OMBUDSMAN
TASMANIA

OMBUDSMAN TASMANIA:

Investigation into a complaint about the conduct of kinship assessments (and related matters) by Child and Family Services

March 2013

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EXECUTIVE SUMMARY

In April 2010 Ms C made a complaint to my office in relation to various aspects of the management of her nephew, Z, by Child and Family Services. Z was taken into foster care on 27 June 2009 following the arrest of his mother by Tasmania Police. At the time he was taken into foster care, Z was five years old.

From the time Z was taken into care, Ms C and other family members were in regular contact with CFS staff seeking updates on Z's wellbeing and requesting that he be placed in their care. Ms C complained to my office that CFS staff did not explore any kinship care options with extended family members and had not conducted any assessments to determine what would be in Z's best interest. Instead he had automatically been placed in foster care where he remained until 17 November 2010.

My office conducted extensive preliminary enquiries into the matters raised by Ms C and a number of serious practice deficiencies were identified. As a result, my predecessor commenced a formal investigation on 6 June 2011.

My Investigation Officer obtained and reviewed all CFS case notes, files, meeting minutes and documentation regarding Z's care, policy information and guidelines relating to kinship care and the assessment process, transcripts from all court hearings relating to the custody and guardianship of Z and all relevant police file material. My Investigation Officer also formally interviewed seven CFS staff responsible for Z's care, and three officers from Tasmania Police.

During the course of the investigation, it became evident that Z's case had been very poorly managed and that a number of recommendations would be necessary to ensure that a similar situation did not recur.

While numerous shortcomings were highlighted and noted, this investigation report focuses on four main issues:

- the failure by CFS staff to undertake any assessments or consider kinship care when Z was removed from his mother's care;
- the influence of Tasmania Police over CFS staff and their case direction;
- the inaccuracy of statements made by CFS staff in Case and Care Plans and affidavit material presented to the court; and
- the unreasonable delays by CFS staff in facilitating contact between Z and his extended family, and in referring him to the Australian Childhood Foundation for therapy.

As a result of my investigation, I reached the following conclusions:

- That the CFS staff responsible for the management of Z's case failed to conduct any assessments or explore kinship care options for him. The workers involved were judgemental in regard to Z's extended family and therefore did not conduct any

independent assessment of their suitability to care for Z. This failure demonstrated a total disregard for the importance of family identity for children in care.

- That CFS staff did not take Case and Care Plans or affidavit material seriously and that material contained therein was often inaccurate and skewed (and thus, the court misled) to improve the chances that the order being sought would be obtained. I found that lack of supervision or vetting of case file material by senior staff enabled this to occur.
- That CFS staff were aware of best practice guidelines and legislative requirements around the custody and guardianship of children but wilfully disregarded them.
- That Tasmania Police had significant influence over the management of this case and that the inter-departmental relationship between CFS and Tasmania Police needed to be reviewed to ensure appropriate boundaries are in place.

I make seven recommendations to CFS and DHHS:

- That CFS provide all staff with formal training on the importance of family connections and on the guidelines in place which must be followed.
- That CFS staff conduct kinship care assessments immediately when children are taken into care in accordance with the formal kinship care guidelines.
- That CFS amend relevant policies to ensure team leaders and senior managers provide more adequate supervision, and that team leaders check the accuracy of the content of Case and Care Plans and affidavit material.
- That CFS train staff and develop guidelines on the legal requirement to provide truthful and accurate information in affidavit material. Staff must be aware that knowingly providing false information is a criminal offence.
- That CFS develop guidelines for dealing with cases where there is Police involvement. Very clear boundaries need to be set detailing the role of each agency. CFS staff must be aware of their responsibilities and must not be influenced by concurrent Police investigations.
- That CFS or DHHS provide a written apology to Ms C for the mismanagement of Z's care. I recommend that the content of this apology be disclosed to me before it is given.
- That the Director of CFS addresses serious practice issues with specific staff in relation to their role in the management of Z's case.

A draft of this report was provided to the Director of Operations for Child and Family Services and also to Mr Des Graham, Deputy Secretary (Children) of the Department of Health and Human Services, and their comments and response to the recommendations sought. Comments and responses were given, and where appropriate, these have been included in the body of the report. A draft of the section in this report relating to police involvement was provided to the three police officers involved for their comments which, where relevant, have also been included in the report.

1. THE COMPLAINT

1.1 Ms C made a complaint to my Office on 19 April 2010 about various aspects of the management of her nephew, Z, by Child and Family Services.[1] Z was placed in foster care on 27 June 2009 and Ms C complained that a kinship care placement was not explored by CFS. Ms C further complained that Z's case management in the 17 months he was in foster care was unsatisfactory, and led to significant psychological distress to both Z and his extended family.

2. BACKGROUND

2.1 Z was taken into foster care on 27 June 2009 following the arrest of his mother by Tasmania Police. Z was already known to CFS due to previous notifications from family members; at the time he was taken into foster care, Z was five years of age.

2.2 From the time Z was taken into care, his aunt (Ms C) and other extended family members were in regular contact with CFS staff seeking updates on Z's wellbeing and requesting that Z be placed in their care. Ms C complained to my office that CFS staff did not explore any kinship care options with extended family members and did not conduct any assessments to determine what would be in Z's best interest. Ms C and the extended family made multiple requests for contact with Z during this time, all of which were denied by CFS staff.

2.3 In early 2010, members of the Family Inclusion Network[2] contacted Mr Mark Byrne, the then-Director of CFS, expressing their concern about the case management of Z. On 1 February 2010, Manager 1 met with members of FIN and Ms C to discuss their concerns, including that Z's family had not been assessed as kinship carers despite numerous requests and that affidavit material presented to the Magistrates Court contained inaccurate information about Z and his family.

2.4 Following this meeting, Manager 1 conducted a comprehensive file review, which was completed in March 2010. The review revealed a number of serious practice concerns and made a number of urgent recommendations.

2.5 On 19 April 2010, ten months after Z had been taken into care, Ms C contacted my Office for assistance. At that time she sought an undertaking from CFS that

[1] Throughout this report, I use the acronym CFS to describe the Child and Family Services Division of the Department of Health and Human Services, as it was known when Ms C made her complaint. The relevant section of the Department is now called Child and Youth Services.

[2] The Family Inclusion Network is an advocacy and support service for parents and families who have children in state care or who are at risk of having their children placed in state care. FIN provides support workers who offer a range of assistance to affected families including court support, development of therapeutic programs, and referrals to legal practitioners and other community agencies.

reunification between Z and his extended family was their common goal and that regular contact would be established.

2.6 In response to an initial letter from my Office notifying CFS of the complaint, Mr Byrne assured my Investigation Officer that contact would soon commence and that the intention was to reunify Z with his extended family in the future. While contact between Z and Ms C began soon thereafter, it was spasmodic and required continuous pressure from the family to ensure that visits were scheduled.

