



**Planning for children in care: An Ombudsman's own motion
investigation into the administration of the care planning provisions of
the *Children and Community Services Act 2004***

Ombudsman Western Australia
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Ombudsman's Foreword

As Western Australian Ombudsman, I review certain child deaths, identify patterns and trends arising from these reviews and make recommendations designed to prevent or reduce further child deaths.

In undertaking my child death review function I identified a need to undertake an investigation of planning for children in the care of the Chief Executive Officer of the Department for Child Protection – a particularly vulnerable group of children in our community.

This investigation has involved the Department for Child Protection, the Department of Health and the Department of Education and has considered, among other things, the relevant provisions of the *Children and Community Services Act 2004*, the internal policies of each of these departments along with the recommendations arising from the Review of the Department for Community Development undertaken by Ms Prudence Ford.

In the five years since the introduction of the *Children and Community Services Act 2004*, these three agencies have worked cooperatively to operationalise the requirements of the Act. In short, significant and pleasing progress on improved planning for children in care has been achieved, however, there is still work to be done, particularly in relation to the timeliness of preparing care plans and ensuring that care plans fully incorporate health and education needs, other wellbeing issues, the wishes and views of children in care and are regularly reviewed.

My report makes 23 recommendations that are designed to assist with this work to be done. I am very pleased that each agency has agreed to these recommendations and has, more generally, been very co-operative and positively engaged with our investigation.

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1 Executive summary

1.1 Children in care and their care planning

For the majority of Western Australian children, their parents and family network provide for their protection and care. However, at the commencement of this investigation there were 3356 children in the care of the Chief Executive Officer (**CEO**) of the Department for Child Protection (**DCP**).¹ For these children (referred to as 'children in care'), the State provides protection and care. The way in which the State is to perform this role is set out in the *Children and Community Services Act 2004 (CCS Act)*, the objects of which include 'to provide for the protection and care of children in circumstances where their parents have not given, or are unlikely to give that protection and care...' (s.6(d)).

As part of providing for the protection and care of children in care, the CCS Act contains a number of provisions requiring care planning for children in care. These include requirements for the preparation, timing, content and review of care plans, as well as provisions specific to participation by the child, their family and carers in care planning, and to Aboriginal and Torres Strait Islander children in care.

There are also further instruments that have the effect of regulating the administration of care planning responsibilities in Western Australia, in particular the policies and procedures established by DCP.

Cooperation between DCP, the Department of Health and the Department of Education is a critical aspect of the care planning system and is promoted by the CCS Act. This cooperation is consistent with the recommendations of the Review of the Department for Community Development (undertaken by Ms Prudence Ford, and subsequently known as the **Ford Review**), which were endorsed by the (then) Western Australian Government in 2007. Recommendation 63, in particular, recommended that 'the Departments of Health and Education and Training (now the Department of Education and the Department of Training and Workforce Development) respectively be required to develop a Health Plan (covering physical, mental and dental health) and an Educational Plan respectively for each child or young person in care.'

¹ Section 30 of the *Children and Community Services Act 2004* identifies that a child is in the CEO's care if the child is in one of the following five circumstances: the child is in provisional protection and care (s.29); the child is the subject of a protection order (time-limited) (s.54); the child is the subject of a protection order (until 18) (s.57); the child is the subject of a negotiated placement agreement (s.75(1)); or the child is provided with placement services under section 32(1)(a).

1.2 About the investigation

1.2.1 Rationale

The Western Australian Ombudsman has four core functions:

- To investigate and resolve complaints about public administration;
- To improve the standard of public administration over time;
- To review certain child deaths; and
- To undertake certain inspectorate functions as specified in legislation, and other specialist investigations.

Through the undertaking of reviews of child deaths, the Ombudsman identified a need to undertake further investigation of care planning for children in care.

1.2.2 Objective

The objective of the investigation was to examine how State Government agencies have administered the requirements of the CCS Act regarding care planning for children in care, in particular whether:

- DCP has established policies and procedures for care planning that are consistent with the requirements of the CCS Act;
- DCP is appropriately complying with the requirements for the preparation, timing and review of provisional care plans and care plans, set out in the CCS Act and its own policies and procedures;
- Care plans address the areas that the CCS Act and DCP's policies and procedures identify as necessary to ensure a child's wellbeing; and
- Health care planning and education planning are undertaken in accordance with the agreements that DCP has established with the Department of Health and the Department of Education, and in accordance with the related policies and procedures of the three agencies.

The investigation examined the administration of care planning for those children in care who were of primary school age at the commencement of the investigation, had been taken into care after 1 July 2008, and were still in care when the investigation commenced. This cohort numbered 443 children in total. This age of child and time period cohort was chosen because:

- Primary school aged children (those between six and 13 years of age) can be assumed to have certain core health and education needs enabling an examination of interagency cooperation;

- It was reasonable to consider agencies' performance against the requirements for care planning set out in the CCS Act, which was proclaimed in 2006, and the recommendations of the Ford Review, finalised in 2007, for children taken into care after 1 July 2008; and
- It yielded a cohort that was conducive to a cost effective investigation with a timely outcome.

1.3 Key messages

- In the five years since the proclamation of the CCS Act, the three State Government agencies that are primarily responsible for planning for children in care have cooperated to operationalise the requirements of the CCS Act. This work has resulted in the agencies redesigning the system for care planning, as follows:
 - DCP has developed a series of policies and procedures for care planning that are consistent with the CCS Act;
 - DCP and the Department of Health have agreed and developed a comprehensive strategy for health care planning that addresses the Ford Review recommendations regarding health care planning for children in care; and
 - DCP and the Department of Education have taken initial steps to address the Ford Review recommendations regarding education planning for children in care.
- DCP had prepared provisional care plans and/or care plans for nearly all children included in the investigation, as required by the CCS Act, however:
 - In most instances examined, DCP did not achieve the timeframes for care planning, as required by the CCS Act and its own policies and procedures, although timeliness varied widely across DCP districts; and
 - In many instances examined, DCP had not conducted reviews of care plans, as required by the CCS Act.
- Many of the children in care included in the investigation had not received appropriate health care and education planning. More particularly:
 - Although DCP and the Department of Health have commenced a comprehensive strategy for health care planning, only one third of children included in the investigation had received health assessments and/or medical examinations, as agreed in the strategy; and
 - Although DCP and the Department of Education have taken initial steps to establish a strategy for education planning, they have not yet implemented the education component of care planning and therefore few *Documented Education Plans* had been prepared for children included in the investigation.

- Many care plans did not record or otherwise demonstrate that the children in care included in the investigation were given the opportunity to express their wishes and views about their own care planning, as required by the CCS Act.
- Only half of the care plans we examined in detail covered all of the areas of child wellbeing identified in the CCS Act and DCP's policies and procedures.

1.4 Observations of the investigation

1.4.1 DCP, the Department of Health and the Department of Education have cooperated to redesign the care planning system for children in care

DCP has developed a series of care planning policies and procedures which operationalise all the requirements of the CCS Act

Since the proclamation of the CCS Act in 2006, DCP has developed and continued to refine a series of policies and procedures that describe how each of the requirements of the legislation should be implemented by its staff, as follows:

- The *Children and Young People in the CEO's Care Policy* came into effect in June 2007, to be superseded by DCP's *Care Planning Policy*, which came into effect in June 2009; and
- DCP's *Care Planning Policy* identifies that guidelines based on this policy are provided in DCP's *Casework Practice Manual (the Manual)*, which was also developed in 2009, and has been updated on an ongoing basis. For care planning, the Manual sets out the legislative authority, relevant standards, practice requirements and procedures for putting these into operation.

DCP has established a number of corporate governance arrangements for care planning. However, these have not included regular reporting to the agency's corporate executive on district performance in provisional care plan and care plan preparation and timeliness.

DCP and the Department of Health have agreed and developed a comprehensive strategy for the health component of care planning

In 2008, DCP and the Department of Health agreed a process for identifying the health needs of children in care and including them in care plans. This process was piloted during 2009, the pilot evaluated, and rollout of the process across Western Australia commenced in June 2010. DCP and the Department of Health have advised that the rollout was fully implemented on 16 May 2011. In July 2010, both agencies signed a Memorandum of Understanding (**Health MOU**) regarding the state-wide implementation of the agreed process. It included agreed monitoring and reporting processes. The mechanism at the operational level by which DCP and the Department of Health can identify and promptly follow up on health assessments that have not been undertaken was not yet operational in six of 17 districts at the beginning of the investigation, however during the investigation, DCP advised that all 17 districts now have this mechanism established.

To date, the Department of Health has not reported on health care planning for children in care in its annual report, as recommended by the Ford Review (recommendation 65). However, the Health MOU indicates that, in response to the Ford Review recommendation, the agencies have agreed that DCP will report on the progress of this strategy in its annual report, on behalf of both agencies.

DCP and the Department of Education have taken initial steps to establish the education component of care planning

At the commencement of the investigation, DCP and the Department of Education had taken initial steps to address the education component of care planning for children in care. On 13 July 2009, the Director General of the Department of Education and Training (now the Department of Education) and the Chief Executive Officer of DCP signed a *Memorandum of Understanding for Education Access and Support for Children in Care (Education MOU)*. A summary of the Education MOU was subsequently emailed by the Department of Education to all Directors of Schools, Principals, Deputy Principals and Student Services staff. These school responsibilities were reinforced in the Department of Education's *Guidelines for Implementing Documented Plans in Public Schools (the Guidelines)*.

At the commencement of this investigation, the Department of Education was not centrally monitoring the implementation by schools of the Education MOU or the Guidelines. To date, the Department of Education has not reported on children in care and their education planning in its annual report, as recommended by the Ford Review (recommendation 65).

Subsequent to this investigation commencing, the Department of Education has made plans to reiterate to schools the need to develop *Documented Education Plans* and provided information on how to do so. It also plans to monitor the preparation of *Documented Education Plans* across schools. This will provide the basis for reporting, including in its annual report, and follow up action if necessary.

1.4.2 Provisional care plans or care plans have been prepared for nearly all of the 443 children in care included in the investigation, however, other key components of the care planning system have not been fully implemented

DCP has prepared a provisional care plan and/or a care plan for nearly all children included in the investigation, as required by the CCS Act

The CCS Act requires the Chief Executive Officer of DCP to prepare provisional care plans and care plans for children in care. Provisional care plans and care plans are written plans that identify the needs of the child, outline steps and measures to address these needs and set out decisions about the care of the child. These requirements differ depending on the circumstances under which the child is taken into care.

- At the commencement of the investigation, 443 primary school aged children who were taken into care after 1 July 2008 were recorded by DCP as being children in the care of the Chief Executive Officer of DCP. The number of these children who required provisional care plans and care plans is summarised below.

Number of primary school aged children who were taken into care after 1 July 2008	Number of children in the cohort for whom a provisional care plan was required	Number of children in the cohort for whom a care plan was required
443	440 ²	282

We examined the implementation of the legislative requirements for the preparation of provisional care plans and care plans, as follows:

- We observed that a provisional care plan and/or a care plan had been prepared for 420 (95 per cent) of the 443 children in our cohort; and
- We observed that a provisional care plan had been prepared for 407 (93 per cent) of the 440 children in our cohort for whom a provisional care plan should have been prepared and that a care plan had been prepared for 222 (79 per cent) of the 282 children for whom a care plan should have been prepared.

DCP were notified during the investigation of the five per cent of children in care for whom a provisional care plan or care plan had not been prepared, and has advised that this has been rectified, where the child is still in care.

DCP and the Department of Health have commenced an agreed comprehensive strategy for health care planning and some progress has been made

We also examined the implementation of the Health MOU. As part of doing so, we examined the DCP files for the children in our cohort to identify whether there was evidence that the child had undergone either a health assessment by a community health nurse and/or a medical examination by a general practitioner. We examined this aspect of care planning for the 293 children in our cohort who had been taken into care through a protection order (time-limited), a protection order (until 18) or a negotiated placement agreement. For these children, the full care planning process, beyond the development of a provisional care plan, should have been evident.

We observed that, for 103 (35 per cent) of these 293 children, the DCP file recorded that they had undergone a health assessment and/or a medical examination. Districts included in the 2009 pilot study for health care planning achieved this outcome more often.

DCP and the Department of Education have taken initial steps to establish a strategy for education care planning, but have not yet implemented the education component of care planning

We also examined the implementation of the Education MOU. We examined the DCP files for the same 293 children discussed above to identify whether there was evidence that the school had prepared a *Documented Education Plan* and returned this to DCP to form the education dimension of the child's care plan. For 63 (22 per cent) of the 293 children, we observed a *Documented Education Plan* on the child's DCP file.

² Three of the 443 children in care were taken into care under a negotiated placement agreement and did not require a provisional care plan.

In many instances examined, DCP had not conducted reviews of care plans, as required by the CCS Act

The CCS Act provides that the 'CEO must carry out an investigation of the operation and effectiveness of every care plan at regular intervals not exceeding 12 months' (s.90(1)).

For 75 of the 293 primary school aged children in our cohort who were taken into care under a protection order or negotiated placement agreement, a care plan had been approved more than 12 months before the commencement of this investigation, and a review was therefore due. We observed that review of care plan documents had been completed for 28 of these 75 children (37 per cent). For a further 20 children (27 per cent), a new care plan had been prepared within the last 12 month period. For the remaining 27 children (36 per cent), we could not identify a review of care plan document or a new care plan that had been prepared within the last 12 months.

In most instances examined, DCP did not achieve the timeframes for care planning, as required by the CCS Act and identified in its own policies and procedures, although timeliness varied widely across DCP districts

The CCS Act requires that the Chief Executive Officer of DCP must prepare and implement a provisional care plan for a child taken into provisional protection and care within 7 working days after the child is taken into this type of care. Of our cohort of 443 children in care, a provisional care plan should have been prepared for 440 children. We observed that provisional care plans were completed within the 7 working day timeframe for 108 (25 per cent) of these 440 children.

The CCS Act requires that 'as soon as practicable after a child first comes into the CEO's care the CEO must prepare and implement a care plan for the child' (s.89(2)). DCP has determined that, as a matter of policy, care plans should be prepared and implemented within 20 working days of the child entering the care of the CEO (excluding children in provisional protection and care).

Of our cohort of 443 children in care, a care plan should have been prepared for 282 children. We observed that care plans were prepared within the 20 working day timeframe for 26 (9 per cent) of these 282 children.

Timeliness in the preparation of both provisional care plans and care plans varied markedly across DCP districts, with some districts achieving significantly higher levels of compliance with these timeframes than the average level of compliance for all districts. Districts that are successfully achieving the established timeframes offer potential models for other districts.

1.4.3 Many care plans did not record or otherwise demonstrate that children in care included in the investigation were given the opportunity to express their wishes and views about their own care planning, as required by the CCS Act

The CCS Act requires that children be given the opportunity to express their wishes and views freely, according to their abilities, to ensure that they are able to participate in decisions about their own care plan (s.10).

DCP has established policies and procedures which aim to ensure that children are given the opportunity to participate in the preparation of their own care plans. To assist Field Workers fulfil the requirements of the CCS Act and to assist them achieve the standard of practice established through policy, DCP has provided them with opportunities to attend internal and external training to increase their skills in working with children, and tools for Field Workers to use when assisting children of different ages and abilities to express their wishes and views.

However, there are gaps between DCP's policy and its practice regarding the participation of children in the preparation of their own care plans. We examined in detail the care planning documentation for 61 children from four DCP districts. Fifty of these children had care plans. Our examination of these 50 care plans found evidence that the child had participated in the care planning process in 20 (40 per cent) of these cases. DCP's own monitoring of care planning found that most children could not recall an opportunity to be involved in their care plan and that this was not always due to age or the developmental level of the child.

The CCS Act requires that parents and carers have opportunities and assistance to participate in decision-making processes that are likely to have a significant impact on the child's life (s.9(j)). DCP has also established policies and procedures which aim to ensure that parents and carers participate in care planning. For the 50 children whose care plans we examined in detail, 43 care plans (86 per cent) documented that at least one parent or step-parent was included in the care planning process, with carers being involved in 46 care plans (92 per cent).

1.4.4 Half of the care plans we examined in detail covered all the dimensions of child wellbeing identified in DCP's policies and procedures

The CCS Act provides that 'care plan means a written care plan that identifies the needs of the child; and outlines steps or measures to be taken in order to address those needs; and sets out decisions about the care of the child...' (s.89(1)). DCP has developed policies and procedures for the content of care plans, including a care plan template that contains eight dimensions of child wellbeing to be addressed in a care plan. These dimensions are safety; care arrangements; health; education; social and family relationships; recreation and leisure; emotional and behavioural development; and identity and culture.

Our examination of care planning documentation observed that, for the 50 children whose care plans we examined in detail:

- In 26 care plans (52 per cent) we reviewed, the needs of the child were identified in all eight dimensions of child wellbeing in the care plan template; and
- Analysing each of the eight dimensions individually, the needs of the child were identified between 96 per cent and 74 per cent of the time. The dimensions of health, education, emotional and behavioural development, and identity and culture were addressed the least number of times.

DCP's *Care Planning Policy* states that 'In addition to the legislative requirements, the care plan should also include ... a proposal to meet identity and cultural requirements.' We observed that 34 (68 per cent) of the 50 care plans we examined in detail identified needs

and included decisions and steps to address these needs for the identity and culture dimension. This rate was slightly higher, at 75 per cent, for Aboriginal and Torres Strait Islander children and children from culturally and linguistically diverse backgrounds.

DCP's *Care Planning Policy* also states that Aboriginal and Torres Strait Islander children and children from culturally and linguistically diverse backgrounds 'need to have well researched cultural plans as part of their care plans.'³ Our observations were consistent with DCP's own review of cultural plans, which in general found there to be inconsistent practice in developing cultural plans.

1.5 Recommendations and monitoring

1.5.1 Recommendations

The care planning system for children in care

Recommendation 1: Given the observations of the investigation, and particularly the observed instances of non-compliance with legislative requirements, DCP review, develop and implement improvements to its corporate governance mechanisms for care planning, including planned reporting within and external to DCP.

Recommendation 2: DCP and the Department of Health ensure that they proceed with their agreement to report on the progress of their strategy for health care planning for children in care through DCP's annual report, as set out in the Health MOU agreed by both agencies.

Recommendation 3: DCP and the Department of Health collaborate in performance monitoring and evaluation of health care planning for children in care so as to monitor the gap between the health status of children in care and those not in care.

Recommendation 4: The Department of Education ensure that it proceeds with the commitments made during the investigation to reiterate to schools the need to develop *Documented Education Plans*, to monitor the preparation of these plans across schools as part of the education component of the care planning system, and to report on children in care and their education planning in a way that is consistent with the Ford Review recommendations.

Implementing the key care planning components

Recommendation 5: DCP ensure that provisional care plans and care plans are prepared for all children in care, as required by the CCS Act.

³ Department for Child Protection, *Care Planning Policy*.

<<http://www.dcp.wa.gov.au/Resources/Documents/Policies%20and%20Frameworks/Care%20Planning%20Policy%202009.pdf>>. Accessed 25 May 2011

Recommendation 6: DCP and the Department of Health collaborate to ensure that the agreed processes set out in the Health MOU are implemented by the agency nominated as responsible in the Health MOU, so that every child in care ultimately:

- Receives a medical examination and health assessment, as set out in the Health MOU, within the agreed timeframes; and
- Is enrolled in the School Dental Service.

Recommendation 7: DCP ensure that a *Strengths and Difficulties Questionnaire*, focussing on mental health, is completed and analysed for every child in care (four years or older), as set out in the Health MOU and their own policies and procedures.

Recommendation 8: DCP and the Department of Health collaborate to ensure that referrals for health checks are followed up to ensure that they are fulfilled. Specifically:

- DCP revise their procedures for identifying when children in care have not received health checks for their physical and dental health to ensure that the child is referred for these checks, the results are returned to DCP and are incorporated into the child's care plan; and
- The Department of Health monitor the progress of referrals to ensure they are acted upon and the results returned to DCP.

Recommendation 9: DCP and the Department of Education ensure that *Documented Education Plans* are prepared by schools and are returned to DCP to form part of the child's care planning.

Recommendation 10: DCP ensure that reviews of every care plan are carried out at regular intervals not exceeding 12 months, as required by the CCS Act.

Timeliness of care planning

Recommendation 11: DCP ensure that provisional care plans are prepared within the 7 day timeframe required by the CCS Act.

Recommendation 12: DCP reconsider its approach to provisional care plan preparation, including its policies and procedures, so that it can achieve the 7 day timeframe and the content requirements for provisional care plans set out in the CCS Act.

Recommendation 13: DCP consider its approach to meeting the 'as soon as practicable' timeframe requirements for care plan preparation to meet the objectives and requirements of the CCS Act.

Recommendation 14: DCP ensure that care plans are prepared within the timeframe identified by its policies and procedures.

Recommendation 15: DCP identify approaches used in districts that have achieved higher timeframe compliance rates for the preparation of provisional care plans and care plans and assist other districts to adopt these approaches.

Participation in care planning

Recommendation 16: DCP ensure that children in care are given the opportunity to participate in decisions about their own care planning, as required by the CCS Act.

