CPSU/CSA
WE MAKE WORK
LIFE BETTER.

Supplementary Information

Contents

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1. INTRODUCTION

The CPSU CSA would like to thank the Committee for the opportunity to provide this information on behalf of our members in the Department of Child Protection and Family Support.

The CPSU CSA has been raising members concerns with the Department for a number of years.

We see the tragic incident in Bunbury as a symptom of a system under immense pressure, where inadequate resourcing has created an environment of uncertainty and where CPFS staff are forced into situations inherent with an unacceptably high level of risk. This significantly hinders the management of children at risk.

Aspects of the boy's situation raise concerns with the union. These concerns can be grouped into:

- Workload Management and Measurement issues
- Quarterly Assessments not being monitored for compliance
- Co-working concerns and;
- Placements

We can discuss each of these concerns in more detail.

We strongly believe that the incident is indicative of wider problem of inadequate resources not allowing staff to do their job properly.

On top of the concerns that directly to the incident in question,

- Excessive Workload leading to Delays in Safety and Wellbeing Assessment being completed in a timely manner and The Monitored List (caused by Workload Management and Measurement Issues)
- Contact between parents and children when a child is first taken into care
- Culture of the Department concerning putting children into care.
- Working with Children Checks;

are all areas where inadequate resourcing is hindering the department's ability to undertake the management of children at risk. We have information from members to illustrate with examples what happens when not enough resources are provide to protect vulnerable children.

We believe that the information we have warrants the Committee to conduct a broader inquiry into the Department of Child Protection and Family Support and how inadequate resources is hindering the management of children at risk.

2. DETAILS OF THE INCIDENT IN QUESTION IN REGARD TO THE FATHER

Father

- Father was 15 years old when incident occurred
- Was abandoned from mother at 12 years old
- Very disturbed young man, very difficult to care for
- Didn't settle in any one place
- Involved in the Juvenile Justice system
- Department did not have a strong level of engagement with him, they argue this was not through lack of trying
- When baby was born, father was living with the mother of the child and her family. This was not endorsed by the Department but was reality of the situation
- Through this, the department came into contact with the mother
- When Department were aware he was living with mother and her family, they were in contact with him
- He was a child in care but he had chosen himself to live with the mother of the child
- Department were assessing a placement option for him (general foster care, relative foster care, supervision order) at the time of the incident.
- Before the birth of the child, father was attending a men's group to deal with his violent behaviour.

Management of Father

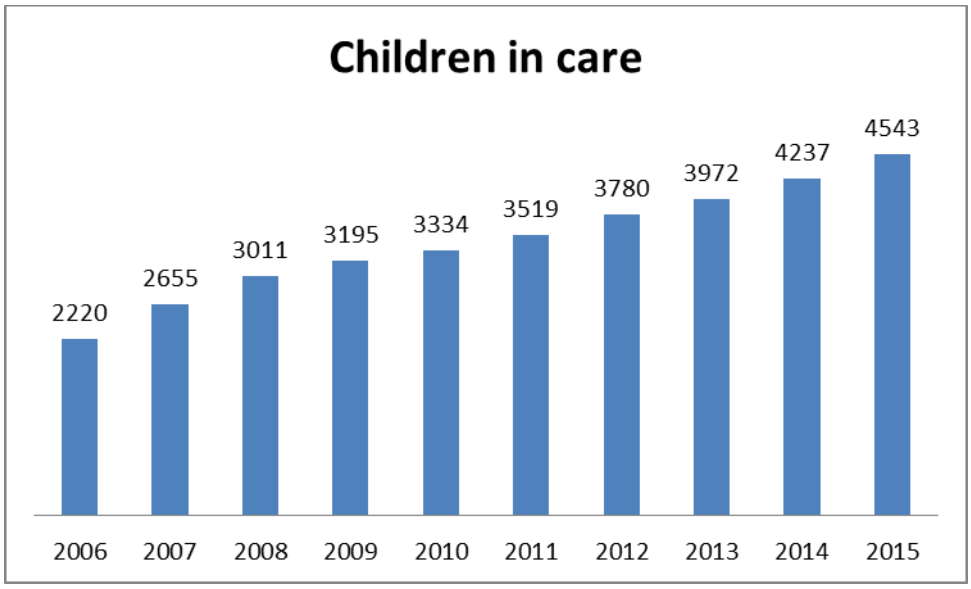
- He was taken into care approximately two years prior to the incident.
- Had a caseworker from two years up to incident, same case worker.
- Department claim that caseworker **had approximately 11 cases (raises issue of workload, inaccurate numbers and not measuring complexity of cases).**

2. CONCERNS DIRECTLY RELATED TO BOY'S SITUATION

A) Increase of the amount of children in care

Children in Care numbers 2006-2015

- The number of children in care has more than doubled since 2006.
- From 2006, 2323 more children have been placed in care.