2.7 During the time Z was in foster care, Ms C considered potential civil action against CFS. For this reason, it was not until March 2011 that Ms C requested my Office to make formal enquiries of CFS about its case management of Z. Extensive preliminary enquiries were undertaken into the issues raised by Ms C, and all CFS files relating to Z were requested and delivered to my office. My Investigation Officer reviewed all the material and flagged a number of serious practice concerns, most of which arose as a result of procedures not being followed by staff responsible for Z's case management. Following that review, my predecessor, Mr Simon Allston, determined that the complaint should be formally investigated.

2.8 Pursuant to s 23(1) of the *Ombudsman Act* 1978, both the Secretary of the Department of Health and Human Services and the Director of Child and Family Services were notified of the investigation on 6 June 2011.

2.9 I have made reference to Z's foster carer in the body of my report, and it is important to provide some background information into her expectations for Z's care. When the carer agreed to take Z into her care in June 2009, she was of the belief that it would be a long term placement. She had been advised by Child Protection Case Worker A, that Z would not be returned to his family and that he would remain with her until he reached the age of 18. From the time Z was placed with the carer he was immediately treated differently to the other foster children residing in her home. Z referred to his carer as his new 'mum' (this was not corrected nor was he encouraged to maintain any family connections with his natural family). Z was included in family outings and holidays interstate, while the other foster children were placed in respite care during these periods.

2.10 The carer developed a close relationship with Case Worker A as well as with the Police Officer in charge of the concurrent Police investigation involving Z's mother, Senior Constable X. Both Case Worker A and SC X provided the carer with information about Z's family, about the criminal proceedings against his mother, and gave her the distinct impression that Z's family were not suitable to care for him (I refer to these matters in more detail later in this report). As noted, the expectation Z's carer had was that he would remain in her care until he was 18 years old. As such, it came as a shock to her when CFS announced in May 2010 that Z did, in fact, have a loving extended family suitable to care for him.

2.11 Following this revelation, according to CFS, the carer became uncooperative; she was reluctant to facilitate contact with Z's family and became emotionally detached from Z, causing him significant distress. The relationship between the carer, Z and CFS deteriorated to such a point that, on 17 November 2010, Z was removed from her care as the placement was no longer deemed suitable.

2.12 During the course of this investigation, it became apparent that Z's case had been very poorly managed on all fronts, but to have included all the shortcomings in this report would have proved too cumbersome. I therefore decided to focus this investigation report on four main issues, although I am of the view that it needs to be recorded that a number of other significant concerns were raised.

2.13 Ms C reported a number of incidents of CFS staff being obstructive and dismissive of her and her family's requests for involvement in Z's care. These allegations are supported by case notes which show that general processes of family inclusion were not followed. Ms C gave numerous examples of personal judgements made against her and her family which are again supported by case notes, written in what I would characterise as inflammatory language.

2.14 I am of the opinion that the unprofessional and inappropriate conduct by particular CFS staff would not have occurred, or continued for as long as it did, if correct process had been followed throughout the management of this case.

3. JURISDICTION

3.1 The Department of Health and Human Services, of which CFS is a part, is a public authority as defined by s 4 of the *Ombudsman Act* 1978. Pursuant to s 12, I have jurisdiction to investigate any administrative action taken by, or on behalf of, that public authority.

4. RELEVANT LEGISLATION AND GUILDELINES

4.1 The *Children Young Persons and Their Families Act 1997* confers significant powers on the Secretary of DHHS to carry out assessments of a child he or she believes, or reasonably suspects, is *at risk*, as that phrase is defined in s 4 of the Act. In practice, these powers have been delegated to the Director of Child and Family Services.

4.2 Best practice also requires that the 'Formal Kinship Care Guidelines' are followed when making determinations about a child's placement. CFS has produced a comprehensive Child Protection Manual available to all CFS staff. Included in the manual are the guidelines which provide:

- That if Child Protection Services is required to remove a child from his or her parents, a placement with a carer who is known to the child (usually a relative) is the preferred option.

- The option of a placement with kin must be considered at the time that a child requires placement.
- Case Workers should recognise the benefits to the child of being placed with relatives. Compared to a placement with a stranger, kinship placements tend to be less traumatic, more stable, provide a stronger sense of belonging and maximise opportunities for connections with family.
- If a child protection intervention involves the child being removed from the immediate family, a suitable placement with kin should be explored from the outset. Practice experience in Tasmania suggests that many children placed with foster carers develop strong attachments to their carers within short periods of time (four to six weeks) and such attachments undermine opportunities for securing a kinship care placement.

5. METHODOLOGY

5.1 In the course of the investigation, the following documents were obtained and reviewed:

- CFS case notes and files (both current and historical) relating to Z.
- CFS files relating to Z's foster carer and to Ms C.
- Informal and formal written responses from CFS to the issues raised.
- Policy information and guidelines relating to kinship care and the assessment process.
- Minutes from the Court Application Advisory Group (CAAG) meetings held in relation to Z (which were not included in the CFS files).
- Transcripts from all the Magistrates' Court hearings relating to the custody and guardianship of Z.
- Relevant police file material.

5.2 In addition, the following tasks were undertaken:

- Numerous discussions took place between my Investigation Officer and Ms C to obtain detailed information and examples of the issues raised in her complaint.
- Seven CFS staff members who had been responsible for Z's care were formally interviewed by my officers. All interviews were recorded and transcribed. The CFS staff interviewed were:
    - Manager 1
    - Manager 2
    - Manager 3
    - Case Worker A
    - Case Worker B
    - Case Worker C

- Case Worker D

- Three officers from Tasmania Police were also interviewed:
  - Senior Constable X
  - Detective Sergeant Y
  - Detective Inspector W

- A meeting was held between my Investigation Officer and Ms C's legal representative on 7 March 2011, at which time the legal representative raised potential civil remedies against CFS.

6. ISSUES

6.1 After interviewing the seven CFS staff involved in Z's care and reviewing all file material, I determined that the main issues arising from the complaint which required investigation were:

(a) the failure by CFS staff to undertake any assessments or consider kinship care when Z was removed from his mother's care;
(b) the influence of Tasmania Police over CFS staff and their case direction;
(c) the inaccuracy of statements made by CFS staff in Case and Care Plans and affidavit material presented to the court; and
(d) the unreasonable delays by CFS staff in facilitating contact between Z and his extended family, and in referring him to the Australian Childhood Foundation for therapy.

6.2 As noted at 2.12, while Ms C raised a number of other issues in her complaint, and several practice concerns were identified during the course of the investigation, the focus of this investigation has been confined to the four issues set out above.

7. THE INVESTIGATION

(a) The failure by CFS staff to undertake any assessments or consider kinship care when Z was removed from his mother's care

7.1 On 27 June 2009, CFS removed Z from the care of this mother on a warrant issued pursuant to s 20(3)(a) of the *Children, Young Persons and their Families Act* 1997. This warrant granted custody of Z to the Secretary for a period not exceeding 120 hours. On 2 July 2009, a four week assessment order was sought and granted by the court pursuant to s 22 of the Act.