Recommendation 17: In ensuring that children in care participate in their own care planning, it is recommended that DCP:

- Revise its policies and procedures to specify the legislative requirements regarding children's participation in their own care planning and how they are to be met;
- Ensure Field Workers are able to implement these revised policies and procedures; and
- Monitor the introduction of its new tools for Field Workers to use to encourage child participation to determine whether they are proving to be effective.

Recommendation 18: DCP continue to ensure that parents and carers are involved effectively in care planning.

Content of care plans

Recommendation 19: DCP ensure that a child's care plan identifies the needs of the child, outlines steps or measures to be taken to address those needs and sets out decisions about the care of the child as required by the CCS Act.

Recommendation 20: DCP ensure that its own policies and procedures regarding the content of care plans are met.

Recommendation 21: DCP revise its current process for care plans to incorporate checks to ensure that each dimension of the care plan has been completed and that the dimensions indicate how the child's identified needs are to be addressed.

Recommendation 22: DCP revise its current approval process for care plans to incorporate checks to ensure that the results of a child's medical examination and/or health assessment have been incorporated into the relevant dimension of their care plan.

Recommendation 23: DCP revise its policies and procedures to specify clearly what constitutes a significant change in a child's circumstances and therefore warrants a modification to a child's care plan and ensure that the modification is undertaken in a way that is timely in the context of the need for the modification.

1.5.2 Monitoring the implementation and effectiveness of recommendations

Each of these recommendations will be monitored by the office of the Ombudsman to ensure their implementation and effectiveness in relation to the observations made in this investigation.

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2 Children in care and their care planning

2.1 Definition of the term 'children in care'

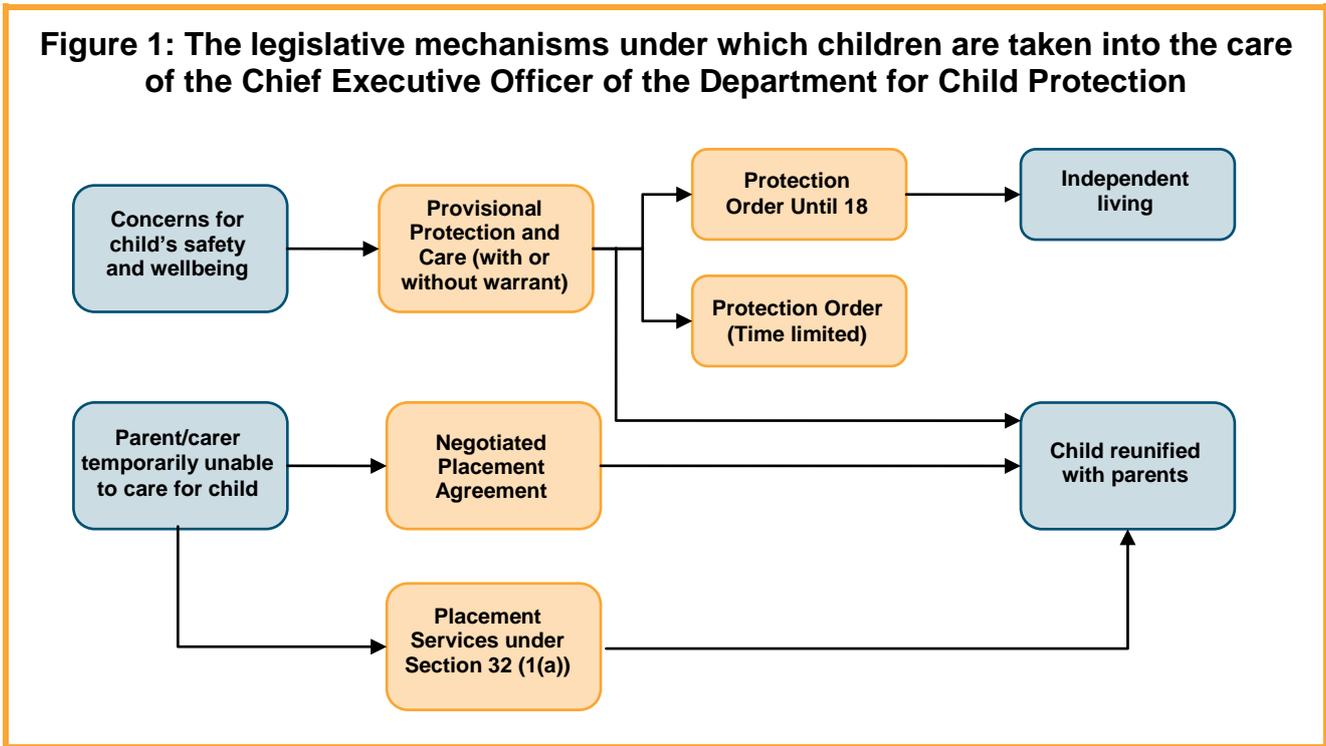
In this report, the term 'children in care' is used to refer to children who are in the care of the Chief Executive Officer (CEO) of DCP. Section 30 of the CCS Act identifies that a child is in the CEO's care if the child is in one of the five circumstances set out in the table below.⁴ The table also shows the CEO's responsibilities for children who have been taken into care in these circumstances.

Circumstances	CEO's responsibilities
1. The child is in provisional protection and care (s.29 CCS Act)	The CEO, subject to any interim order, has responsibility for the day-to-day care, welfare and development of the child to the exclusion of any other person (s.29 (2)).
2. The child is the subject of a protection order (time-limited) (s.54 CCS Act)	The CEO has parental responsibility for a child for the period specified in the order, to the exclusion of any other person (s.54(1)-(2)). The CCS Act defines 'parental responsibility' in relation to a child to mean 'all the duties, powers, responsibilities and authority which, by law, parents have in relation to children.'
3. The child is the subject of a protection order (until 18) (s.57 CCS Act)	The CEO has parental responsibility for a child until the child reaches 18 years of age, to the exclusion of any other person (s.57(1)-(2)). The definition of parental responsibility is as described above.
4. The child is the subject of a negotiated placement agreement (s.75(1) CCS Act)	This agreement is used where the parents of a child are unable to care for the child and the parents acting together and the CEO enter into an agreement under which the CEO is required to make a placement arrangement for the child. There is no transfer of parental responsibility for the child to the CEO under this type of agreement.
5. The child is provided with placement services under section 32(1)(a) (s.32(1)(a) CCS Act)	In certain circumstances the CEO can provide, or arrange for the provision of, social services to the child, such as a placement for the child. There is no transfer of parental responsibility for the child to the CEO.

⁴ DCP's *Care Planning Policy* identifies a sixth circumstance in which a child is in the care of the CEO, specifically 'child is in a consented placement made prior to the proclamation of the CCS Act 2004. (*Children and Community Services Regulations 2006*, Regulation 29).'

<<http://www.dcp.wa.gov.au/Resources/Documents/Policies%20and%20Frameworks/Care%20Planning%20Policy%202009.pdf>>. Accessed 25 May 2011

Figure 1 illustrates the legislative mechanisms for children being taken into care.



2.2 Number of children in care

At the commencement of the investigation, there were 3356 children in care.⁵ This represents approximately 0.6 per cent of all children in Western Australia. Historical figures for children in care are identified in DCP's Annual Report 2010 – 2011 (**DCP's Annual Report**).

Figure 2, drawn from DCP's Annual Report, shows an increase in the number of children in care of 59 per cent over the period from 30 June 2006 to 30 June 2011. For comparison, over the period 30 June 2006 to 30 June 2011⁶, the number of children in Western Australia grew by just over 10.5 per cent (52 783 children).⁷

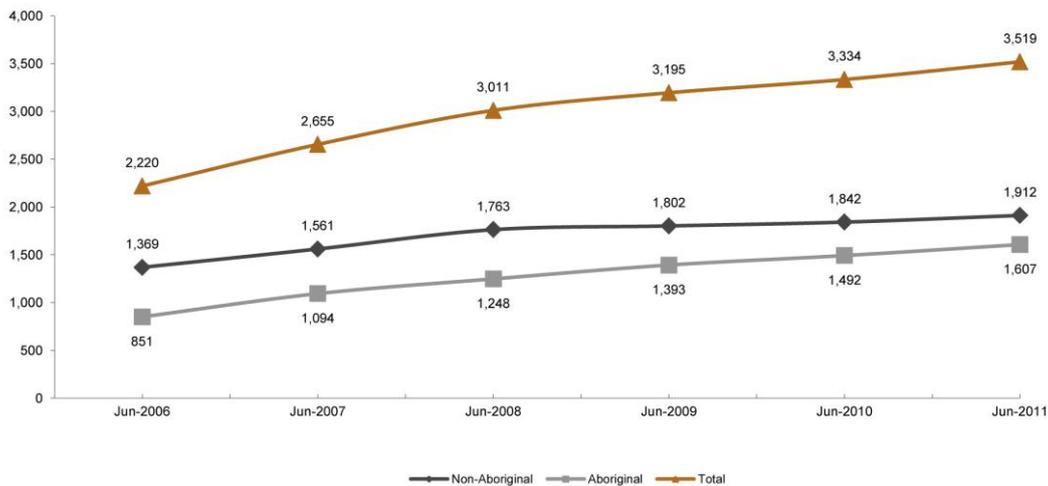
⁵ This number represents the total of the number of children in care for all 17 DCP districts as shown in DCP's ASSIST system on 3 November 2010. It does not include a very small number of children allocated to DCP's Adoption and Fostering Services Unit who are in the care of the Chief Executive Officer of DCP under the provisions of the *Adoption Act 1994*.

⁶ Population growth extrapolated for the period March to June 2011 using Australian Bureau of Statistics 3101.0 Australian Demographic Statistics March 2011, Media Release. <http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/3101.0Main%20Features1Mar%202011?opendocument&tabname=Summary&prodno=3101.0&issue=Mar%202011&num=&view=>. Accessed 8 November 2011

⁷ Australian Bureau of Statistics 3101.0 Australian Demographic Statistics September 2010, Table 55 - Estimated Resident Population By Single Year Of Age, Western Australia. <http://www.abs.gov.au/ausstats/abs@.nsf/mf/3101.0>. Accessed 16 June 2011.

According to DCP's Annual Report, as at 30 June 2011, 46 per cent of children in care were Indigenous (compared with Indigenous people representing 3 per cent of the general population).

Figure 2: Number of children in the care of the Chief Executive Officer of the Department for Child Protection between 30 June 2006 and 30 June 2011



Source: DCP's Annual Report 2010-11

The increase in the number of children in care in Western Australia, and the over-representation of Indigenous children in this group, is consistent with national statistics. The Australian Institute of Health and Welfare (AIHW) reported that, as at 30 June 2010, there were 35 895 children in out-of-home care⁸ in Australia.⁹ This was a 5 per cent increase on the previous year and a 51 per cent increase from 2005 to 2010. (Over this same period, the number of children in Australia grew by 5.2 per cent.¹⁰) AIHW suggests that one factor in the increase in the number of children in care is that:

...more children are being admitted to care than discharged each year. One explanatory factor for the overall increase is the complex family situations of these children, which impacts on the length of time children remain in care.¹¹

⁸ Out-of-home care refers to the provision of alternative overnight accommodation to children and young people under 18 years of age who are unable to live with their parents and are in need of care and protection. This concept is comparable with the Western Australian concept of children in the care of the Chief Executive Officer of DCP.

⁹ Australian Institute of Health and Welfare. Child Protection Australia 2009-10, Child Welfare Series no.51, January 2011 Cat. no. CWS 39, Canberra: AIHW.

¹⁰ Australian Bureau of Statistics 3101.0 Australian Demographic Statistics September 2010, Table 59 - Estimated Resident Population By Single Year Of Age, Australia. <<http://www.abs.gov.au/ausstats/abs@.nsf/mf/3101.0>>. Accessed 16 June 2011.

¹¹ Australian Institute of Health and Welfare 2009. Child Protection Australia 2007-08, Child Welfare Series no.45, Cat. no. CWS 33, Canberra: AIHW. <<http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442455316>>. Accessed 16 June 2011.

AIHW also reported that the national rate of Indigenous children in out-of-home care at 30 June 2010 was 48.4 per 1000 children, which is over ten times the national rate of non-Indigenous children in out-of-home care. AIHW reported that at 30 June 2010, 40.4 Indigenous children per 1000 and three non-indigenous children per 1000 were in out-of-home care in Western Australia.¹²

In practice, coordinating protection and care for each child in care is generally allocated to a Field Worker working within one of DCP's 17 administrative districts. Table 1 shows the number of children in care allocated to each DCP district at the commencement of the investigation.

Table 1: Children in care at commencement of the investigation, by Department for Child Protection administrative district

DCP districts – Metropolitan	Number of children in care	DCP districts - Country	Number of children in care
Armadale	348	East Kimberley	130
Cannington	272	Goldfields	118
Fremantle	231	Great Southern	155
Joondalup	244	Mandurah	169
Midland	239	Murchison	139
Mirrabooka	297	Pilbara	109
Perth	209	South West	187
Rockingham	162	West Kimberley	144
		Wheatbelt	203
Total			3356

2.3 Budget allocation for children in care

In the 2010-11 *Budget Statements*, DCP received \$214 million to support children and young people in the CEO's care. This was an increase from \$189 million in the 2009-10 State budget allocation. This allocation has increased further in the 2011-12 *Budget Statements* to \$233 million.¹³

¹² Australian Institute of Health and Welfare 2009 Child Protection Australia 2007–08, Child Welfare Series no.45 Cat. no. CWS 33, Canberra: AIHW.

<<http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442455316>>. Accessed 16 June 2011.

¹³ Government of Western Australia, *The Government of Western Australia 2011-12 Budget Statements, Budget Paper No.2, Volume 2*, p718. <<http://www.dtf.wa.gov.au/cms/budget.aspx?id=2018>>. Accessed 16 June 2011.

2.4 Legislation and policy for care planning for children in care

2.4.1 Overview of legislative requirements for care planning for children in care

For the majority of Western Australian children, their parents and family network provide for their protection and care. For children in care, the State provides for this protection and care. The way in which the State is to perform this role is set out in the CCS Act, the objects of which include 'to provide for the protection and care of children in circumstances where their parents have not given, or are unlikely to give that protection and care...' (s.6(d)).

As part of providing for the protection and care of children in care, the CCS Act contains a number of provisions detailing the level of care planning required and principles to be applied when making decisions about children in care. An overview of these provisions is provided below. A more detailed discussion of each provision and its requirements is given in subsequent chapters, together with the observations of our investigation regarding agencies' administration of these requirements.

Sections specific to care planning

The sections of the CCS Act that are specific to care planning for children in care, and are of particular relevance to this investigation, are ss.39, 89 and 90. These sections, relevantly, provide as follows:

39. Provisional care plans, preparation etc. of

- (1) In this section —
provisional care plan means a written plan that —
 - (a) identifies the needs of the child while the child is in provisional protection and care; and
 - (b) outlines steps or measures to be taken in order to address those needs; and
 - (c) sets out decisions about the care of the child including —
 - (i) decisions about placement arrangements; and
 - (iia) decisions about secure care arrangements; and
 - (ii) decisions about contact between the child and a parent, sibling or other relative of the child or any other person who is significant in the child's life.
- (2) This section applies if —
 - (a) a child is taken into provisional protection and care under this Division; and
 - (b) the CEO decides, or is required, to make a protection application in respect of the child.
- (3A) The CEO must prepare and implement a provisional care plan for the child.
- (3B) ... the CEO must prepare the provisional care plan within 7 working days after the child is taken into provisional protection and care.
- (3) The CEO may modify a provisional care plan at any time if the CEO considers that it is appropriate to do so.

89. Care plans, preparation etc. of

- (1) In this section —
- care plan** means a written plan that —
- (a) identifies the needs of the child; and
 - (b) outlines steps or measures to be taken in order to address those needs; and
 - (c) sets out decisions about the care of the child including —
 - (i) decisions about placement arrangements; and
 - (iia) secure care decisions referred to in section 88G; and
 - (ii) decisions about contact between the child and a parent, sibling or other relative of the child or any other person who is significant in the child's life.
- (2) As soon as practicable after a child first comes into the CEO's care, the CEO must prepare and implement a care plan for the child.
- (3) Subsection (2) does not apply in the case of a child taken into provisional protection and care.
Note: Section 39 requires the CEO to prepare and implement a provisional care plan for a child taken into provisional protection and care.
- (4) The CEO may modify a care plan at any time if the CEO considers that it is appropriate to do so.

90. Review of care plan

- (1) The CEO must carry out a review of the operation and effectiveness of every care plan at regular intervals not exceeding 12 months.

Principles for participation in care planning by children, parents and carers

Section 10 of the CCS Act sets out the Principle of child participation as follows:

10. Principle of child participation

- (1) If a decision under this Act is likely to have a significant impact on a child's life then, for the purpose of ensuring that the child is able to participate in the decision-making process, the child should be given —
- (a) adequate information, in a manner and language that the child can understand, about —
 - (i) the decision to be made; and
 - (ii) the reasons for the Department's involvement; and
 - (iii) the ways in which the child can participate in the decision-making process; and
 - (iv) any relevant complaint or review procedures; and
 - (b) the opportunity to express the child's wishes and views freely, according to the child's abilities; and
 - (c) any assistance that is necessary for the child to express those wishes and views; and
 - (d) adequate information as to how the child's wishes and views will be recorded and taken into account; and
 - (e) adequate information about the decision made and a full explanation of the reasons for the decision; and
 - (f) an opportunity to respond to the decision made.

Section 10 of the CCS Act also sets out how the Principle of child participation is to be applied in making decisions which impact on a child's life, including decisions relating to the preparing, modifying or reviewing of care plans or provisional care plans (s.10(3)(b)).

The CCS Act also provides that parents and carers have the opportunity to participate in care planning. Sections 9 and 90, relevantly, provide as follows:

9. Principles to be observed

- (j) the principle that a child's parents and any other people who are significant in the child's life should be given an opportunity and assistance to participate in decision-making processes under this Act that are likely to have a significant impact on the child's life;
- (k) the principle that a child's parents and any other people who are significant in the child's life should be given adequate information, in a manner and language that they can understand, about —
 - (i) decision-making processes under this Act that are likely to have a significant impact on the child's life; and
 - (ii) the outcome of any decision about the child, including an explanation of the reasons for the decision; and
 - (iii) any relevant complaint or review procedures;

90. Review of care plan

- (2) In the course of the review the CEO must have regard to any views expressed by —
 - (a) the child; and
 - (b) a parent of the child; and
 - (c) any carer of the child; and
 - (d) any other person considered by the CEO to have a direct and significant interest in the wellbeing of the child.

Principles relating to Aboriginal and Torres Strait Islander children

Division 3 of Part 2 of the CCS Act contains three principles relating to Aboriginal and Torres Strait Islander children, which apply in the administration of the CCS Act and accordingly apply to care planning for children in care. These are:

- Aboriginal and Torres Strait Islander child placement principle (s.12);
- Principle of self determination (s.13); and
- Principle of community participation (s.14).

These principles, and their application to care planning for children in care, are discussed in further detail at Chapter 8.

Requirements for interagency cooperation

Section 22 (1) of the CCS Act provides that, 'in performing functions under this Act, the CEO must endeavour to work in cooperation with public authorities, non-government agencies and service providers.' Accordingly, the processes that have been established to ensure this cooperation occurs were included in the investigation.

Three of the recommendations of the 2007 Review of the Department for Community Development, discussed below, also address interagency cooperation.

2.4.2 Recommendations of the 2007 Review of the Department for Community Development

In 2006, the (then) Western Australian Government announced a review of the Department for Community Development, to be undertaken by Ms Prudence Ford (subsequently known as the Ford Review). The final report of the Ford Review highlighted the health and educational needs of children in care and the importance of interagency cooperation in meeting these needs. Three of the review's 70 recommendations addressed these issues, stating:

Recommendation 63: The Departments of Health and Education and Training¹⁴ respectively be required to develop a Health Plan (covering physical, mental and dental health) and an Educational Plan respectively for each child or young person in care.

Recommendation 64: The Department of Health and the Department of Education and Training be responsible for providing the specialist support, resources and services needed to implement the plans for each child and young person in care.

Recommendation 65: The Department of Health, and the Department of Education and Training and the Department for Child Safety and Wellbeing¹⁵ report in their Annual Reports each year, the proportion of children and young people in care who have a health or education plan and an annual assessment of the proportion who have achieved improvement in their health/education status, and the gap between the health/education status of children and young people in care and those not in care.¹⁶

These recommendations, along with an additional 66 of the Ford Review's recommendations, were endorsed by the (then) Western Australian Government in March 2007.¹⁷

¹⁴ Now the Department of Education and the Department of Training and Workforce Development.

¹⁵ Now the Department for Child Protection.

¹⁶ Ford, P. (2007) Review of the Department for Community Development, Review Report, p 117. <<http://pandora.nla.gov.au/pan/85594/20080616-356/www.community.wa.gov.au/NR/rdonlyres/96699E41-3DE1-4907-A1C9-B21B0C4647CD/0/DCCRPTFordReview2007.pdf>>. Accessed 20 May 2011.

¹⁷ Ministerial Media Releases, *Government Response to Ford Review to Revolutionise Child Protection in WA*. <<http://www.mediastatements.wa.gov.au/Lists/Statements/DispForm.aspx?ID=125741>>. Accessed 2 June 2011.