Figures from CPFS annual reports

- As the number of children entering care continues to grow, so do the demands on workers in Child Protection and Family Support.
- When the effects of the Workforce renewal policy, targeted voluntary separations and efficiency dividends are factored in it is not surprising that the system struggles to cope with any increase in demand.
- On average the number of children in care increases by **6% per year**.
- In 2014-15 there were **18602 notifications** and **14130 safety and wellbeing assessments** completed.

3. CONCERNS DIRECTLY RELATED TO BOY'S SITUATION

B) Workload Management and Measurement

i) Workload Management Tool Background

- The Department and the Union jointly developed a Workload Management Tool around 10 years ago
- The aim of the tool was to look at each body of work (or collection of assigned tasks) and measure how difficult, complex, intensive and time consuming they would be so as to ensure that there was some level of measurement of work exceptions.
- There was an understanding that staff shouldn't be allocated more work than they could reasonably be expected to complete in their working week.
- The WLM tool was a points based system that assigned a score for each aspect of tasks. These were required to add up to a maximum of 150 points.
- Underpinning this, there was a case number which was set at a maximum of 15. The discussion around this was to ensure that staff weren't overwhelmed by being expected to have intimate knowledge of a large number of cases which had low workload.
- The original WLM tool counted family groups or children in placements as one 'body of work' but also included community work or projects as workload to be counted.

3. CONCERNS DIRECTLY RELATED TO BOY'S SITUATION

B) Workload Management and Measurement

ii) Average Case Numbers are an Inaccurate Reflection of Caseload (Complexity)

Year	2008 Nov	2009 Nov	2009 Nov	2011 Nov	2012 Nov	2013 Nov	2014 Nov	2015 Nov
Caseload	12.6	12.2	12.4	12.6	12.27	12.24	12.71	12.73

Information provided by DCPFS at WAIRC Feb 2015

"The staff-to-client ratio is also the lowest it's ever been so this is not adding to the problem or concerns of staff in terms of their workload,**" Ms Morton said.**

The department continues to use average case numbers as the primary indicator of a manageable workload.

The caseworker involved in the Bunbury case had an allocation of 11 cases a number which according to the Department and Minister is an indication of a manageable workload.

This overly simplistic measure fails to account for the complexity and intensity or the capacity of the case worker.

In the Bunbury case the caseworker's caseload should have been reduced to account for the complexity of the case.

3. CONCERNS DIRECTLY RELATED TO BOY'S SITUATION

B) Workload Management and Measurement

iii) Measuring Intensity and Complexity

The current system does not count complexity or the intensity requirements of work as the Department employs a case counting system.

An expectation has developed that the case load for a worker will be 15. What constitutes a case is counted differently depending on the Department's intervention.

At the initial contact and through the investigation or if family support is being provided, a family group is classed as 1 case.

The Department measures its own work in different KPIs. When initial contact is made to the Department, an interaction is recorded on the system.

This is counted by the Department as 1 interaction regardless of the number of children involved.

The next stage could be intake to an initial inquiry. At this point, the Department measures this by the number of children and the number of concerns. e.g. 5 children in a family with concerns about physical abuse and neglect would be measured as 10 initial inquiries.

If the matter progresses to a Safety and Wellbeing assessment, then each child is counted as 1 SWA regardless of the number of concerns- so in the above example, this would be 5 SWAs. Regardless, for the worker, this would be allocated as only 1 case.

The system in current use counts a case only when an allocated to a worker classified as being able to hold casework. If a case is allocated to someone else then it is not counted in the current case counting system and appears on the exception list.

The current system also only counts a case for the purpose of workload management when the database has an open activity.

