Wood Special Commission of Inquiry into Child Protection Services in NSW

Submission of NSW Ombudsman

Part 1: Children's Court

10 March 2008

Ombudsman ref: ADM/5824

Terms of reference: roles and responsibility of the courts

We note that the terms of reference require the Commission

> *"...to examine, report on and make recommendations in relation to... the adequacy of the current statutory framework for child protection including roles and responsibilities of... the courts."*

Children's Court – Previous Submissions

Children's Court Discussion Paper

We have given detailed consideration to a range of matters connected with Childrenøs Court proceedings in our Discussion Paper õCare Proceedings in the Childrenøs Courtö which we finalised in July 2006. A full copy of our discussion paper is provided with this submission.

You will note that the paper canvasses a number of issues relevant to the Commissionøs examination of child protection proceedings including, among other things, a discussion of:

- s(9)(d) relating to the least intrusive intervention principle in the context of the paramount concern to protect children from harm and promote their development;
- the need for greater use of alternate dispute resolution at the pre and post court stages;
- the development and enforcement of care plans and the related issue of restoration and permanency planning;
- challenges that have arisen in relation to the interpretation of the requirements in s93 that proceedings are not conducted in an adversarial manner, including related evidentiary issues;
- concerns around contact orders;
- the need to trial models which involve more meaningful participation by indigenous people in child protection matters, including genuine participation by indigenous representatives in care and protection decisions, as envisaged by the Act;
- the timeliness of care proceedings;
- the absence of systems for capturing accurate and reliable data about critical aspects of care proceedings and the impact that this has on our ability to make informed decisions about court related practices and outcomes; and
- the handling of significant care and protection issues involving juveniles appearing in the criminal jurisdiction of the Childrenøs Court.

For the purpose of our research, we interviewed more than 50 people including:
- Childrenøs Magistrates, Childrenøs Registrars, and court officials;
- senior officers and staff from DoCS;
- senior officers and staff of the Legal Aid Commission;
- private sector lawyers who specialise in care matters;
- staff and clinicians from the Childrenøs Court Clinic;
- child welfare academics; and
- non-government child welfare workers and their peak association representatives.

We concluded our Childrenøs Court discussion paper with the following comments:

> **"The lack of accurate and reliable data in relation to many aspects of care proceedings in the Children's Court is therefore of significant concern. The absence of such data means that there is a considerable gap in information about key aspects of the child care and protection system. One effect of this gap is to make it extremely difficult to draw conclusions about sometimes competing or conflicting positions on issues of process and practice in care proceedings.**
>
> **However, it is also important to recognise that data collection and associated research are not the only matters that need to be addressed. This paper demonstrates that there are divergent views about a number of important issues such as:**
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> - **how the principle of "least intrusive" action should be applied;**
> - **how the principle of the participation of children and young people should be applied;**
> - **how the principles of indigenous participation should be applied;**
> - **the quality and consistency of the application of the indigenous placement principles;**
> - **the role of ADR in care proceedings;**
> - **how evidence should be put before, and tested by, the Court;**
> - **circumstances relevant to the level and frequency of the granting of interim orders;**
> - **the interpretation of the requirement that proceedings should not be conducted in an "adversarial" manner;**
> - **the adequacy and appropriate use of care plans;**
> - **the use of preliminary conferences;**
> - **the use of examination and assessment orders;**
> - **the use of undertakings;**
> - **the extent to which the principle of permanency planning is being given effect;**
> - **the use of contact orders;**
> - **the quality of the assessments undertaken regarding the possibility of restoration;**

- **the effectiveness of arrangements for the monitoring of orders concerning parental responsibility;**
- **the extent to which there may be greater use of the option of adoption;**
- **the role of Guardians ad Litem; and**
- **the handling of care and protection matters involving juveniles appearing in the criminal jurisdiction of the Children's Court.**

Clearly, data collection and analysis alone will not guarantee progress on many of these issues. With some of them, there might be a need for a simple legislative amendment. With others, this will not be sufficient.

The review of the legislation provides a timely opportunity to clarify the legislation. We have referred in this paper to specific provisions possibly requiring legislative amendment, such as sections 54, 73 and 82.

The review also allows for consideration of some of the broad principles in the legislation. From our discussions, there seems to be a general acceptance of these principles, although there is contention as to how some of them should be interpreted. For example, there are clearly differences in interpretation of the "least intrusive" principle. There are also differences about the appropriate manner in which care proceedings should be conducted – in particular, the role of ADR in the process, and how "adversarial" proceedings should be. Again, different interpretations of the principles have led to debate about the appropriateness of contact orders. What would constitute good progress on some of these issues is a complex matter.

For many issues, it is important to recognise that legislative change at this stage might not be desirable or might only be part of the solution. For example, while there would be benefit in the legislation "fleshing out" issues such as ADR, how proceedings before the Court should be conducted, and the nature of indigenous participation in care and protection decisions, legislative change alone will not ensure best practice.

Progress on these issues will also need to involve appropriate research and/or ongoing debate. In this regard, it is important to recognise that many issues involve principles that are heavily value-laden. As this paper reflects, there is considerable scope for different parties seeking to apply the principles in different ways.

The fact that there is already discussion on a number of these issues is healthy. However, to ensure that there are good outcomes, the discussion needs to be open and transparent, involve a broader range of stakeholders, and lead to concrete outcomes within reasonable timeframes.

In this paper, we have sought to outline some of the important issues arising in connection with care proceedings. We intend to circulate the paper broadly to assist people understanding the issues involved and to promote further discussion. We look forward to receiving constructive feedback that would assist in further consideration of the issues.

In a draft version of this discussion paper, we suggested that there might be value in considering the organisation of a forum to focus on a number of the matters discussed in this paper. We also suggested the possible creation of a standing committee or working party comprising a broad range of experts, which could advise the government and Parliament of proposals for improvements in practice and, where necessary, the need for legislative reform.

In response to these suggestions, DoCS observed that our suggestions appeared to have given inadequate consideration to the existence of two forums in which relevant issues were already discussed. One of these was a working party consisting of the Children's Court, DoCS and the LAC, with other parties such as the Attorney General's Department, the Department of Juvenile Justice, and the Department of Ageing, Disability and Home Care being involved for specific issues. This working party is "endorsed" by the Attorney General and the Minister for Community Services. The working party deals with "technical" matters involving legal processes and procedures.

There is also a Ministerial Advisory Council, which comprises:

- **the Chief Executive Officer of the NSW Council of Social Service**
- **the Chief Executive Officer of the Association of Children's Welfare Agencies**
- **the Chief Executive Officer of the Aboriginal, Child, Family and Community Care State Secretariat**
- **the Children's Commissioner**
- **Dr Judy Cashmore**
- **a representative of DoCS.**

This Ministerial Advisory Council considers broad issues, and has been working intensively on advice to the Minister for Community Services about the review of the legislation.

We acknowledge the valuable contribution of the Ministerial Advisory Committee. However, the question is whether the current arrangements of the Committee would be adequate to ensure that the many complex and critical issues canvassed in this discussion paper are fully addressed. The creation of a standing committee or one or more working parties to research and debate many of these issues may serve to complement the work of the Committee. We recognise that research of the kind that we have proposed needs to be supported by appropriate funding.

> **It would also seem that the current working party involving the Children's Court, DoCS and the LAC appears not to have been able to resolve many of the issues raised in this discussion paper. Furthermore, there is a need for an open and transparent process with clear timeframes that entails the involvement of other stakeholders beyond those represented. In these circumstances, we maintain our recommendation that consideration be given to the creation of an additional forum to research and consider the issues involved."**

Matters raised about the Children's Court in our response to DoCS' Green Paper

On 30 March 2007, we also made further comments on matters relating to the Childrenøs Court in our submission to the review of the *Children and Young Persons (Care and Protection) Act 1998* regarding DoCSø Green Paper entitled õ*Discussion Paper for Review – Statutory Child Protection in New South Wales: Issues and Options for Reform*ö. A copy of that submission is attached. In particular, you will note our opposition to the proposal in the Green Paper for the creation of a tribunal to replace the current role of the Childrenøs Court in care proceedings.