2.4.3 DCP's policies and procedures

There is a range of further instruments that have the effect of regulating the administration of care planning responsibilities in Western Australia. These are discussed in detail throughout this report. In summary, these instruments are as follows:

- DCP's *Strategic Plan 2010-2012*, which identifies care plans as an 'Elevated Priority';
- DCP's *Care Planning Policy*, which came into effect in June 2009, superseding its 2007 *Children and Young People in the CEO's Care Policy*;
- DCP's *Casework Practice Manual*, also developed in 2009;
- DCP's *Better Care, Better Services: Standards for Children and Young People in Protection and Care*, completed in 2007;
- DCP and the Department of Education's *Memorandum of Understanding for Education Access and Support for Children in Care*, signed in 2009; and
- DCP and the Department of Health's *Level 2 Operational State-wide Memorandum of Understanding between the Department of Child Protection and WA Health*, signed in 2010.

2.4.4 National Standards for Out-of-Home Care

In April 2009, the Council of Australian Governments released the *National Framework for Protecting Australia's Children 2009–2020 (the Framework)*. The Framework outlines a national approach to ensuring the safety and wellbeing of Australian children. As part of the Framework, 13 National Standards for out-of-home care were agreed by Community and Disability Services Ministers on 16 December 2010, to be implemented from 1 July 2011. The National Standards were developed to 'seek to drive improvements in the quality of care so that children and young people in out-of-home care have the same opportunities as other children and young people, to reach their potential in life wherever they live in Australia.'¹⁸ Our examination of care plans during this investigation was informed by and consistent with these National Standards.

¹⁸ Department of Families, Housing, Community Services and Indigenous Affairs together with the National Framework Implementation Working Group (December 2010) *An Outline of National Standards for Out-of-home care. National Framework for Protecting Australian Children, 2009-2020*. <http://www.fahcsia.gov.au/sa/families/pubs/nat_std_4_outofhomecare/Pages/default.aspx>. Accessed 16 June 2011.

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3 About the investigation

3.1 Core functions of the Western Australian Ombudsman

The Western Australian Ombudsman has four core functions:

- To investigate and resolve complaints about public administration;
- To improve the standard of public administration over time;
- To review certain child deaths; and
- To undertake certain inspectorate functions as specified in legislation, and other specialist investigations.

3.1.1 Own motion investigations undertaken by the Western Australian Ombudsman

The Western Australian Ombudsman undertakes Ombudsman's own motion investigations of matters of administration including investigating systemic and thematic patterns and trends arising from complaints made to the Ombudsman and from the review of investigable child deaths: s.16 *Parliamentary Commissioner Act 1971*.

3.1.2 The Ombudsman's Child Death Review function

On 30 June 2009, following the passage of the *Parliamentary Commissioner Amendment Act 2009*, the Ombudsman commenced a new jurisdiction to review investigable child deaths. Investigable deaths are defined by s.19A(3) of the *Parliamentary Commissioner Act 1971*. So that the Ombudsman can carry out this function, the Chief Executive Officer of DCP is required to give the Ombudsman written notice of any death of a child that is an investigable death within 14 days after the date on which the Coroner notifies the CEO of the death (s.242A CCS Act). For these investigable deaths, the Ombudsman's functions are as follows:

- a) to review the circumstances in which and why the deaths occurred;
- b) to identify any patterns or trends in relation to the deaths; and
- c) to make recommendations to any department or authority about ways to prevent or reduce investigable deaths (s.19B(3) *Parliamentary Commissioner Act 1971*).

3.2 Rationale for the investigation

Under the Child Death Review function, the Ombudsman's review of the circumstances of a child's death includes a review of the involvement of the child and their family with any Western Australian Government agency (including, but not limited, to DCP). These reviews, over time, give rise to patterns and trends, which can be examined further through an Ombudsman's own motion investigation.

Through the undertaking of reviews of child deaths, the Ombudsman identified a need to undertake further investigation of care planning for children in care.

3.3 Objective of the investigation

The objective of this investigation was to examine how State Government agencies have administered the requirements of the CCS Act regarding care planning for children in care, in particular whether:

- DCP has established policies and procedures for care planning that are consistent with the requirements of the CCS Act;
- DCP is appropriately complying with the requirements for the preparation, review and timing of provisional care plans and care plans, set out in the CCS Act and its own policies and procedures;
- Care plans address the areas that the CCS Act and DCP's policies and procedures identify as necessary to ensure a child's wellbeing; and
- Health care planning and education planning are undertaken in accordance with the agreements that DCP has established with the Department of Health and the Department of Education, and in accordance with the related policies and procedures of the three agencies.

3.4 Methodology

Step 1 – Understanding care planning requirements and how agencies administer them

To develop an understanding of care planning, the office undertook:

- A review of the literature on care planning for children in care;
- A review of the legislative and regulatory requirements and other Government policies for care planning, agencies' policies and procedures for care planning and other relevant materials;
- Meetings with staff of DCP, the Department of Health and the Department of Education, including to discuss how they have established agreements between agencies and developed and implemented their own care planning policies and procedures; and
- Training in DCP's information and communications technology (**ICT**) system and their records management system (referred to as 'ASSIST' and 'Objective' respectively). This enabled us to access DCP's care planning data and records directly.

Step 2 – Selecting a cohort

At the commencement of the investigation (3 November 2010), there were 3356 children in care. The investigation examined the administration of care planning for those children in care who were of primary school age at the commencement of the investigation, had been taken into care after 1 July 2008, and were still in care when the investigation commenced. This cohort numbered 443 children in total. This age of child and time period cohort was chosen for three reasons:

- Age - Primary school aged children can be assumed to have certain core health and education needs (such as attendance at school). By focussing on primary school aged children, the investigation could examine interagency cooperation between DCP, the Department of Health and the Department of Education. The involvement of all three agencies will generally be required if health and education needs are to be incorporated into the child's care planning;
- Time - By focussing on care planning that had taken place after 1 July 2008, it was reasonable to consider agencies' performance against the requirements for care planning set out in the CCS Act, which was proclaimed in 2006, and the recommendations of the Ford Review, finalised in 2007; and
- Size - It yielded a cohort that was conducive to a cost effective investigation with a timely outcome.

Extrapolation of results based on cohort selection

We can be definitive at a point in time about our observations concerning this cohort as it contained 100 per cent of the children in care within the age and time parameters. Our cohort did not include children who were younger or older than primary school age and therefore observations about these broader cohorts are extrapolations. It is important to note, however, that a number of the investigation's observations relate to the system for care planning established jointly by the three agencies, interagency cooperation for health care planning and education planning and agencies' policies for all children in care. This increases confidence that these observations have a general level of applicability to all children in care.

Step 3 – Fieldwork

The office investigated the administration of care planning for the children in the cohort, at three levels of detail, over three phases of fieldwork, as set out below.

Phase 1 – Examination of the preparation and timeliness of provisional care plans and care plans for all children in the cohort

The office examined whether a provisional care plan and a care plan (where relevant) had been developed for each of the 443 children in the cohort, together with the timeframes for the development of these plans. In March 2010, DCP implemented a new ICT system to hold records about children in care. As the period of care for many children in our cohort extended over this timeframe, we extracted data regarding each child's care planning process from both DCP's current ICT system (referred to as ASSIST) and its previous ICT system (referred to as CCSS). The data for each child sourced from these systems was

then manually examined and compared to original records to eliminate duplication and identify the correct preparation dates for plans. Using this 'clean' dataset, we examined the DCP records for each child to determine the preparation and timeliness of the two major care planning components – provisional care plans and care plans.

Phase 2 – Examination of key features of the care planning process for children on a protection order or negotiated placement agreement

Of the 443 children in the cohort, 293 children had been taken into care through a protection order (time-limited), a protection order (until 18), or a negotiated placement agreement. For these children, the full care planning process beyond the initial development of a provisional care plan should be evident. The office examined the preparation and timeliness of the key features of the care planning process for these 293 children. More specifically, in addition to the aspects of care planning examined during Phase 1, we examined the DCP files to determine if the following had been undertaken for each child:

- Health care planning, including a health assessment and/or medical examination, enrolment in the School Dental Service and completion of a *Strengths and Difficulties Questionnaire*;
- Education planning, including the development of a *Documented Education Plan* by a school; and
- Reviews of the care plans.

Phase 3 – Detailed examination of care planning for children in four DCP districts

For a subset of the 293 children whose records we examined during Phase 2, the office conducted a further, more detailed examination of the content of their care plans. This detailed examination was undertaken for the 61 children in our sample whose care planning was coordinated by two metropolitan districts (Cannington and Fremantle) and two country districts (Pilbara and South West). These districts were selected as they are geographically diverse, and include one metropolitan and one country district that participated in the 2009 pilot study for health care planning.¹⁹ In addition to the aspects of care planning examined during Phases 1 and 2, we examined the DCP records for each child to determine whether:

- A care plan had been prepared for the child;
- Each care plan addressed the eight dimensions of child wellbeing identified in DCP's care plan template, and whether it identified needs and steps or measures for addressing these needs in each dimension;
- The results of health assessments and/or medical examinations and associated information were reflected in the care plan;

¹⁹ This study was a pilot of the joint DCP and Department of Health process for health assessments and is discussed in more detail in subsection 4.3.2.

- Education plans and associated information were held on file to form the education dimension of the care plan;
- Cultural planning was addressed;
- There was evidence of participation in the care planning process by children, parents and carers; and
- Care plans were modified to reflect a child's changing circumstances.

As part of Phase 3, the office also:

- Met with the District Directors of the four DCP regions to discuss care planning at the district level;
- Met with DCP's Complaints Management Unit and Standards Monitoring Unit and collected information from them regarding the views of children, parents and carers on the care planning process; and
- Met with staff from the Department of Health and the Department of Education and collected information from them regarding health care planning and education planning respectively.

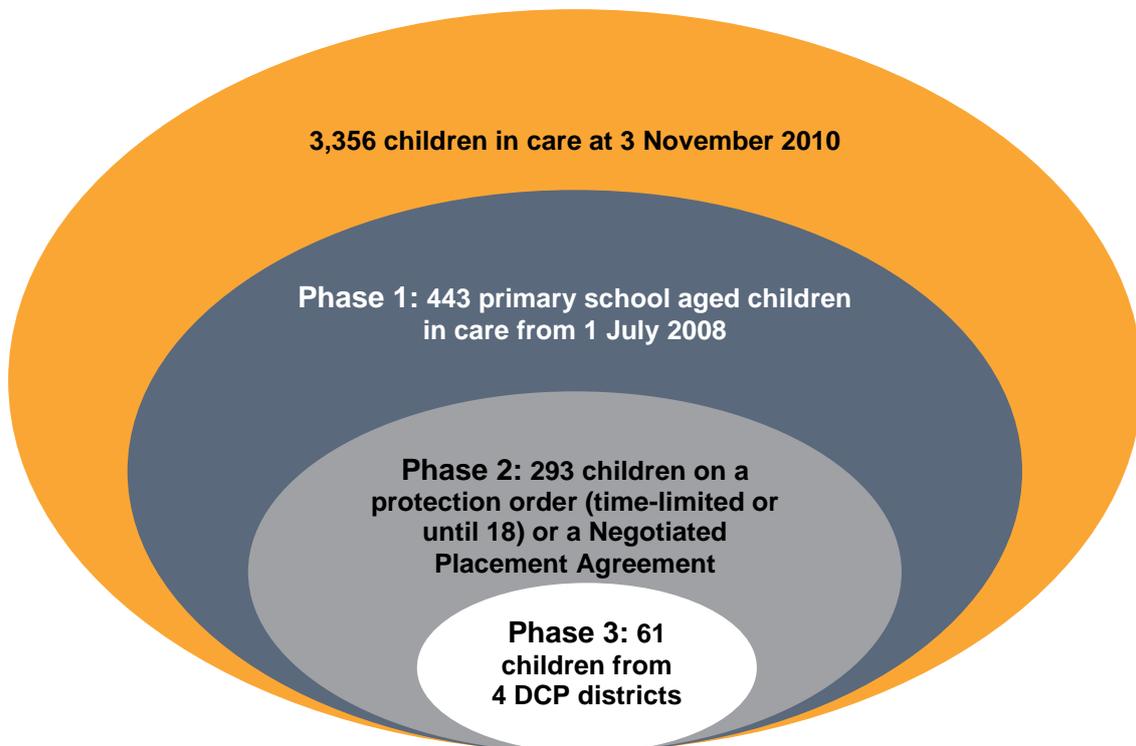
In addition, our literature review, conducted in Phase 1, identified a number of recent projects that researched children's views on their participation in care planning.²⁰ The investigation drew on this research where relevant.

Figure 3 depicts the breakdown of the cohort into the three phases of the investigation together with the number of children in care included in each phase. Phase 1 includes the complete cohort of 443 children in care and examined the preparation and timeliness of provisional care plans and care plans. Phase 2 includes 293 children in care and is the subset of children in the cohort who are the subject of a protection order or negotiated placement agreement. This phase examined the key features of care planning. Phase 3 is a further subset of the children included in Phase 2 and includes 61 children whose care planning was conducted by four of the 17 DCP districts. This phase involved a more detailed examination of the child's care planning for the children who had care plans prepared (50 of the 61 children²¹).

²⁰ For example: CREATE Foundation (2010) *Be Heard Tasmania July 2008 – June 2010, Final Report, Feedback from Children and Young People about their Experiences in Out-of-home Care*. <http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0007/76084/Be_Heard_final_report_2010_Tasmania_PD_F.pdf>. Accessed 2 June 2011. Tasmania CREATE Foundation (2009), *Inaugural National Youth Advisory Council Summit Report*. <www.create.org.au/wp-content/uploads/2009-NYAC_report-FINAL.pdf>. Accessed 2 June 2011.

²¹ One child was not due to have a care plan prepared as they had been taken into care less than 20 working days previously. The other 10 children should have had care plans prepared.

Figure 3: Investigation breakdown - characteristics and numbers for Phases 1 to 3



Step 4 – Analysis, feedback and procedural fairness

At the completion of the fieldwork, the office:

- Analysed agencies' policies and procedures against the requirements of the CCS Act;
- Analysed the information collected through the fieldwork against the relevant legislative requirements, policies and guidelines; and
- Discussed our preliminary observations with operational staff and senior managers at each agency.

4 The care planning system for children in care

4.1 Overview of chapter

- In the five years since the proclamation of the CCS Act in 2006, the three State Government agencies that have been involved in planning for children in care (DCP, the Department of Health and the Department of Education) have cooperated to operationalise the requirements of the CCS Act. This work has resulted in the agencies redesigning the system for care planning so that it incorporates the five key care planning components: provisional care plans, care plans, health plans, education plans and care plan reviews.
- DCP has developed a series of policies and procedures for care planning that are consistent with the CCS Act. DCP has established corporate governance arrangements for care planning. However, these do not include regular reporting to the agency's corporate executive on district performance in provisional care plan and care plan preparation and timeliness.
- In 2008, DCP and the Department of Health agreed and developed a comprehensive strategy for health care planning that addresses the Ford Review recommendations regarding health care planning for children in care. This process was piloted during 2009, the pilot evaluated, and rollout of the process across Western Australia commenced in June 2010. DCP and the Department of Health have advised that the rollout was fully implemented on 16 May 2011 with all DCP district offices now included in the agreed process. In July 2010, both agencies signed a Memorandum of Understanding regarding the state-wide implementation of the agreed process. It included agreed monitoring and reporting processes. The mechanism at the operational level by which DCP and the Department of Health can identify and promptly follow up on health assessments that have not been undertaken was not yet operational in six of 17 districts at the beginning of the investigation, however during the investigation, DCP advised that all 17 districts now have this mechanism established.
- To date, the Department of Health has not reported on health care planning for children in care in its annual report, as recommended by the Ford Review (recommendation 65). However, the Health MOU indicates that, in response to the Ford Review recommendation, the agencies have agreed that DCP will report on the progress of this strategy in its annual report, on behalf of both agencies.
- DCP and the Department of Education have taken initial steps to address the Ford Review recommendations regarding education planning for children in care. In 2009, DCP and the Department of Education signed a Memorandum of Understanding regarding the development of education plans for children in care. The Department of Education subsequently advised schools of their responsibility to develop a *Documented Education Plan* for children in care. At the commencement of this investigation, the Department of Education was not monitoring or reporting on the implementation of these requirements by schools. To date, the Department of Education has not reported on children in care and their education planning in its

annual report, as recommended by the Ford Review (recommendation 65). Subsequent to this investigation commencing, the Department has made plans to reiterate to schools the need to develop *Documented Education Plans* and how to do so. It also plans to monitor the preparation of *Documented Education Plans* across schools. This will provide the basis for reporting, including in its annual report, and follow up action if necessary.

4.2 DCP's care planning process

4.2.1 DCP's policies and procedures for care planning

The CCS Act was proclaimed in 2006. As part of providing for the protection and care of children in care, the CCS Act contains a number of provisions requiring care planning for children in care. These include requirements for the preparation, timing, content and review of care plans, as well as provisions specific to participation by the child, their family and carers in care planning and to Aboriginal and Torres Strait Islander children in care.

To operationalise these provisions, DCP has developed a series of policies and procedures for care planning that are consistent with the CCS Act. The ways in which DCP has operationalised the requirements of the CCS Act through their care planning policies and procedures are discussed below.

The *Children and Young People in the CEO's Care Policy*, which came into effect in June 2007, summarises the CCS Act's requirements regarding children in care. DCP's main policy for care planning, entitled *Care Planning Policy*, came into effect in June 2009. This also summarises the legislative requirements for care planning, such as the 7 working day timeframe requirement for provisional care plans and the requirement for the review of care plans, as well as principles for putting these requirements into effect. The key statement of the *Care Planning Policy* is that:

Children in the Chief Executive Officer's care are vulnerable to a range of negative outcomes and, as such, comprehensive care planning is essential. Care planning is specifically focussed on identifying and meeting the needs of a child in care. It is concerned with ensuring that their entry into care, any movements between carers and leaving care experiences are managed sensitively. In all care planning decisions, the child's best interests must be the paramount consideration.²²

The *Care Planning Policy* identifies that revised guidelines based on this policy are provided in the Manual, which was also developed in 2009. The relevant section of the Manual states that its purpose is 'to inform Field Workers of the legislative and practice requirements in relation to care plans for children in the CEO's care'.²³ For care planning, the Manual sets out the legislative authority, relevant standards, practice requirements and procedures for putting these into operation. The Manual addresses all the requirements of

²² Department for Child Protection, *Care Planning Policy*.

<<http://www.dcp.wa.gov.au/Resources/Documents/Policies%20and%20Frameworks/Care%20Planning%20Policy%202009.pdf>>. Accessed 25 May 2011.

²³ Department for Child Protection, *Casework Practice Manual*, section 10.3.

<http://manuals.dcp.wa.gov.au/manuals/cpm/Pages/03CarePlans.aspx>. Accessed 15 July 2011.

the CCS Act that are specific to care plans. The Manual also identifies how other requirements of the CCS Act (such as the Principle of child participation and the Principles Relating to Aboriginal and Torres Strait Islander children) should be implemented in the care planning context. DCP requires all Field Workers to follow the Manual when conducting care planning for children in care.

Quality assurance over care planning is provided for in three ways:

- Field Workers are supervised by Team Leaders, who, when they sign off on the care plan document as a whole, are indicating that the content of the provisional care plan or care plan meets DCP's policies and procedures;
- DCP's Case Practice Unit reviews selected provisional care plans or care plans, either on its own initiative, or at the request of a District Director or an Executive Director. DCP may also engage an external reviewer to review independently the content of a care plan; and
- Section 93(1) of the CCS Act provides that the child, a parent of the child, any carer of the child, or any other person considered by the CEO to have a direct and significant interest in the wellbeing of the child, may make an application to the CEO for the review of a care planning decision (but not a decision relating to a provisional care plan). The CEO must refer the application together with other relevant material to the Case Review Panel (**the Panel**) established under s.92 of the CCS Act. The Panel must consider the application and other material (if any) and report to the CEO on its recommendations in respect of the application. The CEO, after considering the report of the Panel and any other information available to the CEO, must: confirm, vary or reverse the care planning decision; substitute another decision for the care planning decision; or refer the matter back to the Panel for further consideration and report. The CEO must give the applicant written notice of his or her decision and written reasons for it (s.93(1)-(7)).

Complaints about provisional care plans are dealt with through DCP's Complaints Management Unit.

4.2.2 Corporate governance of the care planning process

DCP's corporate governance framework for care planning comprises the following elements:

- DCP's *Strategic Plan 2010-2012* identifies the strategic priorities for improving its services and outcomes. Under the strategic priority of 'Performance,' care plans are identified as one of DCP's 'Elevated Priorities.'²⁴ Care plans for children in out-of-home care were also one of DCP's four strategic priorities for the period 2008-2010.²⁵

²⁴ Department for Child Protection, *DCP Strategic Plan 2010-2012*.
<<http://www.dcp.wa.gov.au/Organisation/Documents/DCP%20Strategic%20Plan%202010-2012.pdf>>.
Accessed 19 May 2011.