If the worker fails to complete an entry to progress to an activity (e.g. completes and investigation but doesn't then complete the screen to progress to family support) then despite the case being allocated to them and then having responsibility for the work, this no longer appears in the current case count.

This family group might consist of parents and a number of children but can also include extended family. If the Department brings children into care, then it changes to reflect 1 child in care equaling 1 case.

The current system doesn't allow for counting of any project or work not related to these 2 categories.

Additionally if the Department has 1 child in care in a family group but is still investigating other children in the family group, then the automatic system only recognises the Child in care and doesn't add any credit for the additional tasks/work involved.

As such a worker on a child in care team could have responsibly for 15 children in care and perhaps be working with a number of other children in a family or working with a parent regarding a pregnancy.

A worker on the investigation or child centred family support teams might be allocated up to 15 family groups which involves 15, 30, 45 or more children.

A staff member with 8 cases of high complexity could be overloaded without the Assist case counting system picking it up.

Feedback from Departmental Staff Member has been at department for 19 years.

Complex cases of children that are runaways or exhibiting antisocial behaviour or predatory behaviour can consume a lot of a case workers time.

In these instances, other cases are ignored as the case worker has to deal with the consequences of the child's behaviour.

Liaising with police, hospitals, carers and children to deal with behaviours such as under age sexual activity, homelessness, prostitution, drug dealing, fire lighting and car theft means that there is less time to manage other cases whose situation may currently be as acute.

Workers that are over allocation (or have cases that are complex and beyond their capacity to respond) are often behind in their recording and administrative tasks and will often not complete work in legislated time frames or be meeting best practice guidelines for investigations, initial inquiries, SWA and care planning.

3. CONCERNS DIRECTLY RELATED TO BOY'S SITUATION

B) Workload Management and Measurement

iv) Figures that Department provides regarding casework/workload are not accurate

Caseworkers with more than 15 cases 2015

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
139	135	132	114	128	115	111	114	117	117

Workload management data provided monthly by DCPFS

Even if the figures the Department provided were accurate, on average in 2015:

122.2 caseworkers per month have over 15 cases.

Members frequently tell us that the Department "cleanses" the figures before they report to the CPSUCSA to give the impression that workloads are manageable.

Quote from a Senior Child Protection Worker

"Team leaders are requested to check that allocations are correct. The Team leader reallocates the cases from the case worker to the Monitored List (so case work does not go over 15). Then once the data collection is completed, the case is reallocated back to the staff member."

Other issues with workload data

1. The amount of data stored in ASSIST is massive and there are insufficient resources to manage data integrity. Members have told us that because of this, **cases go missing.**

2. Reports that are supposed to run to ensure the figures are accurate often fail to run, so data Quality Assurance is not possible at times.

These issues with the integrity of data and reporting anomalies increase risk factors for vulnerable children as cases can become lost in the system, priority cases can be wrongly allocated to the monitored list or to caseworkers who no longer work in the district.

3. CONCERNS DIRECTLY RELATED TO BOY'S SITUATION

B) Workload Management and Measurement

v) 15 Case Limit is not appropriate for Some Staff Due to the Type of Work They do.

- Child Centred Family support as a work activity is very intense as it involves trying to prevent a child from coming into care.
- There is a conceptual limit of 8 cases for these workers.
- Senior staff are not given the time to supervise and support other staff, meaning that some junior staff dealing with 15 cases or above are not given adequate support to manage their workload.
- Time that used to be allowed for senior staff to supervise and develop other staff, as well as project work and other activities to help junior staff manage their workload have been ignored over time due to a lack of time/resources.
- This means senior staff while taking on the more complex cases, are not given the time to support junior members manage their own case load.

3. CONCERNS DIRECTLY RELATED TO BOY'S SITUATION

B) Workload Management and Measurement

vi) Lack of FTE Staff Dealing with Casework

Caseworker FTE 2009-2015

Year	2009	2010	2011	2012	2013	2014	2015
FTE	659.40	660.35	683.75	706.70	706.70	777	774.34

Figures from Hansard

The current Liberal Government publically boasts about its record in funding caseworker FTE.

The increase in 2014 was welcomed; however members indicated that the lack of funding in the years 2009-2013 meant that the additional resource was simply compensation for the inadequate resourcing of the previous years.

