific information about the role of DOCS in child protection and related matters.

Underlying the procedures is a practice manual: *Working with Children and Families Practice Manual*. This manual has only just been provided to departmental staff and replaces an earlier, interim manual issued in July 1996. It provides working detail and explanation of the department's child protection policies and procedures, and what it refers to as its "*Case Coordination Framework*".

While Mr Prasad included the new manual in his analysis of what took place at Coffs Harbour and Tweed Heads CSCs in light of policy and procedural requirements, there is differing information about when the new manual took effect and whether it was available to staff at the time.

Information from the Director-General provided for this inquiry indicates that the manual was issued in August 1997. (See letter from Director-General, 23 October 1997, Att 1, p.3) However, information provided to Mr Prasad during his investigation was that, at least for Coffs Harbour CSC, the manual did not become available until 29 September.

Even if it did reach CSCs in August, its scope and size might suggest that there was not sufficient time for staff to familiarise themselves with its contents prior to the notifications of Jordan. There has not been the opportunity or time to pursue these issues.

For the purposes of this inquiry the manual is considered relevant because it brings together existing policies and procedures guiding the department's practice, a key aspect of which is the Case Coordination Framework. It is also crucial to any analysis of whether the "improved" system will minimise the chances of a recurrence of the events that are the subject of this inquiry.

It is important to note that this manual and the interim Child and Family Services Practice Manual, issued in July 1996, provided the first basis for the new Case Coordination Framework which replaced the former, notorious "category-based" and highly prescriptive child protection procedures that the department had operated with for the previous decade or more.

A key aspect of the new framework (and relevant to this case) was the extent to which front line officers were permitted to make judgements based upon their own observations, inquiries and professional expertise, rather than simply following a prescribed path regardless of the sense of this to the case at hand.

This issue is referred to by Ms Castell-McGregor in her commentary:

*“The extent to which (child protection) workers use their professional judgement or discretion in implementing agency policy is a matter of current debate...A balance has to be struck between agency accountability on the one hand and respect for professional expertise on the other.” (p.9)*

Finally, as the Prasad report highlights, two policy documents contained in Departmental Memoranda, are crucial to any examination of what took place at Coffs Harbour and Tweed Heads CSCs. These documents, respectively titled memo CFS-292 and memo CFS-296, outline special procedures for dealing with babies under 1 year of age. They were issued in April and May 1997 respectively.

## 8.2 Departmental policy in relation to the notification of babies under one year

The full titles of the two policy documents mentioned in the previous section are: Memorandum CFS-292 *Case Management - New mandatory procedures for babies under 1 year of age notified to the Department* (7 April 1997); and Memorandum CFS 296 *Clarification of Case Management procedures for babies under one year of age distributed in CFS - 292* (12 May 1997). Jordan Dwyer was, of course, under 12 months of age at the time of the notifications and at the time of his death.

However, close examination of these two policy documents makes it difficult, if not impossible to determine exactly what action is required in relation to notifications of babies under 12 months of age.

### a) Memorandum CFS-292

#### *(i) Relevance of memorandum CFS-292*

Following the death of Jordan Dwyer, much has been made of the fact that departmental officers failed to sight the baby, apparently in breach of departmental policy in relation to notifications of babies under one year. As the Prasad report indicates, the Minister, the Director-General of DOCS and the Opposition Spokesperson on Community Services have all referred, publicly or otherwise, to the requirement for babies under one year of age to be sighted by departmental officers (p.10 of Prasad report). This requirement, insofar as it exists, was introduced by CFS-292 issued on 7 April 1997.

The terms of reference for the investigation carried out by Mr Vishnu Prasad stated that the case was to be looked at “under the terms of the department’s policy on dealing with children under the age of one year.”

*(ii) Background to the issuing of memorandum CFS-292*

Documentation attached to the Prasad report states that the department had been concerned about practice trends in relation to under one year olds, following a review of child deaths in 1996. Divisional Case Coordination Framework Coordinators were given the task in November 1996 to develop strategies in their Areas to focus on the departmental response to under one year olds at risk. (Prasad report, attachment 11, p.2)

However the death of a baby in March 1997 suggested that the department had not responded in an appropriate or timely manner or in a way which reflected the vulnerability of babies. In response to the Minister's concerns about these issues, a draft procedural document was prepared by the Child Protection Unit. Following urgency expressed by the Minister and concerns for the vulnerability of babies held by the Director-General, modifications were made to the draft procedures and they were signed by the Director-General on 7 April 1997 for distribution to the field. (Prasad report, attachment 11, p.2)

Media coverage of the new policy at the time of its introduction placed it in the context of a rise in infant deaths, a report showing that 30 per cent of those children renotified to the department 4 or 5 times had never been sighted by a DOCS officer, the new intake system allowing referral of some cases on to other services after assessment, and concern that this new system was allowing some serious cases to slip through the net. (See Sydney Morning Herald, 29 September 1997 - "Rules changed after rise in abuse deaths", p.6 and "Sick system's safety net fails abused youngsters", p.25)

*(iii) Ministerial briefing concerning memorandum CFS-292*

According to the Director General, in written response to questions asked by the commission as part of this inquiry, there was no specific ministerial directive or instruction that the policy be introduced. She states that a briefing note prepared by the department and cleared by her on 25 March 1997 informed the Minister that the new policy would be brought in (letter from Director-General, 23 October 1997, attachment 1, 1.1 (a)).

Documentation provided to the commission included a briefing note to the Minister titled "Case management response - monitoring and review of high risk and vulnerable babies" dated 19 March 1997. The briefing note outlines concerns with the number of child deaths over the last 12 months where the child was known to the department.

It noted that there was an overall increase in child deaths compared with previous years, and that all but 2 in the last 12 months involved babies under 12 months. Reference is made to a drop in the number of deaths from November on, following the requirement that serious notifications/re-notifications for children under 2 be reviewed to ensure appropriate management.

However the briefing note points out that “the recent death of baby Lewis this month highlights the failure of some field staff to recognise the vulnerability of babies and of administrative systems to monitor responses to notifications.” It goes on to say that the Children and Family Services Directorate will implement new mandatory measures for babies at risk based on: information available from previous child death reviews; the initial information on this recent death of a baby; and the trend information available.

The briefing outlines the specific procedures as being:

- all information about a child under 1 has to be entered on to CIS with no provision for screening;
- such notifications to be brought immediately to the attention of the Assistant Manager; and
- “irrespective of the circumstances within 2 days of notification the following must occur:
  - allocation of the case;
  - commencement of the investigation; and
  - sighting of the child.
- in all cases an immediate response is required, extra time should only be utilised if the child was difficult to locate and further information was required or the child was safe in hospital or in care.”

The briefing note refers to these requirements and other related changes as ‘short term’ but gives no indication of why this is the case, nor what the long term plan is. The briefing note does not inform the Minister of any resource implications, concerns in relation to implementation, or of any conflict with other relevant policies.

*(iv) The consultation and approval process for memorandum CFS-292*

According to the department, a draft of the policy CFS-292 was distributed for comment in keeping with the usual process for policy development in the C&FS program (letter from Director-General, 23 October 1997, attachment 1, 1.1(b)). However supporting documentation makes it unclear the extent and use of such consultation.

A DOCS Executive Information Paper dated 18 March 1997 was considered by State Executive on 19 March 1997. This paper is a one page pro-forma which states “new measures for improved case management, monitoring and review of high risk and vulnerable babies are required to be implemented immediately” and “these measures are to be implemented immediately - as detailed in the attachment”. The paper provides very limited background information, gives some consideration to reporting/ensuring compliance, but makes no reference to any resource, workload or field implications.

The attached Internal Memo to Assistant Directors General and Area Managers titled Management of babies at risk (the copy provided to the commission has a handwritten "draft" at the top), provides more background information and details the new procedures, as outlined in the briefing to the Minister. The memo also indicates that the Area Compliance Reporting Manual has been modified to take into account the new requirements and attaches an update for the manual in keeping with the proposed new procedures (letter from Director-General, 23 October 1997, attachment 3, volume 1, document 2).

Minutes from the State Executive Meeting are dated 17 March 1997, although information from the Director-General is that this meeting took place on 19 March 1997. The item "New measures for high risk and vulnerable babies" is listed under the heading of "Area Compliance Report", and refers participants to papers tabled on 19 March 1997.

The minutes do not record any discussion on the item but indicate that the paper was to be considered draft and set out a comment and review process which gave Area Managers until 25 March 1997 to provide feedback to their Assistant Director-General, and Assistant Directors-General until 26 March to get comments to the contact person in central office. There were no instructions recorded in the minutes or in other documentation sent to the commission on how consultation on the draft procedures at an area or CSC level should be undertaken, nor whose comments should be sought.

Following this process, according to the minutes, the Child and Family Services Directorate would provide revised circulars, these would be forwarded to Area Managers by mid April, and the new policy and procedures would be effective by 1 May 1997.