²⁵ Department for Child Protection, *DCP Annual Report 2008-09*.
<<http://www.dcp.wa.gov.au/Resources/Documents/Annual%20reports/Annual%20Report%20200809.pdf>>.
Accessed 19 May 2011.

- Over time, DCP has set out its care planning policy in a series of documents, which were discussed at 4.2.1.
- The Manual, also discussed above, sets out the procedures that Field Workers are required to follow when conducting care planning.
- Field Workers are supervised by Team Leaders, who are required to approve provisional care plans and care plans. In turn, District Directors and two Executive Directors in DCP's central office monitor the work of the Field Workers and Team Leaders, including by using ASSIST²⁶ to provide electronically generated reports. However, there is no regular reporting to DCP's Corporate Executive regarding district performance in provisional care plan and care plan preparation and timeliness. DCP has advised that:

Over the period of the Ombudsman's investigation, the Department changed data systems from CCSS to ASSIST. Previous reports on CCSS were not able to capture data in relation to provisional care planning and until recently ASSIST was not able to provide this data. In the interim, recognising the importance of the legislative requirement, the Department has been manually collecting data in relation to provisional care plans and monitoring the progress. Once ASSIST is fully developed, internal and external reporting will be able to proceed regularly and reliably.

In 2007, DCP developed *Better Care, Better Services: Standards for Children and Young People in Protection and Care 2007 (the Standards)* through a consultative process, including a Reference Group of key stakeholders. Standard 5.1 states that:

Every child or young person in care has an individual Care Plan that promotes the welfare, education, interests and health needs of the child or young person and addresses their emotional and psychological needs.

Standard 5 is expanded through a series of 'supporting standards' which sets out further care planning requirements.

DCP's Standards Monitoring Unit conducts biennial district reviews, focussing on adherence to the Standards. The Standards Monitoring Unit also reports on trends in care planning, the occurrence of care planning meetings and participation by children, parents and carers in care planning. In 2009-10, the Standards Monitoring Unit examined practice in five metropolitan and five country districts, carrying out file reviews and interviewing a sample of children in care, parents of children in care and carers. Observations regarding these trends were reported back to the districts and to the CEO via the Unit's Executive Director, together with recommendations for 'Required Actions' and 'Opportunities for Improvement.'

²⁶ DCP's Information and Communications Technology system used to store children in care's records, including care planning documentation

4.3 Interagency cooperation

4.3.1 Requirements for interagency cooperation

The CCS Act promotes cooperation between DCP and other agencies in relation to the protection and care of children. The CCS Act requires that, 'in performing functions under this Act, the CEO must endeavour to work in cooperation with public authorities, non-government agencies and service providers' (s.22(1)).

Interagency cooperation was considered an important part of the development and passage through Parliament of the CCS Act, particularly in relation to the care and protection of children. During the second reading speech of the *Children and Community Development 2003 Bill* (which later became the CCS Act), the (then) Minister for Community Development, Women's Interests, Seniors and Youth, Hon Sheila McHale MLA stated that:

The Bill promotes a collaborative approach between the Department for Community Development and other agencies in the provision of social services and provides for interagency cooperation, particularly in relation to the protection and care of children and the provision of financial or other assistance. Effective collaboration and cooperation have been consistently highlighted in child death inquiries as being of critical importance to the prevention of such deaths.²⁷

Cooperation between DCP and the Department of Health and the Department of Education is a critical aspect of the care planning system. These processes also aim to address recommendation 63 of the Ford Review, which recommended that 'the Departments of Health and Education and Training (now the Department of Education and the Department of Training and Workforce Development) respectively be required to develop a Health Plan (covering physical, mental and dental health) and an Educational Plan respectively for each child or young person in care.'

4.3.2 Interagency cooperation in health care planning

DCP and the Department of Health have jointly agreed and developed a process for addressing the health dimension of care planning for children in care. The agencies have focussed on establishing cooperative arrangements between agency staff at the district level and embedding these in district office culture and practice.

In 2008, the two agencies jointly developed a 'pathway', which is an agreement that formalises the process by which DCP will refer children for health checks. These health checks are undertaken by health professionals and the results are communicated back to DCP for inclusion in the child's care planning as their health plan and the associated timeframes. The pathway enables the involvement of health professionals in the development of the health dimension of each child's care plan. Children entering care are referred by DCP to a General Practitioner for a medical examination. A standardised form (including suggested Medicare item numbers) was developed for this purpose in consultation with the Western Australian General Practitioner network. DCP also refers all

²⁷ Hon Sheila McHale MLA, Minister for Community Development, Women's Interests, Seniors and Youth, Legislative Assembly, *Parliamentary Debates (Hansard)*, 4 December 2003, pp14244b-14247.

children who are already in care for health assessments by the Department of Health's Community Health Nurses. A flowchart depicting this process is provided at Figure 4.

The pathway also incorporates agreements regarding the enrolment of children in care in the School Dental Service.

During 2009, this pathway was piloted across four DCP districts (Midland, Fremantle, Great Southern and Pilbara). The pilot has since been evaluated and, among other things, found that 'while the pilot demonstrated the pathway could work effectively, it is recognised that implementation without additional resource allocation will be challenging.' The report further states:

...the results highlight the variability of staff capacity to effectively implement the pathway. Successful implementation required intensive governance and was highly dependent on local leadership, existing relationships between DCP and the Department of Health staff, and a range of external factors impacting on staff workload.²⁸

In June 2010, the two departments commenced a phased roll-out of the health care planning pathway. DCP and the Department of Health have advised that the roll-out was fully implemented in 16 May 2011 with all DCP district offices now included in the agreed process. To oversee and monitor the implementation of the pathway as it is rolled out across the state, DCP and the Department of Health jointly convened the Steering Group, comprising representatives from both agencies. The Steering Group also developed a *Level 2 Operational State-wide Memorandum of Understanding between the Department of Child Protection and WA Health (Health MOU)*, which was signed by the Director General of each agency in July 2010. The Health MOU sets out the roles and responsibilities of each agency.

At the district level, the Health MOU is complemented by the development of a Local Service Agreement between each DCP district office and associated Area Health Service. The Local Service Agreement identifies the team of local professionals across both agencies who will be involved in implementing the pathway, together with their roles and responsibilities. Local Management Team meetings are to be established by the DCP District Director (or delegated representative) and held every four to six weeks. These are meetings of DCP and Department of Health representatives, and representatives of other relevant agencies, such as the local Aboriginal medical and health services. Local Management Team meetings are intended to provide a mechanism by which DCP and the Department of Health can promptly identify and follow up on health assessments that have not been undertaken. At the beginning of the investigation, eleven districts were holding regular Local Management Team meetings, and the remaining six districts were still establishing a regular meeting schedule. During the investigation, DCP advised that all 17 districts now have this mechanism established.

Lastly, the Health MOU also provides that both agencies will undertake data collection and reporting. Annual reporting is to be provided to the Steering Group, detailing issues with the health care planning process and recommending strategies to address these. The

²⁸ Department of Health and Department for Child Protection, *Health Care Planning for Children in Care Pilot: Final Evaluation Report April 2010*. (Internal report, unpublished).

Steering Group was to compile an interim report in July 2011, to include recommendations about the effectiveness of the program.

To date, the Department of Health has not reported on health care planning for children in care in its annual report, as recommended by the Ford Review (recommendation 65). However, the Health MOU indicates that, in response to this recommendation, the agencies have agreed that DCP will report on the progress of this strategy in its annual report, on behalf of both agencies.

Health services which are not funded through the Department of Health, such as Aboriginal medical and health services in regional and remote areas, are not captured under the Health MOU. DCP expects that health assessments and medical examinations for children in care residing in these locations will be subject to a Local Service Agreement between DCP District Offices and the local Aboriginal medical and health service.

4.3.3 Interagency cooperation in education planning

On 13 July 2009, the Director General of the Department of Education and Training (now the Department of Education) and the Chief Executive Officer of DCP signed a *Memorandum of Understanding for Education Access and Support for Children in Care (Education MOU)*. A summary of the Education MOU was subsequently emailed by the Department of Education to all Directors of Schools, Principals, Deputy Principals and Student Services staff. In relation to care planning, this summary advised that the Department of Education had agreed to:

- Assist DCP to identify an appropriate school for children in care;
- Forward information about a child in care from a previous school to the Principal at the new school, including copies of the child's *Documented Education Plan*;
- Convene a case conference within six weeks of being informed that a child is in care; and
- Develop a documented plan in collaboration with DCP after the school has completed and returned the DCP *Educational Assessment Form* and after DCP has participated in the case conference convened by the school.

An accompanying flowchart highlighted that a *Documented Education Plan* is to be developed by the school and a copy is to be provided to DCP's Field Worker. These school responsibilities are reinforced in the Department of Education's *Guidelines for Implementing Documented Plans in Public Schools (the Guidelines)*.²⁹ This document states:

²⁹ Department of Education, *Documented Plans Supporting Education for All Guidelines for Implementing Documented Plans in Public Schools*. <<http://www.det.wa.edu.au/detcms/inclusiveeducation/ies/resource-topics/documented-plans/guidelines-for-implementing-documented-plans-in-public-schools.en?oid=com.arsdigita.cms.contenttypes.FileStorageItem-id-1039851>>. Accessed 20 May 2011.

Students in the care of the Chief Executive Officer of the Department for Child Protection are often vulnerable and at educational risk. It is expected that each of these students will have a Documented Plan that is developed in collaboration with staff from the Department for Child Protection. The Documented Plan will form part of the overall Care Plan for the student.

At the commencement of this investigation, the Department of Education was not centrally monitoring the implementation by schools of the Education MOU or the Guidelines. To date, the Department of Education has not reported on children in care and their education planning in its annual report, as recommended by the Ford Review.

Subsequent to this investigation commencing, the Department of Education has advised that it is planning modifications to their student information systems, which will enable it to capture information about the preparation of *Documented Education Plans* for children in care. This information will also potentially form the basis of reporting, including in the Department's annual report, and follow up action where necessary. To support the reconciliation process of the student information system the Department of Education has requested from DCP a list of students in care to be provided four times a year. The Department of Education has also indicated that the following actions are in progress:

- A statement to all schools has been prepared reminding Principals of the requirement to have a *Documented Education Plan* for every child in care;
- Revision of the Education MOU to ensure documented planning processes are clear and unambiguous; and
- Simplification of the Guidelines documents to ensure schools are adequately supported in the development of *Documented Education Plans*.

All public schools that have students in care are being contacted by officers of the Department of Education to ensure *Documented Education Plans* are developed and sent to DCP.

A very small number of children in care attend non-government schools. To cover these children, in July 2009 DCP signed a memorandum of understanding with the Department of Education Services (**DES**). The purpose of the DES memorandum of understanding is to establish information sharing protocols between the two parties to facilitate compliance with education planning for children in care within the non-government schools sector.

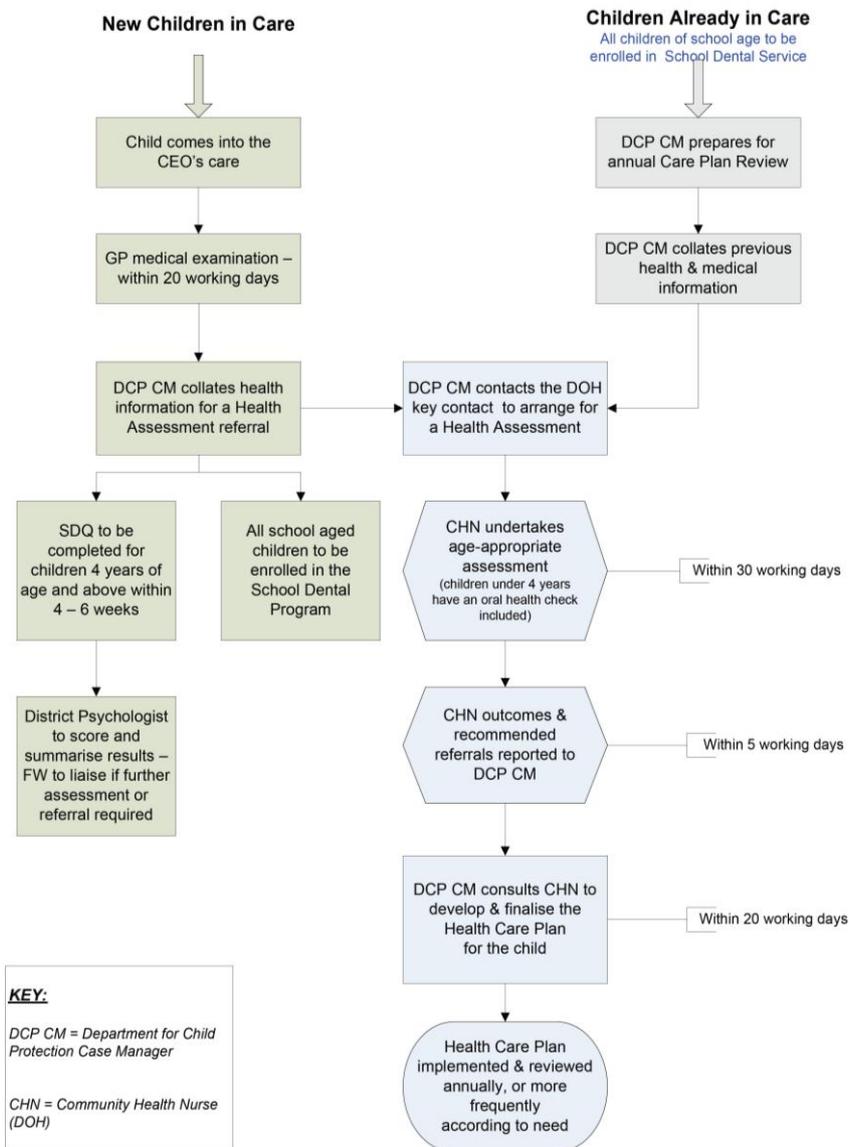
DES establishes policies and procedures for registering non-government schools in accordance with the requirements of the *School Education Act 1999* and *School Education Regulations 2000*. Registration provides assurance that the schools meet minimum acceptable education standards across important areas such as the curriculum, qualifications of teaching staff, buildings and facilities, enrolment and attendance procedures, and duty of care for students. DES also manages State government funding to non-government schools.³⁰ In the memorandum of understanding, DES has agreed to

³⁰ Department of Education Services, *Non-Government Schools*. <http://www.des.wa.gov.au/pages/non_gov.php>. Accessed 4 April 2011.

include the requirement that all children in the CEO’s care who are enrolled at non-government schools have *Documented Education Plans* prepared for them in the next edition of its standards and other requirements for registration and re-registration.

DCP has signed a similar memorandum of understanding with the Catholic Education Office of Western Australia, and has signed an agreement outlining *Reciprocal Protocols for Educational Access and Support for Children in Care* with the Association of Independent Schools Western Australia.

Figure 4: Health care planning for children in care flowchart



Source: Department of Health



Ombudsman Recommendations

Recommendation 1: Given the observations of the investigation, and particularly the observed instances of non-compliance with legislative requirements, DCP review, develop and implement improvements to its corporate governance mechanisms for care planning, including planned reporting within and external to DCP.

Recommendation 2: DCP and the Department of Health ensure that they proceed with their agreement to report on the progress of their strategy for health care planning for children in care through DCP's annual report, as set out in the Health MOU agreed by both agencies.

Recommendation 3: DCP and the Department of Health collaborate in performance monitoring and evaluation of health care planning for children in care so as to monitor the gap between the health status of children in care and those not in care.

Recommendation 4: The Department of Education ensure that it proceeds with the commitments made during the investigation to reiterate to schools the need to develop *Documented Education Plans*, to monitor the preparation of these plans across schools as part of the education component of the care planning system, and to report on children in care and their education planning in a way that is consistent with the Ford Review recommendations.

5 Implementing key care planning components

5.1 Overview of chapter

- The CCS Act requires the Chief Executive Officer of DCP to prepare provisional care plans and care plans for children in care. We observed that a provisional care plan and/or a care plan had been prepared for 420 (95 per cent) of the 443 children in our cohort. DCP were notified during the investigation of the five per cent of children in care for whom a provisional care plan or care plan had not been prepared, and has advised that this has been rectified, where the child is still in care.
- A provisional care plan had been prepared for 407 (93 per cent) of the 440³¹ children in our cohort for whom a provisional care plan should have been prepared. A care plan had been prepared for 222 of the 282 (79 per cent) children for whom a care plan should have been prepared.
- We examined the DCP files for the children in our cohort to identify whether there was evidence that the child had undergone either a health assessment by a community health nurse and/or a medical examination by a general practitioner. We examined this aspect of care planning for the 293 children in our cohort of 443 children who had been taken into care through a protection order (time-limited or until 18) or a negotiated placement agreement. For these children, the full care planning process, beyond the development of a provisional care plan, should have been evident. We observed that, for 103 (35 per cent) of these 293 children, their DCP file recorded that they had undergone a health assessment and/or a medical examination. Districts included in the 2009 pilot study for health care planning achieved this outcome more often.
- We also examined the DCP files for these same 293 children to identify whether there was evidence that the school had prepared a *Documented Education Plan* and returned this to DCP to form the education dimension of the child's care plan. For 63 (22 per cent) of the 293 children, we observed a *Documented Education Plan* on the child's DCP file.
- The CCS Act requires that the 'CEO must carry out an investigation of the operation and effectiveness of every care plan at regular intervals not exceeding 12 months' (s.90(1)). For 75 of the 293 primary school aged children in our cohort who were taken into care under a protection order or negotiated placement agreement, a care plan had been approved more than 12 months before the commencement of this investigation, and a review was therefore due. We observed that review of care plan documents had been completed for 28 of these 75 children (37 per cent). For a further 20 children (27 per cent), a new care plan had been prepared within the last 12 month period. For the remaining 27 children (36 per cent) a review of care plan document or new care plan prepared within the last 12 months was not identified.

³¹ Three of the 443 children in care were taken into care under a negotiated placement agreement and did not require a provisional care plan.

5.2 Requirements for provisional care plans and care plans

The CCS Act requires the Chief Executive Officer of DCP to prepare provisional care plans and care plans for children in care. These requirements differ depending on the circumstances under which the child is taken into care. The legislative requirements, and a brief explanation of the rationale underpinning them, are discussed below.

5.2.1 Legislative requirements for provisional care plans

The CCS Act requires that the CEO must prepare and implement a provisional care plan for a child within 7 working days after that child is taken into provisional protection and care (s.39(3A) and (3B)) (unless the provisionally protected child is placed in a secure facility under a secure arrangement (s.88I(2)) in which case other planning arrangements apply).

The *Children and Community Development Bill 2003 Explanatory Memorandum* states that this clause (clause 39) ensures that every child coming into provisional protection and care has a plan identifying his or her needs and outlining steps to address those needs and setting out decisions about the care of the child.³² During the *Children and Community Development Bill 2003, Consideration in Detail*, the (then) Minister for Community Development, Women's Interests, Seniors and Youth, Hon Sheila McHale indicated that provisional care plans already existed as agency policy but the Government was proposing to elevate them to a legislative requirement. She stated:

I understand that that is current policy. The reason this provision has been included in the Bill is that the practice has not been as thorough as I would like it to be. It is inconsistent in its application and is certainly not monitored. Therefore, it is important that it is contained within the legislation, to make sure that it is absolutely clear that that occurs. This is very much a part of ensuring that early planning provisions are in place for children in care, and that it actually happens.³³

5.2.2 Legislative requirements for care plans

The CCS Act requires that, as soon as practicable after the child first comes into the CEO's care, the CEO must prepare and implement a care plan for the child (s.89(2)). This legislative requirement for care plans incorporated aspects of DCP's pre-existing care planning process, which had been first introduced in 2001.

Ms Jane Brazier, the (then) Acting Director General of the Department for Community Development, during the Legislative Council Estimates Committee in 2001³⁴ indicated that care plans were modelled on the United Kingdom's *Looking After Children* system. She also stated:

³² Children and Community Development Bill 2003 Explanatory Memorandum, Clause 39, p 20.