Further commentary on Children's Court proceedings

We note that many of the issues canvassed during your public forum on the Role of the Courts are the same as those raised with us during our consultations on the Childrenøs Court. We also note that there has only been limited progress made on these critical issues since the time of our July 2006 Childrenøs Court Discussion Paper.

Given our earlier work in this area we do not propose to provide a further detailed submission on the Childrenøs Court. However, below are some additional observations on a number of key issues.

Data collection

In our Childrenøs Court Discussion Paper we highlighted the paucity of relevant data captured relating to Childrenøs Court proceedings. We are also aware that there was a meeting in August 2004 between a range of agencies to better identify data needs. From that meeting, the types of data that was identified as being worthwhile to capture included:

- types of application;
- orders sought;
- grounds of application;
- difference from what was sought and the outcome;
- issues relating to the filing application -
  - domestic violence
  - drug and alcohol
  - mental illness
  - homelessness;
- disabilities of subject child;
- disabilities of parents/parties;

- language background;
- Aboriginal/Torres Strait Islander status;
- outcomes/orders in matters of serious and persistent conflict;
- child placement options;
- interstate placements;
- long term v short term Orders;
- allocation of parental responsibility Orders;
- aspects of parental responsibility allocated/shared;
- length of Orders;
- number of unrepresented parties;
- number of District Court appeals;
- grounds of appeal;
- number of appearances, adjournments, hearings and conferences;
- reasons for adjournments;
- any existing Orders in other jurisdictions ó family law, crime, interstate and overseas;
- hearings by specialist magistrates;
- continuity of magistrates;
- kinship placements for Aboriginal children ó family and identified placement;
- number of notifications to Department of Community Services;
- number of notifications to police;
- Childrenøs Court Clinic information;
- interstate transfers and registrations;
- Hague Convention child protection matters;
- appeals;
- witnesses;
- expert witnesses information;
- crime prevention processes, eg Youth Justice Conferencing, police cautions;
- Guardian ad Litems for children;
- Guardian ad Litems for adults;
- any alternative dispute resolution processes;
- services used;
- reports tendered in evidence and the source; and
- medical assessments.

Leaving aside any issues around the merits of collecting any of the specific types of data referred to above, what is clear from this list is the valuable and useful information that could be gleaned from capturing data of this kind. There has been very little progress on this issue since that meeting. Ongoing inquiries we have made do not suggest a prompt solution is imminent.

While we are aware that the NSW courts are introducing a computerised court management system ó called Justice Link ó which may go some way to improving data collection, reporting and related analysis, our advice is that it will be a number of years before the Childrenøs Court is likely to benefit from this initiative. We would be keen to see some firm commitments being made to progress this issue.

Children's Court – Magistrates and Registrars

Under the *Children's Court Act 1987* a Childrenøs Magistrate õshall hold office for such period (not exceeding 3 years) as may be specified in the Childrenøs Magistrateøs instrument of appointment, but is eligible (if otherwise qualified) for reappointment.ö

The specialised nature of Childrenøs Court proceedings is not in dispute. Given the distinctive nature of these proceedings, there would appear to be strong grounds for having magistrates with a particular commitment to, and considerable experience in, this jurisdiction.

We are aware that there is currently significant rotation among Childrenøs Court magistrates and believe there would be value in considering whether the current practice of regular rotation adequately promotes the development of judicial expertise in this important jurisdiction. In this regard, we believe that it may be useful to compare the system for appointing Childrenøs magistrates in Victoria with the system in NSW. Our understanding is that there is no legislative restriction on how long magistrates can be appointed to sit on the Childrenøs Court in Victoria.

On a separate but related note, we understand that the Childrenøs Court has been funded for nine registrars but has never had more than five registrar positions filled. In these circumstances, we believe that there would be merit in considering whether having extra registrars in place may assist the court in improving the efficiency of care proceedings, particularly in regional areas.

Non adversarial conduct of proceedings and related evidence based procedures

In our Childrenøs Court Discussion Paper (at page 33) we discussed this issue in some detail. Among other things we noted that:

> **"Section 93 says that proceedings are not to be conducted in an adversarial manner. The section also says that proceedings are to be conducted "with as little formality and legal technicality and form as the circumstances of the case permit".**
>
> **Some of the people we talked to were concerned that, despite the aims of the care and protection legislation, Children's Court proceedings seem to be handled on an adversarial basis.**
>
> **Senior Children's Magistrate Mitchell told us the requirement that hearings should proceed with as little formality and technicality as possible does not permit the Court to dispense with natural justice and standards of procedural fairness. Magistrate Mitchell said that oral cross-examination of witnesses and the receiving of submissions by parties are two ways of giving effect to procedural fairness principles.**
>
> **Senior Children's Magistrate Mitchell also told us that care proceedings in the Children's Court could be summarised as a hybrid between an adversarial model and a modified inquisitorial model. He said that where there are disputed matters of fact the Court more closely follows a traditional adversarial model of**

> **cross-examination. Where there are not factual issues in dispute, the procedure more closely follows an inquisitorial model. It should also be noted that the Court must determine the matter on the evidence the parties choose to place before the Court.**
>
> **DoCS has told us that it is aware that the Children's Court is considered to be unnecessarily adversarial."**

In the submission DoCS made to the Ombudsman in relation to our research on the Childrenøs Court, it made a broad claim that the Childrenøs Court is unnecessarily adversarial. To support this claim, DoCS:

- referred to ÷evidenceø relating to caseworker concerns around the level of respect shown to them in Childrenøs Court proceedings;
- referred to the high costs it incurred when conducting proceedings in St James as compared to other Childrenøs Courts. In this regard, DoCS expressed the view that this was evidence of a more adversarial approach at St James;
- expressed concerns about certain casework information having to be supplied to the Court by way of affidavit rather than report.

In our Childrenøs Court discussion paper we canvass the competing arguments that were put to us around these issues (see pages 33 to 37).

Against this background, it is important to acknowledge that the Childrenøs Court has tailored its practices in recognition of the Actøs requirements in section 93. We note the Courtøs submission to the Commission (at paragraph 38) in which it states:

> **"By section 93(3), the Court is not bound by the laws of evidence and is prepared to and, in almost every care case, does deal with material that in other Courts would be quite unacceptable. For example, multiple hearsay, the disclosures of children, the untested conclusions of unnamed caseworkers and of the unnamed authors of entries in departmental files and other problematic material are admitted because, in the nature of child care matters, they are often the best and sometimes the only available indicators of the facts."**

As to whether more could be done to reflect section 93(3), we would make the following observations:

(1) While recognising judicial independence, there are obvious benefits in there being a high level of consistency in the way Childrenøs Court proceedings are conducted.

(2) We believe that there would be merit in the Commission considering the scope for the admission of certain material by way of a report rather than affidavit.

(3) We support the initiative involving representatives of DoCS, the Attorney Generaløs Department, Legal Aid NSW and the Childrenøs Court, which is exploring the scope

for DoCS to present to the Court only sufficient material on the first mention day to establish a case. If this proves successful, it could potentially lessen the adversarial tone of the proceedings and lessen the workload on DoCS staff and other participants.

(4) Greater use of ADR both before and after the commencement of proceedings, is directly relevant to the goal of seeking to avoid or minimise an adversarial contest between the parties.