Documentation provided by the department to assist the commission's inquiry includes a printout of an e-mail message, dated 20 March 1997 and sent to all Area Managers and Assistant Directors-General requesting comments on the proposed "new measures for high risk and vulnerable babies" by 25 March 1997, and stipulating that the new measures (attached to the e-mail) are in draft (letter from Director-General, 23 October 1997, attachment 3, volume 1, document 4). Additional documentation provided by the department on 28 October 1997 includes memorandums from 3 Area Managers and 1 Assistant Director-General, written during the consultation period of 20 March to 25 March 1997 (although two were dated 26 and 27 March) and providing comments on the draft procedures.

Only two of the memos give any indication that the comments were developed through a consultative process. These are the more detailed memos which highlight concerns and seek clarification of specific issues. One points out that the draft procedures are inconsistent with the new Intake/Assessment process, that sighting "almost" every child under one would lead to a dramatic increase in District Officer (DO) workloads, and that there is no room to exercise judgement, as required by the

Case Coordination Framework. The other asks whether it is the intention that “irrespective of the nature of the information regarding a child under 1 year of age that we always proceed to an investigation involving a home visit at which the DO sights the child?” (letter from Director-General, 28 October 1997, attachments).

Of the other two, one appears to express the views of the Child Protection Specialist only. The other, which is intended to convey feedback from a departmental region, makes only one comment on the draft, in relation to responsibility for reviewing cases on a weekly basis, and it is unclear where this comment has come from or how consultation was undertaken (letter from Director-General, 28 October 1997, attachments).

It is not clear from the information provided whether other comments from other Areas and regions were forthcoming or whether the documents provided to the commission represent the extent of feedback received. It is also not clear how concerns or questions raised were considered, who considered them, whether senior staff within central office were alerted to them, and how they were resolved. The information does suggest, however, that the consultation process was hurried, it was ad hoc with no specific requirements as to how it should be undertaken, and the results do not appear to have been drawn together, systematically analysed and then submitted to senior management for consideration, in the context of the Minister and Director-General’s wishes and the original proposal.

Indeed, a close look at the draft procedures of 18 March 1997 and the memo of 7 April 1997 - CFS-292 - outlining the new mandatory procedures for babies under 1 year, suggests that very few changes were made as a result of the consultation process. The main ones appear to be that whereas the draft procedures stipulate that all information received about children under 1 year has to be entered on the CIS, whether this is a s.22 notification, request for service, *referral or report of concern*, CFS-292 does not include these final 2 categories.

As well, the draft splits the handing of the CIS printout to the Assistant Manager and the commencement of the field response into 2 separate steps, and refers to the latter as “the investigation/assessment field response”. CFS-292 lists both the handing of the CIS printout to the Assistant Manager and the immediate commencement of the field response as step 2. In CFS-292, the field response, perhaps unfortunately, is not qualified as “the investigation/assessment field response”.

It is also clear that, contrary to the standard procedures for policy development outlined by the department for Mr Prasad’s investigation (see attachment 11, Prasad report), the senior executive of the department did not consider and approve a final version of the policy following the consultation process. According to the Director-General “State Executive considered a draft internal memorandum on 19 March 1997, and it was decided that the final version would be issued without further consideration by State Executive” (letter from Director-General, 23 October 1997, attachment 1, 1.1 (c)).

This process of policy development also appears at odds with that outlined in the recently released *Working with Children and Families Practice Manual* and which according to documentation provided for the Prasad investigation, explains more fully “the way in which policy and procedures are written (for the Child and Family Services Program)” (Prasad report, attachment 11).

Chapter 5 of this manual, titled Policy Development and Implementation talks about policy development as “a dynamic process with many participants. Insights and ideas come from practical experience, research and best practice in other states and countries. Consumers, child and family staff, people working in other agencies, politicians, Ministerial advisers, academics and policy specialists all have a role to play.”(5-1)

It lists key questions to be addressed in the policy formulation process, including “how important is the issue and how does it impact on existing priorities?” and “What consultative steps are appropriate?”

The manual refers to the need to test the policy in draft form internally for appropriateness and accuracy, and of the need to seek wider input before it is finalised. At the implementation stage, the manual highlights the importance of a comprehensive implementation strategy that includes an analysis and assessment of the resources required to implement the policy: “This may include training and development of staff, recruiting new staff, introducing new technology...”(5-3) It goes on to say that the policy must then be widely communicated and promoted within the department and to other agencies and clients, and the need for formative and summative evaluation of the policy formulation process.

From the information provided to the commission as part of this inquiry and that obtained as part of Mr Prasad’s investigation, it appears that the policy development process that led to the issuing of CFS-292 was lacking in a number of respects. It did not involve extensive or properly planned consultation, there was no explicit requirement or process to “test” the implications of the policy at the service delivery level, opinions from external agencies were not sought, the resource implications and effects on other departmental priorities were not considered, and Senior Executive only saw one draft of the document and did not sign off on the final version.

Had a more thorough and considered policy development process been employed, in keeping with the department’s own requirements in this regard, the problems that CFS-292 apparently caused in the field may have been identified and resolved while it was in draft form. Such a process may also have picked up on the confusions and anomalies that were contained in CFS-292, and which led to the issuing of CFS-296, as discussed later.

(v) *The content of memorandum CFS-292*

According to the Director-General, CFS-292 established the absolute priority for dealing with, and responding to, notifications and requests for service in relation to babies under one, which is why they were introduced as mandatory procedures (letter from Helen Bauer, 23 Oct, attachment 1, p.8). However a close examination of what CFS-292 says makes it less clear exactly what these mandatory procedures required of staff.

Memo CFS-292 states, at step 1, that all information received by the department about babies under 12 months of age must be entered on the CIS immediately, whether the information be a request for service or a notification under s.22 of the *Children (Care and Protection) Act* that a child has been, or is in danger of being, abused, or is a child in need of care.

The memo goes on to say at step 2 that, following entry onto the CIS, the Intake form and the CIS printout must be personally handed by the intake worker to the Assistant Manager and “the field response must commence immediately and must include sighting the baby”. It is not clear whether this means that, for *all* information received by the department in relation to babies under 12 months, there *must* be field response, or whether this requirement itself is discretionary, or applies only to *notifications*, as opposed to requests for a service or more general information.

Steps 3 and 4 relate to internal reporting/review requirements to ensure that each case involving a baby under 12 months of age is being managed appropriately. However, both of these steps as outlined in the memo relate to notifications only, not to all information received by the department in relation to babies under 12 months, as in step 1.

The memo by itself therefore makes it unclear if a field response involving sighting the baby is always required for any information received by the department in relation to under 1 year olds, or only for notifications involving under 1 year olds, or only for certain notifications involving under 1 year olds. There is no explicit statement that a field response and sighting of the baby is necessary and must be undertaken for all information/notifications received in relation to babies under one, or under what particular circumstances such a response is mandatory.

When the memo is read in conjunction with the flow charts attached to it (and which are incorporated into the policy by specific reference to them), the mandatory nature of the policy or response required in relation to under 1 year olds becomes even less clear. These flowcharts titled *Phase one - intake action by intake staff*, *Phase 2 - field action by field staff* and *Phase three - on-going action by field staff* were referred to in and distributed with memo CFS-292, presumably to either add clarity to the memo and the different steps involved, or to place the requirements in relation to under 1 year olds in the broader context of child protection practice.

The flowcharts quite clearly break the case management process into 3 distinct phases of intake, field response and ongoing action. The intake flowchart indicates

that a risk assessment process should be used for matters that constitute a request for service or a s.22 notification and that, at various points in the assessment process, the case can be treated as “intake only” and closed. Questions to be asked following the initial receipt of information are: What are the current safety, risk and well-being issues? What have we been told? What do we already know? What have we found out from others? The flow chart indicates that if no safety or well-being issues are identified, the case can, and should be, closed at the intake stage.

Cases that are not closed at this point move from the assessment stage to the planning stage. The questions posed at this point of the intake procedure are: Who should be involved? Who should be informed? Who has responsibility? Should there be a planning meeting? How quickly should we respond? What further investigation and/or assessment is required if any? When, where, by whom and with whom? The flowchart indicates that following this planning stage, a decision or judgement needs to be made about whether harm, injury or high risk is confirmed or not. It highlights that even where these factors are confirmed, there is still the option of recording the case as “intake only” and closing it.

Only where it is decided that further assessment and/or investigation *is* required, must an investigation and/or assessment plan be completed and the case moves from the intake phase to the field action phase which, according to the flow chart, can either be a joint investigation by police and DOCS, or can involve action by the CSC alone.

The Phase 2 - field action by field staff flowchart details the different decisions to be made and options available for field staff in implementing the investigation and/or assessment plan during the field action phase. The third flowchart relates to stage 3 and lists the decisions and options in implementing the protection and/or care plan or case plan.

If the 3 flow charts are looked at together, they indicate that:

- the 3 distinct phases involved in child protection responses are intake, field action, and on-going action;
- cases can be closed at a number of points throughout these phases, including during the intake phase after an initial assessment of risk and/or need;
- cases can be categorised as “intake only” and closed even where there is confirmed harm and injury and/or high risk.

The flow charts do not indicate at what point the child or children the subject of the notification must be sighted, nor that there are special requirements or procedures to be followed in relation to babies under 1 year of age.

If CSF-292 is read in conjunction with the 3 flow charts, it is difficult to determine exactly what is required of departmental officers in response to the different types of information that a CSC can receive in relation to babies under one.