- Between 2009 and 2013 FTE was only increased by 47.3FTE, less than 10 per year
- Over this period there was an increase of almost 800 children brought into care

FTE numbers tabled in Hansard in June 2015 indicate that there is 774.34 caseworker FTE within the Department.

This figure is misleading as not all of the funded FTE has a role with direct casework responsibilities.

DCPFS figures show that in June 2015 there was **517.06 FTE** available for direct casework.

		Jan 15	**Feb 15**	**Mar 15**	**Apr 15**	**May 15**	**Jun 15**	**Jul 15**
FTE available for case work	Metro	290.44	300	308.64	303.21	304.96	302.10	303.60
	Country	193.77	194.34	212.19	214.34	214.49	218.14	213.46
	Total	**484.21**	**494.34**	**520.83**	**517.55**	**519.45**	**520.24**	**517.06**

Figures from Executive Directors report July 2015

This lack of FTE for direct casework has huge ramifications for the workloads of DCPFS workers and for vulnerable children in Western Australia.

Members tell us that they are forced to do more with less and that they are directed to leave children at risk as they do not have the resources to dedicate to case management or to find placements for them.

Case Study-Example Shared with us from a Child Protection Worker at a Regional Office

In the last 6 months, a Child Protection Worker was at a home visit.

The Child Protection Worker witnessed a parent throwing a baby against a couch.

The Parent was exhibiting erratic behaviour.

When the Child Protection Worker discussed what they saw to senior staff, senior staff indicated that the issue was not deemed serious enough to warrant any further action, as the department had tried to contact the family, even though they were not successful.

A number of staff requested that the baby be taken into care. This request was denied as extremely high caseloads in the office meant that this was not a priority case.

Staff feel so overwhelmed that situations that would otherwise warrant further investigation cannot be followed through as the volume of work is so high.

Staff are constantly having to deal with crisis and make decisions about where they can dedicate their time and resources. Normally in situations where harm against a child is witnessed a visit would have occurred within a week of the incident. This did not occur.

Targeted Voluntary Separation scheme

To make things worse for DCPFS workers 12 positions with casework responsibilities across the state were abolished in 2014 as part of the TVSS.

These positions included Team Leaders and caseworkers.

Vacancies

There are currently 30 caseworker vacancies across the state with 22.10 of these in regional areas. (Questions on Notice, 16/6/15).

3. CONCERNS DIRECTLY RELATED TO BOY'S SITUATION

C) Quarterly Assessments not Being Monitored for Compliance

- **Department claim that boy had regular quarterly and annual reviews.**
- Children in care require Quarterly and Annual Care Reviews with the Department
- Members have told us that Executive does not review the compliance of the Quarterly Care Review in executive reporting.
- This lack of attention at executive level means failure of compliance in Quarterly Reviews.
- This is a legislated responsibility which the Department lets slip.

Quote from a Member working at the Department

"The Quarterly Reports for some children are only occurring yearly."

3. CONCERNS DIRECTLY RELATED TO BOY'S SITUATION

D) Co-Working

- **Boy was being co-worked between Cannington and Bunbury)**
- Feedback from Members tells us that the family group structure in Assist makes it complicated to split case management and often one districts priorities are different to another, so there is tension between the provision of services and the 2nd district's priorities.
- The extra work that is required when a case is being co-worked is not adequately recognised through Assist.
- The case counting rules in Assist mean each office gets a half point.

3. CONCERNS DIRECTLY RELATED TO BOY'S SITUATION

E) Placements

i) People Wanting to be Carers are Waiting up to 6 Weeks for their Interest to be Responded to

In regard to the Bunbury case, former DG Terry Murphy said at the Public Hearing held by this Committee last year:

"For some of them, it is quite hard to find an immediate placement, if we have to remove them in crisis, but that does not affect our decision to remove children".

- The Department is crying out for Foster Carers, however, due to inadequate resourcing, we have been informed by members that some people who have expressed interest in fostering to the department have had to wait 6 weeks for any follow up.

- This lack of application to recruiting has meant that there are limited numbers of placement options available for Children in Care

- The lack of placements can result in children not being brought into care and being left in high risk situations.