Alternative dispute resolution

We made the following conclusions on this subject in our Childrenøs Court Discussion paper (at page 13):

> **"… the legislation supports the use of alternative dispute resolution services that are designed to resolve problems at an early stage and to reduce the likelihood that a care application will need to be made. The legislation also envisages the use of ADR services after a care application is made "to work towards the making of consent orders that are in the best interests of the child".**
>
> **While we acknowledge that ADR will not be appropriate in all cases, we would support moves to expand its application in a range of ways before and during care proceedings. We would also support associated research on how such expansion might best be achieved.**
>
> **...**
>
> **We would therefore be keen to see the major players come together in exploring further options for and approaches to ADR, and that future use of ADR should be supported by associated research that evaluates the outcomes of the various ADR strategies that employed."**

We reiterated our views in our submission responding to the Green Paper, adding that:

> **"In this regard, the potential for expanded use of ADR options such as family conferencing and, for care matters involving indigenous children and young people, circle sentencing, warrant close examination."**

Since our submission, progress on the greater use of ADR has been slow. However, the work underway to trial care circles in Nowra seems to be a positive initiative. We also note the Family Group Conferencing work being done by UnitingCare Burnside in relation to matters at the pre and post court stages. Consistent with the Act, these kinds of initiatives need to be promoted and, if their evaluation demonstrates that they are successful, rolled out more broadly. In this context, while noting the relative lack of use of ADR to date, we are encouraged by the commitment to ADR expressed by the major parties at the Commissionøs recent public forum on the Role of the Courts.

In supporting ADR, we acknowledge that it will not be appropriate for certain matters. However, given that the need for õcare and protectionö is often not disputed in care

proceedings, there would appear to be considerable scope for ADR to be used to canvass what might be in the best interest of a child relating to decisions such as the allocation of parental responsibility; placement; specific care arrangements and contact. If these issues can be explored through a resolution process which focuses on a childøs best interests, this would appear to be more consistent with the legislatureøs intentions.

Contact Orders

Section 86 provides that the Court can order minimum contact arrangements. Although it can order that contact be supervised, it cannot do so without the consent of both the parent and the supervising agent.

Assertions made to this office about the making of contact orders have included:

(1) that DoCS only provides the court with limited details of proposed contact arrangements;

(2) that the Court can sometimes make contact orders without having before it the information necessary to formulate an informed judgement about the best orders to make;

(3) that some welfare agencies oppose regular contact between parents and children, particularly for children in long term foster care; and

(4) that there are inconsistent practices adopted by magistrates in relation to the making of contact orders.

We made the following observations about contact orders in our Childrenøs Court Discussion Paper (at pages 31-32):

> **"We recognise that the current arrangements present a challenge to all parties to work in the best interests of children and come up with flexible solutions regarding the important issue of children's contact with family and other significant people in their lives.**
>
> **We also acknowledge that there are divergent views about the circumstances in which contact is in the child's best interests and about the extent of contact that is appropriate. We would make several points in relation to this debate.**
>
> **It is clear that adequate information and further research is needed to inform the debate. In this respect, we note that DoCS has supported the need for further research. It is our view that lack of research in this are makes it difficult to assess the precise nature of and reasons for the perceived flaws in the current system. This in turn makes it difficult to determine whether an overhaul of the current arrangements is required (and, if so, what the changes should be) or whether the approaches employed under the current system might be abetter way forward.**

> **In these circumstances, we believe there should be an informed public debate between all of the key players involved, with a view to deciding on a pathway for effectively promoting the maintenance of ties between children and their family – but only where this is clearly consistent with the best interests of the child."**

In our submission responding to the Green Paper (at pages 14-15) we included the above quote and additionally noted:

> **"Whether or not a decision is made to remove or limit the current role of the Children's Court in relation to the question of the determination of contact, we submit that it is essential to establish what constitutes "good practice" on the issue of contact in the light of evidence-based research, and to introduce appropriate "benchmarks" for the application of such practice."**

Against this background, we now make the following additional observations:

(1) From our review of the documents connected with the court processes relating to a significant number of children in care, we have noted that the Court frequently refrains from making contact orders as part of its final care orders ó and that this practice appears appropriate.

(2) We do have some difficulty with the notion that the Court can put in place appropriate final contact arrangements for children who are placed in long term care, given that their circumstances and needs in connection with contact are likely to change over time.

(3) Our review work also indicates the important role of the Court in relation to interim contact orders and we believe that it is critical for the Court to retain this role.

(4) We note that the Childrenøs Guardian already has a role in setting guidelines for the disclosure of placement information to parents. On this issue of contact, we have previously argued that it is essential to establish what constitutes ÷good practiceø In our opinion, it would not be inconsistent with the Childrenøs Guardianøs existing responsibilities for her to play a strong role in setting clear guidelines in this area and assisting in resolving contact disputes when appropriate. An enhanced role for the Childrenøs Guardian in this area could mean that either the Childrenøs Court or the Administrative Decisions Tribunal would only need to play a last resort role in determining contact arrangements.

Permanency planning and restoration issues

Care Plans

Section 83(7)(a) of the Act says:

> *"The Children's Court must not make a final care order unless it expressly finds:*
>
> *(a) that permanency planning for the child or young person has been appropriately and adequately addressed."*

In our Childrenøs Court Discussion Paper (at page 27) we noted DoCSø position on final Care Plans:

> **"It is the submission of DoCS that the present role of the Court is to look at what is planned, and not to consider whether individual care arrangements will adequately meet what is planned. To hold otherwise would be to require the Court to assess individual carers and to directly require all carers and their suitability to be interrogated by the Court."**

However, as stated in our Childrenøs Court Discussion Paper (at page 27):

> **"While noting DoCS' submissions, we believe that it is difficult to make a clear distinction between the question of whether permanency planning has been appropriately and adequately addressed (s83(7)(a)) and the question of whether individual care arrangements will adequately meet what is planned."**

In its submission to the Commission at paragraphs 12-15, the Childrenøs Court stated:

> **"Far from leaving permanency planning exclusively to the Director-General, the Act at section 83(7) prohibits the Children's Court making a final care order until it is able expressly to find "that permanency planning for the child or young person has been appropriately and adequately addressed." This provision was inserted into the Act as a response to the Department's previous habit of leaving children and young persons in temporary, short term placements and, often, in a series of such placements rather than ensuring long term placements. The destabilising impact of the Department's failures in this area led to significant amendments to the Act regarding permanency and one of those is section 83(7).**
>
> **It is the policy of several of the agencies with which the Director-General does business and of the Department itself not to recruit and in many cases not to seek permanent placements until *after* a final long term care order has been made. The result is that the Court is often unable to ascertain the sort of placement in which a child or young person will end up if an order is made in favour of the Minister - whether it will be culturally appropriate, whether it will be a placement in which contact to birth family and other significant people is likely to be embraced or opposed, whether siblings will be kept together or separated and whether finding a suitable placement is likely to occur quickly or only after lengthy delay while the child or young person will wait in a short term placement or a series of short term placements. The need to be satisfied as to permanency and this has become a point of difference between the court and the Director-General.**
>
> **Recently, a written decision on this point, *Re Rhett* [2008] CLN 1, was delivered in the Children's Court which it is hoped will clarify the position and prove philosophically acceptable to both the court and the Director-General. In dealing with permanency**

> **planning and the requirement in section 83(7) that, before making a final care order, the court be satisfied the same has been adequately and appropriately addressed, the judgment acknowledges the separate roles of the Director-General and the Children's Court in the child care and protection system. It is the Director-General who formulates the Care Plan and who, subject to a monitoring role introduced in sections 82 and 83 (whose equivalent is not to be found in the English statute), has the responsibility of administering it at least until an application is brought under section 90 to vary/rescind the orders. On the other hand, in order to ensure the integrity of the system and to protect the vital interests of children and young persons and others concerned, it is the court that has the responsibility of deciding to approve or not approve the care plan. In order to do that intelligently and responsibly and in order to provide procedural fairness to all concerned and in order to comply with section 83(7), "the court should normally have before it a plan which is sufficiently firm and particularised for all concerned to have a reasonably clear picture of the likely way ahead for the child in the foreseeable future."**
>
> **There will always be unforeseen events which cannot be the subject of the Care Plan and will be dealt with by whoever ultimately holds parental responsibility and there will other matters of detail which the court doesn't need to know about because they are details. But the broad outline of the kind of placement envisaged - including whether a child or young person will be brought up with or separated from siblings, the methods by which the special needs of a child or young person as to health, mental health, education, growth and development, heritage and the like will be addressed, how contact to parents, siblings or extended family will be accommodated, whether and in what time frames restoration and/or placements will be undertaken - should be disclosed to the court by the Director-General as best they can be. There will be cases where the Director-General will be unable, for perfectly proper reasons, to address permanency planning as he would wish and, in those cases, he must do his best but the court needs and is entitled to have proper information available to it in order to perform its duty."**

After reviewing DoCSø position on section 83(7), the decision in *Re Rhett* and the position put by Louis Voight of Barnardos at the recent pubic forum, we are far from convinced that *Re Rhett* represents a statement that is likely to be õphilosophically acceptable to both the Court and the Director-Generalö. In saying this, we acknowledge that where the line should be drawn on the level of detail required in the Care Plans is a matter for the Court. However, what also needs to be recognised is that without the support of the out-of-home care sector, DoCS may often not be in the position of being able to meet the Courtøs demands as to providing a Care Plan which in the view of the Court is õsufficiently firm and particularisedö.