7.2 Section 22 deals with assessment orders and provides:

(1) The Secretary may apply to the Court for an assessment order.

(2) On the application of the Secretary, the Court may make an assessment order in respect of a child if the Court is satisfied –

(a) that there is a reasonable likelihood that a child is at risk; and

(b) that further assessment of the matter is warranted or a family group conference should be held; and

(c) that –

(i) the assessment cannot properly proceed unless an assessment order is made; or

(ii) it is desirable that the child be protected while the matter is being assessed or a family group conference is being convened and held; and

(d) that it would be in the best interests of the child to make the order.

7.3 Clearly, the purpose of such an order is to enable CFS time to carry out the necessary assessments to determine a course of action to adopt, and to provide an opportunity for staff to review all aspects of the matter.

7.4 It was evident from the file material that no assessments had taken place during the four week assessment order period, nor was a family group conference held. When interviewed, CFS staff were asked why this was the case; they stated that the four week assessment order period was spent waiting for any outcomes from the concurrent Police investigation.

7.5 On 30 July 2009, CFS applied for a four week extension of the assessment order. The extension was granted by the Court. From the file material and interviews conducted, it is clear that the four week extension was only obtained to enable extra time for the Police investigation, rather than for CFS staff to conduct any assessments. As will be discussed in more detail below, CFS was waiting to see what came out of the investigation, as Tasmania Police had suggested that family members might have been involved in criminal matters.

7.6 Case Worker A, who was responsible for managing Z's case for the first two months he was in care, stated at interview:

> *…it was decided we'd go for a four week extension because the Police said that they would be able to finish their investigation within that time frame which would then better guide further orders….We are always guided by Police investigations because obviously you don't want to be contaminating evidence.*

7.7 During the initial eight week period that Z was in care, members of Ms C's family contacted CFS several times a week seeking updates on Z's wellbeing, requesting contact with him and offering themselves as kinship carers. Ms C and Z's uncle both provided Police clearances required of prospective carers, and requested that CFS staff conduct kinship assessments of them.

7.8 Case notes show that family members were told by CFS staff that nothing could be progressed until Tasmania Police had finalised its investigation. Subsequent interviews with senior managers revealed, however, that this was not the case and that assessments should have been undertaken, and kinship care proposals should have been considered, regardless of the Police investigation and despite SC X's view that the family would be unsuitable as carers.[3]

7.9 As noted at 4.2 above, CFS has 'Formal Kinship Care Guidelines' contained in its comprehensive Child Protection Manual which refer to the importance of considering kinship options at an early stage.

7.10 At interview, Manager 1 clarified the assessment process stating that, during the first four week assessment order period, workers should be conducting a holistic assessment of the child, including assessing the immediate family and assessing extended family members. Manager 1 said:

> *I was alarmed when down the track it was revealed that no assessments had been completed as I had been told that they had been … It's not just because of the legislation that we are required to, it's the best thing for a child that we try and place children with their families.*

7.11 Manager 1 recalled workers arguing with her that it was not necessary to do any family assessments as Tasmania Police were of the view that Z should not be placed with his family. Both Manager 1 and Manager 2 acknowledged that, while this particular case was out of the ordinary given the circumstances, both said at interview that they had a very clear recollection of telling Case Worker A to assess Z's extended family members as kinship carers, even if it was thought they would be unsuitable.

7.12 In contrast, Case Worker A said during her interview that the 'hold' on conducting any assessments was cleared by Manager 1 and Mr Byrne. This was flatly denied by both Manager 1 and Mr Byrne. Case Worker A's team leader, Case Worker C, also said at interview that she did not recall any management decision not to assess Z's family.

7.13 As early as 14 July 2009 (17 days after Z had been taken into care), case notes indicate that Case Worker A had suggested to the carer that it was likely Z would be placed with her long term. This suggestion was made despite assessments not having been conducted and at a very early stage in Z's case management. Manager 3

[3] There are numerous case notes which refer to the fact that SC X did not want Z to have any contact with his family and that he was of the view that they were unsuitable as kinship carers.

said during her interview that workers should not be having any discussions with carers around permanency planning until CFS has a long-term order:

> *We wouldn't be looking at that until we are considering an 18 year order which we never had in respect to Z. The goal is always to be reunification wherever possible … I think that at the early stages the police had a lot of influence on the carer and I believe that they were also saying that Z will* [sic] *be with her long-term. I think that there were a lot of judgements made around the family, around their ability and past criminal history … I think also that the handover* [from response to case management] *was pivotal, so when it came over, it would have been mentioned that the case direction was long term care.*

7.14 Manager 1 was also of the view that the discussions about long term placement should not have taken place with Z's carer, as it set up false expectations for both Z and the carer which led to significant problems in later months.

7.15 In an undated letter Ms C wrote to Mr Byrne in early 2010, she complained about the lack of her family's involvement in decision-making for Z, and the continuing delay in arranging contact. It was following the receipt of this complaint that Manager 1 conducted her comprehensive file review and that senior managers became aware of Z's extended family and its significant involvement with him. Manager 1 said at interview:

> *I was told very clearly, mainly by Case Worker A, that the family were no good, that the family had not been involved in his life and that he had quite clearly been neglected. It was not until I did this review later - I nearly died when I read the file and realised that the family was there…. you only have to be in a room with Ms C for thirty seconds to know what a genuine person she is, and if they* [the workers] *had taken some time to meet with her, interview her, connect with her, do the police checks, go and visit her home with the animals and the grandparents who live on the same property… It just should have been done, so as soon as they'd been cleared of any wrong doing, Z should have been placed with them.*

7.16 Manager 1 made a number of urgent recommendations in her review, one of which was that the kinship care assessment for Ms C should be completed forthwith.

7.17 In late April 2010, Manager 3 did a follow up on Manager 1's recommendations and found that the urgent kinship care assessment had still not been completed as directed. The worker responsible for conducting the assessment was Child Protection Case Worker B. At interview, Case Worker B was unable to offer an explanation as to why she had not followed the direction.

7.18 In late May 2010, Manager 3 attended the home of Ms C and completed the assessment herself. At interview, Manager 3 said that it was unusual for someone in her position to carry out a kinship assessment, but she had felt there was no other option given workers had failed to do so.

7.19 Both Case Worker A and Case Worker B conceded at interview that the assessments should have been carried out when Z was first taken into care. Case Worker A said that, in hindsight, assessment of prospective kinship carers should have been done regardless of the concurrent Police investigation. She also noted that kinship assessments and the focus on kinship had evolved, and that CFS do things differently now.

7.20 Similarly, Case Worker B said:

> *I think that there was a very strong feeling when we first brought Z into care amongst all the staff that were working with him, not just myself…it was extremely stressful for everyone involved because of the issues surrounding him coming into care. And yes, there probably were a lot of things that could have been done in a more timely manner, but unfortunately they weren't.*

7.21 The senior managers interviewed all stated that assessments should have been conducted regardless of the Police involvement. They all agreed that, despite any concerns, suspicions, or even confirmed worries about family members that might exist, family connections and working with families are the core principles of child protection. The material reviewed by my Officer did not include any notes, emails, memoranda or other notifications which indicated that management had directed that no assessments be made while Police investigated or, indeed, that it was even aware of the fact that assessments were not being conducted.