*(vi) Concerns expressed with memorandum CFS-292*

According to a memo from the Manager of Child Protection, Policy and Planning Directorate, to Mr Prasad, dated 7 October 1997, "the release of the procedures was followed by an influx of phone calls, e-mails and representations by field staff (District Officers, Assistant Managers and Managers) Area Managers and Assistant Directors General expressing concern, frustration and indignation that the procedures appeared to be at odds with the new Case Coordination Framework." (Prasad report, attachment 11, p.2).

Information supplied by the department in the course of the commission's inquiry initially indicated that these concerns were not documented (letter from Director-General, 23 October 1997, attachment 1, 1.1 (d)). However additional information supplied on 28 October 1997 included documentation of concerns at the Area level once the policy was introduced. These concerns included the discrepancies between the new procedures and the Case Coordination Framework, the lack of clarity around what was now required, the apparent incongruity between the flow charts and the policy requirements, and the resource implications.

Some specific comments were:

*"There are major resource issues in the country where the child may be up to 2 hours away from the CSC, especially if they are not at home and 2 or 3 visits are required!"* (Queanbeyan CSC, 15 May 1997)

*Managers throughout the New England Area are interpreting these procedures in very different ways. Some Managers have interpreted the procedures in a very literal manner, sighting the baby notified to the Department irrespective of the intake decision. This approach is very intrusive for families and requires that they be recorded on a statewide computer system, irrespective of the nature of the notification. This approach doesn't align with the philosophies in the Case Coordination Framework, which gives greater flexibility in our field response and align service provision to meet the child and family's needs. Other Managers are interpreting these procedures in line with this framework, sighting the child pending the decision at Intake and an appropriate field response. ....This response requires enormous resources to effect an immediate field response and sighting the baby, especially those matters which clearly do not warrant this form of response. A notification is any piece of information received by the Department and given the current climate in the Child Protection services, Agencies are notifying all matters which may vaguely reflect abuse." (New England Area, 9 May, 1997)*

*The flow charts suggest there continues to be Management discretion in the decision making process, including whether there is to be a field response. However, the Memo (CFS 292) doesn't appear to allow for management discretion or professional judgements." (Hunter Area, 21 April, 1997)*

Clearly, concerns, inconsistencies and ambiguities with CFS-292 were being picked up in the field and were making it difficult for managers and staff to know what to do when a notification of a baby under 12 months was received.

However it appears that such concerns were not brought to the attention of the Director-General and that she was not aware, until the Prasad investigation, that they led to the development of CFS-296 (letter from Director-General, 23 October 1997, attachment 1, 1.1 (2)).

b) Memorandum CFS-296

(i) *Development of memorandum CFS-296*

Memo CFS-296, titled *Clarification of case management procedures for: babies under one year of age* was issued on 12 May 1997. It states that “clarification was sought on the procedures (in CFS-292) and the following information is provided according to the points in the procedures” (Prasad report, attachment 10).

Information supplied to the commission by the department on 28 October 1997 suggests that CFS-296 was developed in direct response to a memorandum prepared by the Hunter Area Child and Family Reference Group to the Hunter Area Manager, for submission to the Director-General. This memo posed a series of questions in relation to CFS 292 and highlighted the ambiguities and inconsistencies contained within it. An e-mail message from the Manager of the Child Protection Program to the Assistant Director-General, Service Improvement, dated 15 May 1997, states:

*“We misread the heading and didn’t realise the request was to forward the memo to the D-G so we utilised the questions in preparing the memo to staff clarifying the issues around the memo...We are now in a dilemma about what to do with the request. Should it be forwarded to the D-G? Should we just inform the group... that the questions have been responded to in the memo?”*

While no documentation was provided indicating what was decided in relation to this matter, the Director-General’s response of 23 October 1997 to questions relating to the inquiry clearly stated that she was not informed of any concerns in relation to CFS-292.

A further e-mail printout is included in the documentation provided by the Director-General on 28 October 1997. It is from the Assistant Director-General, Policy and Planning, dated 17 May 1997, and is addressed to those who had raised concerns with, and sought clarification on, CFS 292. It states:

*“Apparently (the Manager of the Child Protection Program) has sent out a circular providing clarification on this policy.”*

This suggests that the “clarifying” memo CFS-296 may not have been sighted or cleared by the head of the Policy and Planning before it was sent out.

(ii) *Content of memorandum CFS 296*

The opening paragraph of this memo stresses the vulnerability of babies, “the priority of under one year olds within the context of the case coordination policy

framework”, and the need for decisions about them to be based on “rigorous analysis of all available and relevant information, timely and well documented.”

It goes on to state that only those cases where there is a s.22 notification or a request for Child and Family Service should be entered on the CIS, and that cases involving babies under one year must be entered on the CIS immediately so that CSC managers can ensure a timely response.

Point 1B of the document then refers the reader to the intake action flow chart - assessing risk and/or need stage, and states that cases involving under one year olds can be closed at this point but that “the decision.... must be carefully made and well documented. Such cases will be included in the review by the Community Services Manager.” It also says that “professionals consulted need to have demonstrated expertise in child protection, paediatrics, child development **and** (our emphasis) post natal depression” and lists a range of factors associated with the deaths of babies. It does not however say whether, or at what point in the intake process and prior to deciding to close a case, these professionals *must* be consulted.

In contrast, point 1C of the document relates to the Planning stage of the intake action (first) flow chart and clearly states that appropriate professionals must be consulted before a case is closed:

*“Closure of cases at this point must be based on information received from professionals with child protection, paediatric, child development and post natal expertise, must be carefully made and must be well documented.”*

This makes it unclear whether the requirement to consult professionals is only mandatory at the planning stage of the intake process (1C) and that cases closed prior to this (ie: at 1B) can involve consultation with professionals but that it is not mandatory. It is not clear on who should be considered a suitable professional, whether they require expertise in all of the categories listed above or only some of them, and how they should be consulted. These issues are particularly relevant for rural areas such as Coffs Harbour, where the availability of a range of professionals able to work in a consultative capacity with the department may be limited.

However, it is quite clear that CFS-296 allows for cases involving babies under one to be categorised as “intake only” and closed without the child having been sighted by a DOCS officer.

Memo CFS-296 then details procedures to be followed where cases proceed to the field action phase. It states that, following the provision of relevant information to the Assistant Manager in relation to the case, it must be allocated, implementation of the Investigation and Assessment Plan must begin immediately and this **MUST** include sighting the baby. It goes on to say that:

*“It will be necessary for field staff to have sighted the child and be well progressed in the risk and/or needs assessment for the family to ensure the Community Services Centre*

*Manager is able to adequately review the case within 72 hours of the unit receiving the notification"*

In summary, this "clarifying" memo instructs relevant managers that the case management procedures for babies under one year do not require that, in all cases, the baby must be sighted before the matter is closed, including at the intake stage. According to this memo, the requirement to sight the child only comes into effect during implementation of the Investigation and Assessment Plan, where a case has progressed to the field action phase.

The memo also states that, at a particular point in the intake stage, professionals with relevant expertise *must* be consulted prior to closure. However it is unclear on whether, at an earlier point in the intake process, the decision to close the case can be taken which may, but will not necessarily, involve consultation with professionals. There is no guidance in CFS-296 on who appropriate professionals might be, exactly what experience they are required to have, and criteria departmental staff should apply to determine if they are suitably qualified to carry out assessments. These issues are particularly relevant to how the notification of Jordan was handled at Coffs Harbour CSC.

*(iii) Status of memorandum CFS-296*

The Prasad report stressed the fact that memo CFS-296 was "not authorised" and was "issued without the Director-General's clearance" (pages 10 and 11, Prasad report).

Nevertheless, the Prasad investigation used elements of both CFS-292 and CFS-296, referred to in the report as "DCS policy on dealing with children under the age of one year", to review and assess the actions of Coffs Harbour CSC and Tweed Heads CSC staff in relation to the notifications of Jordan Dwyer. (See pages 15, 16, 23 and 24 of Prasad report). It is unclear, therefore, whether Mr Prasad believed that the requirements of CFS-292, or CFS-296, or both should have been followed.

The response from the Director-General on 28 October 1997 states:

*"if CSF-296 is regarded as having changed the mandatory procedures issued by the Director-General in CFS-292, CFS-296 should not have been issued without the Director-General's prior approval. If CSF-296 is regarded as not changing CFS-292, the Director-General's approval was not required."*

This again expresses uncertainty as to the precise status and effect of CFS-296, even at senior levels within the department. It is not surprising then that problems were encountered at the service delivery level when trying to decipher and implement policy in relation to notifications of under one year olds.

There was confusion at central office level about the intent and effect of CFS-296 and/or by implication, confusion about the intent and effect of CFS-292. If it did and still does cause confusion for senior staff, there is little wonder that staff at the CSC level, undertaking difficult work in a high pressure environment, also found it hard to interpret.

c) Monitoring of compliance with babies under one year policy

Both CFS-292 and CFS-296 detail reporting/accountability requirements in relation to procedures for babies under 1 year of age, that are supposed to ensure that at CSC, Area Manager and Assistant Director-General level, it can be ascertained that policy and procedure have been complied with. Various steps involving review of the case by the CSC Manager within 72 hours, weekly certifications to the Area Manager in relation to compliance with case management procedures for babies entered on the CIS, monthly compliance reports to the Assistant Director-General and the conduct of random compliance checks by the Area Manager on at least 10% of notifications involving babies under 1 year, are detailed in CFS-292 and referred to (but not substantially changed) by CFS-296.