As things currently stand, we do not see a way forward on this issue unless the legitimate concerns of the Court to receive better particulars in relation to Care Plans can be

accommodated together with the legitimate concerns of the out-of-home care sector. (In relation to the sectorøs concerns, we acknowledge its genuine desire to avoid potential hurt and disappointment to potential carers, by locking them into making firm commitments relating to care without first giving them the security that a final care order provides.)

Therefore, given the current impasse on this critical issue, we fully support the Commissionerøs view, which was expressed at the public forum, to have further discussions around this issue. There may be some benefit in examining how this issue has been dealt with in England and Wales as we are aware that similar provisions exist in the legislation relating to their child care and protection systems.

Restoration post the granting of parental responsibility to the Minister

A separate issue concerns decisions by DoCS to restore a child to their birth parent(s) in circumstances where the child is under the parental responsibility of the Minister. Notwithstanding that such a decision is arguably consistent with the concept of parental responsibility, we appreciate why there are grounds to argue that DoCSø decision in these cases should be subject to some review.

One problem in deciding what oversight there should be of DoCSø decisions in cases of this kind, is that the circumstances in which such a decision can be made can vary greatly (eg, the decision might be based on the clear wishes of a teenager whose natural parentsø situation may have altered substantially from the time when the parental responsibility orders were made). Given the broad range of situations that can arise, there may be some merit in considering whether the Childrenøs Guardian might be able to play a role in this area. For example, there may be merit in the Childrenøs Guardian at least being advised of all decisions of this kind and having the power to require DoCS to refer those matters to the Court for review which the Childrenøs Guardian believes warrant judicial scrutiny.

Balancing the principle that safety, welfare and wellbeing of the child is paramount with the least intrusive intervention principle section 9(d)

We have commented on this issue in our previous work in this area. In particular, in our Childrenøs Court Discussion Paper (at page 5) we said:

> **"DoCS said it was aware of instances where the application of the "least intrusive" principle was capable of clouding the application of other principles. For example, DoCS said it had been alleged that caseworkers had wrongly assumed that adopting a least intrusive approach will mean that court action should be a response of last resort, and that this erroneous assumption had led to unnecessarily detailed contact arrangements. However, DoCS said that to talk about a corporate DoCS "view" was wrong because it seeks to apply the principle appropriately in individual cases.**
>
> **The department told us that, based on its understanding of concerns expressed by others and its own experience, it expected submissions to the current review of the legislation to comment on the application of the "least intrusive" principle.**

In our own submission to the review [dated 28 February 2006] we noted our concern about how the principle is being interpreted and applied in practice. Specifically, we noted that our investigations and reviews have identified cases where the level of protective intervention by DoCS following reports of risk of harm was not commensurate with the apparent level of risk to the child or young person."

We also noted DoCS' July 2002 policy statement on taking action in the Children's Court:

> **The [Act] provides a number of options for meeting the safety, welfare and wellbeing [of] children and young people. Provision for action in the Children's Court is made where all less intrusive casework actions have not met the care and protection needs of the child or young person.**

This policy provides some suggestion that court proceedings are not appropriate unless other casework actions have been previously attempted.

In addition, we noted practitioners in this area had advised us that the "least intrusive" principle is often interpreted as a presumption in favour of keeping a child with their family even if this involves ongoing significant risks to the child's safety.

As to the content of the DoCS policy statement quoted above, and the interpretation of the least intrusive principle by DoCS caseworkers, the Senior Children's Magistrate, Mr Mitchell, has made the following observations:

To the extent that the "least intrusive option" principle is often interpreted as a presumption in favour of keeping the children with the family, while this may be the mistaken view of individual DoCS caseworkers, it most certainly is not the view of the Court. In particular, it is not the view of the Court that the proper application of the "least intrusive option" policy should necessarily argue against the commencement of proceedings, and DoCS' July 2002 policy statement …should be reworked."

Notwithstanding Mr Mitchellø comments about the Courtø clear understanding of the least intrusive principle, we have supported the removal of the principle because of evidence suggesting that, in practice, it can be open to misinterpretation. We also question whether section 9(d) is necessary in light of the clear and overriding principles of intervention articulated in section 36 which state:

"(1) In deciding the appropriate response to a report concerning a child or young person, the Director-General must have regard to the following principles:

(a) The immediate safety, welfare and well-being of the child or young person, and of other children or young persons in the

usual residential setting of the child or young person, must be given paramount consideration.

(b) Subject to paragraph (a), any action must be appropriate to the age of the child or young person, any disability the child, young person or his or her family members have, and the circumstances, language, religion and cultural background of the family.

(c) Removal of the child or young person from his or her usual caregiver may occur only where it is necessary to protect the child or young person from the risk of serious harm.

(2) The principles in this section are to be applied in priority to the principles in section 9 in deciding the appropriate response to a report concerning a child or young person."

Children's Court identification of risk of harm – Siblings of children the subject of the care application and young people the subject of criminal proceedings

We are aware that, in its submission to the Commission (at paragraph 96), the Childrenøs Court has said that:

> **"It is submitted that, where it appears to the Children's Court that a child or young person, not him/herself the subject of care proceedings but mentioned in such proceedings or the subject of criminal proceedings, may be in danger or in need of assistance, the Court should be entitled (leaving aside sections 45(3), 76(4) and 82) to require the Director-General to make a report to it as to care and protection issues regarding such child or young person and as to the steps which the Director-General proposes to take to address those issues and, if he proposes to take no steps, the reasons for his decision. Such a provision would address two problems which frequently arise – firstly where, in the course of care proceedings, it emerges that other children or young persons have been left in the same unsatisfactory or dangerous situation from which the child, the subject of the care proceedings, has been removed and, secondly, where a young person is the subject of criminal proceedings and entitled, on juvenile justice principles, to be released either on bail or on probation but lacks adequate supports and will face serious danger is released and left to his/her own devises. In each of those instances, the Children's Court is presently entitled to make a report to the Director-General, either via the Helpline or, pursuant to a special arrangement, by telephoning the Department's Director of Legal Services but, because the Director-General does not report back to the Court, a very useful form of judicial oversight of the Department's operations is lost. Currently there are negotiations between the Department of Community Services, JusticeHealth, DADHC and others to address this issue but the matter is still not resolved;"**

In relation to the issues raised in the Childrenø Court submission, we have only commented on the juvenile offending aspect. In this regard, in our Childrenø Court Discussion Paper (at pages 45-47) we said:

> **"Some people we interviewed raised concerns about what they saw as the exclusion of some juveniles from the care jurisdiction of the Children's Court. We heard suggestions that DoCS was concerned with taking action in court for the care and protection of younger children but refrained from doing so for juveniles. Some people we interviewed argued that some young people were being categorised as a "Juvenile Justice problem", even though they might have long histories of child protection concerns.**
>
> **Senior Children's Magistrate Scott Mitchell has said that what he calls an "unwelcome consequence" of the division between the criminal and care jurisdictions of the Children's Court is that DoCS only comparatively rarely makes an appearance in the criminal jurisdiction. He said that DoCS is not present in the court in a majority of cases where juvenile offenders are already under the parental responsibility of the Minister.**
>
> **Section 7 of the Children (Protection and Parental Responsibility) Act provides that a court exercising criminal jurisdiction with respect to a child may require the attendance of one or more parents of the child. However, the section specifies that the term parent does not include the Minister for Community Services or the Director-General of DoCS. Senior Children's Magistrate Mitchell argues that there should be an arrangement, either through a legislative amendment or an administrative agreement, requiring the Minister to ensure that juvenile offenders already in her parental responsibility are properly supported at court.**
>
> **Magistrate Mitchell said that the absence of DoCS from juvenile justice proceedings is even more troubling when a Children's Magistrate learns of care and protection concerns relating to a young person who is before the Court's criminal jurisdiction.**
>
> **Procedures were introduced through a Court Bulletin whereby Children's Magistrates would report any of their concerns by facsimile to DoCS, rather than ringing the DoCS Helpline. In addition, Children's Magistrates are able to make after hours reports by telephoning the Department's Director of Legal Services.**
>
> **Senior Children's Magistrate Mitchell has said that the experience of Children's Magistrates who have made reports to DoCS is that it is often not clear what action, if any, DoCS would be able and prepared to undertake. He acknowledged DoCS is bound by its resources and it is not unreasonable that the department prioritises certain cases. However, he said the present arrangement provided by DoCS is inadequate as an aid to keeping a young person out of trouble and reassuring a judicial officer that a young person will be safe if released on bail or on probation.**

Magistrate Mitchell says what is needed is a formal method of invoking the assistance of DoCS where it becomes clear that a child or young person is in need of assistance in the course of proceedings in the Children's Court in its criminal jurisdiction. He said that a Children's Magistrate sitting in the criminal jurisdiction should be entitled to enumerate his or her concerns and call upon DoCS to provide a prompt report as to the care and protection issues surrounding any young person before the Court. The report should indicate what steps DoCS has taken or proposes to take to address those issues and, if no steps are to be taken, the reasons for that decision.

For its part, DoCS noted that the two jurisdictions of the Court had been combined under the Child Welfare Act 1939 but that legislation separating them was enacted in 1987. DoCS told us that, since July 2004, the Court has put in place its own system to report to DoCS children that Magistrates consider are at risk of harm, with 32 children being reported to DoCS through this system in 2005.

DoCS says that, if its role is to provide a report on the care and protection of the child, then the Department of Juvenile Justice which is already present in all cases in the criminal jurisdiction can obtain this information under section 248 of the Children and Young Persons (Care and Protection) Act. DoCS also argues that the report is likely to contain information that would not normally be available to a court prior to a finding of guilt. The department says this then raises the question of whether this would be appropriate as a matter of procedural fairness. DoCS told us that there are discussions between the Directors-General of DoCS and Juvenile Justice and the Chief Magistrate on the issue of providing reports and subsequent services.

We would observe that the question is not whether the information would normally be available to the Court, but whether it might be appropriate for proper sentencing. As to procedural fairness, we believe that this is something that could be addressed in consultation with the Court.

Finally, DoCS says if its role is to be a provider of services, then the particular needs of a number of children before the criminal jurisdiction must be identified. DoCS says it must be recognised that it has no powers greater than those of a parent. The department says that the range of services that it can provide is no broader than any parent can provide (assuming that the parent has the financial capacity). However, the Department of Juvenile Justice has access to other services available to children in detention. DoCS has therefore questioned the merit of a proposal that would see it ordered to provide a report to the Court.

We would observe that, while the Court's criminal and care jurisdictions are indeed separate, there is ample evidence that children who are at risk of harm may also be at risk of

involvement with the criminal justice system. In 1997, the Bureau of Crime Statistics and Research (BOCSAR) reviewed national and international evidence on family factors and juvenile delinquency, reporting that child neglect was more likely to lead to juvenile delinquency than drug use or poor school performance. In 2005, BOCSAR reported on the results of a study of 5,476 juvenile offenders who appeared in the NSW Children's Court for the first time in 1995. More than 68 per cent of these offenders reappeared in a NSW criminal court within the next eight years, and 13 per cent ended up in an adult prison within that period. BOCSAR said that its study highlighted the critical importance of intervening as early as possible to break the cycle of juvenile crime.

Our own work in reviewing child deaths has also shown that some children – notably adolescents – had lives marked by extensive involvement with DoCS, police and the Department of Juvenile Justice . In our Report of Reviewable Deaths in 2004, we noted the inherent difficulties of protective intervention for young people who may be prone to risk taking behaviour and who may be unwilling to accept the services of human services agencies. DoCS has no powers of coercion under the Children and Young Persons (Care and Protection) Act and cannot force young people to accept or engage with services. Although sections 123 to 133 of the Act provide for 'compulsory assistance', these sections have not been proclaimed.

Given the difficulties referred to above, it is our view that when opportunities for protective intervention do arise, these should be accepted by human services agencies. The appearance of a young person in the criminal jurisdiction of the Children's Court may present such an opportunity. For this reason, we would hope for positive results from the discussions between the Court, DoCS and Juvenile Justice on the issue of providing reports and subsequent services for children and young people who are charged or convicted of criminal offences.

DoCS has expressed concern that the position of the Court on this issue does not adequately take into account the distinction between care and criminal proceedings. Specifically, DoCS has referred to the observations of Brennan J in the High Court decision of J v Lieschke (1987) 162 CLR 447:

> **The two classes of proceedings are distinct. There is some uniformity of treatment of children when they are apprehended and some similarity of incidents attendant on the respective classes (for example, requiring a parent or guardian to attend the Court), but the nature and purpose of 'neglect proceedings' are quite distinct from the nature and purpose of criminal proceedings.**

In response, we would observe that there is nothing in our view on this issue that would contravene the principle set out by Brennan J. Instead, we believe that the Children's Court being provided with adequate information to assist them to understand

> **the general lifestyle of young people in appropriate cases will assist the Court in properly exercising its role in its criminal jurisdiction which includes the appropriate sentencing of young people according to law."**

Against this background and the Childrenøs Court submission to the Commission referring to the Courtøs concerns about siblings who remain in õat riskö households as well as õat riskö juvenile offenders, we would make the following additional comments.

From DoCSø submission to the Commission on Mandatory Reporting we note that õDoCS gives priority to the investigation and assessment of reports from the Childrenøs Court, Federal Magistrateøs Court and the matters in the Magellan Project of the Family Court.ö While DoCS giving these matters õpriorityö should give the Childrenøs Court some comfort, it does not guarantee that the risk factors will be addressed. Therefore, there is merit in the Court receiving timely feedback about DoCSø response to the Courtøs reports about these matters. The Court would then be well placed to assess whether its concerns about the õrisksö to these children and young people were being appropriately addressed. In circumstances where the Court had outstanding concerns about the adequacy of the response, then this could be the subject of a complaint to the Ombudsman.

Finally, we also understand that, at least in relation to õat riskö juvenile offenders notified by the Court to DoCS, there has been some progress made in relation to establishing a process for developing an integrated agency response. But without more detail, we are not well placed to comment on the merits of this proposed initiative. However, in a later submission to the Commission, we will be making further comment on õat riskö adolescents generally.

Monitoring of orders concerning parental responsibility – section 82

Concerning section 82 orders, in our Childrenøs Court Discussion Paper (at page 29) we made the following comments:

> **"Section 82 allows the Court the option of requiring written reports about the suitability of care arrangements relating to orders reallocating parental responsibility. DoCS produces the reports for the consideration of the Court. If the Court is not satisfied that proper arrangements have been made for the child, the case can be recalled for a review of "existing orders".**
>
> **Section 82(1) empowers the Court to require the written report within six months or such other period as it may specify.**
>
> **Some people we have talked to said that the magistrates do not all agree on the meaning of section 82. Children's Magistrate John Crawford published a paper on the subject in October 2004, in which he observed that section 82:**
>
> > **… does not enlarge upon the nature and scope of such 'review' and this has given rise to some uncertainty of its meaning. Any uncertainty may have contributed to what have been few review hearings.**

Our sources say there are two current interpretations of section 82. One is that a review allows for existing orders to be changed. The other is that the Court can express its concerns, but that new orders will require an application by a party to the proceedings.

In the view of DoCS, there are questions about whether the Court is using its power to review appropriately, and whether that power is appropriate in principle.