3. CONCERNS DIRECTLY RELATED TO BOY'S SITUATION

E) Placements

ii) Lack of Carer Support

Due to a lack of resourcing, when a carer does take a child on board, they are not always given the support and assistance needed to keep the child, especially if the child is on the Monitored List.

A lot of children who are taken into care have difficult behaviours to manage, without sufficient resources and support, the small pool of carers available dwindles, as people stop providing a refuge for vulnerable children.

On the other hand the lack of stable placements can result in children suffering prolonged emotional trauma from the uncertainty that comes from being moved from placement to placement

Feedback from Senior Child Protection Worker

"Last year, two children, both aged under 3, were taken into care in.

In a nine month period, either one or both of the children have been placed in 18 placements, including at times with staff.

The siblings are no longer in care together."

3. CONCERNS DIRECTLY RELATED TO BOY'S SITUATION

E) Placements

iii) Children's Feedback on 'Viewpoint' Not Being Followed Up

- Children in care of the department as a part of the Annual Review fill out a 'Viewpoint Survey' online. Members have told us there is a significant amount of children who do not answer the question:

"Do you feel safe in your placement?"

- There is no formal reporting or follow up for children who do not answer this question. We have been informed by members that the amount of children who do not answer this question is statistically significant. The boy would have been requested to fill in a Viewpoint Survey.

4. OTHER CONCERNS RAISED BY MEMBERS DUE TO A LACK OF RESOURCES, WHICH IS HINDERING THE MANAGEMENT OF CHILDREN AT RISK

A) Caused by Workload Management and Measurement

i) Excessive Workload Leading to Delays in Safety and Wellbeing Assessments

- Members have informed us that there are many instances where the write up of a SWA has not been completed in a timely manner due to the competing demands on a case workers time.

- Some SWA's have been open for over a year due to the complex nature of the case work and the workers inability to get to resolution of the assessment and recording due the children exhibiting risky behaviours (e.g. under age sexual activity, homelessness, prostitution, drug dealing, fire lighting, car theft).

- Inadequate recording means that other people in the Department e.g. Crisis Care or another office are not aware of any risk or case management problems if SWA's are not completed in a timely manner.

- WA time lines for completion are determined on risk with the departmental standard for completion being 30 days; it's common for 70% to be overdue.

- DCPFS Annual report 2014-15 states that **only 45% of Safety and Wellbeing assessments were completed within 30 days.**

4. OTHER CONCERNS RAISED BY MEMBERS DUE TO A LACK OF RESOURCES, WHICH IS HINDERING THE MANAGEMENT OF CHILDREN AT RISK

A) Caused by Workload Management and Measurement

ii) The Monitored List

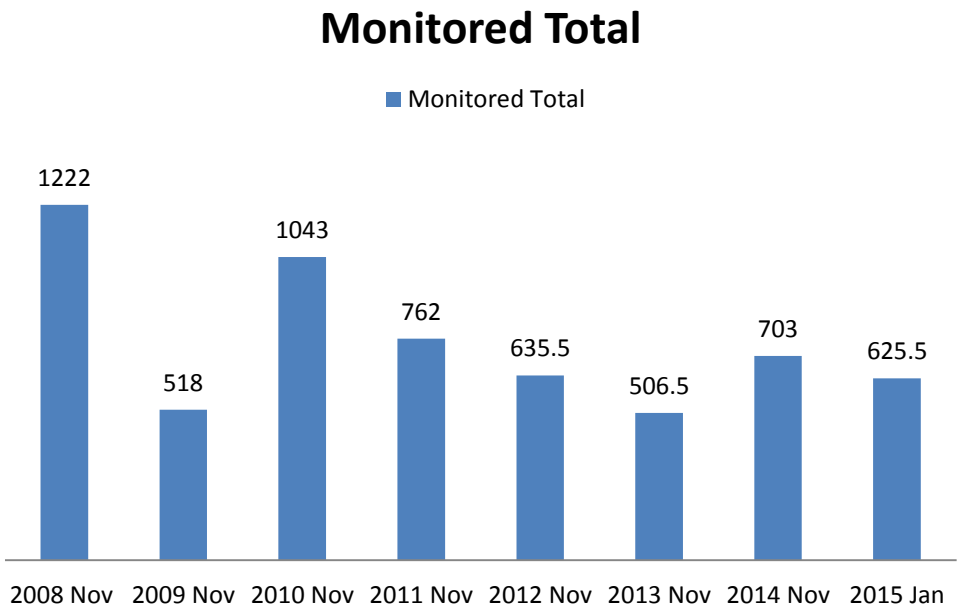


Table from document provided by the Department to the WAIRC, Feb 2015

The Department consistently argues that cases on the Monitored List are stable cases requiring minimal intervention however feedback from members disputes this.