7.22 The fact that no assessments were undertaken indicates a total lack of understanding by the child protection workers involved of the importance of family identity for children in care. The lack of assessments might indicate that the workers had no apparent knowledge of their own guidelines, yet none of the workers interviewed denied knowing of them. It seems reasonable to conclude that the guidelines were known, but were wilfully disregarded.

(b) The influence of Tasmania Police over CFS staff and their case direction

7.23 The case file material clearly shows that the ongoing Police investigation had a significant influence over the way some members of CFS staff managed Z's case. As noted above, workers said that Z's case management was virtually stalled, awaiting the outcome of the Police investigation.

7.24 Case notes show, and the workers responsible have acknowledged, that the two four week assessment orders were obtained to allow Police further time to investigate. This is not the statutory purpose of a section 22 assessment order.

7.25 As I have noted at 7.3 above, the purpose of such an order is to enable CFS time to carry out the necessary assessments to determine what course of action to take, or alternatively, allow sufficient time to convene a family group conference. Case Worker A advised, however, that when Z was originally removed from his mother's care on the five day order, it was always intended to be a longer term placement while Police investigations took place.

7.26 As previously noted, SC X of Tasmania Police had carriage of the Police investigation and was in regular contact with Case Worker A during the first eight weeks Z was in care. Case Worker A said at interview:

> *Because it was a Police investigation the assessment process was quite different… The Police didn't want CFS to have any contact with the family because they didn't want their investigation contaminated ….*

7.27 Case Workers A and B both advised that not only were the assessments put on hold due to the Police investigation, but also that CFS had been "guided" by Tasmania Police in terms of contact with family members. There are multiple case notes in the files which record family members being advised that contact was not possible, nor were kinship assessments, until Police had finalised its investigation. During interview Case Worker A confirmed:

> *They [*Tasmania Police] *feed us the information, but ultimately we could override that. It's highly unlikely that you would go against a Police investigation, but, I mean, you could do. He* [Z] *wasn't allowed to have contact with anyone in the family because at that stage, I think it was a couple of months in, they weren't sure if he was actually going to be called as a witness.*

7.28 Team Leader, Case Worker C, confirmed this view at interview, stating:

> *The Police didn't want us to place the child with anybody who may influence their investigation basically…. To be honest, I probably should have said more but I was pushed out of the way because he* [SC X] *was dealing with the worker* [Case Worker A] *who was giving him this information. I tended to back-step a bit because I'd never been involved in a Police investigation like that.*

7.29 Ms C, together with Z's mother, wrote to CFS on 29 September 2009 requesting CFS to convene a family group conference to discuss the ongoing care and protection of Z. This request was denied by CFS on the basis that *in view of the pending criminal court case, it is not appropriate to hold a family group conference.* The

request should have been granted, however, given that s 39 of *the Children Young Persons and Their Families Act* provides that:

> 39. A family group conference **must** [my emphasis] be convened for the purpose of reviewing the arrangements for the care and protection of a child implemented following the approval of those arrangements by the Secretary under section 37 in any of the following circumstances:
>
> (a) if the Secretary is required to convene such a conference under those arrangements;
>
> (b) if the Secretary –
>
> (i) has been requested by the child or any 2 or more members of the child's family to convene such a conference; or
>
> (ii) considers it necessary or desirable to convene such a conference.

7.30 The failure to convene the conference when requested to do so by two members of Z's family was a clear breach of the Act, and just one example of Z's extended family being denied procedural fairness by CFS staff.

7.31 There are a number of references in the case notes to the effect that all queries from Z's family about him were to be forwarded to SC X to answer. File notes also show that SC X advised Case Worker A on several occasions that he was concerned about Z being placed with extended family members. SC X stated at interview, however, that:

> *It was never my intention to stop the family from knowing Z was alright. It was more a situation that I did not want any direct interaction between the two at that stage. I would find it hard to believe that they* [CFS] *would think it was my decision to be honest, I don't try to influence their decisions. If I'm asked for an opinion or something on those lines then I would give it, but it certainly wasn't a "this is what I want and expect" – it's not that sort of situation. We assist each other.*

7.32 This statement is not reflected by CFS file notes of a number of meetings and telephone calls, which clearly show that the workers involved were of the view that SC X was directing them as to whether or not Z could have contact with any family members. An email sent by SC X to CFS staff on 29 October 2009, four months after Z was taken into care, supports this conclusion:

> *I am composing a letter for M* [support worker], *FIN Tasmania and Z's family in which I will lay out once and for all the reasons why I will not allow Z to have contact with his mother or his extended family. It won't go down well, but such is life.*

7.33 SC X acknowledged at interview that this email gave the clear impression that it was he who was not allowing contact between Z and his extended family, and that he expected full cooperation from all involved.

7.34 Senior managers were asked at interview whether this level of Police involvement was normal or commonplace. Manager 3 said:

> *No, I don't understand why they* [Tasmania Police] *needed to be, I mean if they were still investigating, it would be good for us to be kept in the loop but they certainly should have no influence over our case direction unless they have significant concerns for the safety of a child. Obviously we would take that on board, but in this case I don't understand why that level of contact was maintained or why there was the level of involvement between the Police and the carer, or why the Police were having, I think, quite frequent discussions with the carer. The carer was, I understand, quite pre-occupied with this case, and was quite fascinated with what was happening with Z's mother.*

7.35 In July 2010, 13 months after Z had been taken into care, SC X attended a Care Team meeting for Z. He was accompanied by Detective Sergeant Y. SC X was invited to the meeting by CFS for the purpose of offering some information to the Australian Childhood Foundation about Z's disclosures which may assist them with his therapy. The minutes of the meeting, however, record that SC X was unable to provide any details in relation to the police investigation. In regard to his presence at the meeting, Manager 3 said at interview:

> *At the Care Team meeting, I was quite appalled with a comment that SC X made, he actually said to Z's carer that she deserved to have Z. It wasn't appropriate, and in hindsight we shouldn't have had him there at the meeting.*

7.36 Manager 1 made a similar comment in her interview:

> *SC X sat in front of me at a meeting, he got very angry with me when I said I wanted Z reunified* [with his family]. *He said the carer deserved to keep Z.*

7.37 Manager 3 said that, during this meeting, SC X was pre-occupied with the criminal backgrounds of some members of Z's family. The meeting minutes show that SC X suggested that CFS subpoena the Police file so that it had a complete picture of the Police investigation. He also enquired as to whether CFS would be doing Police checks on family members.

7.38 Information about the significant relationship Z had with his extended family was available to workers, but they chose to ignore it. It is clear to me from the case

notes and information provided at interview that the decision to ignore this information was heavily influenced by SC X.