DoCS has told us that not all magistrates will arrange for matters to be re-listed upon receiving a report. The department observes that if a matter is not re-listed, it is difficult to see the use of the report. (DoCS notes that as well as section 82 reports, the Court can require reports under section 76(4) on the effects of supervision.)

DoCS says that sometimes a series of reviews is ordered over a period of years. The department has said that that this has the consequence of rendering ineffective the notion of the finality of an order and the permanency of a placement. DoCS also argues that this means that emphasis during any subsequent work is placed on a need to respond to a Court timeline, with a potential incapacity to address the needs of a child as they arise.

DoCS also questioned the extent of the Court's ability to judge the changing needs of a child by relying solely on a section 82 report. The department said the Court was not prepared to rely upon a single report from DoCS at the time of making initial or final orders, but was prepared to make new orders based upon a single report. In DoCS' view, this appeared to be an inconsistent approach.

DoCS said there is no data on the use of section 82 reports, but that, anecdotally, it is understood that they are used frequently.

Magistrate Crawford has said that "most section 82 reports point to a favourable outcome for the child". Evidence to corroborate this assertion is not available.

Some lawyers we talked to said some magistrates are assiduous in following up on section 82 reports. However, one source says there is no judicial function available to monitor compliance with section 82 orders.

For its part, the Legal Aid Commission said there is a problem in the lack of consistent court practice of notifying parties that section 82 reports have been provided to the Court. The LAC said there is no provision in the Act as to who should be served. It says some DoCS offices send the report to the Court, and others serve the parties. Each court also has its own procedure for dealing with the reports. There is no obligation to provide copies to the former parties.

LAC also argued that a section 82 report has no proper status and it is unclear whether the report is confidential. LAC says that inconsistent orders and practice are prevalent as there is no

guidance in the Act or in the practice directions about how to treat them.

LAC said that it has become good practice for the former child lawyer to follow up on section 82 reports. However, this was a decision for individual lawyers and there was no standard practice in this regard. If a lawyer changed employment or retired, there would be no follow up at all.

As to lawyers following up section 82 reports, DoCS observed:

> **This appears to be happening without any participation of, or involvement with, any other party to the proceedings, including the child. Irrespective of the child's wishes for the matter to be brought before the Court, the former child's lawyer is having matters relisted. Whatever the merits of enforcing court orders and reviewing care matters, this practice of lawyers acting without instructions needs further consideration.**

LAC told us that, in its experience, section 82 reports are often incomplete or even inaccurate. Furthermore, the LAC said that, while the system requires that orders are made for the long term placement of children in out of home care, no actual placement is identified or even guaranteed. The Court and legal representatives must rely on section 82 reports to provide information as to the placement and stability of the child.

LAC said that, at St James, DoCS is arguing in each case where section 82 reports are sought that only one report can be sought under the Act. One case where this argument was not successful is being taken on appeal to the District Court.

Court officials say a section 82 register may be set up in future. This is clearly desirable.

It is clear that this is an area that warrants legislative review to deal with the procedural problems outlined by DoCS and LAC, and to clarify the scope of the Court's powers.

We believe that provisions such as sections 82 and 76 (the latter relating to reports on supervision orders) that enable the court to require reports, provide important safeguards for children who have been removed from the care of their parents or have been placed under the supervision of DoCS. Accordingly, we believe that the Court's power to require reports at whatever periods the court considers appropriate should not be restricted or narrowed. We consider that any issues of procedural fairness could be addressed through legislative amendment or court rules.

The question of whether, and in what circumstances there should be a review of existing orders, and when and how such orders are followed up, raises important issues. Law and policy should reflect the resolution of these questions. One of the more difficult

> **questions is what sort of cases should be followed up in the best interests of the child. This should certainly not be determined upon the basis of individual practice, but grounded in a solid policy position."**

Last year, we conducted a review of 49 children younger than five in out-of-home care. We will provide a detailed discussion of that review in a later submission to the Commission on out-of-home care. However, for the purposes of this submission, it is relevant to set out what we found in relation to the operation of section 82. In our final report we said:

> **"Pursuant to section 82 (1) of the Children and Young Persons (Care and Protection) Act 1998, the Children's Court monitored progress in relation to the implementation of the care plan and permanency for 24 of the 49 children (49%). In 11 of these matters, the department did not submit the required report to the court. This included three instances where an initial report was submitted; however, a second report was not. Failure to submit the report often occurred when case management responsibility had transferred from one CSC to another.**
>
> **Section 82 (2) of the Act provides for the court to review orders: 'If, after consideration of such a report, the Children's Court is not satisfied that proper arrangements have been made for the care and protection of the child or young person…' Failure to submit reports in accordance with the requirements of s82 (1) did not trigger any response by the Children's Court for any of the 11 children. The following is an example of the department's failure to comply with an order under section 82.**
>
>> **The child and his siblings were placed in their grandmother's care. The family identify as Aboriginal. The child was removed from his mother's care shortly after birth, and was nine months old when placed with his grandmother. The Children's Court made an order requiring written reports, within six and 12 months of completion of the care proceedings, on both his progress and the support provided to his grandmother. The first report was submitted and the file was then transferred to another CSC where, until recently, it has remained unallocated. In reviewing this matter we raised concerns that there was no information on the departmental file regarding the child's health and that there had been limited discussion with the grandmother regarding what support she required. We also noted that no contact was occurring with another sibling who had been placed in departmental foster care. In addition, there had been no follow up regarding the grandmother's possible entitlement to the Commonwealth Government 'baby bonus'; a submission for financial support was not progressed when the file became unallocated; the contact plan had not been reviewed; and the second report to the Court had not been submitted."**

In light of the observations that we made in our Childrenøs Court Discussion Paper and the practice issues which we identified in our recent review, it is clear that this is an area that warrants clear guidelines in terms of practice, and potential legislative amendments to clarify the scope of the Courtøs power.

The Children's Court, Aboriginal communities and their children

At pages 39-43 of our Childrenøs Court Discussion Paper we raised issues relating to care applications involving Aboriginal children. In particular, at pages 42-43 we refer to the need for greater participation of indigenous families, kinship groups and communities in significant decisions about indigenous children.

At page 43 we conclude our discussion on this issue by stating:

> **"…we believe that it is now essential that indigenous communities, government agencies, and other key players work constructively towards facilitating more meaningful participation by indigenous people in strategies for child protection. In this respect, we suggest that there is room for trialling models which involve genuine participation by indigenous representatives in child care and protection decisions, as envisaged by the Act itself. Indeed, we note that this sort of work is being explored in other Australian jurisdictions. This experience could be used for indigenous participation models in NSW."**

In our submission in response to the Green Paper (at page 14), we noted the potential for expanded use of ADR options such as family conferencing and care circles, involving the participation of community representatives for care matters involving indigenous children and young people. In that submission (at page 16) we also noted that the use of these types of models would also assist in ÷fleshing outø at a practical level the application of the general principle under section 12 of the Act that indigenous people are to participate in the care and protection of their children with as much self-determination as possible.

Given our support for innovative processes for engaging Aboriginal communities in the protection of their children, we are encouraged by the care circle trial in Nowra. We understand that Absec sees this trial as an important initiative and has also noted some of the challenges that will need to be met for it to be successful both in Nowra and elsewhere. In separate submissions we will provide further details of our work examining Aboriginal child protection and out-of-home care issues.

Bruce Barbour
NSW Ombudsman

Steve Kinmond
Community and Disability Services Commissioner (Deputy Ombudsman)

Special Commission of Inquiry into Child Protection Services in NSW

Submission of NSW Ombudsman

Part 2: Oversight Agencies

26 March 2008

Ombudsman ref: ADM/5824

1. Introduction

This submission concerns the Special Commission of Inquiry term of reference:

> *The adequacy of the current statutory framework for child protection including roles and responsibilities of (mandatory reporters, DoCS, the courts), and oversight agencies.*

The submission is focused solely on oversight agencies, and will have regard to the question posed in the opening address for the Special Commission in relation to such agencies:

> *Does each of these agencies have the right role and function? Are children protected and well served by these oversight bodies?*[1]

An ÷oversight agencyø is taken to be a body that has a statutory role in monitoring or regulating the provision of services. Oversight of child protection and out-of-home care services, particularly those provided or funded by DoCS, is a primary responsibility of:

- the Ombudsman; and
- the Office for Children: The Childrenøs Guardian.