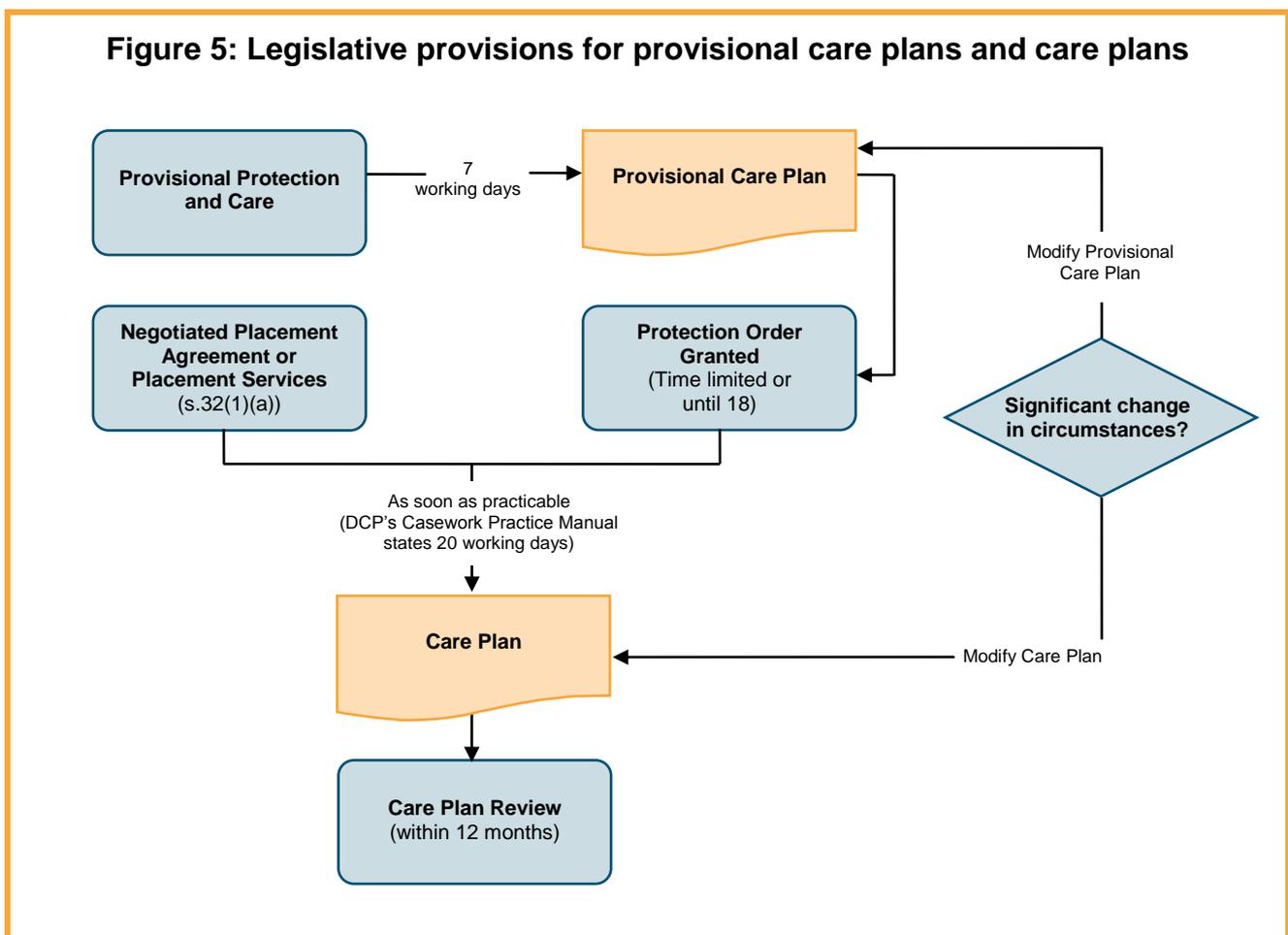
³³ Hon S. M. McHale MLA, Minister for Community Development, Women's Interests, Seniors and Youth, Legislative Assembly, *Parliamentary Debates (Hansard)*, 30 March 2004, pp1189b-1229a.

³⁴ Ms Jane Brazier, Acting Director General, Department for Community Development, Western Australia, Legislative Council Estimates Committee – Supplementary Information, *Parliamentary Debates (Hansard)*, 18 October 2001, pp834b-839a.

The Looking After Children (LAC) system was designed in the United Kingdom to ensure that from the moment a child or young person enters care, assessment and planning is immediately undertaken and remains ongoing, together with the provision of appropriate services. Since 1993 the department, in conjunction with the non-government sector, has been developing and piloting a locally adapted model of the LAC system prior to state-wide implementation commencing in October 2001.

The LAC system requires the comprehensive gathering of information regarding a young person’s circumstances and care needs from the initial point of entry into care. For young people remaining in long-term care, assessment and action records will be completed on an annual basis and will track the young person’s progress across 7 developmental dimensions of wellbeing, that is, health, education, identity, family and social relationships, social presentation, emotional and behavioural development and self care. Within each dimension age specific objectives are identified and the young person’s experiences and progress are measured against these to inform planning in respect of the young person’s developmental and other needs whilst in care

Figure 5 illustrates the care planning cycle including these two key care planning components.



5.3 Preparation of provisional care plans and care plans

5.3.1 Preparation of provisional care plans and care plans for cohort as a whole

At the commencement of this investigation, 443 primary school aged children were recorded by DCP as being children in the care of the CEO, having come into care after 1 July 2008. The office first examined whether these children in care had a provisional care plan and/or a care plan.

We observed that a provisional care plan and/or a care plan had been prepared for 420 (95 per cent) of the 443 children in our cohort. For the remaining 23 children (of whom 11 were in provisional protection and care and 12 were in care on a protection order), neither a provisional care plan nor a care plan had been prepared. These children had been in care for up to eight months. DCP was informed during the investigation that these 23 children did not have any care plans and has advised that, where they are still in the care of the Chief Executive Officer of DCP, care plans have now been prepared for these children.

Secondly, we examined whether the correct type of care plan had been developed for the children in our cohort. We observed that a provisional care plan had been prepared for 407 (93 per cent) of the 440 children in our cohort who should have had a provisional care plan and that a care plan had been prepared for 222 (79 per cent) of the 282 children who should have had a care plan, as shown in Table 3.

Table 2: Type of care applicable to children in cohort

Circumstances under which children were taken into care	Number of children
Children in provisional protection and care	150
Children on a protection order (time-limited)	248
Children on a protection order (until 18)	42
Children on a negotiated placement agreement	3
Children provided with placement services under s.32(1)(a)	0
Total	443

Table 3: Number of children for whom the required type of care planning document had been prepared

Type of care planning document required at commencement of investigation	Number of children for whom this care planning document was required	Number of children for whom this care planning document had been prepared	Percentage of children for whom this care planning document had been prepared (%)
Provisional care plan	440*	407	93
Care plan	282**	222	79

* Three children had been taken into care under a negotiated placement agreement and therefore a provisional care plan was not required.

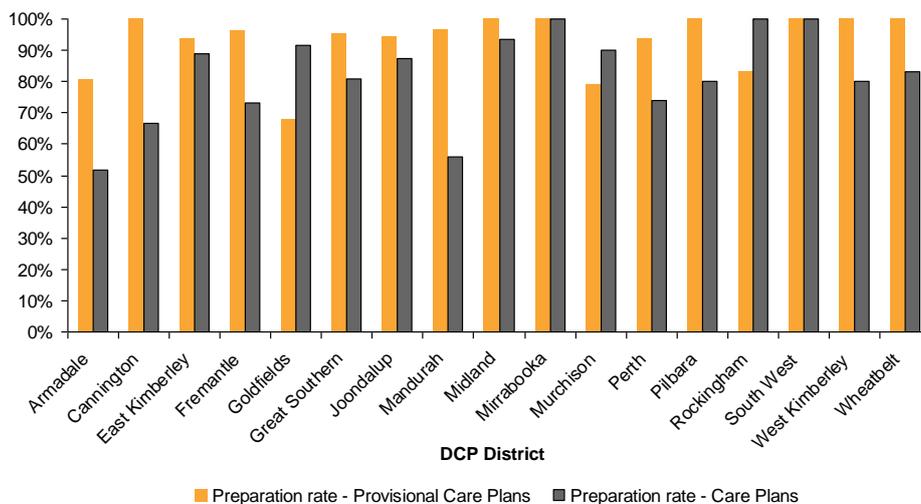
** Eleven children had been on a protection order for less than 20 days and therefore did not require a care plan.

5.3.2 Preparation of provisional care plans and care plans on a district by district basis

As previously discussed, care planning is generally administered by DCP at the district level. The number of children in our cohort varied across the 17 DCP districts from eight children to 46 children. Preparation rates³⁵ on a district by district basis ranged from 100 per cent to 68 per cent for provisional care plans and from 100 per cent to 52 per cent for care plans, as shown in Figure 6. Both Mirrabooka and South West districts, for example, had prepared provisional care plans and care plans, as appropriate, for all children in care within their region at the time of the investigation.

Figure 6 also illustrates that, on the whole, preparation rates were not significantly different between metropolitan and country districts or between larger and smaller districts.

Figure 6: Preparation rates for provisional care plans and care plans, by district



³⁵ Calculated by comparing the number of children for whom each type of plan should have been prepared with those for whom that type of plan had been prepared, at the time of the investigation.

5.4 Health components of care planning

5.4.1 Health care planning procedures

The Manual provides procedures for implementing the health care planning process jointly developed by DCP and the Department of Health. Section 10.14 of the Manual (which outlines the processes to be followed by DCP Field Workers) states:

- As part of the care planning process, all children in the CEO's care must have a **health assessment** to assist in developing and implementing the health dimension of each child's care plan;
- Health Plans for children in the CEO's care should be developed in consultation with Community Health Nurses as part of the care planning process and recorded in each child's care plan. The term 'Health Plan' refers to a documented action plan, within the care plan, that aims to improve the physical and developmental outcomes for a child in the CEO's care;
- When a child first comes into the CEO's care, including provisional protection and care, the Field Worker must arrange for a medical examination of the child with a General Practitioner within 20 working days unless an examination has already occurred (for example, where a child has been examined at the Princess Margaret Hospital Child Protection Unit);
- All children in care who are of school age should be enrolled in the School Dental Service program;³⁶ and
- All children coming into the CEO's care aged four years and older require a *Strengths and Difficulties Questionnaire* (focussing on mental health) to be completed within four to six weeks. The Questionnaire is to be analysed by the District Psychologist.³⁷

Section 1.17 of the Manual also deals with engaging private practitioners for treatment/therapeutic services, and provides direction on accessing a private practitioner when particular assessment or treatment services required for a client do not exist within the Department, existing departmental services are unable to provide the service within the referral timeframe, or impartiality is, or could be, important for legal or therapeutic reasons.

³⁶ The School Dental Service program is run by the Department of Health and provides free general dental care to school children aged from five to 17 throughout the state.

³⁷ Developed by Dr Robert Goodman, Institute of Psychiatry, Kings College, University London, the *Strengths and Difficulties Questionnaire* is a one page brief behavioural screening tool designed for children aged four to 17 years of age. Different versions of the tool are used depending on the child's age group and if the 'parent' is reporting on the child or the young person is self reporting. Each version has 25 questions - five relating to each of the psychological attributes areas of emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems, and prosocial behaviour. Source: Commonwealth of Australia (2005) *Australian Mental Health Outcomes and Classification Network: Strengths and Difficulties Questionnaire Training Manual*.

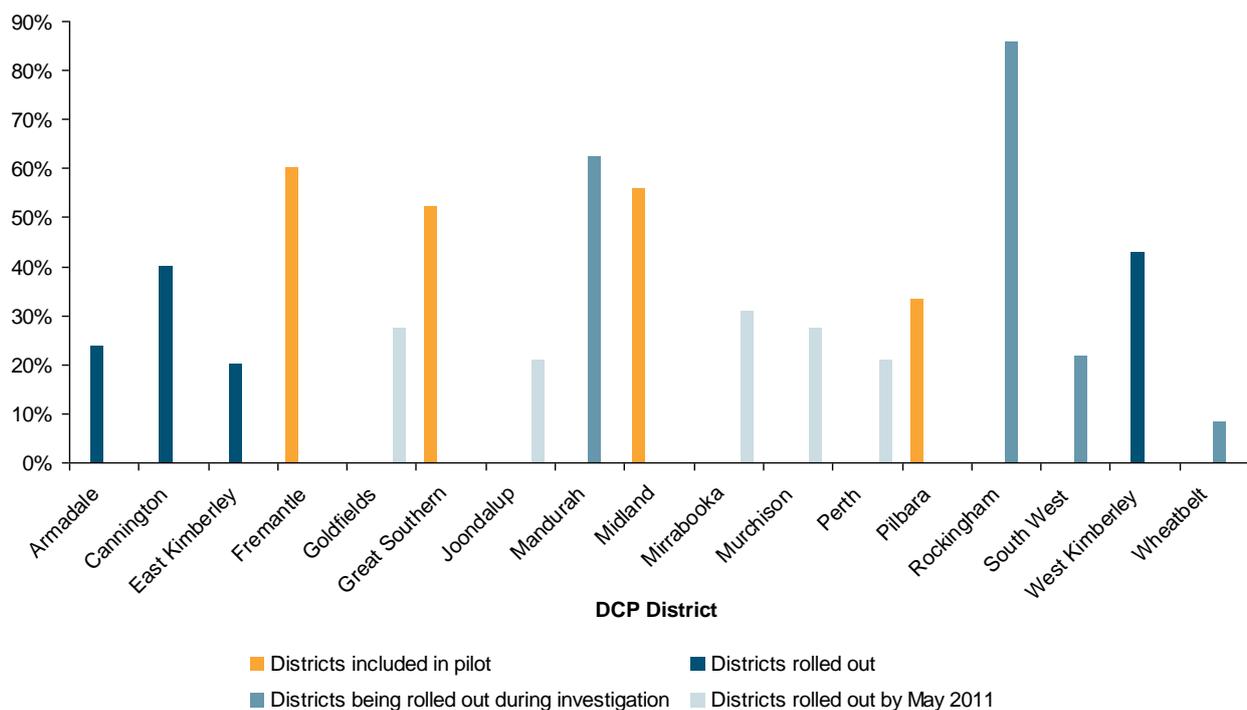
The Manual does not provide any process for ensuring that relevant health service providers (such as the child's general practitioner or paediatrician) receive a copy of the relevant sections of a child's care plan once it has been prepared.

5.4.2 Health assessments by a community health nurse and/or medical examinations by a general practitioner

We examined the DCP files for children in our cohort to identify whether there was evidence that the child had undergone either a health assessment by a community health nurse and/or a medical examination by a general practitioner. (The Manual requires that both of these tests are undertaken, however we focussed on whether either test had been undertaken as either test would assist in completing the health dimension of a child's care plan). We examined this aspect of care planning for the 293 children in our cohort who had been taken into care through a protection order (time-limited or until 18) or a negotiated placement agreement. For these children, the full care planning process, beyond the development of a provisional care plan, should have been evident.

We observed that, for 103 (35 per cent) of these 293 children, their DCP file recorded that they had undergone a health assessment and/or a medical examination. Results for individual DCP districts ranged from 86 per cent to eight per cent, as shown in Figure 7. DCP districts that were included in the 2009 pilot study for health care planning described in section 4.3.2 of this report (Fremantle, Midland, Great Southern and Pilbara) and those DCP districts that correspond to the Fremantle/Peel Department of Health administrative district (Fremantle, Mandurah and Rockingham) showed relatively higher percentages of children who had undergone health assessments and/or medical examinations.

Figure 7: Health assessment and/or medical examination held on child's DCP file, by district



5.4.3 Enrolment in School Dental Service

As discussed in Phase 3 of the Fieldwork outlined in chapter 3, for a subset of 61 children in our cohort of 443 children in care, we conducted a detailed examination of their care planning process. We examined the DCP file for these 61 children to identify whether there was evidence that the child had been enrolled in the School Dental Service. We observed evidence on the DCP file that 14 (22 per cent) of the 61 children had been enrolled in the School Dental Service. Since the School Dental Service operates a manual records system it was not practical to determine if other children in care had been enrolled in the School Dental Service without this being recorded on the child's DCP file.

In 2011, DCP and the School Dental Service have implemented a new process to ensure that children in care are enrolled in, and receiving treatment (if needed). This process involves DCP Field Workers sending a notification and consent form to the School Dental Service which then identifies if, and at what Dental Centre, the child is enrolled, obtains the child's clinical records, and forwards this information to DCP with a referral to the Dental Centre relevant to the child's current school. The School Dental Service reports that through this process, all children in care who have been notified to the School Dental Service have now been enrolled.

5.4.4 Assessment of mental health using the *Strengths and Difficulties Questionnaire*

For the same subset of 61 children in our cohort of 443 children in care, we examined the DCP file to identify whether the *Strengths and Difficulties Questionnaire* had been completed for each child and if this completed questionnaire had been analysed by the DCP District Psychologist for appropriate action.

We observed that a *Strengths and Difficulties Questionnaire* had been completed for nine (15 per cent) of the 61 children.

We also examined whether or not children in care were receiving professional support for mental health needs that had been identified by DCP. We examined the DCP files³⁸ (which includes the care plan) for 293 children in care to identify whether:

- The child in care had been identified as needing professional support;
- Referrals had been made for the child; and
- Professional support had been provided to the child.

We found that the DCP files for 100 children (34 per cent) indicated some form of emotional, mental health or behavioural concern for the child. In 75 (75 per cent) of these cases, the child had been referred to and received some form of counselling.³⁹ In 22 cases (22 per cent), it was not clear from the documentation in the child's file if the child's

³⁸ We reviewed the information in the child's general case file only. We did not access the internal 'Psychology Department' files held by DCP.

³⁹ Counselling service providers included DCP psychological services, private psychologists or psychiatrists, school psychologists, and counselling programmes or services provided by non-government organisations.

emotional, mental health or behavioural concerns had been addressed. In three cases (3 per cent), the child was on a waitlist for counselling services at the time of the investigation.

For the remaining 193 (66 per cent) of the 293 children whose files we examined, emotional, mental health or behavioural concerns were not mentioned in the DCP file.

5.5 Education components of care planning

5.5.1 Education planning procedures

The Manual provides procedures for implementing the education planning process agreed by DCP and the Department of Education. Section 10.10 of the Manual states that:

- Every child in the CEO's care of compulsory school age (six to 17 years of age) enrolled in school must have a Documented Education Plan;
- Documented Education Plans should be developed by schools in collaboration with relevant Department staff such as Field Workers and Education Officers;
- Documented Education Plans should be reviewed at least annually and form the education dimension of a child's care plan;
- Carers should be encouraged to participate in the education planning process; and
- Field Workers should ensure that carers are provided with a copy of the Documented Education Plan.

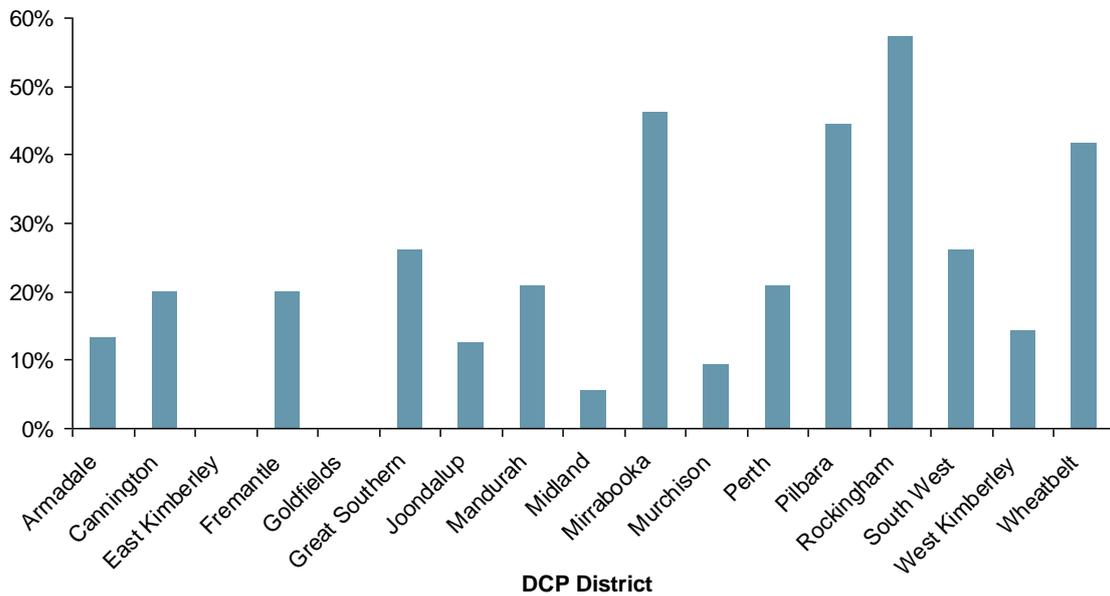
5.5.2 Documented Education Plans

We examined the DCP files for children in our cohort to identify whether there was evidence that the school had prepared a *Documented Education Plan* (in the form of either an Individual Education Plan or a Behavioural Plan) and returned this to DCP to form the education dimension of the child's care plan. We examined this aspect for the 293 children in our cohort of 443 children who had been taken into care through a protection order (time-limited or until 18) or a negotiated placement agreement. For these children, the full care planning process, beyond the initial development of a provisional care plan, should have been evident. For 63 (22 per cent) of these 293 children, we observed a *Documented Education Plan* on the child's DCP file.

For a subset of 61 children from four DCP districts, we examined their files in more detail. For these 61 children, a *Documented Education Plan* was held on file in 15 instances (25 per cent). In a further 18 instances (30 per cent), a *Documented Education Plan* was not held on file, although we observed evidence of some communication between DCP Field Workers and schools regarding the child.

The rate for preparation and return of *Documented Education Plans* varied across DCP districts from zero to more than 50 per cent, as shown in Figure 8. Whether a district is located in the metropolitan or country area and whether or not the district had a relatively large number of children in care did not appear to affect the percentage of children in that district whose DCP file contained a *Documented Education Plan*.