7.39 During the course of the investigation, my Investigation Officer contacted Tasmania's Police Commissioner requesting copies of all documents held on file relating to Tasmania Police's concerns with Z having contact with his immediate and extended family. The Professional Standards Unit of Tasmania Police conducted an audit of all available databases, archives and email holdings but was unable to locate any reference to SC X's involvement with CFS or Z's family. A request to have historical emails retrieved also proved fruitless, as Tasmania Police had recently updated its email system and the previous system did not have the capacity to recover emails which were not saved to an individual folder or server.

7.40 At the time of this incident (June 2009) there was a Memorandum of Understanding in place between Tasmania Police and Child Protection Services which provided that 'during any investigation Tasmania Police will be the leading agency in investigating the offence that has allegedly occurred and Child and Family Services will take carriage of care and protection issues'. It was, therefore, inappropriate for Tasmania Police to have any final influence regarding the care and protection of Z.

7.41 Based on the evidence available to me, which included emails from SC X retained on the CFS files, I formed the view that SC X acted outside his role and without instruction from his superiors. His level of involvement with CFS was inappropriate and unjustified. Comments made by CFS senior managers during interviews support me in this view.

7.42 SC X was given the opportunity to read and comment on this section of the report and contested many of the conclusions reached. He stated that his actions during the investigation were sanctioned by his senior officers and requested that they be interviewed. Consequently, my staff interviewed Detective Inspector W and Detective Sergeant Y, who both confirmed that Tasmania Police had initially held concerns about Z being potentially influenced by family members if he was placed in their care.

7.43 Both officers advised, however, that they were unaware of the full extent of SC X's involvement with CFS staff and were not aware of particular phone calls and email correspondence. While DS Y initially commented at interview that the 'buck stops with [her] and [her] wishes as conveyed to SC X were that Z was not to be returned to his family', she said that she could not take responsibility for the emails or correspondence between SC X and CFS staff of which she was unaware. Both officers advised that, had they been aware, they would not have supported or endorsed SC X's actions.

7.44 DI W said that Z was significant to initial Police enquiries and had been a material witness to the investigation. He confirmed that there was a significant level of

concern that Z may be influenced by other family members who appeared torn in their loyalty towards Z's mother. DI W added, however, that he had not been aware how involved or how subjective SC X had become.

7.45 DI W said that, had he known, he would have tried to 'look after' SC X and supervise him more closely. While I accept this as genuine, both officers must have had some insight into the fact that SC X had become too close to the case, as DI W indicated that he thought SC X had become too subjective. While neither officer sought to justify SC X's conduct, DI W said that the case had clearly taken its toll on SC X, and when the charge against Z's mother did not proceed, SC X was very distressed. I have no hesitation in accepting that this was the case.

7.46 Both officers accepted that the case file notes kept by CFS staff detailing the contact with SC X were contemporaneous notes and should be accepted as true records. Had corresponding notes been recorded on the police running sheet, then SC X's superiors would have noted his conduct and been able to manage it as soon as it became apparent. For reasons unknown, not all the notes of correspondence between SC X and CFS were recorded on the running sheet. DI W was firm in his view that SC X should have remained objective at all times, and should have recorded all communications on the running sheet by providing a brief description of each contact he had with CFS staff.

7.47 DI W said that, if Tasmania Police had held such strong concerns about Z being placed with his family that they wished to prevent it, then the correct process to follow would have been to go to the Director of Public Prosecutions to discuss available options; Tasmania Police procedure is not to go directly to CFS and direct that a child is not have contact with his or her family.

7.48 SC X commented in his response to the draft report that at no time during the police investigation were any formal objections raised by any staff at CFS in relation to the time that Z was in care or not seeing his family. This is not disputed and CFS staff have been criticised in this report for their inaction.

7.49 In his written response to the draft report, SC X also referred to the care team meeting he attended in July 2010 and stated that his comments regarding the carer had been taken out of context, and that he had only meant that she had done an excellent job looking after Z and deserved recognition. DS Y who attended this meeting with SC X was unable to recall the details of the meeting and advised she was not in a position to comment on the veracity of any comments made.

7.50 SC X made a number of other comments in his two written submissions to my office which refer to CFS having responsibility for Z's placement, and he was critical of CFS staff for failing to adhere to their own guidelines. SC X did not have the benefit of the entire report, so was not aware that these criticisms and adverse comments had already been made by me.

7.51 SC X denied that he purposefully attempted to influence anyone involved in the matter (CFS staff or Police). He said that he was never referred to a supervisor, and was never told of any unhappiness with his decisions, nor was it ever suggested to him that he was overly influencing the matter. While I accept that this might be the case, it was evident from our interview with his superiors that they were unaware of all of his actions. In a written submission to my office commenting on the draft report, however, DS Y advised that:

> *My express and clear direction to SC X during the investigation was in support of the fact that our wish was that Z certainly not be returned to his mother or any of her family members due to the fact that for an extended period of time Z was in our consideration likely to be called as a witness in any pending trial….. I stand firm in my support of SC X as far as our stance in relation to Z. As his Detective Sergeant at the time of the investigation and the Senior Officer overseeing that investigation, I have to take responsibility for SC X's actions and interactions with CFS.*
>
> *I was aware that he maintained a very close working relationship with Case Worker A in relation to this case, however what I stated to the Ombudsman's office during my interview was that I did not believe that I could be responsible for every telephone attendance or email that SC X had with CFS as clearly I was not privy to them all… If the totality of the emails and telephone attendances and correspondence between SC X and that agency indicates that his relationship was 'inappropriate and that he may be overstepped the mark or gone outside his role or exerted undue influence on CFS workers' then I must ultimately accept responsibility for that as I should have provided more stringent supervision of SC X.*

7.52 SC X also raised a number of questions and made a number of assertions in his submissions regarding my investigation. As is clear, the focus of this investigation was the manner in which CFS officers managed Z's case; during the course of the investigation it appeared some of those officers had been inappropriately influenced by Tasmania Police's involvement. This report is designed to illustrate the perceived deficiencies in CFS's internal administrative processes and to clarify the separate, though often complimentary, roles filled by CFS and Tasmania Police when managing children at risk. The report is not designed to discredit SC X. All this has been pointed out to him.

7.53 DI W and DS Y both had the opportunity to read the draft report in its entirety and the concluding recommendations. Neither officer wished to raise any other issues in so far as the report relates to Tasmania Police. In terms of the draft recommendation relevant to Tasmania Police, both officers were of the view that it may be a timely opportunity to revisit the MOU between Tasmania Police and CFS.

7.54 The current MOU between the two agencies is quite brief and covers information exchange, restraint orders and referral processes. Both officers were of the view that it would be beneficial for a new MOU to be developed which clearly identifies each agency's role and establishes defined boundaries of responsibility and power in decision-making for situations involving children at risk.