Members have provided evidence that cases on the list do not have to be stable to be monitored.

Quote from a Team Leader

"When a child is on the Monitored List, it is likely that because there is no active involvement over a period of time that their cases get worse over time. It's a cycle.

These children have no regular contact, even though in report after report it finds that kids want more contact with staff when in care.

One Team Leader in the past 12 months had over 57 cases on the Monitored List."

In the latest Annual Report pg. 35:

*"The Advocate promotes participation by young people in care using an online self-interviewing program called Viewpoint…**Many young people indicated that they would like more contact with their Department case managers".***

Caseworkers are regularly instructed to allocate cases to the monitored list as they do not have the resources to effectively case manage.

This puts an immense strain on the caseworker who is instructed to make decisions which go against their own professional judgement and that are not in the best interests of the child.

4. OTHER CONCERNS RAISED BY MEMBERS DUE TO A LACK OF RESOURCES, WHICH IS HINDERING THE MANAGEMENT OF CHILDREN AT RISK

A) Caused by Workload Management and Measurement

iii) The Exception List

Further to the hundreds of unallocated cases on the monitored list there is another list known as the exceptions list, another example of unallocated or wrongly allocated cases.

As of July 2015 there were 121 cases on this list.

The ***Exception report*** is a report that finds cases that have not be picked up in the correct allocation of cases with workers in their respective teams

If this is added to the monitored total we are looking at over 700 cases that are not actively managed.

Quote from a Team Leader

"The list is there to try and capture all those cases that are not on the WLM counting system but 'should' be – like Family Support cases that are open to non – case workers staff such as YFSW or CP cases that are co-worked with services such as Best Beginnings and Parent Support. We call them the hidden cases as they are not reported on."

Exception Report							
	03-Jan-15	#######	#######	04-Apr-15	02-May-15	########	04-Jul-15
Responsible Parenting Service	Data unavailable	25	24	44	24	30	29
Case Support		14	22	23	11	16	15
Child Protection Worker		33	16	28	43	23	21
Child Protection Worker (CiC Team)		54	0	0	31	37	1
Team Leader		8	4	3	8	5.5	29.5
Other		8	7	8	15	16	25.5
Total	**0**	**142**	**73**	**106**	**132**	**127.5**	**121.0**

4. OTHER CONCERNS RAISED BY MEMBERS DUE TO A LACK OF RESOURCES, WHICH IS HINDERING THE MANAGEMENT OF CHILDREN AT RISK

A) Caused by Workload Management and Measurement

iv) Contact Between Parents and Children when a Child is First taken into Care

Contact opportunities for parents and children taken into care are significantly hampered by lack of resources.

Staff have raised time and time again that if there were more resources to manage contact and if there were more possibilities for contact, more kids would be unified with their families.

Contact is determined by the Caseworker based on age of the child, history, etc.

If it is a young baby then there is a need for more contact-the problem is that contact decisions are influenced by resources.

Member have told us that Limited resources equates to limited contact and that there is also a 'black hole' of minimal contact for up to the first six weeks that a child is taken into care.

Feedback from Senior Child Protection Worker

"*It can take up to 6 weeks for the 'Court Proposal' to be completed. This sets up the conditions parents must meet if they want to be re-unified with their child. During this time, the FRW does not have the case. It is the Child Protection Worker. Given the workload issues that case workers experience, in many instances, there will be no contact between the parent's and child. This means extended periods of time that parents and children are not together after the initial decision has been made to take the child away."*

Members have informed us that DCPFS workers in their exit interviews have cited the lack of resources to facilitate more contact between parents and children once the child has been taken into care as one of the reasons why they have left.

Member's feedback is that In some of these situations the Department has directly contributed to the breakdown of a family unit and the emotional turmoil of children.