Figure 8: Documented Education Plan held on DCP file, by district



5.6 Reviews of care plans

5.6.1 Legislative requirements for reviews of care plans

A review of the operation and effectiveness of every care plan is required to be carried out at regular intervals not exceeding 12 months. Section 90 of the CCS Act relevantly provides:

90. Review of care plan

- (1) The CEO must carry out a review of the operation and effectiveness of every care plan at regular intervals not exceeding 12 months.
- (2) In the course of the review the CEO must have regard to any views expressed by —
 - (a) the child; and
 - (b) a parent of the child; and
 - (c) any carer of the child; and
 - (d) any other person considered by the CEO to have a direct and significant interest in the wellbeing of the child.
- (3) The CEO must prepare a written report on the outcome of the review and must ensure that, where practicable, a copy of the report is given to each of the people mentioned in subsection (2).
- (4) The CEO must keep a record of reviews carried out, and reports prepared, under this section in a manner that the CEO considers appropriate.

5.6.2 Review procedures

In section 10.4, the Manual outlines DCP's policy for reviewing care plans. This includes:

- Care Plans for children in the CEO's care must be reviewed at least once every 12 months.
- The review of the Care Plan should be an inclusive process (where possible) that includes the child, the parent(s), the carer(s) and others deemed to have a direct or significant interest in the wellbeing of the child.

This section of the Manual also specifies DCP's procedures to be followed when reviewing a care plan. These procedures include:

- The review of Care Plan document will populate with the decisions of the previous Care Plan. The review process should:
 - assess the implementation and effectiveness of the decisions of the Care Plan
 - present the views of all parties (the child, the parents, the child's carer and anyone else with a direct and significant interest in the child) about the current situation and the future
 - discuss any changes and decisions that may have occurred in the last 12 months
 - ensure cultural links are maintained for Aboriginal children in care
 - ensure that all children from a Cultural and Linguistically Diverse (CaLD) background remain connected with their culture
 - provide a synopsis of the child's current circumstances
 - include a proposal in relation to anticipated costs for the child over the next twelve months.
- The review must result in a new Care Plan being produced or confirming the ongoing adherence to the previous Care Plan.
- A written report on the outcome of the review must be produced and sent to all parties. This can be the review of Care Plan document in ASSIST or it can be a simple letter summarising the outcome of the review.
- These documents should be distributed within 14 working days of the review and should be accompanied by information advising the parties on how they may progress to the formal complaints process if they are dissatisfied with decisions. The new Care Plan must be sent to all parties with the report of outcome of the review. It is recommended that key elements of Care Plans changed during the formal review process are discussed within one week with the respective party if he or she has not been present.
- The Care Plan must be published through ASSIST.
- ASSIST must also be updated to record the date of the review and that a new Care Plan has been produced.

5.6.3 Care plan reviews

Seventy-five of the 293 primary school aged children who had been taken into care under a protection order or negotiated placement agreement after 1 July 2008, had a care plan approved more than 12 months before the commencement of this investigation. Therefore, the care plans of these 75 children should have been reviewed.

Review of care plan documents had been completed for 28 of these children (37 per cent). For a further 20 children (27 per cent), a new care plan had been prepared within the last 12 month period. For the remaining 27 children (36 per cent) a review of care plan document or new care plan prepared within the last 12 months was not identified.

Ombudsman Recommendations



Recommendation 5: DCP ensure that provisional care plans and care plans are prepared for all children in care, as required by the CCS Act.

Recommendation 6: DCP and the Department of Health collaborate to ensure that the agreed processes set out in the Health MOU are implemented by the agency nominated as responsible in the Health MOU, so that every child in care ultimately:

- Receives a medical examination and health assessment, as set out in the Health MOU, within the agreed timeframes; and
- Is enrolled in the School Dental Service.

Recommendation 7: DCP ensure that a *Strengths and Difficulties Questionnaire*, focussing on mental health, is completed and analysed for every child in care (four years or older), as set out in the Health MOU and their own policies and procedures.

Recommendation 8: DCP and the Department of Health collaborate to ensure that referrals for health checks are followed up to ensure that they are fulfilled. Specifically:

- DCP revise their procedures for identifying when children in care have not received health checks for their physical and dental health to ensure that the child is referred for these checks, the results are returned to DCP and are incorporated into the child's care plan; and
- The Department of Health monitor the progress of referrals to ensure they are acted upon and the results returned to DCP.

Recommendation 9: DCP and the Department of Education ensure that *Documented Education Plans* are prepared by schools and are returned to DCP to form part of the child's care planning.

Recommendation 10: DCP ensure that reviews of every care plan are carried out at regular intervals not exceeding 12 months, as required by the CCS Act.

6 Timeliness of care planning

6.1 Overview of chapter

- The CCS Act requires that the Chief Executive Officer of DCP must prepare and implement a provisional care plan for a child taken into provisional protection and care within 7 working days after the child is taken into provisional protection and care (s.39(3B)). Of our cohort of 443 children in care, a provisional care plan should have been prepared for 440 children. We observed that provisional care plans were prepared within the 7 working day timeframe for 108 (25 per cent) of these 440 children.
- The CCS Act requires that 'as soon as practicable after a child first comes into the CEO's care the CEO must prepare and implement a care plan for the child' (s.89(2)). DCP has determined that, as a matter of policy, care plans should be prepared within 20 working days of the child entering the CEO's care. Of our cohort of 443 children in care, a care plan should have been developed for 282 children. We observed that care plans were prepared within the 20 working day timeframe for 26 (9 per cent) of these 282 children.
- Timeliness varied widely across DCP districts, with some districts achieving significantly higher levels of compliance with these timeframes than the average level of compliance for all districts.

6.2 Requirements for timing of provisional care plans and care plans

Target timeframes have been established for provisional care plans and care plans, either through the CCS Act or DCP's policies. These are discussed below.

6.2.1 Legislative requirements for provisional care plan timeframes

Section 39 of the CCS Act relevantly requires that:

- (2) If –
 - (a) a child is taken into provisional protection and care under this Division; and
 - (b) the CEO decides, or is required, to make a protection application in respect of the child.
- (3A) The CEO must prepare and implement a provisional care plan for the child.
- (3B) Unless section 88I(2) applies, the CEO must prepare the provisional care plan within 7 working days after the child is taken into provisional protection and care.

During the *Children and Community Development Bill 2003, Consideration in Detail*, when discussing 'Clause 29: Provisional protection and care: meaning and effect,' the (then) Minister for Community Development, Women's Interests, Seniors and Youth, Hon Sheila McHale stated that:

Broadly speaking, it is a new provision and it clarifies that any child for whom the chief executive officer may have a protection order before the court is essentially deemed to be a child in the CEO's care. Therefore, that child will receive the same care and attention as any other child. It formalises that period of time from when the child initially comes into care and a court order is issued or not issued, which can be up to six months or more depending on the processes of the court. This provision ensures that the child has access to proper care planning during that time and it formalises the importance of having those services and attention in place.⁴⁰

Along with other provisions of the CCS Act, this provision was intended to contribute to ensuring that 'the child will not languish in care arrangements that are not monitored and not planned'.⁴¹ At that time, it was envisaged that the child would stay in care for as short a period as possible and that 'after a court order has been made and the type of protection order has been determined, a care plan will then be developed'.⁴²

6.2.2 DCP's policies and procedures for provisional care plans

The 2007 *Children and Young People in the CEO's Care Policy*, discussed in Chapter 4, identifies that a provisional care plan 'outlines the immediate placement and contact needs and identifies steps and measures to address those needs'.⁴³ The DCP policy reference to immediate placement and contact needs is not supported by the CCS Act, which provides that a provisional care plan should identify the needs of the child while the child is in provisional protection and care and outline steps and measures to be taken in order to address these needs. The reference to immediate needs appears to reflect the *Looking After Children* system on which DCP's care planning system was initially based.

DCP's *Care Planning Policy*, established in 2009, does not contain any specific instructions on this point. The Manual that accompanies the *Care Planning Policy* encourages Field Workers to go beyond the child's immediate placement and contact needs, stating that 'the Provisional Care Plan outlines the needs of the child during the time the child is in provisional protection and care, where an application for a protection order is before the Court. It is important to consider long-term plans that may be

⁴⁰ Hon Sheila McHale MLA, Minister for Community Development, Women's Interests, Seniors and Youth, Legislative Assembly, *Parliamentary Debates (Hansard)*, 11 March 2004, p862.

⁴¹ Hon Sheila McHale MLA, Minister for Community Development, Women's Interests, Seniors and Youth, Legislative Assembly, *Parliamentary Debates (Hansard)*, 30 March 2004, p1208.

⁴² Hon Sheila McHale MLA, Minister for Community Development, Women's Interests, Seniors and Youth, Legislative Assembly, *Parliamentary Debates (Hansard)*, 30 March 2004, p1209.

⁴³ Department for Child Protection, *Children and Young People in the CEO's Care Policy*, p6.
<<http://www.dcp.wa.gov.au/Resources/Documents/Policies%20and%20Frameworks/CYP%20in%20CEOs%20Care%20Policy%202007.pdf>> Accessed 15 July 2011.

appropriate if the protection order is granted.⁴⁴ DCP's template for provisional care plans (now integrated into ASSIST) reinforces the 2009 policy and guidelines, asking for the same information about the child's needs as it does for care plans, which go beyond the child's immediate placement and contact needs.

6.2.3 Legislative requirements and DCP's policy for care plan timeframes

The CCS Act requires that 'as soon as practicable after a child first comes into the CEO's care the CEO must prepare and implement a care plan for the child' (s.89(2)). The Explanatory Memorandum and debate in the Western Australian Parliament concerning the CCS Act provide no further guidance regarding care plan timeframes.

The 2007 *Children and Young People in the CEO's Care Policy* mirrored the CCS Act, in that it states that care plans must be prepared and implemented 'as soon as practicable'.⁴⁵ However, by 2009, DCP had determined that, as a matter of policy, care plans should be developed within 20 working days of the child entering the CEO's care. The Manual states that 'The Care Plan must be prepared and implemented as soon as practicable after the child first comes into the CEO's care. In practice, this means within 20 working days.'⁴⁶ This does not reflect the *Looking After Children* system, which sets out two further care planning steps, at six weeks and three months intervals, beyond the initial plan at 14 days.⁴⁷ During the investigation, DCP indicated that this internal timeframe was modelled on their existing practice of conducting case conferences within 28 calendar days of the child being taken into care.

6.3 Preparation timeframes

6.3.1 Provisional care plans

Of our cohort of 443 children in care, a provisional care plan should have been developed for 440 children (provisional care plans were not required for three children who were taken into care under negotiated placement agreements). Provisional care plans were completed within the legislated timeframe of 7 working days for 108 (25 per cent) of these 440 children. A further 129 (29 per cent) of provisional care plans were completed between eight and 21 working days after the child came into provisional protection and care.⁴⁸ For 60 (14 per cent) of these children, provisional care plans were not completed until the child had been in provisional protection and care for more than 60 days. These results are shown in Figure 9 below.

⁴⁴ Department for Child Protection, *Casework Practice Manual*, section 10.2.

<<http://manuals.dcp.wa.gov.au/manuals/cpm/Pages/02ProvisionalCarePlans.aspx>>. Accessed 15 July 2011.

⁴⁵ Department for Child Protection, *Children and Young People in the CEO's Care Policy*, p6.

<http://www.dcp.wa.gov.au/Resources/Documents/Policies%20and%20Frameworks/CYP%20in%20CEOs%20Care%20Policy%202007.pdf>. Accessed 15 July 2011.

⁴⁶ Department for Child Protection, *Casework Practice Manual*, section 10.3

<<http://manuals.dcp.wa.gov.au/manuals/cpm/Pages/03CarePlans.aspx>>. Accessed 15 July 2011.

⁴⁷ State Government of Victoria, Australia, Department of Human Services, Children, Youth and Families, *Looking After Children Processes and Timelines Flowchart*.

http://www.cyf.vic.gov.au/__data/assets/pdf_file/0019/361621/lac-flowchart.pdf. Accessed 15 July 2011.

⁴⁸ The date a provisional care plan was deemed as being 'prepared and implemented' was the date it was logged as being prepared on CCSS or as being approved on ASSIST.

Figure 9: Preparation times for provisional care plans, by working days

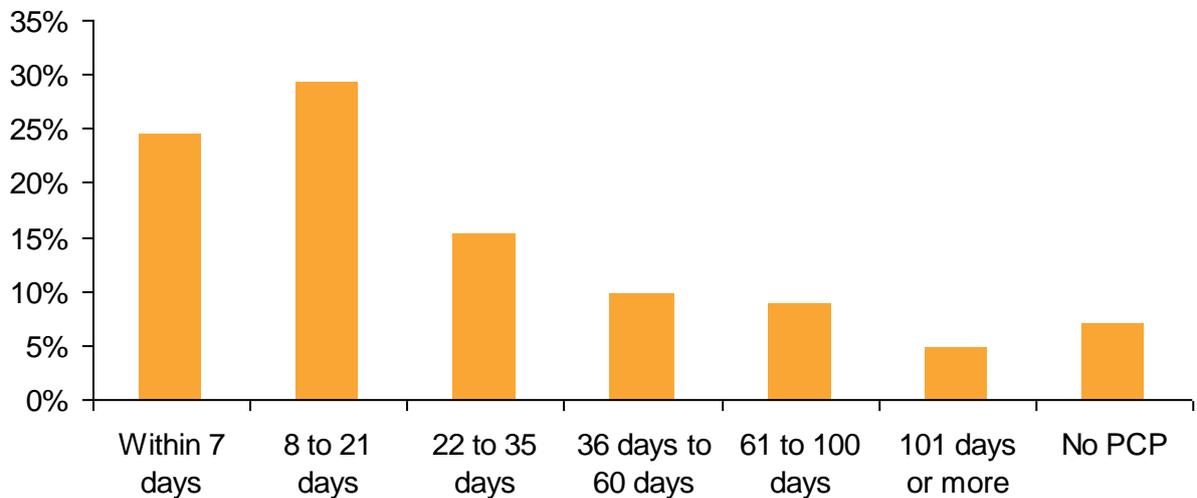


Table 4 below shows individual district compliance with the 7 working day timeframe (in order of districts with the largest to the smallest number of children in the cohort). The table shows that compliance varied from 67 per cent to nil. For example, 67 per cent (16 out of 24) of provisional care plans were completed within 7 working days in the Midland district, 45 per cent (13 out of 29) were completed within this timeframe in the Mandurah district, and in the Wheatbelt district (15 out of 33).

Table 4: Percentage of provisional care plans, prepared within timeframe brackets by district

DCP district (number of children in our cohort)	Within 7 days (compliance rate)	8 to 21 days	22 to 35 days	36 to 60 days	61 to 100 days	101 days or more	No provisional care plan
Armadale (46)	17%	22%	15%	13%	2%	11%	20%
Great Southern (40)	28%	25%	15%	13%	10%	5%	6%
Joondalup (34)	21%	65%	9%	0%	0%	0%	6%
Wheatbelt (33)	45%	6%	12%	12%	15%	9%	0%
Cannington (31)	19%	26%	23%	10%	23%	0%	0%
Perth (30)	20%	23%	10%	17%	13%	10%	7%
Mandurah (29)	45%	31%	7%	7%	7%	0%	3%
South West (29)	17%	48%	3%	10%	21%	0%	0%
Goldfields (25)	4%	44%	20%	0%	0%	0%	32%
Fremantle (25)	28%	32%	32%	4%	0%	0%	4%
Midland (24)	67%	13%	21%	0%	0%	0%	0%
Murchison (19)	0%	32%	11%	0%	11%	26%	21%
Mirrabooka (19)	5%	21%	16%	32%	26%	0%	0%
Rockingham (18)	22%	11%	39%	11%	0%	0%	17%
Pilbara (15)	27%	40%	20%	0%	13%	0%	0%
East Kimberley (15)	20%	27%	7%	40%	0%	0%	7%
West Kimberley (8)	13%	38%	0%	0%	13%	38%	0%

During the investigation, DCP advised that the preparation of provisional care plans was identified as a 'current elevated priority' during 2010, that is, districts had been asked to focus on the timeliness of provisional care plans and care plans. To consider the impact of this increased operational focus, we analysed provisional care plan preparation times for the 141⁴⁹ children in our cohort who were taken into provisional protection and care on or after 1 January 2010 on a month by month basis.

Table 5 shows this analysis and indicates that the percentage of provisional care plans prepared within the legislated time requirement of 7 working days was 45 per cent for January 2010 and 20 per cent for February 2010. However for the period March 2010 to August 2010, no provisional care plans were prepared within 7 working days of the child being taken into care. This rate improved markedly in September 2010 and slightly in

⁴⁹ All 141 children in care required a provisional care plan to be prepared within 7 working days.

October 2010 with 55 per cent and 27 per cent of provisional care plans being prepared within the legislated time requirement.

Taking the period 1 January 2010 to 30 October 2010 as a whole, 17 provisional care plans (12 per cent) were prepared within 7 working days and 47 provisional care plans (34 per cent) were prepared between eight and 21 days. However more than half of the 141 (77) provisional care plans took 22 days or more to prepare.

When comparing the rate of provisional care plans being prepared within 7 days for the period 1 July 2008 to until November 2010 (Figure 9) of 25 per cent and the period 1 January 2010 until November 2010 (Table 5) when the preparation of provisional care plans was an 'elevated priority' and the rate was 12 per cent, there does not appear to have been an improvement over the second period.

Table 5: Number of days taken to complete provisional care plans in 2010, by month

Month - 2010	Number prepared - 7 days or less	Number prepared - 8 to 21 days	Number prepared - 22 days or more	Total number of provisional care plans	% of provisional care plans in 7 days
January	5	5	1	11	45%
February	3	4	8	15	20%
March	0	1	15	16	0%
April	0	0	19	19	0%
May	0	1	6	7	0%
June	0	0	9	9	0%
July	0	16	12	28	0%
August	0	11	3	14	0%
September	6	1	4	11	55%
October	3	8	0	11	27%
Total	17	47	77	141	12%

6.3.2 Care plans

Of our cohort of 443 children in care, a care plan should have been developed for 282 children. Care plans were prepared within a 20 working day timeframe for nine per cent (26) of these 282 children, and a further 16 per cent (44) were prepared between 21 and 35 working days. Care plans for 16 per cent (46) of the 282 children were not prepared until more than 101 days after the child had been taken into care under the relevant order. For a further six per cent (16) of these children, care plans were prepared before they were taken into care under the relevant order. These results are shown in Figure 10 below.

Figure 10: Preparation times for care plans, prepared within timeframe brackets by days

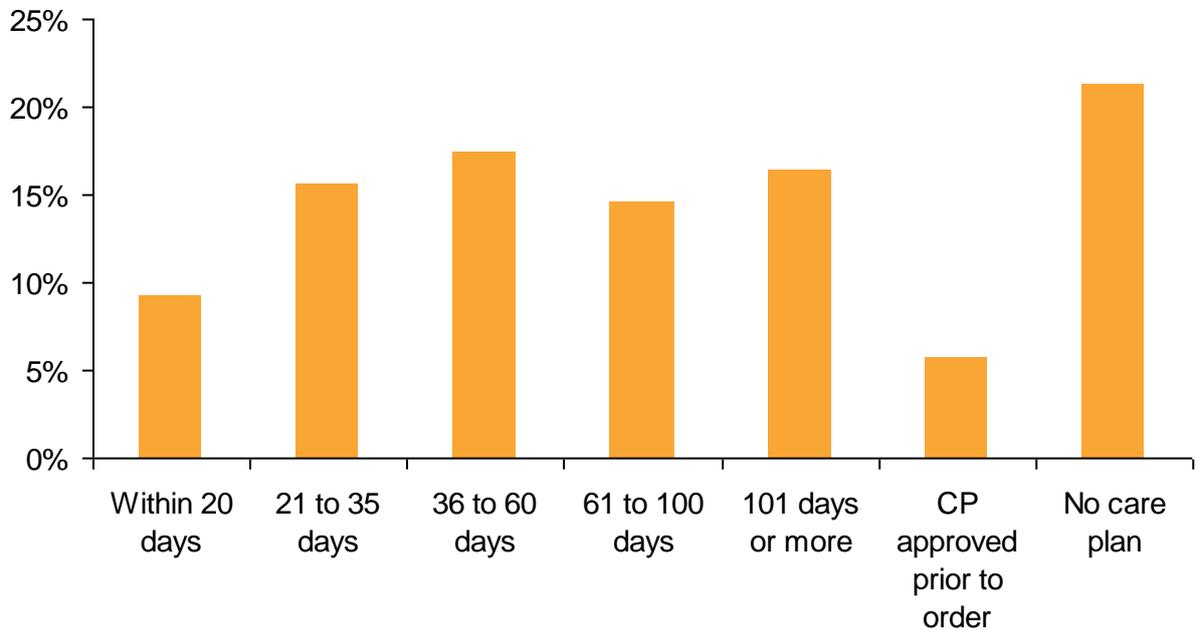


Table 6 below shows that there are variations in the times taken to prepare care plans across the different DCP districts. For example, the Pilbara district prepared nearly two out of three care plans within 20 working days, although two of the 10 children in the Pilbara did not have a care plan as required. The South West district prepared all their required care plans within 100 days. The East Kimberley district prepared 44 per cent (four out of nine) of care plans prior to the child being taken into care under the relevant order, that is, while the child was in provisional protection and care. Table 6 also shows that almost half of the DCP districts (8 out of 17) did not have any care plans prepared within the set 20 working day timeframe and in approximately one-third (6 out of 17) of the DCP districts, one out of every five care plans was prepared in 101 days or more following the child being taken into care under the relevant order.