(c) The inaccuracy of statements made by CFS staff in Case and Care Plans and affidavit material presented to the court

7.55 When reviewing the file material, my Investigation Officer noted that information in the Case and Care Plans and affidavits presented to the court was inconsistent with the information in the case files. She found that the material provided by Case Worker A and Case Worker B in these documents was inaccurate and contained information which was not based on factual evidence. Further, Z's family connections were not identified in any of these documents and pertinent information about the assessment process (or lack thereof) was either omitted or inaccurately recorded.

7.56 At interview, Case Worker A was asked why there was no information about Z's extended family included in the Case and Care Plan and why she had not detailed the fact that assessments had not been carried out. Case Worker A answered:

> *I don't know, I don't have an answer, I don't know why it's not in there. Generally I would put that sort of stuff, so I don't know why it's not.*

7.57 When it was suggested that this appeared to be a significant omission on her part, Case Worker A downplayed the importance of Case and Care Plans, saying:

> *A Case and Care Plan is just a really basic initial document that's done for the purpose of handing over a case.*

7.58 This comment conflicts with information in the Child Protection Manual which provides:

> *Case and Care Planning is developed incrementally over the period of intervention. It reflects developments in the child's life, the child's family, the child's living circumstance and the child's wider community. Information on the Case and Care Plans for the future of the child should detail the reason for intervention and the overall plan for the child. It should include a list of the goals that need to be reached in order to achieve the overall plan, as well as the rationale behind the plan, tasks, timelines and people responsible for undertaking them. It is essential to understand what has led to the child coming into care and that a Care Plan must consider the rationale behind the case and care direction. Remember that for most children who come into care, the primary goal is to reunite the child or young person with his or her own family in the first instance.*

7.59 Similarly, CFS's 'Formal Kinship Care Guidelines' provide:

> *The Case and Care Plan format includes a section that outlines what measures have been taken to place children with relatives. This section must be completed when the Case and Care Plan is being developed and during ongoing reviews.*

7.60 Case Worker B completed a Case and Care Plan in December 2009 which included this comment:

> *Kinship assessments of Z's extended family have been assessed as unsuitable and not in his best interests.*

7.61 This comment is contradicted by the file material which shows that, as at December 2009, Z's family had not been assessed as possible kinship carers at all. At interview, Case Worker B was unable to offer any explanation for this comment.

7.62 When asked about the process for vetting Case and Care Plans by senior CFS staff, all three Managers confirmed that it is the responsibility of the Team Leader to check the content of the Plan, as well as make simple grammatical corrections, before it is endorsed. They also advised that Z's family should have been involved in developing the Case and Care Plan.

7.63 Manager 3 said:

> *Family meetings are pertinent and family members should actually be involved in developing that Case and Care Plan. It is very much a family led process developing that Plan. We have to have a meeting with family members; and they actually sign the Case and Care Plan.*

7.64 Case Worker A had been promoted from a Child Protection Case Worker to Case Worker B's Team Leader when the December 2009 Plan was written. This meant that Case Worker A became responsible for vetting its contents, rather than someone not previously involved in the case (who would have looked at it with fresh eyes). At interview, Case Worker A was unable to answer why she had endorsed a Plan which was factually incorrect. She was also unable to answer why Z's family had not been included in drafting the Case and Care Plans as the Guidelines suggest they should have been.

7.65 When asked about the 'vetting' of Case and Care Plans, Case Worker C provided an alarming response:

> *To be honest, Case and Care Plans are not worth the paper they're written on - because of a lack of resources they're often just quickly done to tick the box. I know of a lot of workers that cut and paste, I'm sorry, but we have*

> *workers that, "if the child's between one and three, then they like coco pops for breakfast and they go to bed at six thirty... If they're between fifteen and sixteen, they have toast". It's just cut and paste. I probably shouldn't be saying that, but that's the way it is. They* [Case and Care Plans] *are not accurate, workers don't actually have time to get to know a child as an individual child, they've got so many cases that they're just going through the process.*

7.66 Senior managers had a very different view and reported that they rely on the material in Case and Care Plans to be accurate and truthful, as it is this material that forms the basis of a case's direction. All the managers interviewed confirmed that workers have full access to historical files and the current electronic database to gather information when developing Plans in the early phases.

7.67 Manager I advised:

> *I constantly drum into workers the need to read all historical material because there is so much that can be missed if you don't read the history. I say to them frequently, I don't care if there* [is] *27 volumes and I don't care if it takes you six months, you must read every volume, because there's so much that you can miss if you don't read the history.*

7.68 In Z's case there were two volumes of files.

7.69 My Officer's review of the file material also disclosed that information contained in affidavits presented to the Magistrates' Court was inaccurate. Given that this information is being presented to the court, which relies on it when determining the custody and guardianship of a child, the information **must** be true and correct. Affidavits are sworn statements, they are no different to the giving of evidence on oath in person, and it appears that not enough weight was given to the importance of the accuracy and truthfulness of these documents. To provide false information knowingly in a sworn statement to the court amounts to perjury, and is a criminal offence.[4]

7.70 During interview, when asked why important information about Z's family was not included in the affidavit material, Case Worker A said:

> *We write affidavits quite quickly in the first four days so it may be that there was other information in the file that wasn't in the affidavit … It's normally factual things about the parents and why you are going with the order. If he* [Z] *was placed with a family member you may mention that, but generally it's just the facts … Kinship options are an internal process generally.*

[4] *Criminal Code Act 1924*, Schedule 2, sections 94 and 95.

7.71 Manager 1 disagreed. She said that the affidavit material presented to the court should detail kinship options and what is considered to be in the child's best interests. Manager 2 concurred at her interview:

> We [CFS staff] *need to outline that we've considered certain sections of the Act when we're making any application and one of those is section 55*[5] *which is about actual family or extended family. We used to have a really fixed template for affidavits where we would basically respond to each of the section 55 considerations so that was really up there front and centre for the Magistrate. That's changed over time in that the Magistrates didn't feel that was an evidence based affidavit. Again, there is trust that the Secretary is doing what they're meant to do under the Act … so do they* [the Magistrates] *really need that depth of detail and scrutiny of 'have you, as an officer of the court done what you are paid to do?'*

7.72 In 2009 when this case was being managed, it was CFS practice that the worker responsible would write the affidavit, it would be vetted by his or her Team Leader for quality assurance, and then sent to a nominated legal practitioner who would check it for grammatical errors and ensure the structure was acceptable. Generally, the material would be left unaltered and unchallenged from the original draft.

7.73 Manager 2 said at interview:

> *I wouldn't expect a Team Leader to be going back and checking all of the material to make sure it's true and correct. You've got that level of trust in your staff that what they're putting on paper is actually true. That's a real risk for our agency… you are putting trust in staff that the information provided is the full material and that there has not been something that is missed accidently or otherwise.*

7.74 When asked about the accuracy of material presented to the court in affidavits, Case Worker C gave a surprising response:

> *It* [the affidavit material] *is taken on face value because if a case proceeds to hearing then that's when the information from the affidavit is dissected and objected to … The aim is to get the order on that child. The affidavit is not about the future, it's about getting the four week assessment order and then, I mean, a terrible thing to say, we dish up as much dirt as we can. We put ridiculous things in affidavits just to paint a picture of how bad the mother is so that we get the order. If we consider that child at risk, we do everything possible to get that order.*

[5] Section 55 of the *Children Young Person and Their Families Act* 1997 lists the matters that the Court must consider when determining what is in the child's best interests. The matters include the child's wishes, their relationships with family members and the likely effect of changes in their circumstances.

