Case recording Practice Paper

1. Introduction

Case recording is an essential function that underpins high quality child protection casework. This practice paper outlines the best practice approaches and legal requirements for case recording the Department for Child Protection's (DCP) involvement with children and young people, their families and carers. This includes creating, maintaining and storing documentation.

This practice paper applies to all DCP staff, students and volunteers who contribute to or manage case records for children and young people who have had contact with DCP (including those in care), their families and carers. This includes DCP residential care staff and agency carers working in DCP residential care houses and offices.

Residential care staff must also refer to Residential care: E-log (electronic log) Procedure and Residential care: Observation logbook recording and records management Procedure for further guidance.

2. Why is case recording important?

Case recording is more than an administrative function and forms an essential part of child protection practice. The quality of case recording has been shown to impact on client outcomes (AASW 2016), and their importance featuring repeatedly in reviews when children are fatally and severely harmed (O'Keefe 2024).

Accurate, quality case recording:

- provides a meaningful source of information about a child or young person's life story and journey in care
- records services provided by DCP and other agencies
- ensures accountability and transparency in decision making by documenting referrals, assessments, rationales and outcomes
- supports the evaluation of service provision and family progress
- supports reflective practice and analysis
- provides crucial evidence regarding assessment and decision making for legal proceedings.

3. Child-centred case recording

Children and young people should always be at the centre of case recording. Child-centred case recording involves writing and maintaining records in a way that is respectful and sensitive to children and young people, their families and their broader community. This approach to case recording supports best practice with children and young people and provides them with important information about their lives into the future (Hawke 2024). Case records can be the only written information capturing important decisions and life events for people who have spent time in care and form a crucial part of them being able to make sense of their lives (O'Keefe 2024).

Careful use of language is essential to effective and professional case note recording. It is important to use language that is strengths based, accurate and kind (O'Keefe 2024). Language should be accessible and easily

understood by the child or young person or their family (Hawke 2024). DCP staff should avoid jargon and use simple contemporary language in case notes. DCP staff should use culturally appropriate language, noting that cultural advice must be sought for appropriate terminology or approaches to case recording.

DCP staff should bring trauma-informed and strengths based perspectives into their case recording to ensure that it is child-centred. Refer to the Trauma lens and Strengths based Practice Papers for further information.

It is important that case notes reflect multiple perspectives wherever possible, including those of the child or young person. This can reduce bias and re-balance power (O'Keefe 2024). It is important that DCP staff consider their own biases when case recording and write in a way that is free from bias. Refer to the Bias in child protection practice Practice Paper for further information.

4. What are case records and case notes?

Case records include all documentation recorded in a client file (electronic or hardcopy). This includes images or photographs, records in C3MS and entries in E-logs and Observation logs and handwritten notes. Case notes are defined as records in C3MS about a child, young person, family member or carer.

Examples of case records	
• case notes including details of conversations, telephone calls, home visits and/or details of child protection investigations • family contact records • emails • text messages • assessment summaries, case conceptualisation and case transfer forms • consult or decision record • case plans and cultural identity support tools • safety and wellbeing plans • care team meeting minutes • images or photographs	• entries in E-Logs and Observation logs • handwritten notes • Structured Decision Making® assessments, genograms and eco-maps • life story books • internal reports such as psychological assessments, agency referrals, annual reviews, court reports • external reports such as assessments, medical • personal records such as birth certificate, bank accounts, photos, school reports • consultations with supervisors, managers, practice leaders, Principal Aboriginal Consultants and the Crown Solicitors Office.

Examples of case notes	
• details of home visits, including behaviours and other observations, and the DCP case worker's assessment of these • communication with or relating to a client • reports • consultations • meetings	• court hearings • appointments • family contact • referrals.

5. Confidentiality of case records

It is important to inform families, children (where it is developmentally appropriate), young people, carers and service providers/other professionals about:

- the type of information being collected and recorded
- the purpose for which it is being collected and recorded
- how the information may be used
- the limits of confidentiality.

DCP staff must ensure they are aware of and uphold their responsibilities regarding gathering and sharing information and obligations of confidentiality pursuant to section 164 of the *Children and Young People (Safety) Act 2017* (CYPS Act). For further guidance, refer to the Information gathering and sharing chapter of the Manual of Practice.