In spite of what appear to be quite stringent and resource intensive reporting requirements, which presumably are implemented across the state, it does not appear that they were able to alert senior management to the facts that:

- CFS 296 was viewed by at least some in the department as having substantially changed the requirement to sight the baby for all notifications involving an under 1 year old, so that this was not happening in all cases in accordance with the original briefing to the Minister and the apparent requirements of CFS 292;
- different CSC's were interpreting the policy in relation to under 1 year olds differently;
- the existence of both CFS 292 and CFS 296 was causing some confusion in the field.

The explanation was put in documentation attached to Mr Prasad's report that because the Dwyer notification was closed at intake stage, compliance with procedures in relation to notifications for babies under 1 was irrelevant:

*"Please note there was a nil return in relation to compliance with procedures for babies under 1 year. The CSC Manager did not report on compliance in relation to the Dwyer baby, as the notification was "intake only" (Memo to Mr Prasad from Area Manager, MNC, 3 October 1997)*

In the course of this inquiry the commission requested information from the department about the number of notifications of babies under 12 months since the introduction of CFS-292, and of these, the number where the baby had been sighted by a departmental officer. While the department was able to give us the total number of notifications since 7 April and up to 30 September 1997, and could break this down to "intake only" and "not intake only", it could not tell us how many of

the total figure had involved the baby being seen (letter from the Director-General, 23 October 1997, attachment 2, p.17). Additional information sought from the Information and Research Unit suggested that the focus of the department's compliance testing in relation to CFS-292 was on whether the case had been reviewed by the CSC Manager within 72 hours of the notification (step 4 of the procedures set out in CFS-292).

Reporting requirements therefore appear to have been largely unable to pick up anomalies, inconsistencies and problems with the implementation of the babies under one year policy. Consequently, the worth of such compliance reporting requirements has to be seriously considered. This is especially so when they are resource intensive and add to the already considerable workloads of management out in the field.

### 8.3 Other relevant policies and procedural documents

As already mentioned, CFS 292 and CFS 296 are not the only policy documents that child protection and family services staff must understand and implement in carrying out their duties.

Of course the very number, volume and complexity of these is part of the pressured context in which officers of the department operate. This will be discussed later. However, the following are the policies and procedures that potentially have some direct bearing on this case.

In looking at these documents, the comments and expert opinion of Sally Castell-McGregor in relation to the practice issues raised by this case should be kept in mind. It is Ms Castell-McGregor's view that Jordan should have been sighted by DOCS officers, and that the police should not have been seen as child protection experts and relied on to provide an assessment of Jordan and his family circumstances. Her written comments to Mr Prasad state that physical confirmation of Jordan and the other children's well-being was required, as well as an assessment of the mother's emotional well-being, and a psycho-social assessment of the family's circumstances.

As we have already established CFS 292 and CFS 296 provided conflicting advice in relation to these matters and, in any event, by themselves were not clear on what needed to happen and when.

The *Interim Child and Family Services Practice Manual* places child protection work in the context of the Case Coordination Framework and identifies the 3 phases of: intake, initial action and on-going action.

This manual makes no reference to sighting the child, let alone sighting babies under one year of age, either as a mandatory requirement or as good practice. The closest reference is in the initial action section where it states:

*“Initial Action may involve case conferencing with the family and child, agencies and other professionals to identify issues and plan resolutions... Involvement of children, their families and carers in decision making about their future is essential” (1.2.1)*

As part of the intake phase, mention is made of the possible need to draw information from more than one source, “such as a school or doctor”. There is also a section titled “Seeking Additional Information and Specialist Consultation” which states that:

*“Identifying information gaps, deficits and areas that need validation may result in liaison with other sources of information and specialist staff...The intake worker needs to use the most available resources in the community and therefore must have a good knowledge of services and resources.” (1.1.2.2)*

This is all that is said in relation to the need to consult experts and other professionals. As can be seen, it is very general, open to interpretation, is not clear on exactly who should be consulted and at what point in the process, and certainly does not imply that this sort of consultation is mandatory. In the case of Coffs Harbour CSC, it could be argued that they did use the most available resources in the community in responding to the notification of Jordan.

The *Interagency Guidelines for Child Protection Intervention* set out the main roles and responsibilities of the various agencies involved in child protection, including the police.

The Department of Community Services is seen as having lead responsibility (p.10), while the role of police is to “detect and investigate alleged child abuse and neglect and to initiate legal proceedings” (p.12)

Part 3 of the guidelines details the practice framework and identifies six broad stages, being: recognition, notification, assessment and investigation, protective intervention, ongoing care and support and closure. (p.39) At no point is reference made to any special or mandatory requirements in relation to babies under one year of age.

A sub-section titled “Sight the child” is contained in the Assessment and Investigation section. It has symbols next to it indicating that both DOCS and police have responsibilities in this area. It states:

*In all cases that proceed to assessment and investigation, the child who is the subject of the notification must be sighted by the officer conducting the investigation. (p.71)*

However, the exact roles and responsibilities of police and DOCS in relation to sighting the child are not spelt out. It is not clear whether both are required to sight, or whether one or the other undertaking this role is sufficient.

The section "Receiving notifications" states that "the focus of the intake assessment (by DOCS) is on risk assessment" (p.56) and specifies the following roles for DOCS officers:

*The officer of the Department of Community Services will seek from the notifier as much information as possible concerning the child and the circumstances of the allegation. Information relevant to the immediate safety and welfare of the child will also be gathered from other sources as necessary, including the Department's Client Information System, the police and other agencies such as schools, family support services or community health centres. Other relevant information may be gathered from professionals and agencies that have had recent contact with the child, their parents or other family members. (p.55)*

The Interagency Guidelines do stress at a number of different points, that a medical examination or other health assessment may be necessary (pages 57,60, 66) as part of the intake assessment or assessment and investigation phase. However it is certainly not clear that these are mandatory requirements, when they should be carried out, nor what particular expertise is required to undertake them.

The *Child Protection: Procedures for recognising, notifying and responding to child abuse and neglect* make no mention of special mandatory requirements in relation to babies under 1 year of age.

The sub-section Interviewing of Children is contained in section 9 Worker Response to an Allegation and says that "in carrying out their responsibilities, officers of the Department of Community Services and/or the Police may wish to carry out interviews with the child in a place the child does not feel threatened" (p.25). No information is provided in relation to when it is mandatory to sight the child, at what point in the process this needs to happen, etc.

In the same section, under the heading Responding to Notifications, it is stated:

*"Where there is actual harm or high risk injury which has been determined then: Take protective action, including: specialist assessment (psychological, developmental, etc); S23 notice served for medical examination....."*

This is the only mention in the document of the need to seek specialist advice or opinion, and again, it is unclear when this should happen, and how the need for it should be determined.

As already indicated, the recently released *Working with Children and Families Practice Manual* replaces the *Interim Child and Family Services Manual*. However, its relevance to the present case is doubtful because of its limited availability at the time. Nevertheless, it is important because it purports to be the department's latest word, "state of the art" document on child protection practice.

The first part of the manual sets out the NSW government policy framework, services available from DOCS or funded by DOCS, the policy development/

implementation process, and the legal framework for the department's work.

Chapter 8 details case coordination policy and practice guidelines, with protective intervention based on professional judgement, assessment and supervision rather than prescriptive measures. It concludes with three flowcharts that are virtually the same as those that were attached to CFS 292, the only difference being that Flowchart 1 contains additional information around determining response type at the assessment of risk and/or need point.

Prompts/questions listed on the flowchart under this heading are: "is there a role for DCS and Police? If yes, does it require a response by both DCS and Police? If yes, does it have to happen at the same time to ensure a child's safety and/or for protection evidence?" As with the flowcharts that formed part of CFS 292, their usefulness in informing action and determining a response is limited.

Chapter 8 makes it clear that notifications **can** be closed at intake only, following a risk assessment. It makes no mention of when a child, under one or otherwise, should be sighted and does not refer to the need to consult professionals or to seek expert assessment at either the intake, field action, or ongoing action phases.

Chapter 9 talks about the assessment process in some detail and different options available, such as a risk assessment, Child and Family Needs Assessment, and a specialist assessment by a departmental psychologist. No mention is made of any requirements in relation to babies under one the subject of a notification. It is also unclear how the different assessment processes relate to one another, exactly when they should be used, when they will need to involve other professionals (with the exception of the specialist assessments) and within each, at what point the child needs to be seen.