Table 6: Preparation times for care plans, by district

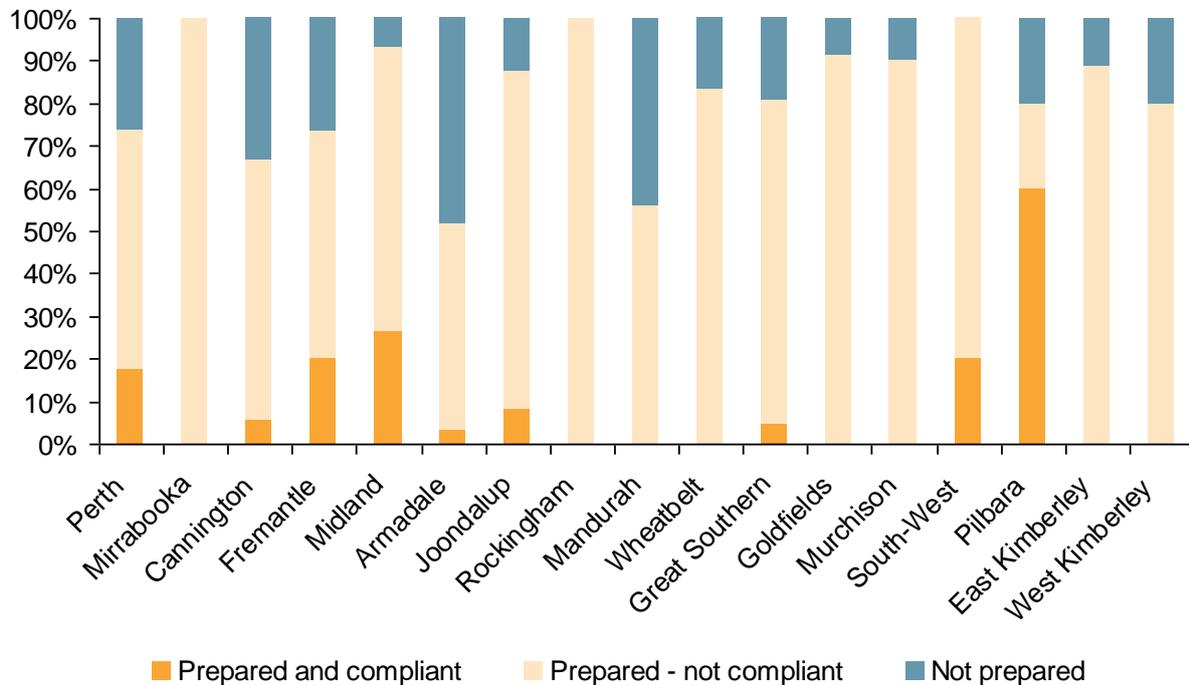
DCP District (number of children in cohort who required care plans)	Within 20 days	21 to 35 days	36 to 60 days	61 to 100 days	101 days or more	Care plan approved prior to order	No care plan
Perth (23)	17%	26%	9%	13%	9%	0%	26%
Mirrabooka (13)	0%	38%	23%	23%	8%	8%	0%
Cannington (18)	6%	6%	11%	22%	11%	11%	33%
Fremantle (15)	20%	27%	0%	7%	20%	0%	27%
Midland (15)	26%	33%	20%	7%	7%	0%	7%
Armadale (31)	3%	13%	10%	0%	26%	0%	48%
Joondalup (24)	8%	17%	33%	8%	17%	4%	13%
Rockingham(7)	0%	0%	29%	0%	43%	29%	0%
Mandurah (25)	0%	8%	0%	16%	24%	8%	44%
Wheatbelt (24)	0%	0%	42%	29%	13%	0%	17%
Great Southern (21)	5%	14%	0%	48%	10%	5%	19%
Goldfields (12)	0%	8%	58%	0%	8%	17%	8%
Murchison (10)	0%	0%	30%	0%	50%	10%	10%
South West (20)	20%	35%	25%	20%	0%	0%	0%
Pilbara (10)	60%	0%	10%	10%	0%	0%	20%
East Kimberley (9)	0%	22%	0%	11%	11%	44%	11%
West Kimberley(5)	0%	0%	0%	0%	80%	0%	20%

As with provisional care plans, care plan preparation times did not improve in 2010. Analysis of care plan preparation times for those children in our cohort who had been taken into care under the relevant order on or after 1 January 2010 (19 children) revealed that one (5 per cent) care plan was prepared within 20 working days and six (32 per cent) were prepared within 50 working days of the child being taken into care under the relevant order. When comparing these results with those of the whole cohort (ie those taken into care after 1 July 2008), it appears that care plans were not prepared in a more timely manner in 2010.

6.4 Preparation rates and timeframes considered together

Figure 11 below compares the number of care plans required but not prepared (termed 'not prepared'), prepared but not compliant with the 20 day timeframe (termed 'prepared – not compliant'), and those prepared within the 20 day timeframe (termed 'prepared and compliant'), by individual DCP districts. For example, the analysis for Midland district shows that 7 per cent of care plans were not prepared, 67 per cent were prepared but not within 20 working days and 26 per cent were prepared within 20 working days.

Figure 11: Percentage of care plans prepared and compliant within 20 working days timeframe, prepared in more than 20 working days and not prepared, by district



6.5 Factors potentially impacting on timeframes

Explanations in the file documentation and discussions with DCP District Directors and staff indicated that they believed two factors contributed to delays in preparing provisional care plans and care plans.

Firstly, at the same time as the provisional care plan was meant to be prepared, Field Workers were also attending to the immediate tasks associated with taking children into care. These tasks may include finding a placement, working with parents on reunification strategies, enrolment in school, obtaining basic health information such as medical and immunisation records, inputting data (required before a child can be placed) and preparing legal documents for the Children’s court. Discussions indicated that attending to these immediate tasks creates a consequent delay in finalising the provisional care plan. Further delays may arise when multiple children in one family are being taken into care simultaneously or when there are difficulties bringing the relevant parties together in order to complete these tasks.

The second factor that impacted on compliance with required timeframes for provisional care plans was that Field Workers were attempting to develop provisional care plans (within a 7 day timeframe) that were as comprehensive as care plans (that have a 20 working day timeframe). The discussion in section 6.2.2 of this report identifies that DCP’s approach to provisional care plans has evolved over time, from its original focus on immediate placement and contact needs to more comprehensive plans that contain the same information about the child’s needs as care plans.

To develop these more comprehensive plans, we observed that Field Workers attempted to bring parties together to participate in provisional care planning, sometimes experienced difficulties in doing so, and delayed finalising provisional care plans until they had held these meetings.

DCP's advice to Field Workers on this point appears to be conflicting. On the one hand, DCP's *Care Planning Policy* indicates that 'an inclusive, consultative and formal process' should be considered when developing the provisional care plan.⁵⁰ The Manual is even more definite, stating that 'the Provisional Care Plan is written after an inclusive and consultative process with all relevant parties. Team Leaders have the delegated authority to determine those people who have a direct and significant interest in the child's wellbeing and for ensuring an inclusive process occurs. A planning meeting should be convened, however, the plan may be written following other forms of consultation with all parties.'⁵¹

On the other hand, during the investigation, DCP advised that children generally came into care from families that have had extended contact with the Department, therefore DCP expects that Field Workers should be able to readily complete the comprehensive template for provisional care plans using information that has already been recorded during previous work with the family. It is therefore not anticipated that meetings to discuss provisional care plans will be needed and, accordingly, Field Workers are currently being encouraged to develop provisional care plans without holding meetings.

Explanations in the file documentation also indicated that difficulty in bringing the relevant parties together to participate in care planning was a significant factor in delaying their preparation beyond the 20 working day timeframe for care plans.

⁵⁰ Department for Child Protection, *Care Planning Policy*.

<<http://www.dcp.wa.gov.au/Resources/Documents/Policies%20and%20Frameworks/Care%20Planning%20Policy%202009.pdf>>. Accessed 25 May 2011.

⁵¹ Department for Child Protection, *Casework Practice Manual*, section 10.2.

<http://manuals.dcp.wa.gov.au/manuals/cpm/Pages/02ProvisionalCarePlan.aspx>>. Accessed 15 July 2011.



Ombudsman Recommendations

Recommendation 11: DCP ensure that provisional care plans are prepared within the 7 day timeframe required by the CCS Act.

Recommendation 12: DCP reconsider its approach to provisional care plan preparation, including its policies and procedures, so that it can achieve the 7 day timeframe and the content requirements for provisional care plans set out in the CCS Act.

Recommendation 13: DCP consider its approach to meeting the 'as soon as practicable' timeframe requirements for care plan preparation to meet the objectives and requirements of the CCS Act.

Recommendation 14: DCP ensure that care plans are prepared within the timeframe identified by its policies and procedures.

Recommendation 15: DCP identify approaches used in districts that have achieved higher timeframe compliance rates for the preparation of provisional care plans and care plans and assist other districts to adopt these approaches.

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7 Participation in care planning

7.1 Overview of chapter

- The CCS Act requires that children be given the opportunity to express their wishes and views freely, according to their abilities, to ensure that they are able to participate in decisions about their own care plan (s.10).
- DCP has established policies and procedures, which aim to ensure that children are given the opportunity to participate in the preparation of their own care plans and assistance to do so. To assist Field Workers fulfil these policies and procedures, DCP has provided them with opportunities to attend internal and external training to increase their skills in working with children, and with tools to use when assisting children of different ages and abilities to express their wishes and views.
- However, there are gaps between DCP's policy and practice regarding participation of children in the preparation of their own care plans. We examined in detail the care planning documentation of 61 children from four DCP districts. Fifty of these children had care plans. Our examination of these 50 care plans found evidence that the child had participated in the care planning process in 20 (40 per cent) of these cases. DCP's own monitoring of care planning found that most children could not recall an opportunity to be involved in their care plan and that this was not always due to the age or developmental level of the child.
- The CCS Act requires that parents and carers have opportunities and assistance to participate in decision-making processes that are likely to have a significant impact on the child's life (s.9(j)). DCP has established policies and procedures, which aim to ensure that parents and carers participate in care planning. Our detailed examination of care planning documentation observed that, for the 50 children with care plans, at least one parent or step-parent was included in the care planning process in 43 care plans (86 per cent) examined, with carers being involved in 46 care plans (92 per cent) examined.

7.2 Requirements for participation in care planning

7.2.1 Legislative requirements for participation by children

The Principle of child participation, set out s.10 of the CCS Act, relevantly provides that:

- (1) If a decision under this Act is likely to have a significant impact on a child's life then, for the purpose of ensuring that the child is able to participate in the decision-making process, the child should be given -
 - (a) ...
 - (b) the opportunity to express the child's wishes and views freely, according to the child's abilities; and
 - (c) any assistance that is necessary for the child to express those wishes and views; and....

Section 10(2) of the CCS Act states that, in the application of the *Principle of child participation*, 'due regard must be had to the age and level of understanding of the child concerned.' Section 10(3)(b) of the CCS Act specifies the type of decisions to which the principle is to apply. This includes decisions in the course of preparing, modifying or reviewing care plans or provisional care plans for the child.

7.2.2 Legislative requirements for participation by parents and carers

The CCS Act also requires that parents and carers have the opportunity to participate in care planning, as set out in the relevant sections of the legislation below.

9. Principles to be observed

- ...
- (j) the principle that a child's parents and any other people who are significant in the child's life should be given an opportunity and assistance to participate in decision-making processes under this Act that are likely to have a significant impact on the child's life;
 - (k) the principle that a child's parents and any other people who are significant in the child's life should be given adequate information, in a manner and language that they can understand, about —
 - (i) decision-making processes under this Act that are likely to have a significant impact on the child's life; and
 - (ii) the outcome of any decision about the child, including an explanation of the reasons for the decision; and
 - (iii) any relevant complaint or review procedures.
- ...

89. Care plans, preparation etc. of

- ...
- (6) As soon as practicable after the CEO prepares or modifies a care plan, the CEO must ensure that a copy of the care plan or modification, as the case requires, is given to —
 - (a) the child; and
 - (b) each parent of the child; and
 - (c) any carer of the child; and
 - (d) any other person considered by the CEO to have a direct and significant interest in the wellbeing of the child.

90. Review of care plan

- ...
- (2) In the course of the review the CEO must have regard to any views expressed by —
 - (a) the child; and
 - (b) a parent of the child; and
 - (c) any carer of the child; and
 - (d) any other person considered by the CEO to have a direct and significant interest in the wellbeing of the child.
 - (3) The CEO must prepare a written report on the outcome of the review and must ensure that, where practicable, a copy of the report is given to each of the people mentioned in subsection (2).
- ...

7.2.3 DCP's policies and procedures regarding participation in care planning

DCP's document *Better Care, Better Services, Standards For Children And Young People In Protection And Care (the Standards)* includes a standard specific to participation in planning, as follows:

Standard 5: Children, young people and families participate in the planning and decision-making for matters that impact on their lives and future.

The relevant supporting standards are:

5.2 Children and young people in care are given an opportunity and assistance to participate in decisions that affect them, taking into account their age and understanding.

5.3 A child's parents and any other people who are significant in the child's life are given adequate information and assistance to enable participation in a manner and language that they can understand.

...

5.5 Planning is inclusive of all significant stakeholders. Significant stakeholders are the child, a parent of the child, any carer of the child and any significant other considered by the CEO to have a direct and significant interest in the well being of the child.

...

5.10 A copy of the provisional Care Plan, Care Plan or review of Care Plan is given to the child; a parent of the child and any significant other as determined by the Department's CEO.

Attachment A to the Standards indicates that information and assistance that may be provided to help the child participate includes the need to provide information in a manner and language the child can understand; how the child can participate; opportunities for the child to express their views and wishes; and information about how DCP will take into account the child's views.

The Manual encourages participation by all parties in provisional care plans stating that:

The Provisional Care Plan is written after an inclusive and consultative process with all relevant parties. Team Leaders have the delegated authority to determine those people who have a direct and significant interest in the child's wellbeing and for ensuring an inclusive process occurs.

A planning meeting should be convened, however, the plan may be written following other forms of consultation with all parties. If a planning meeting is to be convened, Field Workers may wish to refer to the resource document *Step by Step Guide to Planning Meetings* (section 10.2).

The Manual also states that:

The Field Worker gathers the views and wishes of all parties, the details of the current situation, the needs of the child, proposals to meet these needs and funding needs recorded and approved in the ASSIST case plan.

The views of the parties should be taken into consideration in developing the Care Plan. The information can be presented on the Report to Meeting document in ASSIST for the initial Care Plan, and the Care Plan review template in ASSIST for follow up Care Plans.

Consultation with all of the relevant parties can occur through a variety of means: a group Care Plan meeting, individual meetings, home visits, telephone consultations between the Field Worker and the parties, or through the parties completing the 'Report to Meeting' form - Carer's/Child's/Young Person's/Parent's Report to Meeting forms: Form 730, Form 731, Form 732 and Form 733. (section 10.3).

To assist Field Workers fulfil the requirements of the CCS Act and to assist them achieve the required standards of practice:

- i) DCP has provided Field Workers with opportunities to attend internal and external training to increase their skills in working with children;
- ii) DCP is currently introducing 'Viewpoint Interactive,' a web-based computer application that uses multi-media with graphics and animation to help children and young people express their views, wishes and experiences.⁵² DCP has piloted the use of Viewpoint in two districts, including as a tool to consult with and include children and young people in care planning. DCP intends to use the results of the pilot to inform the state-wide roll out and evaluation of the use of Viewpoint in care planning;⁵³ and
- iii) The Signs of Safety Assessment and Planning Framework was introduced by DCP at the beginning of 2008 for use by Field Workers as a case management tool to explore allegations, the circumstances and events surrounding allegations, the extent of danger the child faces, and the extent and possibility of the child's safety.⁵⁴ The Framework incorporates tools such as the 'three houses' tool and the 'fairy/wizard' tool to help children express their views. Field Workers can also use these tools when working with children and young people on care planning. DCP is currently updating the Signs of Safety framework to include reference to care planning for children in care.

7.3 Participation in care planning by children, parents and carers

In our sample of 61 children (those included in Phase 3, as discussed in Chapter 3) whose care planning we examined in detail, care plans had been prepared for 50 children. We examined the care plans of these 50 children to identify whether children, parents and carers had been involved in their preparation. In 20 cases (40 per cent), the involvement of the child in developing the care plan was documented. At least one parent or step-

⁵² The Viewpoint Organisation Ltd, *Viewpoint, An Interactive online approach that encourages young people to give their views*. <www.vptorg.co.uk/Youth%20Justice/general_leaflet_julyD.pdf>. Accessed 2 June 2011.

⁵³ Department for Child Protection, *DCP Annual Report 2009-10*. <<http://www.dcp.wa.gov.au/Resources/Documents/Annual%20reports/Annual%20Report%20200910.pdf>>. Accessed 19 May 2011.

⁵⁴ Department for Child Protection, *Western Australian Department for Child Protection's Implementation of Signs of Safety*, <<http://www.signsofsafety.net/westernaustralia>>. Accessed 30 March 2011.

parent was included in the care planning process in 43 care plans (86 per cent) examined, with carers being involved in 46 care plans (92 per cent) examined.

7.3.1 Children's views on their participation in care planning

From 2009 to 2010, DCP's Standards Monitoring Unit monitored care planning meetings and participation against Standard 5 of *Better Care, Better Services, Standards For Children And Young People In Protection And Care* (incorporating supporting standard 5.2 discussed above). The review examined the implementation of the standard in five metropolitan and five country districts (Cannington, Fremantle, Joondalup, Rockingham, Mirrabooka, Murchison, Peel, Great Southern, Pilbara and South West). In each district, a sample of approximately 20 cases was considered. This involved a case file review, discussion with DCP staff, and where possible, interviews with the child, the parent and the carer. The report developed by the Standards Monitoring Unit found that:

...most children interviewed as part of the monitoring process across all of the districts could not recall an opportunity to be involved in their Care Plan decisions. The monitors observed that this was not always due to age or the developmental level of the child.⁵⁵

As part of the report, the Standards Monitoring Unit recommended that DCP should explore methods of engaging with children to gather information for the purpose of representing the child in the care plan, and noted that Viewpoint is one example of this. This report is currently being considered by DCP.

7.3.2 Parents and carers' views on their participation in care planning

The summary report by DCP's Standards Monitoring Unit, discussed above, also found that:

The majority of the parents, interviewed by the monitors across all districts, reported that they were included in care planning and the monitors reported sighting documentation and receiving feedback indicated that Field Officers actively facilitated parent participation by means such as convening separate meetings for parents where there was conflict or safety concerns, teleconferences for parents residing outside the District, visiting parents who were unable to attend the care planning meeting (for example, when at prison) and facilitating parents attending with a support person. Carers generally reported participation in the care planning process.⁵⁶

⁵⁵ DCP (2011) Trend Report for Care Planning, Meetings and Participation, Standards Monitoring Unit, January 2011, p2. (Internal document, unpublished).

⁵⁶ DCP (2011) Trend Report for Care Planning with Children, Carers and Parents, Standards Monitoring Unit, January 2011, p3. (Internal document, unpublished).



Ombudsman Recommendations

Recommendation 16: DCP ensure that children in care are given the opportunity to participate in decisions about their own care planning, as required by the CCS Act.

Recommendation 17: In ensuring that children in care participate in their own care planning, it is recommended that DCP:

- Revise its policies and procedures to specify the legislative requirements regarding children's participation in their own care planning and how they are to be met;
- Ensure Field Workers are able to implement these revised policies and procedures; and
- Monitor the introduction of its new tools for Field Workers to use to encourage child participation to determine whether they are proving to be effective.

Recommendation 18: DCP continue to ensure that parents and carers are involved effectively in care planning.

8 Content of care plans

8.1 Overview of chapter

- The CCS Act provides that 'care plan means a written care plan that identifies the needs of the child; and outlines steps or measures to be taken in order to address those needs; and sets out decisions about the care of the child...' (s89(1)).
- DCP has developed policies and procedures for the content of care plans, including a care plan template that contains eight dimensions of child wellbeing to be addressed in a care plan. These dimensions are: safety; care arrangements; health; education; social and family relationships; recreation and leisure; emotional and behavioural development; and identity and culture.
- We examined in detail the care planning documentation of 61 children from four DCP districts. Fifty of these children had care plans. Our examination of these 50 care plans observed that:
 - In 26 care plans (52 per cent) we reviewed, needs of the child were identified in all eight dimensions of child wellbeing in the care plan template.
 - Analysing each of the eight dimensions individually, needs of the child were identified between 96 per cent and 74 per cent of the time.
 - The dimensions of health, education, emotional and behavioural development, and identity and culture were completed the least number of times.
- Our observations regarding health care planning and education planning indicate that there are the following deficiencies in the interagency process to ensure that all the care planning documents for children in care are completed, provided to DCP and the results incorporated into the main care plan:
 - It is DCP and Department of Health policy that 'Health Plans for children in the CEO's care should be developed in consultation with Community Health Nurses as part of the care planning process and recorded in each child's care plan'.⁵⁷ We observed that for the 50 children whose care plans we examined in detail, 15 of these 50 children had undergone a medical examination and/or a health assessment and the results were contained in their DCP file. In nine (60 per cent) of the 15 cases, the results had also been incorporated into the child's care plan. A further eight children (of the 11 children who did not have a care plan) had undergone a medical examination and/or a health assessment.
 - It is DCP and Department of Education policy that *Documented Education Plans* should be developed by schools in collaboration with relevant Department staff

⁵⁷ Department for Child Protection, *Casework Practice Manual*, section 10.14.
<<http://manuals.dcp.wa.gov.au/manuals/cpm/Pages/14HealthCarePlanningforChildreninCare.aspx>>
Accessed 19 July 2011.

such as Field Workers and Education Officers and ... should form the education dimension of a child's care plan (section 10.10). We observed that for the 50 children whose care plans we examined in detail, a *Documented Education Plan* had been prepared and was held on DCP's file for 12 children. In seven of these 12 instances (58 per cent), the *Documented Education Plan* was reflected in the education dimension of care plan. For three of the 11 children who did not have a care plan, DCP held a *Documented Education Plan* on file.