Both agencies have statutory responsibilities directly relating to child protection and out-of-home care services.

The work of other agencies can also have an oversight component, in that they have the capacity to research, review and examine issues relevant to child protection services, and to make recommendations about these services or matters relevant to them. In this context, it is appropriate to consider the role and responsibilities of:

- the Office for Children: Commission for Children and Young People / Child Death Review Team;
- the NSW Coroner; and
- the Audit Office of NSW.

The multi-functional role of the Ombudsman in community services means that our work often intersects with, and complements, the work of these agencies. In this submission, we consider the outcomes of our role, and our relationship with the other agencies referred to above.

Review of the Community Services (Complaints, Reviews and Monitoring) Act 1993

The *Community Services (Complaints, Reviews and Monitoring) Act 1993* (CS CRAMA) provides for the Committee on the Office of the Ombudsman and the Police Integrity Commission (the Parliamentary Joint Committee) to undertake a review of the Act. Section 53 (1) of the Act states that the purpose of the Committeeøs review is to determine whether the policy objectives of the Act remain valid and whether the terms of the Act remain appropriate for securing those objectives.

This review is currently in progress. The Parliamentary Joint Committee has invited submissions from stakeholders, and has conducted hearings.

[1] Special Commission of Inquiry into Child Protection Services in NSW ó Opening. 25. page 5

Our submission to the Parliamentary Joint Committee Inquiry is at appendix 1. The submission has particular relevance to questions about whether children are *‘protected and well-served’* by the Ombudsman, and whether the current statutory framework is adequate. The submission includes comment and proposals about possible changes to CS CRAMA.

2. The role of the NSW Ombudsman in child protection

The role and responsibilities of the Ombudsman as they relate to child protection services in this State are prescribed by CS CRAMA and the *Ombudsman Act 1974.*

2.1 CS CRAMA

In December 2002, the Community Services Commission was amalgamated into the Office of the Ombudsman. The legislative framework for the merger was provided by the amended CS CRAMA. The Act conferred responsibility for all the statutory functions of the Commission to the Ombudsman, and also provided for several new responsibilities. In summary, the responsibilities conferred upon the Ombudsman that relate specifically to child protection are to:

- review the deaths of certain children and people with a disability. This includes children, or siblings of children, who were reported to DoCS as being at risk of harm at some time in the three years prior to their death; children in statutory care; and children living in disability accommodation services (Part 6);
- review the situation of a child in care, or a group of children in care (s.13);
- handle complaints about the provision of, or failure to provide, a community service, or about the withdrawal, variation or administration of a community service (Part 4);
- review complaint-handling systems of service providers (s.14);
- coordinate and oversight Official Community Visitors, visiting out of home care services (s. 9);
- monitor and review the delivery of community services, and inquire into matters affecting service providers and consumers (s.11); and
- provide information, education and training in relation to standards for community services and complaint handling in community services, and promote access to advocacy support to enable consumer participation in decisions about the services they receive (s. 11).

Certain powers and obligations that the *Ombudsman Act* provides also apply to the exercise of key functions under CS CRAMA. These include the capacity to make preliminary inquiries and conduct investigations, compel statements of information, and interview witnesses. Secrecy provisions are also applicable.

2.2 The Ombudsman Act (Part 3A)

In response to the findings and recommendations of The Royal Commission into the NSW Police Service, NSW Parliament gave responsibility to the Ombudsman for the oversight of investigations into allegations against employees of certain agencies.

The *Ombudsman Amendment (Child Protection and Community Services) Act* commenced on May 7, 1999, and inserted Part 3A into the Ombudsman Act. Part 3A of the Act was amended in 2003. Among other minor changes, including the exemption of trivial matters, the term ‘child abuse’ was replaced with ‘reportable conduct’. Reportable conduct includes sexual offence or sexual misconduct, physical assault, ill-treatment, neglect, and conduct causing psychological harm.

Under Part 3A of the Act, the Ombudsman:

- scrutinises the systems put in place by designated agencies and other public authorities for preventing reportable conduct by employees, and for handling and responding to allegations of reportable conduct or convictions by those agencies and authorities (s 25B);
- receives and assesses notifications concerning reportable allegations or convictions against an employee (s. 25C);
- monitors investigations of reportable allegations and convictions against employees (s 25E);
- conducts investigations concerning reportable allegations or convictions, or concerning any inappropriate handling of, or response to, a reportable notification or conviction (s. 25G); and
- conducts audits and education and training activities to improve understanding of, and responses to, reportable allegations (s 25B).

Matters notified to the Ombudsman under Part 3A of the Act are subject to the complaint-handling and investigative powers contained in Part 3 of the Act. Under Part 3, the Ombudsman can receive and respond to complaints about the way agencies have dealt with specific reportable allegations, or agencies’ systems for preventing and responding to reportable allegations generally.

All public authorities are subject to the requirements of Part 3A where the reportable conduct arises in the course of a person’s employment. Some public authorities are designated agencies and also need to notify reportable allegations where they arise from conduct that takes place outside of employment. [2] Some non-government agencies are also subject to Part 3A requirements and must notify reportable allegations arising both within and outside of employment.[3]

2.3 Outcomes of the Ombudsman’s work in child protection

2.3.1 CS CRAMA

In considering the adequacy of the role and responsibilities of the Ombudsman as an oversight agency, it is pertinent to have regard to the outcomes achieved by the office under present arrangements.

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[2] Designated government agencies include DoCS, Departments of Education and Training, Juvenile Justice, Ageing, Disability and Home Care, Corrective Services, Sport and Recreation, NSW Health, Area Health Services, statutory health corporations, TAFE and the Ambulance Service of NSW.

[3] Designated non-government agencies include all non-government schools, all residential care agencies, all licensed children’s services, family day care services and affiliated health organisations.

As noted above, Attachment 1 provides details of the scope and outcomes of the Community Services Divisionøs work in community services, including services for children and families.

The following provides a summary of our main areas of child protection focused work under CS CRAMA, and the outcomes of this work, since 2003.

Reviewable child deaths

The Ombudsman is required to review the deaths of:

- a child[4] in care;
- a child in respect of whom a risk of harm report[5] was made to DoCS within the three years prior to the childøs death;
- a child who is a sibling of a child in respect of whom a risk of harm report was made to DoCS within the three years prior to the childøs death;
- a child whose death is, or may be, due to abuse or neglect or that occurs in suspicious circumstances;
- a child who, at the time of the childøs death, was an inmate of a children's detention centre, a correctional centre or a lock-up (or was temporarily absent from such a place); and
- a person (whether or not a child) who, at the time of the person's death, was living in, or was temporarily absent from, residential care provided by a service provider authorised or funded under the *Disability Services Act 1993* or a licensed boarding house.

Since December 2002, we have reviewed the deaths of 620 children and young people.[6] The majority of child deaths ó over 90 per cent ó are reviewable because the child, or their sibling, was known to DoCS. Our focus has therefore been predominantly on child protection, and reviews have provided a significant insight into the delivery of child protection services by DoCS and other relevant agencies, particularly NSW Health and the NSW Police Force.

Reviews focus on identifying systemic issues relating to policies or practices that may contribute directly or indirectly to the deaths of children. They aim to identify how these issues can be addressed in order to reduce risk to children.

We have produced four annual reports to the NSW Parliament since 2004. These reports provide an analysis of systems issues identified through reviews, and propose a range of recommendations to address these issues. Recommendations are monitored, and CS CRAMA requires annual reports to include information about agency implementation of recommendations (s 43(2)(c)).