Chapter 10 describes the intake process in more detail, and then looks at Planning Intervention. At this point mention is made of the need to sight the child:

*"In all situations where abuse or neglect is alleged to have occurred, or is highly likely to occur, Child and Family staff must see the child, and wherever appropriate, interview him/her. Sighting the child allows the Child and family staff to: see the injuries; observe the child's age appropriate development and behaviour; assess the child's interactions with carers, siblings and other adults; and provide the child and family with an opportunity to disclose abuse, neglect or their fears.*

*Situations that require a child and family needs assessment but do not indicate that the child is in a high risk situation **may not require the child to be seen personally** (emphasis added). Factors detailed in the activity "Determining response time" should be considered when deciding not to sight the child, **especially children under one year of age** (emphasis added). The rationale and decision not to sight the child must be documented and approved by the Assistant Manager." (10-8)*

Under the key activity Determining time frames for Action, it is stated that professional judgement must be applied in the assessment of intake information to establish a timeframe for field action. Contextual factors to take into account include:

*The child/young person's age and stage of development and own sense of time. (All children are vulnerable to injury or threat. Younger children, especially those under 2 years and adolescents, are particularly vulnerable) - (emphasis added). (10-10)*

The next section of chapter 10, titled Mandatory Response Procedures for Babies under one year of age (10-12), sets out case management procedures which are virtually identical to CFS 292. This makes the manual an inconsistent and contradictory guide for staff, in that the same chapter, in the space of a few pages, outlines quite different and conflicting requirements in relation to notifications of babies, and the mandatory procedures for notifications of babies under one appear in the context of a manual that is premised on a risk assessment approach to child protection work that involves the use of professional judgement and directing limited resources to high priority matters. No explanation of the mandatory procedures "fit" with this model, or lack of it, is given.

As well, the mandatory procedures repeat the ambiguity and the significant resource implications of CFS 292 spelt out earlier in this report, that gave rise to so much concern in the field. Their inclusion in the manual ignores the facts that CFS 296 was issued to clarify what was expected of staff, altered the requirements considerably, and introduced the notion of involving other professionals in the assessment process.

In fact the whole of chapter 10 fails to mention when professionals and independent experts should be consulted, who these should be, and whether or not their involvement is discretionary, good practice or a requirement.

The contents of chapter 10 suggest a number of possibilities: the development of the manual did not involve enough discussion at Area and CSC level around practice issues; it did not critically or adequately examine policies already in place and their fit with each other and the Case Coordination Framework; it did not involve an examination of compliance reports to determine what was working and where there were problems; and it was not thoroughly checked prior to publication to ensure it was logical, consistent and comprehensive.

The above analysis indicates that the policy framework within which staff are expected to work is set out in multiple, lengthy documents, and is confusing, ambiguous, at times lacking in both clarity and detail, and in some instances, plain contradictory. In the absence of clear direction, it is no wonder that staff at the coalface have to interpret requirements for themselves and that different CSCs do so in very different ways.

## 9. RELEVANCE OF DEPARTMENTAL POLICIES AND PROCEDURES TO JORDAN DWYER'S CASE

### 9.1 Relevance to events at Coffs Harbour CSC

The existence of both CFS-292 and CFS-296, their relationship with the other policy and procedural documents, and the implications for service delivery and staff understanding of requirements, particularly in relation to notifications of under one year olds, are relevant to the sequence of events at Coffs Harbour CSC.

Mr Prasad's finding in relation to actions by the Coffs Harbour CSC was that:

*"...insufficient information was collected on which to base a decision to close the case at the intake stage; in terms of DCS policy it was necessary either for a DCS officer to sight the baby, or for the CSC to obtain appropriate professional advice from people with demonstrated expertise in child protection, paediatrics, child development and post natal development" (p.3)*

The assumption seems to be that staff should have known to use a combination of, or one or the other, of the two policies and that had this been done, a more appropriate response would have ensued.

The documentation (CFS-292 and CFS-296) does not appear to us to be that clear. CFS-296 did substantially alter the mandatory requirements outlined in CFS-292 by placing notifications of babies under one year in the context of the Case Coordination Framework, and introducing the element of discretion and judgement at the intake stage. It also introduced the concept of seeking appropriate professional advice and using this to inform the decision about when to close a case. CFS-296 was developed because of problems inherent in CFS-292 that meant that it (CFS-292) was unclear, or that it was at odds with the direction of child protection work within the department. Furthermore, neither document is explicit in meaning, and each is open to different interpretations.

#### a) Sighting the baby

Information provided by the Manager of Coffs Harbour suggested that when CFS-292 was first introduced, the office was very concerned about its resource implications and the apparent lack of opportunity for professional judgement.

They point out that many cases may be false alarms (some obviously so) that don't make it necessary to sight the baby and, if all babies were sighted, unallocated cases would "go through the roof" and other urgent and serious cases would not be attended to. (interview with Manager, Coffs Harbour CSC, by the commission on 18 October 1997). However it does not appear

that the issuing of CFS-296 on 12 May 1997 resolved problems at the service delivery level.

According to the Manager:

*“explanation of the under 12 months policy was given to MNC Area Managers and Assistant Managers by (the Senior Program Officer Child Protection), at the MNCA management meeting on 11-12 June. Her strong advice was to follow the “case coordination framework” with under 12 month matters and if intake assessment indicates that there are no elements of harm/risk or wellbeing then it can be dealt with as intake only with no field action, including no sighting of the infant required. (The senior project officer, child protection) repeated this opinion on her visit to the centre on 23/7/97. .... I believe that Coffs Harbour CSC, in a demanding resource context, adhered to procedures and was, in addition, particularly prompt and thorough in recording, assessing and responding to the information received.” (Prasad report, att 21)*

This indicates that CFS-296 did not by itself clarify requirements and that there was still confusion about how notifications of babies under 12 months were to be treated. Advice from the Child Protection Unit in central office however appears to be quite clear, at least in terms of whether or not the baby needed to be sighted.

The Area Manager for the Mid North Coast Area confirmed, in interview with the commission on 28 October 1997, that discussions were held with the Child Protection Unit, DOCS central office, and that, from this, it was understood that the introduction of CFS-296 allowed for the application of a risk assessment model at intake.

Coffs Harbour CSC had therefore interpreted CFS-296 as altering the requirement that notifications of babies under one year of age necessarily had to involve sighting the child. This interpretation was guided by the contents of CFS-296, advice from the Child Protection Unit in central office, and support from the Area Manager, as well as consideration of resourcing and workload implications. In this respect, the interpretation of CFS-296 in relation to the requirements of CFS-292 by Coffs Harbour CSC could be seen as a reasonable interpretation of policy requirements and sound management of finite resources.

b) The use of professional expertise

Mr Prasad appears to be of the view that, if departmental officers were not going to sight the child, then appropriate professionals should have been used and that appropriate professionals did not include the police., particularly to make mental health assessments. He formed the view that the use of police in this regard by the Coffs Harbour CSC was not based on an appropriate interpretation of either the content or the policy intentions

underpinning the *Interagency guidelines for Child Protection intervention.*"(Prasad report, p.3)

His view that police should not have undertaken this assessment role is supported by the professional opinion of Sally Castell-McGregor, who in commenting on the sequence of events at Coffs Harbour, stated:

*"As it transpired, the Police provided the assessment of family circumstances that was the proper responsibility of the Department of Community Services. It is my professional opinion that this assessment was inadequate and vitally important matters were not addressed... Clearly, in the case of Jordan Dwyer, there was sufficient concern to ask the Police to make an emergency visit. It so happens that two support workers from St Vincent De Paul also visited the mother (at the latter's request?). The collective assessment of these three people was that all was well. However, my point is that none of these people was qualified to make the kind of assessment required in these particular circumstances. Whatever their individual competencies within their own profession, assessment of mental illness and possible failure to thrive are complex matters requiring expert diagnosis."* (Prasad report, p.16)

Yet the analysis of CFS-292, CFS-296 and other relevant policy documents clearly shows that the department as a whole is not clear on when professionals need to be involved in the assessment of notifications, and who these professionals should be. As such, what is required of staff in this regard is confusing and open to interpretation.

This lack of clarity at the policy level must be seen in light of other factors influencing service delivery at the CSC level. In documentation provided to Mr Prasad as part of his investigation, the Manager of Coffs Harbour CSC is clearly of the view that police (or these particular police) were appropriately qualified and experienced in child protection matters to attend the caravan park and undertake the kind of assessment of Mrs Dwyer and her children's well-being that one of his District Officers might otherwise have undertaken.

As well, it has to be remembered that police conveyed the information to Coffs Harbour CSC that formed the basis of the notification, and that this information included a suggestion that the baby might be dead. According to the Manager of Coffs Harbour CSC, this necessitated an emergency response which Woolgoolga police were well-placed to undertake, largely because of their geographical location.