Feedback from Senior Child Protection Worker

Because contact is not being facilitated as often as it should be, parents get frustrated and at times aggressive. This at times can lead to a 'self-fulfilling prophecy', where the parent's aggression is used as a reason not to unify the family.

The 'Court Proposal' is the agreement sanctioned by the court that stipulates the amount of contact that must occur between the parents and child if re-unification is to occur.

Members tell us that the amount of contact specified is influenced significantly by the amount of resources available to the office to facilitate the contact, not necessarily what is in the best interests of the child and the family.

How does this impact the management of children at risk?

Contact between parents and children are a window for the department to view the relationship between them.

It displays if the parents are exhibiting behaviour that either warrants the child being taken away longer or there is the potential of re-unification with support and assistance.

Children who are taken away from their parents are at risk of significant emotional damage; this is only exacerbated when for up to six weeks they do not see them, particularly when they are initially removed from their parents.

This also impacts on the emotional bonding of children with their parents and the ability of parents to develop their skills as care givers.

There are risks associated with sending children into care. If this can be averted by facilitating meaningful contact, then this not only a better outcome for the child and family but also for the Department's bottom line.

When a child is in care, a "Parenting Capacity Assessment" needs to be completed for reunification to occur. If sufficient contact does not occur, then it is very difficult to make this assessment.

This is another example of how under resourcing contributes to the ongoing separation of families.

Quote from WA Council of Social Service CEO Irina Cattalini

"The government had failed to respond to calls to invest in the Family Support Network programs that were reducing the rates of children going into care."

4. OTHER CONCERNS RAISED BY MEMBERS DUE TO A LACK OF RESOURCES, WHICH IS HINDERING THE MANAGEMENT OF CHILDREN AT RISK

B) Working With Children Checks

i) Increased demand placed on WWCC but no increase in resources particularly in the compliance section.

- In the Department's response to the Auditor General's Report into WWCC, it stated that it was increasing the capacity of its compliance function and would seek further resources.
- It was stated in the latest Annual Report that the high volume of work had increased the compliance areas activity.
- The AG report said that the Department would seek further resources for the whole WWCC area.

From a staff member who is familiar with the WWCC Unit

"In the compliance area, there has been no increase since the AG Report in 2014. As there have been no increases to the resources of the compliance area including no increase to FTE positions, there still has been no proactive audits to reach out to organisations to ensure that they are only employing people dealing with children who have a WWCC."

4. OTHER CONCERNS RAISED BY MEMBERS DUE TO A LACK OF RESOURCES, WHICH IS HINDERING THE MANAGEMENT OF CHILDREN AT RISK

B) Working With Children Checks

ii) Proactive Audits

The Audit General report specifically recommended that proactive audits occur to ensure that children were not placed at risk.

Not only are Proactive Audits not occurring, audits/investigations on individuals that have been brought to the unit's attention due to alleged non-compliance of the Act that need to be investigated but are not deemed to be the highest level of risk (second level of audit), have not occurred since January this year.

There are approximately 25 cases sitting at this level. This hinders the ability to identify risk early as the second level of audits need to be carried out, as a risk has been identified, however, there are no resources to do this. Meanwhile these organisations and people still have access to children.

4. OTHER CONCERNS RAISED BY MEMBERS DUE TO A LACK OF RESOURCES, WHICH IS HINDERING THE MANAGEMENT OF CHILDREN AT RISK

B) Working With Children Checks

iii) WWCC Unit not being notified of WWCC Holders who are charged with a child related offence

Members have informed us that when people with a WWCC are charged with an offence, the WWCC Unit is not necessarily notified.

This is because there is no protocol or automatic process for pertinent information to be shared between the Department and Police.

The AG report cites a case where this occurred and the Department responded by saying that there was a low chance it would happen again.

Since the AG report in June 2014 similar situations have occurred and will continue to happen until resources are committed to ensure that:

- Information within CPFS can be shared to/and from WWCC to the broader organisation (currently WWCC Compliance do not have access to the CPFS ASSIST information).
- Information sharing between the WWCC Unit and Police is formalised, and other processes including the monitoring of Daily Court lists is enabled.

Some Police staff assume that if they have dealt with one area of CPFS, that pertinent information will be passed onto the WWCC Unit.

From staff member who has been with the Department of 9 years

"As the WWCC Unit does not have access to ASSIST, and CPFS child protection workers may not consider the matter of interest to the WWCSU (as they cannot see if a person or family they are dealing with has any WWCSU contact).