Under section 163 of the *Children and Young People Safety Act 2017* (CYPS Act), DCP staff must not disclose notifier details or any information that may tend to identify the notifier, except in circumstances explicitly stated under the section. This includes recording these details anywhere other than in the designated location in C3MS (maximum penalty: $10,000).

Consultations with both DCP Legal and the Crown Solicitor's Office (CSO) are considered 'privileged' information and can only be released under certain circumstances. DCP Legal and CSO consultations must be clearly labelled in hardcopy, electronic files and C3MS. Subject headings in C3MS notes should clearly identify a DCP Legal or CSO contact as per C3MS Guide – Notes - Naming convention for subject headings. CSO consultations should also be stored using the category 'Consultation – Crown'. This ensures that they are not inadvertently released under Freedom of Information or Subpoena requests.

If the consultation with DCP Legal or CSO relates to a change in case direction, (for example, pursuing court action) this can be recorded on a Consult and decision record note type. The subject heading must indicate that the consultation has included DCP Legal or the CSO.

DCP staff must also follow the C3MS Privacy Policy. DCP staff must not use generative Artificial Intelligence (AI) tools (such as ChatGPT, CoPilot or similar) for case recording. Any information entered into these tools are treated as publicly accessible. AI tools must not be used when writing or preparing case notes as they contain sensitive and confidential information.

6. Timely recording of case records

Case notes and other case records must be recorded in C3MS as soon as possible after all interactions, preferably within 24 hours. This preserves the integrity of the information and strengthens credibility under legal scrutiny or internal or external review. DCP staff must ensure that case notes are completed, reviewed and approved as appropriate where consultation or decision making is recorded.

DCP staff must develop a plan to manage case recording in a timely way and avoid developing a backlog. Strategies to avoid a backlog should be discussed with the supervisor.

For further guidance about recording notes in C3MS, refer to the C3MS Guide - Creating a note. All referrals should be recorded in the 'Referrals' tab in C3MS. For further guidance, refer to C3MS Guide: Referrals and C3MS Referrals Instructions.

7. Release of case records to other parties

Case records must be written in an accurate, respectful and objective way. DCP staff should be mindful that case records can be requested by children and young people, and other parties as relevant. Case records may also need to be disclosed in legal proceedings with copies of case notes provided to parents and carers.

Case records fall within the definition of a 'document' and may need to be released under a Freedom of Information (FOI) application. Exempt information as set out in Schedule 1 of the FOI Act will not be produced on a FOI application.

Any case records, including handwritten notes, may be required to be produced under a court order, summons or subpoena, through a *Freedom of Information Act 1991* application, Provision of Information Release (POIR) application made pursuant to section 153 of the CYPS Act or other request, such as from the Ombudsman.

Case records must be capable of withstanding scrutiny as to their accuracy and written in a professional and evidence based way. DCP staff must ensure that handwritten notes are legible.

DCP staff should refer to the Information gathering and sharing chapter of the Manual of Practice for further information about sharing personal client information contained in case records.

7.1 Informing clients of their rights to access information

Children, young people, family members and carers should be advised of their rights to access case records under the *Freedom of Information Act 1991*.

DCP staff should also ensure young people are aware of their right to request access to their records once they leave care and are of or above 18 years old. For further information, refer to the Provision of Information to Care Leavers Guideline.

8. Structure and detail of case records and case notes

The structure and content of a case note depends on the purpose, nature and details of the event. A range of recording styles may also be appropriate depending upon the type of record. Refer to Appendix 1 for descriptions and examples of recording styles.

8.1 Case note subject

It is important for DCP staff to clearly specify the purpose of the case note, which involves:

- the method of contact (telephone call, face to face, home visit, family contact)
- who was present
- the nature of the case note (the nature of the interaction).

Case notes must adhere to DCP naming conventions to ensure notes are easy to locate. DCP staff must refer to the C3MS Guide: Notes - Naming convention for subject headings for guidance.

8.2 Structuring case notes

DCP staff should structure case notes to allow information to be easily accessible. This includes:

- having key information highlighted in the subject or at the top of the case note, including:
  - who was present including their role
  - the nature and purpose of the interaction
  - any significant outcomes (for example, a disclosure of harm or decision made)
- ensuring actions and outcomes are clearly recorded so they can be monitored. Wherever possible they should be labelled and recorded as bullet points.
- group together similar information (for example, placement update, education, contact) and consider using headings. Information does not have to be recorded in the order that it was discussed during the interaction. Having information grouped under topics allows others to find relevant information quickly.
- ensure that observations, assessments and quotes are clearly identified.