7.75 I find it deeply disturbing that the information recorded in Case and Care Plans and in affidavit material presented to the court was factually inaccurate at best, or deliberately untruthful at worst. Not only does this conduct raise serious practice concerns, but some members of staff were deliberately ignoring the fundamental principle of the 'best interests of the child'. Of equal concern, providing inaccurate information on oath and actively misleading the court undermines the integrity of the court system and, as noted, is a criminal offence.

7.76 The Child Protection Manual has a considerable amount of practice information regarding the 'best interests of the children' principles for practitioners to follow. I am satisfied that the appropriate guidelines are in place and available, but in this case, it seems they were deliberately disregarded by the workers responsible.

(d) The unreasonable delays by CFS staff in facilitating contact between Z and his extended family, and in referring him to the Australian Childhood Foundation for therapy

7.77 On the information available, it seems to me that there was justification for separating Z from his family, both immediate and extended, in the initial period after he was taken into care. I am satisfied that Tasmania Police's initial concerns about Z as a potential witness were reasonable. I am also satisfied, however, that to refuse to facilitate contact with his extended family for nearly 12 months was unjustified and unreasonable, with potentially significant consequences for Z.

7.78 The file notes clearly show that Z had a loving extended family that cared for him and wanted to see him. Various members of the family contacted CFS regularly requesting contact with Z but these requests were ignored, denied or fobbed off by CFS staff. A case note dated 16 September 2009 written by Case Worker B reads:

> *I spoke with my Team Leader and Case Worker A, his previous CPW and it was agreed that it was not in his best interests to see his mother or family at the moment.*

7.79 At interview, Case Worker B said that not allowing Z to have contact with his family was a direction that had come from the Response Team at handover (the Response team consisted of Case Workers A and C). Both Case Workers A and B said that, when asked, Z did not want to see his family, but both workers acknowledged that they did not actively encourage any contact.

7.80 Manager 1's file review recommended that contact between Z and Ms C start immediately, and that workers should take photographs of Z's family to him to encourage rebuilding those relationships. Despite these urgent recommendations, contact was not organised until May 2010, some two months later.

7.81 Case Worker B was the worker responsible for carrying out the recommendations of the file review and, at interview, was unable to offer an explanation as to why contact had been delayed. Once contact was eventually established, Z and his family were scheduled to meet fortnightly, yet Ms C advises (and case notes confirm) that the contact was sporadic and often cancelled by CFS due to staff shortages. It was not until my Office became actively involved that regular contact was maintained.

7.82 Material in the file also highlighted that there had been a substantial delay in referring Z to the Australian Childhood Foundation for counselling and support.[6] While the need for counselling had been discussed informally by CFS staff in the past, it had not been progressed. There was, however, a notation in the Magistrates' Court Order made on 9 December 2009 that the Secretary should refer Z to the ACF.

7.83 When referring a child to the Child Trauma Service, child protection workers should liaise with their Team Leader and complete the brief referral form. This form should then be forwarded to the Child Protection Manager who will prioritise the referral and liaise with the Child Trauma Service.

7.84 When a placement becomes available (usually within eight to ten weeks), ACF embarks on an assessment process which generally involves meeting with the Child Protection Manager to get a thorough overview of the child's situation, gathering information from schools, reviewing historical child protection files, and meeting with family members and other people of importance in the child's life. Once this 'information gathering' is complete, the ACF counsellor will meet with the child and counselling will commence. This entire process can take months depending on the complexity of the case.

7.85 It is fair to say that Z's case would be classified as complex; it is, therefore, very disconcerting that the workers responsible did not place any urgency on making the referral so that Z could begin his recovery.

7.86 Manager 1's review in March 2010 revealed that, despite the court notation, the referral had not by then been made. One of her review recommendations was that the referral be made urgently. I am deeply concerned that this referral was not treated with any urgency given Z's desperate need for therapy and the fact that CFS staff were aware of the lengthy process in having a child referred to, and assessed by, ACF. Case Worker B, who was again the worker responsible for making the referral, was unable to offer any explanation for why it was not made promptly, other than saying that she may have taken some periods of sick leave in January 2010.

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[6] The ACF has been specifically funded by the State government in Tasmania to develop a counselling and support service for children and young people who have been traumatised by abuse and neglect. This is called the Child Trauma Service.

8. INTERNAL FILE REVIEW

8.1 As referred to throughout this report, Manager 1 conducted a file review in March 2010 following receipt of Ms C's complaint to Mr Byrne. I quote her main findings:

- The affidavit material provided to the Court by CPS workers is inaccurate and contains information that is not evidence based. Information on Z's file contradicted with [sic] information contained in the affidavits.
- CPS staff repeatedly misled CPS management staff regarding the family circumstances of Z.
- Information on Z's file makes it clear that a thorough and accurate assessment of his family's circumstances had not been completed.
- It would appear that no efforts have been made to assess family as kinship carers even after family had repeatedly contacted CFS requesting that this occur.
- The criminal investigation of Z's mother … appears to have been used as an excuse not to carry out kinship assessments.
- As part of the referral to the Australian Childhood Foundation, urgent consideration was needed to be given to how Z can be reintroduced to his maternal extended family.
- It is regrettable that by not carrying out family assessments in a timely manner and by not appropriately working with Z with regards to his family identity, CPS may have irretrievably damaged both his relationship with his family and the possibility of being permanently placed with them.

8.2 The main recommendations Manager 1 made (and again I quote her) were:

- Immediate contact needs to be made with Ms C, and a kinship care assessment commenced.
- Police checks must be immediately processed in relation to Ms C, and her parents.
- Home visits to Ms C and her parents, need to be carried out as soon as possible with the aim of commencing a collaborative working relationship with the family.
- Family photographs should be obtained from Ms C with the aim of gradually introducing these to Z.
- Providing that police and child protection checks are satisfactory, access between Z, Ms C and his maternal grandparents' needs to be commenced as soon as possible.

8.3 After extensive investigation of the issues raised, I concur with Manager 1's findings for reasons I have already given. Z's case file material is silent on what action, if any, was taken by management to address these serious practice issues. What is apparent is that the recommendations were not implemented or acted upon by the workers responsible in a timely manner, or at all.

9. CONCLUSIONS AND RECOMMENDATIONS

9.1 The complaint made by Ms C raised serious allegations of seriously flawed administrative practice by CFS staff and this investigation has substantiated her claims.

9.2 As noted at 7.22, the fact that the child protection workers failed to conduct any assessments shows a total disregard for the importance of family identity for children in care. I am of the view that the workers involved were aware of the guidelines in place but chose to ignore them.