- DCP's *Care Planning Policy* states that 'In addition to the legislative requirements, the care plan should also include ... a proposal to meet identity and cultural requirements.' We observed that 34 (68 per cent) of the 50 care plans we examined in detail identified needs and included decisions and steps to address these needs for the identity and culture dimension.
- DCP's *Care Planning Policy* also states that Aboriginal and Torres Strait Islander children and children from culturally and linguistically diverse backgrounds 'need to have well researched cultural plans as part of their care plans.'⁵⁸ Our observations were consistent with DCP's own review of this aspect of care planning practice, which in general found there to be inconsistent practice in developing cultural plans.

8.2 Requirements for the content of care plans

8.2.1 Legislative requirements for the content of care plans

Section 89(1) of the CCS Act provides that:

care plan means a written plan that —

- (a) identifies the needs of the child; and
- (b) outlines steps or measures to be taken in order to address those needs; and
- (c) sets out decisions about the care of the child including —
 - (i) decisions about placement arrangements; and
 - (ii) secure care decisions referred to in section 88G; and
 - (ii) decisions about contact between the child and a parent, sibling or other relative of the child or any other person who is significant in the child's life.

8.2.2 DCP's policies and procedures for the content of care plans

Section 10.3 of the Manual includes the requirements for developing care plans, care plan meetings, and the writing up of care plans. This section states that, on approval, the care plan is published through ASSIST. A template for care plans is provided in ASSIST. The template identifies eight dimensions of a child's wellbeing that Field Workers are to

⁵⁸ Department for Child Protection, *Care Planning Policy*.

<<http://www.dcp.wa.gov.au/Resources/Documents/Policies%20and%20Frameworks/Care%20Planning%20Policy%202009.pdf>>. Accessed 25 May 2011.

complete. For each of these eight dimensions within the care plan, the Field Worker is asked to identify the child's needs and decisions and steps to address the identified needs. The eight dimensions are:

- (i) Safety;
- (ii) Care arrangements;
- (iii) Health;
- (iv) Education;
- (v) Social and family relationships;
- (vi) Recreation and leisure;
- (vii) Emotional and behavioural development; and
- (viii) Identity and culture.

The eight dimensions within the care plan template were largely based on the United Kingdom's *Looking After Children* system and its developmental dimensions (discussed at section 5.2.2 of this report). The care plan template incorporates six dimensions from the *Looking After Children* system.⁵⁹ These six are health, education, emotional and behavioural development, social and family relationships, recreation and leisure (which is included in social presentation dimension in the UK model) and identity and culture. These six areas were supplemented with two additional dimensions in the template that relate to specific requirements in the CCS Act (s.89(1)(c)(i) and (ii)), that is, 'decisions about placement' and 'decisions about contact between the child and a parent, sibling or other relative of the child or any other person who is significant in the child's life.' These areas are incorporated in the safety and care arrangements dimensions of the DCP care plan template.

8.3 Identifying and addressing the needs of children in care

For this phase of the investigation, we selected two metropolitan (Cannington and Fremantle) and two rural (Pilbara and South West) DCP districts, one of each having participated in the 2009 pilot study for health care planning. These four districts provided a sample of 61 children from our cohort who had been taken into care under protection orders. We examined the care plans and all other information on the DCP files for these children to determine whether:

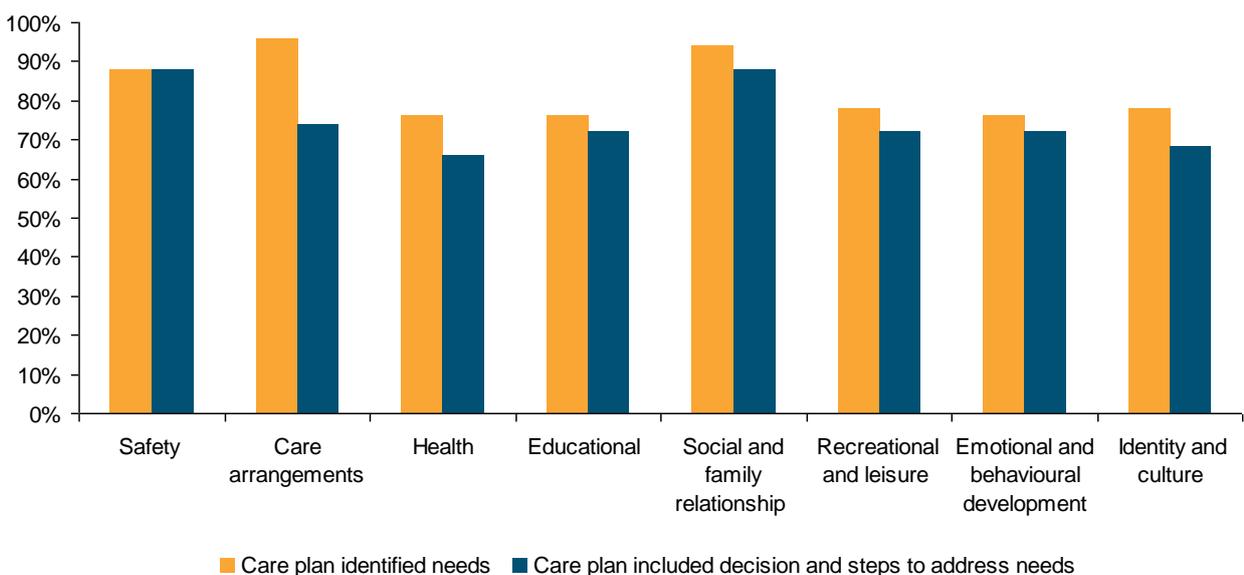
⁵⁹ Ms Jane Brazier, Acting Director General, Department for Community Development, Western Australia, Legislative Council Estimates Committee, *Parliamentary Debates (Hansard)*, 18 October 2001, pp834b-839a.

- (i) Needs were identified and decisions and steps to address these needs were outlined for each of the eight dimensions in the care plan template. In undertaking this examination, we considered whether the needs identified in the care plan reflected other information on the DCP file (DCP files can contain thousands of documents about a child) about the child’s circumstances and needs;
- (ii) Information in the child’s medical examination and/or health assessment was captured in their care plan; and
- (iii) Information in the child’s *Documented Education Plan* was captured in their care plan.

A care plan was held on file for 50 of the 61 children in our sample. A care plan had not been prepared for the other 11 children at the time of our investigation. (One child was not due to have a care plan prepared as they had been in care less than 20 working days. The remaining 10 children should have had a care plan as they had been on a protection order for more than 20 working days).

In 26 care plans (52 per cent) we reviewed, needs of the child were identified in all eight dimensions of child wellbeing in the care plan template. Analysing each of the eight dimensions individually, needs of the child were identified between 96 per cent and 74 per cent of the time. Figure 12 provides a breakdown of the extent to which each of the eight dimensions of the care plan template was completed. The figure shows that under the dimensions of safety and social and family relationships, needs were identified and addressed in nine out of ten of the care plans reviewed. The dimensions of health, education, emotional and behavioural development, and identity and culture were completed the least number of times.

Figure 12: Identifying and addressing needs of children in care, by percentage



8.4 Health needs of children in care

The Manual (which states processes to be followed by DCP Field Workers) states that:

Health Plans for children in the CEO's care should be developed in consultation with Community Health Nurses as part of the care planning process and recorded in each child's care plan. The term 'Health Plan' refers to a documented action plan, within the care plan, that aims to improve the physical and developmental outcomes for a child in the CEO's care (section 10.14).

Figure 12 above shows that 33 (66 per cent) of the 50 care plans we examined in detail incorporated a health care plan in the form of a completed health dimension that identified health needs and outlined decisions and steps to address these needs. In the remaining 17 (34 per cent) of cases, the health dimension of the care plan was not completed or did not contain meaningful information.

The Manual also states that:

- As part of the care planning process, all children in the CEO's care must have a health assessment to assist in developing and implementing the health dimension of each child's care plan (section 10.14);
- When a child first comes into the CEO's care, including provisional protection and care, the Field Worker must arrange for a medical examination of the child with a General Practitioner within 20 working days unless an examination has already occurred (for example, where a child has been examined at the Princess Margaret Hospital Child Protection Unit) (section 10.14).

Of the 61 children in care included in this phase of the investigation, DCP's records show that 50 children had a care plan prepared for them. We observed that 15 of these 50 children had undergone a medical examination and/or a health assessment and the results were contained in their DCP file. In nine (60 per cent) of the 15 cases, the results had also been incorporated into the child's care plan. A further eight children (of the 11 children who did not have a care plan) had undergone a medical examination and/or a health assessment.

8.5 Education needs of children in care

Section 10.10 of the Manual states that:

- Documented Education Plans should be developed by schools in collaboration with relevant Department staff such as Field Workers and Education Officers;
- Documented Education Plans should be reviewed at least annually and form the education dimension of a child's care plan.

The *Documented Education Plan* could be in the form of an Individual Education Plan or an Individual Behaviour Management Plan, which both set out strategies, interventions, services and supports to meet the educational needs of a child for the school year ahead. It is expected that a copy of the *Documented Education Plan* is provided by the school to the Field Worker, and this then either becomes, or informs, the education dimension of a child's care plan.

We examined DCP's files to identify whether any form of a *Documented Education Plan* had been provided by the child's school and was held on the child's DCP file. Of the 61 children in care included in this phase of the investigation, DCP's records show that 50 children had a care plan prepared for them. We observed that for 12 of these 50 children, DCP held a *Documented Education Plan* on file. In seven of these twelve instances (58 per cent), the *Documented Education Plan* was reflected in the education dimension of care plan. For three of the 11 children who did not have a care plan, DCP held a *Documented Education Plan* on file.

Other care plans were written and published on ASSIST before the school had been able to convene a meeting to develop the *Documented Education Plan*, and the education dimension in the care plan listed the development of an education plan as a decision or step, as in Example 1 below.

Example 1

A male child aged 8 years was placed under a protection order (time-limited) 24 months after he had initially been taken into provisional protection and care. A care plan was approved soon after the protection order was granted. The education dimension of this child's care plan stated that he had no reported behaviour concerns but that his attendance had been poor in the last semester. The care plan stated that DCP had been unable to meet with the school to be updated on the school attendance issue and any other academic needs. The care plan noted that an Individual Education Plan was to be developed in the new school year and this was noted as a high priority.

Our investigation was conducted almost two school semesters after the care plan had been approved. We were unable to find a modified care plan on his DCP file or a copy of the Individual Education Plan. It was not clear how he was progressing academically or if his attendance remained an issue of concern.

Figure 12 above shows that 36 of the 50 care plans (72 per cent) we examined in detail identified education needs and included decisions and steps to address these needs. Example 2 summarises one child's case where the documented decisions and steps identified did not appear to address the education needs identified in the child's care plan.

Example 2

A young girl in her final year of primary school had a mild intellectual disability. She had been attending a 'learning centre,' where she had been supported emotionally and academically. The care plan identified that she would be transitioning to high school the following year and would need support. The only decision identified for her in the education dimension of her care plan was '... continue to support (child) so that she can move into high school.' The care plan did not document what her specific support needs were, how this support would be achieved, and what parties would take responsibility for facilitating this. This care plan had been approved a number of months prior to this investigation and there was no revised care plan on file that indicated her education planning for the following school year had been progressed.

Our observations regarding health care planning and education planning set out above suggest that there are deficiencies in the interagency process to ensure that all the care planning documents for children in care are completed, provided to DCP and the results incorporated into the main care plan. Although the framework for care planning involving the Department of Health and the Department of Education has been in place since 2009, there are currently no mechanisms to monitor whether the required health and education materials are prepared by the relevant agency, shared with DCP and included in the child's care planning.

8.6 Identity and culture dimension of care plans

8.6.1 Legislative requirements, relating to identity and culture

There are no specific legislative requirements regarding the ways in which a child's care planning should address their identity and cultural needs. Division 3 of Part 2 of the CCS Act contains three principles that recognise the importance of identity and culture for Aboriginal and Torres Strait Islander children, and their application to decisions made in the administration of the Act. Accordingly, these principles apply to care planning for children in care. These principles are as follows:

- Aboriginal and Torres Strait Islander child placement principle (s.12), which promotes maintaining cultural connection in placement arrangements;
- Principle of self-determination (s.13), which recognises the role of Aboriginal and Torres Strait Islander people in participating in the protection and care of their children with as much self-determination as possible; and
- Principle of community participation (s.14), which recognises that kinship groups, communities and organisations, of which the child is a member, should be given the opportunity, where possible, to participate in the decision-making processes that will have a significant impact on that child.

8.6.2 Policies and procedures for addressing the identity and culture dimension

DCP's *Care Planning Policy* states that 'In addition to the legislative requirements, the care plan should also include ... a proposal to meet identity and cultural requirements.' It also states that Aboriginal and Torres Strait Islander children and children from culturally and linguistically diverse backgrounds 'need to have well researched cultural plans as part of their care plans.'⁶⁰

For Aboriginal and Torres Strait Islander children, the *Care Planning Policy* is reinforced by Section 10.3 of the Manual, which states that:

- Aboriginal children need to have comprehensive cultural plans as part of their Care Plan; and

⁶⁰ Department for Child Protection, *Care Planning Policy*.

<<http://www.dcp.wa.gov.au/Resources/Documents/Policies%20and%20Frameworks/Care%20Planning%20Policy%202009.pdf>>. Accessed 25 May 2011.

- Cultural plans must outline the connection of the child with his or her cultural origins, which is to be secured, provided and maintained throughout their period of care.

It is not clear from the Manual if a cultural plan for Aboriginal and Torres Strait Islander children should be developed as a 'stand alone' document, or incorporated in the 'identity and culture' dimension of the care plan template. During discussions, DCP clarified that the cultural plans envisaged in the 2009 policy were originally a 'stand alone' document. However, since the care plan template was developed, it is has been intended that these plans be incorporated into the child's care plan.

The Manual also provides that, where relevant, consultation occurs with an Aboriginal Practice Leader in the planning and development of care plans for Aboriginal and Torres Strait Islander children. DCP has developed an *Aboriginal and Torres Strait Islander Children Cultural Planning Prompt List*, which provides a number of questions to be considered when preparing cultural plans for Aboriginal and Torres Strait Islander children (use of the Prompt List is not mandatory).

8.6.3 Observations of the investigation

Figure 12 shows that 34 of the 50 care plans (68 per cent) we examined in more detail identified needs and included decisions and steps to address these needs for the identity and culture dimension. In some cases, this dimension of the plans related to Aboriginal and Torres Strait Islander Children or children from culturally and linguistically diverse backgrounds, as shown in Table 7 below. In other cases, the children were from neither of these backgrounds and the identity and culture dimension discussed religion and family values.

Table 7: Identity and culture dimension of care plans

Identity and cultural background of child*	Number of children	Identity and cultural dimension identifies needs?	Identity and cultural dimension identifies needs and decisions and steps to address these needs?
Aboriginal and Torres Strait Islander child	25	21 (84%)	19 (76%)
Child from culturally and linguistically diverse background	3	3 (100%)	2 (67%)
Neither of the above	20	14 (70%)	12 (60%)
Child's cultural background not identified	2	1 (50%)	1 (50%)
Total	50	39 (78%)	34 (68%)

* These are the categories used in DCP's ASSIST system.

We observed that in three out of four DCP districts whose care plans we examined in detail, the cultural plan was incorporated into the identity and culture dimension of the care plan. In the fourth DCP district, the identity and culture dimension was addressed in 'stand alone' cultural plans, an example of this approach is discussed further below. We also observed examples of a separate cultural plan developed by the Aboriginal Practice Leader, addressing the concepts identified in the *Aboriginal Cultural Plan Prompt List*. These separate cultural plans were then incorporated into the child's care plan.

Example 3

A separate care plan for a child in the Pilbara district provided a comprehensive family genogram and understanding of the child's cultural context. The plan provided detailed information including what language the child spoke and what traditional spiritual beliefs the family held. The cultural plan pointed out that the child's mother had previously provided much of his cultural teaching. As such, DCP's Aboriginal Practice Leader made a number of recommendations to ensure this cultural teaching and connection was maintained while the child was in care.

Our observations were consistent with DCP's own review of this aspect of care planning practice. From 2009 to 2010, the DCP Standards Monitoring Unit undertook a review of care planning in ten DCP districts in accordance with the Standards as discussed at Section 7. Among other standards, the review examined compliance with standard 5.7, which states:

The child or young person's cultural, ethnic or religious identity is taken into account when determining what is in their best interests. Decisions are consistent with cultural, ethnic and religious values and traditions relevant to the child or young person and workers will seek relevant advice when assisting and supporting families from diverse backgrounds.

In general, the review found there to be inconsistent practice in developing cultural plans. It found consultation with the Aboriginal Practice Leader in one district was evident but not routinely recorded. The cultural plans of two districts were found to lack detail and direction and for two districts some cultural plans were absent. In one district, staff did not have sufficient knowledge of cultural planning requirements and cultural plans for relative carer placements were inadequate. The review found positive staff awareness of cultural issues at the Pilbara district.⁶¹

The Standards Monitoring Unit recommended that the DCP Aboriginal Engagement and Coordination Unit participate in the development of case practice guidelines to provide clarity for workers on where to record a cultural plan and the role of the Aboriginal Practice Leader in developing cultural plans. Further, it was recommended that the Aboriginal Engagement and Coordination Unit provide field staff with clarity around the purpose and nature of cultural plans for children placed in relative care. It was also recommended that the Pilbara District's strength in this area is used to promote learning.

⁶¹ DCP (2011) Trend Report for Care Planning, Meetings and Participation, Standards Monitoring Unit, January 2011, p2. (Internal document, unpublished).

8.7 Updating the content of care plans

8.7.1 Modifying care plans

The CCS Act provides that the CEO may modify a care plan at any time if the CEO considers it appropriate to do so (s.89(4)). As soon as practicable after the CEO modifies the care plan, the CEO must ensure that a copy of the modification is distributed to identified interested parties (s.89(6)).

DCP's *Care Planning Policy* states that care planning is a cyclical and ongoing process that is modified and reviewed to ensure that the current needs of children in care can be identified and met. The Manual notes that a care plan can be modified at any time if new information emerges or events occur that impact on the planning decisions for the child in care.

While DCP is not required to update or modify care plans, we observed examples where there were significant changes in the child's living circumstances and care needs, but the care plan was not updated. The example below illustrates an occasion where a child's needs had changed since their current care plan had been documented but where their care plan had not been modified to reflect these changing needs.

Example 4

A male child aged 10 years was taken into care and a protection order was subsequently issued a few months later. A care plan was documented within weeks of the protection order being provided.

The care plan indicated that he was living with relative carers. Issues with school performance and behaviour had been identified, and a number of decisions and steps were documented to address these concerns. These involved working with the family and school, and providing counselling for him. However, when we read the DCP files notes for the subsequent months it was apparent that the situation had significantly changed. His behavioural issues had escalated, he was no longer attending school and was involved with the juvenile justice team for criminal activity. He was no longer living at the DCP approved placement and seemed to be of no fixed abode.

The file notes indicated that a number of agencies were communicating and collaborating to re-engage him, however this did not appear to be taking place within the care planning framework. There were no notes on file indicating care planning meetings had been held to discuss the changes in his needs and coordinate an approach. The care plan had not been modified and was no longer relevant.



Ombudsman Recommendations

Recommendation 19: DCP ensure that a child's care plan identifies the needs of the child, outlines steps or measures to be taken to address those needs and sets out decisions about the care of the child as required by the CCS Act.

Recommendation 20: DCP ensure that its own policies and procedures regarding the content of care plans are met.

Recommendation 21: DCP revise its current process for care plans to incorporate checks to ensure that each dimension of the care plan has been completed and that the dimensions indicate how the child's identified needs are to be addressed.

Recommendation 22: DCP revise its current approval process for care plans to incorporate checks to ensure that the results of a child's medical examination and/or health assessment have been incorporated into the relevant dimension of their care plan.

Recommendation 23: DCP revise its policies and procedures to specify clearly what constitutes a significant change in a child's circumstances and therefore warrants a modification to a child's care plan and ensure that the modification is undertaken in a way that is timely in the context of the need for the modification.

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