8.3 What details should be included in a case note?

When determining what information to include in a case note, it is important to consider whether it is relevant to the service of support being provided (AASW 2016). Case notes should be clear with respect to their purpose and relevance to case management.

Case notes should:

- be concise. Include sufficient information for others to understand what has occurred and why, but not so much detail that vital information is difficult to locate. Appendix 1 contains examples of recording styles
- clearly identify fact from opinion
- reflect a current and continuous account of services delivered
- summarise the interaction and not be verbatim, in most cases. Exceptions may include disclosures or allegations of harm.

Case notes should demonstrate the following (where applicable):

• the purpose of the interaction
• clear identification of client(s) and parties present/involved, including children and young people and DCP staff. This includes:
  ○ first name
  ○ surname
  ○ roles and/or relationship to the child or young person
• summary of the current situation and/or issues
• observation and holistic assessment of the client/situation (including safety, risk, strengths and protective factors where relevant)
• child or young person's views, ensuring that all children within a sibling group have their experiences and views captured
• views of other stakeholders on relevant issues (for example, parent, carer, DCP staff, service providers)
• summaries of progress
• details and outcomes of consultations
• points of consensus or dispute between stakeholders
• summary of actions undertaken or to be completed
• outcomes of actions or intervention
• clear rationales for any decisions including details of:
  ○ consultation
  ○ assessment information
  ○ rationale
  ○ delegated authority for making the decision
  ○ reference relevant legislation and policy, where applicable (for example, "The child was removed from the home under section 41 of the *Children and Young People (Safety) Act 2017*."), including the Aboriginal and Torres Strait Islander Child Placement Principle.

The rationale for any assessments or decisions made about families, children and young people should be clearly recorded. Refer to the DCP Assessment Framework and Consult or Decision Record Procedure for guidance about recording assessments and decisions.

If the case note relates to a placement decision for a child or young person in care, refer to the Support the child or young person to transition between placements key step of the Supporting children and young people in care chapter of the Manual of Practice for further guidance about recording requirements.

9. Storing records

Case records are considered official records as defined by the *State Records Act 1997* (SR Act). Under section 13 of the SR Act, the DCP is required to ensure that the official records in its custody are maintained in good order and condition. DCP staff must ensure their appropriate retention and disposal in line with the SR Act.

As official records of the DCP, case records are subject to the SR Act, and must:

- be stored in approved departmental storage (for example, C3MS, hardcopy files)
- be securely stored at all times
- be locked away when not in use
- not be stored on USBs or removable storage
- not be removed from the office without approval.

DCP staff must not intentionally dispose of or remove official records.

Electronic documents should only be kept on the local area network whilst they are in draft. These may include (but are not limited to):

- referrals to external agencies
- forms or letters sent to schools
- exceptional resource funding applications
- court application reports.

Once completed, DCP staff should:

- upload electronic or scanned copies of hardcopy documents to C3MS
- delete any other copies held on network drives, in inboxes or non-preferred locations to prevent duplication
- file the original hardcopy document in the physical client file (known as an '85 file').

For further advice about managing case records contact the Information Governance Team by raising a request in the DCP Service Hub and selecting 'Ask Something'. Requesters needing to archive records or order file supplies should select 'Request Something'.

When storing information in C3MS, DCP staff should be mindful of where it is stored and how easily it can be located when needed. Refer to C3MS Guide: Notes and Documents and Attachments Scanned/Uploaded to C3MS, C3MS Guide: Notes - Naming convention for subject headings and C3MS Quick Reference – Note Categories for further information.

10. Culturally safe and inclusive practice with case recording

Case records should be written in a way that captures cultural identity and connection and demonstrates how and when cultural consultation has occurred. Case records provide formal records of a child or young

person's cultural identity. The category 'Consultation – cultural' should be used for case records in C3MS that capture cultural consultation.

Case records and case notes should use culturally safe, respectful and correct terminology.

Aboriginal and Torres Strait Islander infants, children and young people have a right to know about and experience their identity, family, culture and Country.