RECOMMENDATION ONE

That CFS provides all staff with formal training on the importance of family connections and on the guidelines in place which must be followed.

RESPONSE TO RECOMMENDATION ONE BY CFS:

This recommendation was accepted. CFS was of the view, however, that this issue was confined to staff in the south and as such, it would ensure staff in the south were given formal training as recommended.

9.3 I find that the workers involved were judgemental in regard to Z's extended family and, as a result, did not conduct any independent assessment of their suitability to care for Z. All the staff who were interviewed acknowledged that Z's case was poorly managed, that assessments should have been conducted, and that Z's family should have been involved in his life during that period.

RECOMMENDATION TWO

That CFS staff conduct kinship care assessments immediately when children are taken into care in accordance with the formal kinship care guidelines.

RESPONSE TO RECOMMENDATION TWO BY CFS:

This recommendation was accepted and CFS advised that practice around kinship care had significantly improved since 2010 when this case was being managed. Kinship care assessments are now conducted as a matter of course when children are taken into care.

9.4 The two staff members responsible for Z's day to day case management, Case Workers A and B, were both experienced workers and had been employed by CFS for many years. They were both aware of best practice guidelines and legislative requirements, but appeared to have been heavily influenced by Senior Constable X.

9.5 While an element of trust needs to be afforded to workers, it is apparent from this case that there is insufficient (or no) vetting of the information recorded by workers in Case and Care Plans, in affidavit material or in general case file notes. It was not until Ms C formally complained to Mr Byrne that discrepancies were found and management realised it had been misled by workers.

9.6 I can only conclude that lack of supervision allowed this to happen and to continue. Compounding the problem was the fact that Case Worker A went on to become Case Worker B's Team Leader, meaning there were no 'fresh eyes' on Z's case. CFS needs to ensure that appropriate strategies are put in place so that this situation is not repeated in the future.

RECOMMENDATION THREE

That CFS amend relevant policies to ensure team leaders and senior managers provide more adequate supervision, and that team leaders check the accuracy of the content in Case and Care Plans and affidavit material.

RESPONSE TO RECOMMENDATION THREE BY CFS:

This recommendation was accepted and CFS has altered its process whereby team leaders are now required to sign off on all affidavits and have monthly meetings in relation to Case and Care Plans and the content thereof.

9.7 I am particularly concerned by the evidence that Case and Care Plans were not taken seriously by those who wrote them and, even more concerning, that affidavit material was skewed (and the court misled) to improve the likelihood that the order being sought would be obtained. This issue needs to be addressed as a matter of urgency. Knowingly providing inaccurate information on oath is a criminal offence and undermines the integrity of the court process. Just as importantly for the welfare of the child concerned, providing inaccurate information may lead to inappropriate orders being made that have adverse consequences for that child.

RECOMMENDATION FOUR

That CFS train staff and develop guidelines on the legal requirements to provide truthful and accurate information in affidavit material. Staff must be aware that knowingly providing false information is a criminal offence.

RESPONSE TO RECOMMENDATION FOUR BY CFS:

This recommendation was accepted**.** CFS advised that the establishment of a new process, involving Crown Law mentoring and coaching its staff, should assist in achieving quality assurance standards in affidavit material. Training has also been established and ongoing practice improvement initiatives have been identified to ensure transparent 'Evidence Based Practice (EBP)' is carried out, particularly in the area of information pertaining to public record.

All officers will be counselled in regard to EBP, transparent decision making, sharing of information, objectivity, procedural fairness and general record keeping standards. The two subject officers will also be required to attend additional training on the principles of best practice when completing affidavit material and case noting within case and care planning.

9.8 I find that, for whatever reason, Tasmania Police had far too much influence over the management of this case. SC X was voicing personal views about Z's family and the carer, and was influencing decisions made by staff, particularly Case Worker A. The inter-departmental relationship between CFS and Tasmania Police needs to be reviewed to ensure appropriate boundaries are in place so that this inappropriate relationship does not recur.

RECOMMENDATION FIVE

That CFS develops guidelines for dealing with cases where there is Police involvement. Very clear boundaries need to be set detailing the role of each agency. CFS staff must be aware of their responsibilities and must not be influenced by concurrent Police investigations.

RESPONSE TO RECOMMENDATION FIVE BY CFS:

This recommendation was accepted. CFS acknowledged that there was a need to clarify with child protection workers and team leaders that the 'best interests' of the child is a paramount principle that must still be applied in matters where there is police involvement, and that CFS is responsible for ensuring best practice. CFS also advised that a referral to the Quality Improvement and Workforce Development

Unit was being made for further training of team leaders and child protection workers about the role of CFS in matters with police involvement.

9.9 Ms C has received verbal apologies from two staff members for the mismanagement of Z's case. Interestingly the apologies were made by a subsequent Child Protection Case Worker, and Manager 1, neither of whom was responsible for the mismanagement. Given my findings and the fact that Ms C has continued to suffer ongoing emotional consequences from this situation, I recommend an apology be made to her by either the Director of CFS or by the Secretary of DHHS.

RECOMMENDATION SIX

That CFS or DHHS provide a written apology to Ms C for the mismanagement of Z's care. I recommend that the content of this apology be disclosed to me before it is given.

RESPONSE TO RECOMMENDATION SIX BY CFS:

This recommendation was accepted. The Acting Director of Operations from Children and Youth Services wrote a sincere letter of apology to Ms C, the content of which I endorsed.

9.10 As my findings indicate a wilful disregard of legislative requirements, practice guidelines, and internal procedures by individual staff members of CFS, I recommend that the Director of CFS raise these issues with the specific staff and take whatever action he considers necessary.

RECOMMENDATION SEVEN

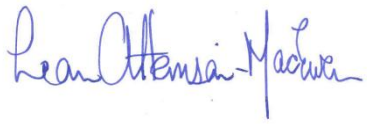
That the Director of CFS addresses serious practice issues with specific staff in relation to their role in the management of Z's case.

RESPONSE TO RECOMMENDATION SEVEN BY CFS:

This recommendation was accepted. The then Director of CFS, Mark Byrne, met with each of the staff members individually and counselled them on their responsibilities under the *State Service Act 2000* and his expectations as to how each of them should perform their duties. Two particular officers were also required to attend additional training that supports kinship care connectivity and were

counselled in regard to the paramountcy of the best interests of the child, and the importance of expeditious referrals to therapeutic services.

9.11 The recommendations made above are effectively made to the Secretary of DHHS, the department which administers the Children Young Persons and Their Families Act. Acting in accordance with s 28(4) of the *Ombudsman Act 1978*, I request the Secretary to notify me, within three months of the date of this report, of the steps which have been, or are proposed to be, taken to give effect to these recommendations. If no such steps have been or are proposed to be taken, in relation to all or any of the recommendations, I request that the notice given to me provide reasons why this is so.



Leon Atkinson-MacEwen

OMBUDSMAN

27 March 2013