This hinders the ability of the department to identify children at risk early, as not knowing if a WWCC holder has been charged with or suspected of an offence that may be considered a risk to children means that the WWCC will not be reassessed, meaning that they are not prohibited from working with children."

4. OTHER CONCERNS RAISED BY MEMBERS DUE TO A LACK OF RESOURCES, WHICH IS HINDERING THE MANAGEMENT OF CHILDREN AT RISK

B) Working With Children Checks

iv) Enforcement of Negative Notices

At the last Annual Report, the Department stated

"588 people have been prohibited from undertaking child-related work; 577 people with negative notices and another 10 people with current interim negative notices."

- The negative notices date back to 2006.
- Members have told us there is no ongoing compliance undertaken by the Department to ensure that people with negative notices are not working with children particularly those issued years ago and that the negative notices are just a piece of paper.
- There is no ongoing monitoring or enforcement of the prohibition by CPFS or WA Police.
- This hinders the department's ability to identify risk early as a person with a negative notice may be working with children but the Department does not do any ongoing monitoring or investigating to find that out.
- As there are no proactive audits of organisations, and currently no level two audits occurring since January this year, the likelihood of this occurring is heightened.
- With only 4 FTE positions and 2 fixed term contracts to oversee compliance of WCCC across the state, there is no capacity for this activity to occur to any degree that would reduce the risk to children.
- Police do not as a matter of course have access to the list of people issued with negative notices as the two departments do not have a formalised, automatic process to share that specific information.

4. OTHER CONCERNS RAISED BY MEMBERS DUE TO A LACK OF RESOURCES, WHICH IS HINDERING THE MANAGEMENT OF CHILDREN AT RISK

B) Working With Children Checks

v) Departmental Foster Carers not having a WWCC

- This information may be on the Assist system but due to WWCC Unit not having unimpeded access to Assist, this may not be known.

- The AG Report specifically raised the issue of 115 departmental foster carers not having a valid card.

- Providing the resources to have ASSIST available unimpeded to Compliance within the WWCC Unit would help to prevent a child in care being cared for by people without a valid card. Although improved, cases of Foster Carers not having a valid WWCC continue.

4. OTHER CONCERNS RAISED BY MEMBERS DUE TO A LACK OF RESOURCES, WHICH IS HINDERING THE MANAGEMENT OF CHILDREN AT RISK

C) Culture Within the Department Concerning Placements and taking a child into Care

- Numerous case studies refer to situations where children were not placed in care or there was a delay in putting children into care, due to Senior Staff not taking the advice of staff on the ground, dealing with the situation.

- Members have told us that is can be at least partly attributed to a culture within the department that is under-resourced and a workforce that is overwhelmed by the volume of work it has to deal with.

- With the increase of the amount of children in contact with the Department there is pressure placed on some Senior Staff not to place children in care, even when staff on the ground are recommending this be done.

Quote from a Child Protection Worker

"I can't help but think that some Senior Staff think…if I put another one on my list [another child into care], that another one against me…there is a push not to put children into care."

According to the Children and Community Services Act 2004, one of the reasons a child is in need of protection is if:

(c) the child has suffered, or is likely to suffer, harm as a result of any one or more of the following —
(i) physical abuse;
(ii) sexual abuse;
(iii) emotional abuse;
(v) neglect,

- Child Protection Workers (CPWs) are supposed to consider the likelihood of abuse or neglect occurring, not just to act when evidence has been provided. Also in the Children and Community Services Act 2004 it states that "the standard of proof in protection proceedings is proof on the balance of probabilities"

- Members tell us that the culture within the Department now pushes some staff to provide forensic evidence before children are taken into care.

- This means that CPW are not able to exercise judgement on the likelihood of abuse occurring.

- CPW staff have told us that they cannot take a child into care until the District Director has approved it.

- Members have told us that some Senior Staff will not take a child into care unless forensic evidence is provided. This has serious implications for the management of children at risk.

- Members also tell us as the numbers of children coming into care increase, the threshold for bringing a child into care has also increased and the Department have become reluctant to bring children into care because of a lack of placements. We have been told that every child that enters care has a negative impact on their numbers and KPI's.