Other information obtained by the commission as part of this inquiry suggests that the Manager of Coffs Harbour CSC is not alone in his view about the use of police in this regard. A memo to the Child Protection Unit from Queanbeyan CSC, dated 13 May 1997, outlines concerns with CFS-292 and makes some suggestions for amendments to the policy to make it more workable, including:

*“In cases where there are staffing/resource/or distance issues, it should again be left to the Asst Manager or Manager to arrange for other professionals to home visit to do an initial assessment of the current situation. In some cases there may simply not be enough information at the intake stage to form a view of the degree of risk. Suitable professionals would include, but not be limited to: Police, and Mental Health Crisis Workers. In cases where Family Support are already involved with a family it may be appropriate for them to visit (if they are willing) to fill in information gaps. I am not suggesting that these other professionals do a thorough risk assessment, but rather to provide DOCS with an up to date assessment of the current situation and whether they consider our immediate involvement is warranted. I particularly envisage this in small offices where no DO may be present, and/or in rural CSCs where the child may be an hour or more away and the Police are a few minutes away.” (Letter from Director-General, 28 October 1997, enclosing additional information)*

The Area Manager of the Mid North Coast Area, in interview with the commission on 28 October 1997, also expressed the view that, depending on the case, police could be regarded as suitable professionals to undertake an assessment. She made the point that experts are “finite resources” and are not always available, particularly in rural or remote areas. Some police are well trained and would be perceived by staff to be “experts” in child protection.

She made the observation that, in small communities, workers develop professional relationships with police and others and that, in this regard, the police (at Woolgoolga) were seen as having the necessary expertise. She also commented that, particularly as it related to experts, CFS-292 and CFS-296 do not recognise the unique nature of rural and remote communities.

Information obtained by the commission during this inquiry from the department’s Child Protection and Family Crisis Service is that the use of police as frontline responders to child protection notifications is commonplace.

All of this indicates that Coffs Harbour CSC is not alone in its interpretation of CFS-296 and the use of police as appropriate professionals. It also seems to indicate that such an interpretation of requirements and the use of police as “experts” is or has been known to some in central office and at senior management level.

In the commission’s view, these facts and the lack of clarity and specificity in CFS-296 around the use of professionals in the first place, mean that the actions of Coffs Harbour CSC cannot be judged in isolation. While Sally Castell-McGregor’s comments may provide an indication of the ideal response, it cannot be said that staff at Coffs Harbour failed to follow *procedures* by relying on police to provide professional input. However it may amount to poor exercise of professional judgement (see below). The issue is also looked at later, in the context of the work environment and availability of relevant experts, particularly in rural areas.

c) The use of professional judgement

Mr Prasad found, in relation to the notification of Jordan to Coffs Harbour CSC, that the decision to close the case at the intake stage demonstrated poor professional judgement.

Furthermore, there is certainly the question, referred to above, as to whether the police *should* have been relied on to make a mental health assessment of the mother, or a physical health assessment of the child. It seems that it was never sufficiently clear precisely what the police role(s) in this episode were.

Sally Castell-McGregor, in her advice to Mr Prasad, describes the intake and risk assessment processes in the following terms:

*The information relayed during a notification of child abuse or neglect marks the beginning of a critical process of assessment. Assessment is an ongoing process of information collation and analysis, with the aim of guiding subsequent action. It includes the identifying of problems and their severity from a position of knowledge about the aetiology of child abuse and neglect. It is a process of exploration, of raising hypotheses which are either confirmed or rejected as information comes to light which will assist in the determination of risk and provide an understanding of the circumstances of the child and family referred. (Prasad report, att 24, p.4)*

As such, the intake and assessment process relies heavily on the relevant officer's professional judgement at critical points.

Certainly the introduction of the Case Coordination Framework and related policy documents places a strong emphasis on professional judgement. However, in the commission's view the exercise of professional judgement cannot be seen in isolation from the environmental factors discussed in the next section of this report.

In the case of Coffs Harbour CSC, the decision to use the police to conduct the assessment was influenced by past practice, lack of access to other experts or specialists, the apparent urgency of the situation, the distance from Coffs Harbour and the proximity of the police. The high volume of unallocated cases (discussed later) must have also, at some level, have had an impact on decision making.

Sally Castell-McGregor's analysis of events at Coffs Harbour when the notification of Jordan was received, and the use of the police in the assessment process points to what she terms "role confusion". She points out how the decision to use the police in this way carried with it the danger of important information and observations being misinterpreted or misunderstood because the people involved lacked the necessary knowledge and expertise. It can also mean that valuable information is lost and a full

picture is not assembled because no one person has the complete set of facts. (Prasad report, att 24)

This highlights how a number of factors led to the judgement and decision that police were best placed to do the assessment, which in turn meant that a thorough assessment was not done, the complete picture was not assembled and the case was closed at intake, on the assumption that the family had been seen by appropriate experts and that everything was “fine”.

The point needs to be made, however, that the mere sending out of a District Officer may not have changed the outcome. The error of judgement, if there was one, may not have been the failure to send a DO to sight the baby - this could have resulted in exactly the same conclusion being reached. The error may have been to decide not to involve a person or persons with relevant medical expertise (if this was available). At the very least it would appear prudent to have talked directly to the caravan residents who brought this matter to attention, to attempt to throw more light on the apparent conflict between the observations that they were reported to have made, and what the police and SVDP visitors were reporting.

## 9.2 Relevance to events at Tweed Heads CSC

### a) Where a notifier gives incomplete information

Mr Prasad formed the conclusion that while the death of Jordan Dwyer could not have been prevented by the actions of Tweed Heads CSC, the CSC failed in a number of respects to observe policy and procedural requirements in relation to the notification of babies under one. He found:

*DCS procedures for entering the notification on the CIS and informing supervisory staff were not followed appropriately; the Intake Officer did not search the CIS for previous entries under the family name Dwyer, did not enter the notification on the CIS until 23 September 1997, and did not inform the Assistant Manager; these failures to comply with mandatory procedures effectively denied more senior staff the opportunity to consider other more professionally appropriate responses. (Prasad report, p.25)*

Mr Prasad also found that the decision to ask Mr Dwyer to contact the Police, and the decision to take no action to attempt to locate Ms Dwyer and her children, demonstrated poor professional judgement.

Comment from Ms Sally Castell-McGregor indicated her opinion that:

- *the information provided by Marlene Dwyer's brother would, I suggest, have had a significant impact on the outcome of this case had it been known earlier - it confirms the emotional vulnerability of the mother;*
- *even though the names Dwyer and Drill were entered, no check was done under the name of the former;*
- *contact should have been made with the Police, the Commonwealth Bank and Queensland relatives in an urgent attempt to locate the mother.*

Certainly, given that the information relayed to the intake officer included the possibility that a baby might be dead, it is hard to understand why the police were not contacted, both to report a possible homicide and also to enlist police assistance in locating the family and ensuring the well-being of the other children. Police investigative resources would have enabled inquiries to be made in relation to the bank account and car, as well as possible location and interrogation of Scott Drill and other family members/acquaintances.

Professional judgement on the part of the CPCWS should have indicated that the above response was necessary. However, as with the actions of staff at Coffs Harbour CSC, policy and procedures and what staff thought was required of them, are crucial.

The relevant policies and procedures that guide staff in child protection practice do not generally specify in detail the particular steps to be taken in response to a notification. There is a significant degree of reliance on professional judgement and "dealing with each case on its merits".

Yet despite this lack of specificity about how to respond to individual notifications, the expectations that central office have of staff were quite clearly stated in the course of this inquiry. For instance, the response to a question about what was expected of staff when a notification was received that did not include an address, was:

*Intake officers and their supervisors are expected to collect the information necessary to allow the Director-General to discharge her statutory duty under section 22(7) of the Children (Care and Protection) Act 1987. ...Where the threat is assessed as being high, every effort should be made to locate the baby.... These matters are not documented. (Response from Helen Bauer, att 1, p.7)*

and in relation to seeking information on possible different family names:

*Where different family names are provided in the notification, intake officers are expected to check for previous notifications under those family names. If the issue of possible different family names does not arise in the notification, it is not expected that the intake officer will seek information on this point. Every notification needs to be dealt with on the basis of its individual circumstances. This requirement is not documented.*

The need to exercise professional judgement and treat each notification on the basis of its circumstances is noted. However it is concerning that the quite basic steps and clear expectations outlined above are not documented anywhere. There may be no need to make them more prescriptive than the statements above, with ample room for professional judgement, but guidance should be given on issues like this which intake officers confront on a regular basis.

The statement from the intake officer who was on duty at Tweed Heads CSC when the notification of 15 September was made by Mr Dwyer, says:

*(Following the phone call from Mr Dwyer and consultation with the CPCWS) I returned to my intake duties, putting my attention to the notifications that were coming in and attending to intake left over from my last duty day. I did not do a debriefing of the day's intake as the a/m was not available.*

*Due to overload in casework and intake duty I did not follow correct procedures for a notification of a child under 12 months of age - in retrospect I believe this was because I had been instructed to enter the matter as intake only and that meant no action would be taken by DCS. For the next week I prioritised other matters ahead of the entry of an "intake only" entry of the matter on the CIS, despite the concerning information." (Prasad report, Att 44)*

Information supplied in the course of this inquiry indicates that the intake system at Tweed Heads is a rotating one, with one person on intake each day. Work not completed by the intake officer on the relevant day is expected to be completed the next day. The Assistant Manager endeavours to review how intake matters have been handled at the end of the day but this is not always possible because of other commitments.

The Area Manager, FNC, in interview on 28 October 1997, stated that there are no guidelines that tell staff what to do if there is no address and the location of the family is not known. He commented that individual discretion and resourcefulness would have to be applied, and that staff would learn what to do in these situations largely through on the job training.