Case records must document active efforts taken to implement the elements of the Aboriginal and Torres Strait Islander Child Placement Principle (ATSICPP), Prevention, Partnership, Participation, Placement and Connection and the precursor, Identification. Case records that are written with an emphasis on cultural safety will support active efforts in the ATSICPP as well as ensuring infants, children and young people are able to grow up strong in culture. For further guidance, refer to the Aboriginal and Torres Strait Islander Child Placement Principle Practice Paper.

Families from culturally and linguistically diverse backgrounds have a right to have their cultural, religious identity and faith recorded correctly. It is critical that case notes and records demonstrate accurate documentation of cultural and religious identity and ensure that heritage, faith, and lived experiences are acknowledged and respected. Case notes should reflect a commitment to diversity by using culturally appropriate terminology and demonstrate efforts to support connection, inclusion, and genuine partnership. Consultation with cultural experts should occur to ensure culturally appropriate terminology and language is used through all facets of case recording. For further guidance refer to the Culturally and linguistically diverse child placement Policy.

11. Inclusive practice with case recording for people with a disability and/or developmental delay

Children and young people and families living with a disability and/or developmental delay have the right to access information that is held about them. This information should be written in a manner that is inclusive, respectful and uses correct terminology.

Ensuring information is accessible, in its format and content (for example, accessible and clear language) is critical. Care should be taken to ensure that case recording for people with a disability and/or developmental delay:

- is free of bias
- uses language preferred by the person, using either 'person first' (for example, 'person with disability) or 'identity first' language (for example, 'disabled person')
- recognises that people with a disability and/or developmental delay are multi-dimensional people with both strengths and areas of difficulty.

12. Key Readings

AASW (2016) Case note recording for social workers https://my.aasw.asn.au/file-asset/0699g000001St4SAAS

Hawkes, M. et al (2024) Caring records: professional insights into child-centred case note recording https://doi.org/10.1007/s10502-023-09430-w

O'Keefe, R. (2024) Case recording in child protection: An exploration of the evidence good and bad https://onlinelibrary.wiley.com/doi/full/10.1002/car.2894?msockid=329569887363640e1ab47d4b728f6500

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Appendix 1

Recording styles and examples

Brief narrative

- A summary of the interaction which captures what was done, when and by whom.
- Best written in dot points or short sentences to ensure information is clear.
- Recommended for most activities in daily casework.

Example of brief narrative recording

21.3.2025 3pm - Home visit with Rebecca (foster carer) – face to face contact with Joshua

Present: Ms Rebecca Williams (foster carer), Joshua, Ms Williams' son Robert, Emily Smith (Social Worker).

Rebecca advised Joshua has:

- *settled into placement well*
- *stopped bed wetting*
- *been calling his mother every second evening.*

Rebecca requested the worker change a family contact visit from 23.3.25 to 24.3.25 to accommodate Joshua's swimming lessons.

Joshua asked:

- *the worker for his photo album from his mother's home*
- *if he could have a snake as a pet. Worker advised Joshua that pets were Rebecca's decision.*

Observation: Joshua presented as relaxed and cheerful, humming and playing with the dog.

Actions:

- *Worker to reschedule family contact to 24.3.25 at 4pm at DCP Hindmarsh Office (as per changes permissible within the contact determination)*
- *Worker to contact mother and ask her to bring the photo album to next family contact.*

Direct quotes

- Direct quotes can be incorporated into brief narrative records as required, to emphasise specific statements or opinions.
- The source of the quote must be clear and inverted commas used to identify the use of a direct quote.

Example of direct quotes

Joshua said to worker "I like living at Rebecca's, sometimes it's hard saying goodbye to Mum".

Verbatim recording

- Recording precisely what was said by all individuals involved in an interaction.
- Not usually necessary, except where highly sensitive information is recorded (for example, a disclosure of harm).
- Accuracy is crucial and the source of the statement must be clearly identified.

Summary recording

- Documents a series of interactions, meetings, telephone calls in a single entry.
- Only appropriate if the contacts all relate to the same issue (for example, several telephone calls to arrange an appointment).

Example of summary recording

22.3.2025 – 2pm Phone calls x 3 Re: family contact change
P/C to mother Julie, P/C to father Andrew and P/C to carer Rebecca to change contact from 23.3.25 to 24.3.25 at 4pm.