He mentioned that a major factor affecting this is the Far North Coast's transient population, with 40% or more of residents in the area having changed their address in the last five years. He also pointed out, in a subsequent phone call, that the intake form as it currently is, does not allow for the entry of "aliases" adjacent to the surname, the CIS does not automatically cross reference to known aliases, and the notification intake screen on the CIS does not display the relevant child or children's' aliases.

This matter also relates to how policies and procedures are developed and communicated to staff, and training.

## 10. ENVIRONMENTAL FACTORS

The above analysis of policy requirements, their interpretation and relevance to actions at Coffs Harbour and Tweed Heads CSCs, has raised issues concerning the environment in which these actions took place. The unclear and confusing guidance provided by policy documents, the number of policy documents that staff must refer to, and the failure of those making the policies to properly consult or consider the resource implications have been mentioned in the previous section. These factors must have an impact on the day to day work environment. The preceding sections have also noted the high pressure, stressful nature of child protection work, the lack of resources and the problem of distance in rural areas (including a lack of access to relevant specialists and a reliance on police to undertake assessments), and the importance of a risk management approach and the exercise of professional judgement when there is a high volume of work.

Documentation attached to the Prasad report and collected by the commission as part of this inquiry highlights other environmental issues that need to be considered.

### 8.1 Changes affecting the department

The Department of Community Services has gone through considerable change and upheaval in recent times. The revelations of the Wood Royal Commission in relation to paedophilia and the department's inability to provide adequate care or protection to vulnerable children, a newly appointed Director-General and senior management team, a strategic plan, an organisational restructure and the implementation of a recovery strategy, community and media interest in the work of the department, and increased external scrutiny of its activities all contribute to an uncertain and stressful environment.

At the micro level, these changes have meant that new policies, procedures and reforms have been brought in, some of which have been analysed earlier in this report. Amidst all of this, staff at the ground level, and those in central office, are required to get on with core business and continue to provide a high quality service to the department's clients. This is no easy task.

### 8.2 Resource/workload issues

In the commission's view, this matter raises a number of issues that concern resources and workloads. The first is the failure of those developing policy in relation to notifications of babies under one to give any consideration to resource or workload implications.

The others are the onus placed on CSC managers to overcome resource problems locally and the apparent reluctance on the part of senior staff within the department to acknowledge and come to grips with the problems identified by those in the field as stemming from a lack of resources.

*(i) Lack of consideration of resource implications in the policy development process*

It has already been pointed out that the development of Memoranda CFS-292 and CFS-296 did not involve any analysis or consideration of their likely resource and workload implications or, for that matter, their impact on officers' capacity to respond to other pressing matters - particularly in rural areas or areas of high demand (see section 8.2 (iv)).

The Director General, in written response to questions asked of her in relation to this inquiry, points out that CSCs were expected to give absolute priority to dealing with, and responding to notifications and requests for services in relation to babies under 1 year. She states:

*"The issue of resources and unallocated cases at Coffs Harbour CSC should not deflect the focus from the absolute priority for dealing with notifications of babies under 12 months. There is no lack of clarity on this point."* (Letter from Director-General, 23 October 1997, p.2)

and further:

*"In an environment of intense competition for resources, setting this absolute priority was intended to provide clear directions on policy and practice, and ensure that resources were allocated to the department's most vulnerable clients. The obligations on Managers were to comply with the Director-General's directions, manage their resources accordingly, and report impacts on workloads and service delivery to their supervisor."* ( Response from Director-General, Att 1, p.9)

With great respect to the Director-General these arguments do not reflect the reality. As has been demonstrated, there was a distinct **lack** of clarity around CFS- 292 and CFS-296, and it was far from clear that notifications of babies under one year were an "absolute priority" in every case. In fact, much that was said and disseminated indicated that they were to be prioritised and risk-assessed like everything also, within the Case Coordination Framework while *bearing in mind* their extra vulnerability.

To say that notifications of babies under one were an absolute priority, and that it was up to Managers to allocate resources accordingly and report on this to their supervisors, raises some concerns. Some flexibility at the CSC level to determine priorities and allocate resources in response to local need is no doubt necessary and good practice. But leaving it up to individual CSCs to determine how such a requirement would be implemented, at the expense of what other work and without any departmental wide guidance or strategy, places enormous responsibility on CSC Managers and allows for considerable variation in responses.

As it turned out, Coffs Harbour CSC interpreted the policy requirements in relation to notifications of under one year olds within the context of the case coordination framework and a risk management approach. Other CSCs chose to "err on the side of caution" and sight every baby under one who was notified.

Statistics obtained by the commission in relation to the notification of under one year olds since the introduction of CFS-292 indicate that there have been resource implications. The number of notifications appears to have increased by over 75% since the policy was introduced, when the 6 month period of April to September is compared with the 6 month period prior to the policy's introduction (letter from Director-General, 23 October 1997, attachment 2). Yet, these resource implications were not anticipated and were not given any consideration at senior management level.

The Council on the Cost of Government's *Review of aspects of the management of the NSW Department of Community Services*, released in February this year, found, among other things, that:

*"There have been many program initiatives and reforms (within the department) occurring simultaneously. However, implementation strategies have been variable, and the time and resources needed for change were often underestimated or assumed to be resource neutral" (p. ii)*

The latter point seems particularly relevant to the way in which the requirements for notifications of babies under one were introduced.

*(ii) Expectations of management at the CSC level*

Documentation attached to the Prasad report and supplied to the commission for this inquiry highlights the considerable expectations on management at the CSC level to resolve resource and workload problems.

A memo from the Manager of Coffs Harbour CSC to the Area Manager, MNC dated 3 June 1997 asserts that: the child and family workload is too high to be undertaken within current staffing levels; the workload of the Assistant Manager has increased since the removal of the Assistant Manager, Disability position and is too much for one position; the long standing nature of these issues; and the occupational health and safety issues for staff, associated with the high workloads. The memo finishes with a request for the Area Manager to undertake a review of workloads and staffing levels within CSCs, support to be provided to the Assistant Manager position, and that the Manager and the Assistant Manager be supported to carry out a review of unallocated cases with a view to closing those which were unlikely to be addressed due to lack of resources. (See Prasad report, attachment 20)

The response to this memo from the Area Manager, dated 12 June 1997, states that a submission for a one-off payment would be made to enable the recruitment of temporary staff to review the unallocated caseload with a view to reducing the numbers and examining contributing factors. It states that in the event that this was not forthcoming, a review of the CSC would be considered, to "assist in identifying the strengths and weaknesses of the existing systems, processes and structures, and examine the utilisation of resources." (Memo to Manager Coff's Harbour CSC from Area Manager, MNC, 12 June 1997)

The memo then outlines the responsibilities of the CSC Manager as being to: provide support and supervision to the Assistant Manager; assist in resolving competing demands and determining key priorities; ensure that the review of unallocated cases occurs; ensure that staff are supervised appropriately; and that workloads are appropriate and adequately managed. The memo goes on to say that the issues raised by the Coffs Harbour CSC manager have been discussed with the director of Operations (Northern) and will be raised at the State Executive. It concludes by saying:

*"In summary, I recognise that there are a variety of challenges in managing a CSC, and that these challenges change in shape and nature over time. However, it is the role of Managers to ensure that our staff are supported and encouraged through the work they do, and as such I would like to reiterate that quality service delivery is paramount not only to the well being of clients, but also our staff."*

It is unclear what action took place as a result of these memos. However a review of the Coffs Harbour child protection program was undertaken by central office on 23 July 1997. The Manager of Coffs Harbour believed that the review came about because of the high level of unallocated work. This is supported by the Area Manager, who stressed however that it was not to look at questions of resources but to examine practice issues.

According to the Director-General, the reasons for the review were:

*"Coffs Harbour had been identified as a CSC which offered a suitable site for review work to develop a case management audit tool. The number of unallocated cases at this CSC meant that a random approach to sampling was feasible. The review included an examination of the workload and the practices in the CSC."* (Letter from Director General, 23 October 1997, attachment 1, p.5)

The conclusion of the review was that:

*"...the intake work occurring was of a high quality, however, the unallocated cases distorted the picture of demand. That is to say, the unallocated caseload was largely work that was section 22 notifications, but relatively lower risk to what was currently being actioned. The review also identified that a number of unallocated cases could have been closed if referred appropriately to other services, but were being kept open because such services were not available or were not accessible. (as above, attachment 1, p.5)*

Of course, to say that the unallocated cases are "lower risk" relative to the allocated cases says nothing about the absolute level of risk of the former, and begs the question as to whether it is acceptable or responsible to leave them unallocated. There is a distinct lack of rigour and frankness about this issue in the responses and documents scrutinised for this inquiry.

According to the Director-General, the action resulting from the review was that oral advice was given to the Area Manager and CSC Manager about the findings of the review, and input to a planned broader project on case management auditing was provided (as above).

According to the Area Manager, the review highlighted that many of the unallocated cases were matters that should have been referred elsewhere but were not, due to the lack of resources and non departmental services in the area. It does not appear that the review lead to any changes in practice, increases in resources or a reduction in the unallocated cases. A review report was not written and there is no documentation available in relation to it or its outcomes.

Overall, the information provided to this commission in conducting its inquiry suggests that, at least for Coffs Harbour CSC, issues raised concerning unallocated cases, excessive workloads and other related problems were not responded to by more senior managers in the department in a way that demonstrated an acknowledgment of the problem and a desire to analyse it in any depth with a view to alleviating it. Rather, it was seen as the CSC Manager's responsibility to resolve these issues locally by effective management of available resources.

There appears to be some recent recognition of the problem of a lack of resources and the need to address it systematically: draft policy and procedures on *Management of unmet demand in the child and family program in community service centres* (dated 22 September 1997) have recently been issued for comment to members of senior executive and Area Managers.

The draft policy states that: "It is the responsibility of Assistant Managers, Managers of Community Service Centres, and Area Managers to manage any gap between demand and supply." It details how each area must have a written plan for the management of unmet demand which addresses: workload and case management trends across CSCs/Area; case management strategies identified to assist in the management of unmet demand; work allocation practices which compound the problem; the process for responding to concerns about unfair workloads; and a mechanism for ensuring information about the management of unmet demand is reported to the Director (Operations). (p2 and 3, Draft policy and procedures for: Management of unmet demand in the Child and Family Program in Community Service Centres, 22 September 1997)

In outlining a process for managing unmet demand, the draft policy does not actually suggest any strategies for dealing with or lessening the problem, such as how priorities should be determined, what criteria should be used to assess unallocated cases, etc. It appears to place considerable emphasis on managers developing these strategies and on reporting requirements, but does not make it clear how these reports will lead to identification of the number and nature of unallocated cases that **should** be receiving attention, but are not - particularly when the issue is workloads and resources - and what will be done in relation to these cases.

However it is acknowledged that obtaining information on the extent of the problem is the first step in understanding and resolving it. This draft document should be subject to comprehensive consultation with Managers and Assistant Managers at the

CSC level and to “testing” at the service delivery level. It also needs to lead to the development of strategies for dealing with unallocated cases in a consistent and logical way. If this is not done, there is every possibility that the policy and procedures when implemented will impose further management and reporting requirements on managers at the CSC level without addressing the more fundamental problems.

*(iii) Lack of acknowledgment of resource problems*

The above discussion has highlighted that there are problems in the department’s service delivery caused by lack of resources, evidenced by a high number of unallocated cases, the development of a strategy to address unmet demand, and CSCs raising resource issues with senior management on a regular basis.

Mr Prasad’s report also contained, in the attachments, substantial information about resourcing issues. Much of it concerns Coffs Harbour CSC where it is clear that repeated efforts had been made to bring to attention the pressing resource and workload constraints. For example, a memo to the Assistant Director General, Northern makes mention of 140 cases unallocated, as at 5 September 1997. The memo cites a previous memo which indicates that the caseload for Coffs Harbour is equivalent to those experienced in metropolitan areas, but without the same level of resources.

An earlier memo, dated 4 June, highlights that the number of protective intervention matters was 2 to 3 times the volume of previous quarters, the centre was short two District Officers at the time, and that recruitment of temporary staff would mean the positions would be filled but the centre would then have three untrained temporary District Officers. Other memos and status reports to the Area Manager from March onwards refer to the high volume of work, the limited resources and the problems for management and staff in dealing with these. For example:

*“This is a very heavy workload, beyond the capacity of the CSC to meet. It puts pressure on CSC systems and individuals. The situation does not seem to be understood by CO executive: hopefully, message can be got through via the current CIS quality control process on overdue outcome decisions. They are mainly unallocated cases. CHCSC has introduced a number of measures, locally, to address this situation but continues to look to Area Office for support in finding answers.”* (Status report for August 1997, Coffs Harbour CSC, sent to Area Manager, MNC on 3 September 1997)

Documentation provided from the Far North Coast Area highlights similar resource issues, including problems with keeping the CIS up to date, the view that if this is done it will be at the expense of casework and the high number of unallocated cases (see attachment 40 to Prasad report).

A memo from the Area Manager, FNC, to the Director of Operations, Northern, dated 11 August 1997 outlines the number of unallocated cases across CSCs and records 30 unallocated child protection matters for Tweed Heads CSC. The memo notes “I would like to suggest we have some discussion about risk management of

unallocated work at the Cluster Executive. I also think we need to be discussing the implementation of the Interagency Guidelines...My concern is that we be clear about what parts of the guidelines we have the resources to give priority to, as we cannot fully implement them.”

This information suggests that relevant offices involved in the notifications of Jordan Dwyer were experiencing what appear to be quite significant resource problems in responding to child protection notifications, that these were on-going and that senior management within the department was kept informed.

Mr Prasad’s report refers to comments provided by Sally Castell McGregor that “detailed procedures and policies will only have meaning if those trusted with their implementation are well-trained, well resourced and have the competence and confidence to do their job.” (p 18, Prasad report) He also includes a quote, provided in Ms Castell McGregor’s report, from Reder et al (1993) that:

*“It is remarkable that child protection practice takes place against a backdrop of appalling resources, severe underfunding, little social or political encouragement and ever changing organisational structures - political as well as professional initiatives are necessary to redress this situation”* (p. 18, Prasad report)

As part of the commission’s inquiry, a number of questions were asked of the Director General in relation to resources, workload and staffing. The response indicates that there are no criteria or benchmarks used to determine appropriate staffing levels and workloads at the CSC level in relation to the positions of Assistant Manager, Child Protection Casework Specialist, District Officer and Intake Officer positions. Rather:

*Within the resources allocated to each CSC, it is the responsibility of Managers, in consultation with their supervisors and staff, as appropriate, to manage the allocation of staff effort to intake and field activities in response to peaks and troughs in service demands, and service delivery outcomes.* (Letter from Director-General, dated 23 October 1997, att 1, p.9)

and, further:

*There is no set staff to case ratio. The workloads for field officers are determined by available hours. There is a workload planning tool which is used for this purpose. Assistant Managers are responsible for setting casework work priorities and allocating work within available hours. Cases may be unallocated to enable a worker to take on a more urgent case. Workload changes in response to demand and the availability of staff on a particular day.....* (Director-General’s letter, p.9)

The department’s response also makes the point that there is no direct evidence from the Prasad investigation that levels of resourcing had any direct impact on how the Coffs Harbour and Tweed Heads CSCs responded to the notifications.

Certainly the terms of reference for Mr Prasad’s investigation did not require him to examine in any detail issues of resources and their impact on departmental actions in relation to Jordan Dwyer. Nevertheless much of the supporting documentation

supplied by the relevant CSCs mentions them, as does the expert and independent advice obtained by Mr Prasad. This advice is supported by the Manager of the department's Child Protection Unit (see attachment 25A to Prasad report).

The answers from the Director-General, documentation supplied and interviews conducted by the commission as part of the inquiry suggest a reluctance on the part of the department, at a senior level, to acknowledge and examine the problems caused by lack of resources and a tendency to unrealistically expect managers at the CSC level to resolve these problems and "cope".

At the very least, the policy development process needs to involve proper consultation with the field and a detailed consideration of the resource implications of any new requirements, their effect on other priorities and how such matters should be managed in a uniform and coherent fashion. Our analysis also suggests that there needs to be a greater acknowledgment of problems caused by lack of resources, a systematic approach to examining the issue, and shared responsibility for finding short and long term solutions.

### 8.3 Training for staff

A key strategy in assisting staff to come to terms with a changing culture and new policies, procedures and requirements must be training. Training is essential in any job that involves a high degree of professional judgement and where the work is stressful and demanding.

Information provided to the commission as part of this inquiry suggests that:

- The introduction of new policies is not necessarily or always accompanied by training in how to implement them;
- Where training is provided, this is often through "information dissemination" in the form of manuals, memos, newsletters, workshops, briefings and discussions, rather than formal training;
- Briefings, workshops and discussions around new requirements, policies and procedures are generally organised and provided at the local, regional or cluster level;
- No training was provided to staff of the department on the new intake procedure that formed a central part of the Case Coordination Framework and was introduced in July 1996 (although training will take place this financial year);
- Training across the state around the introduction of the Case Coordination Framework was organised and provided over a period of less than 2 months so that all staff would be trained by the end of June 1996;
- No training has yet occurred in relation to the new Practice Manual: Working with Children and Families, although a self paced orientation guide is apparently included in each manual.

This suggests that training by the department of its front line staff in a climate of change and continuing workload pressures is somewhat ad-hoc and not reflective of the complexity of the work and the need for highly specialised skills that are

regularly updated. The fact that the introduction of new policies and procedures is not always accompanied by training, or included in a regular training up-date, and that staff often have to rely on memorandums, newsletters and other written documentation to understand what is required of them, is particularly concerning. It means that information is acquired in a piecemeal way, it may not be assimilated into a broader framework, and it places an increased onus on the individual to correctly interpret requirements and their implications for service delivery.

It would appear that the department's approach to training and information dissemination requires some consideration and rethinking to ensure that: the appropriate medium is used to communicate key reforms and changes in a timely and well planned manner; staff acquire the skills and knowledge needed to carry out their work and an understanding of the framework within which they operate; and there are regular opportunities for updating or refreshing these.