Reviews have also resulted in close scrutiny of agency conduct in relation to individual cases, which can range from provision of information to assist agencies in their child protection response, to direct investigation of agency conduct. In the latter case, our focus remains systemic and on identifying areas for service improvement. Since December 2002, this office has:

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4 A child is defined as a person under the age of 18 years.
5 A report must be made under Part 2 of Chapter 3 of the Children and Young Persons (Care and Protection) Act 1998.
6 As at March 2008.

- Provided 70 reports to agencies under s 43(3) of CS CRAMA, arising from 64 child deaths. We mainly use these reports to draw agenciesø attention to information to assist their work, or to issues we have identified that we believe the agency should consider and where appropriate, respond to.
- Initiated 66 investigations arising from 37 child deaths.[7] These investigations have concerned conduct in relation to the child who died, and / or their sibling(s), and are discussed below.

Agencies have largely accepted the findings and recommendations of both systemic and individual work, and we have identified tangible outcomes. In regard to systemic issues, for example:

- NSW Police have:
    - issued guidance to police regarding identifying and reporting risk of harm, including risk associated with parental substance abuse;
    - taken into account our recommendations in connection with their reviews of standard operating procedures relating to domestic violence and child protection; and
    - formed a working party to develop strategies to, among other things, improve compliance with risk of harm reporting requirements and the quality of police response to children at risk of harm.

- NSW Health has advised us that it strongly endorses the work of this office in child protection, and noted the *'improvement in both internal collaboration within NSW Health and interagency collaboration in child protection responses'*.[8] In response to our work, NSW Health has:
    - initiated a state-wide review of drugs-in-pregnancy services, with a view to developing minimum standards for these services;
    - put in place a number of measures to monitor and respond to incidents where children present to emergency departments as a result of methadone ingestion, or suspected methadone ingestion. These incidents are now reportable incidents within NSW Health; and
    - revised domestic violence policy to help ensure child safety when working with victims of domestic violence, and with persons being discharged from mental health inpatient services.

In regard to DoCS, responsibility for reviewing child deaths was given to this office at about the same time that DoCS was in the first stages of implementing the $1.2 billion DoCS reform program. DoCS have stated that the oversight arrangements agreed to in 2002 were not designed with a reform environment in mind, and that, as a consequence, key issues are often well identified in advance of recommendations emerging from this officeøs formal reviews.[9] While we recognise that these are DoCSø views, we believe that this officeøs work has directly resulted in positive changes. For example:

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[7] Current as at February 2008, 46 investigations have been finalised, 13 are ongoing and seven discontinued.
[8] Correspondence from Professor Debora Picone, Director-General. Dated 21 July 2007.
[9] Correspondence from Dr Neil Shepherd, Director-General. Dated 19 September 2007.

- The State Government initiated legislative changes in late 2006 in response to issues identified in our work. The amendments included:
  - the introduction of Parent Responsibility Contracts to formalise agreements made between DoCS and parents to address risk of harm concerns, and to clarify actions where agreements are breached;
  - a child being specifically identified as at risk of harm if they were the subject of a pre-natal report;
  - allowance for information exchange between DoCS and other agencies relating to unborn children subject to a pre-natal report; and
  - the admissibility of evidence that a parent or primary care-giver of a child subject to care proceedings had a child previously removed from them by an order of the Court, and the child has not been restored. The Act identifies this as prima facie evidence that the child is in need of care and protection.

- The revised Secondary Assessment procedure and neglect policy addresses issues arising from our reviews, including clarification of the need to sight a child in the assessment process, and greater focus on history checks in determining responses to risk of harm reports.

We are encouraged that, in a number of key areas, the broader directions of DoCSø reform agenda have also been consistent with issues we have identified, and recommendations we have made. DoCS have commented that it would be ÷alarmingø if reviews suggested new directions or substantial departures from the reform agenda.[10] In 2004, for example, this office recommended that DoCS undertake a systematic performance audit of each CSC in NSW. DoCSø Professional Development and Quality Assurance project will incorporate a quality review of all CSCøs in NSW.

A separate but related issue is the need to recognise that identifying systemic issues is one challenge, ensuring an effective system response to these issues is another. In this regard, the Ombudsman is ideally placed to make an assessment not only as to whether agencies are aware of problems, or have plans to address them, but to also monitor the adequacy of the subsequent response. From our many years of oversight, we are acutely aware that agencies often have good capacity to identify problems, but may fail to effect change.

Investigations

Since 2003, The Community Services Division has initiated 90 investigations into 59 cases. The majority ó 73 investigations into 44 cases ó have concerned child protection issues.

Most of these investigations ó 66 investigations relating to 37 cases ó have arisen from child death reviews and have been predominantly of the Ombudsmanøs own motion:

- In 17 of the 37 matters, our investigations involved more than one agency. DoCS was subject to investigation in 37 matters. Other agencies subject to investigation included NSW Health (10), New South Wales Police Force (NSWPF) (10), DoCS-funded services

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[10] Ibid.

(4), Joint Investigation Response Teams (JIRT) (2), DET (2), the Department of Aging, Disability and Home Care (DADHC) and the Department of Housing.[11]

- In just under half (18) of the 37 cases, the investigation focused only on agency conduct in relation to the child who died. In a further 18 cases, the focus was on agency conduct concerning the child and their sibling(s) and in three cases, on the childøs sibling(s) only.

The type of recommendations made through investigations include:
- a child or children be located and a risk assessment conducted;
- agencies conduct their own review of practice, for example at a particular Community Service Centre or Area Health Service; and
- State-wide policies be changed to address anomalies or weaknesses

The majority of recommendations are accepted by agencies, and we monitor implementation. DoCS has noted to us that recommendations from individual investigations *'serve to reinforce the need for improved performance by individual CSCs and in particular areas of work, and can be a useful management resource.'*[12]

Reviews of children in care

Since 2003, we have conducted four group reviews of individuals in care, pursuant to s.13 of CS CRAMA:

- children under five years of age (two reviews);
- young people with disabilities leaving care; and
- children under the parental responsibility of the Minister placed in Supported Accommodation Assistance Program services.

We have also conducted eight service-based reviews, which examine the care provided to children or young people by a particular service.

We are currently conducting a review of the circumstances of children and young people aged 10 to 14 in out of home care.

In total, the circumstances of over 150 children and young people have been reviewed. Reviews have resulted in recommendations directed to:
- improving the circumstances of individual children and young people in care;
- addressing service-wide issues impacting on the safety or wellbeing of service consumers; and
- addressing systems improvement in cases where identified issues had implications for the wider service system.

Individual outcomes stemming from our review of children with disabilities leaving care included care plans being finalised for a number of the young people subject to review, and young people being provided with services they were eligible for but had not been receiving prior to the review.

[11] Not all of these investigations have been finalised, and in five cases, seven investigations were concluded without making findings under section 26 of the *Ombudsman Act*.
[12] Correspondence from Dr Neil Shepherd, Director-General. Dated 19 September 2007.

On a systemic level, in 2007 we completed a group review of children in statutory care who were under five years of age. We commenced this work in order to follow up on the observations we made in an earlier 2003 in-care review of the same age group. The earlier review identified inadequacies in areas such as permanency planning, support for carers, and clarity of case plans for children. Since that time, funding enhancements and legislative change have changed the environment for provision of out-of-home care. While our most recent review identified some concerns that have been bought to the attention of DoCS, we also observed clear improvements since 2003, particularly in case planning and management for short-term placements, and in relation to support for carers of very young children.

Complaints

The Ombudsman deals with oral and written complaints about the conduct of service providers. This includes DoCS and DADHC, as well as services operated, funded or licensed by these agencies.

Consistently, the issue most frequently complained about is child protection services. In 2006/07, we received 560 formal complaints about community service agencies, 174 (34%) of which related to DoCSøchild protection services. A further 137 (23%) were about out-of-home care services.

For child protection services, the most common complaints were about DoCSøresponse to risk of harm reports ó either the lack of intervention or the type and adequacy of intervention. For out-of-home care services, the most common complaints were about contact arrangements between children in care and their families.

The focus of complaint handling is on resolution, particularly at the local level.

Between 1 July 2007 and 31 December 2007 the Community Services Division finalised 308 formal complaints. 179 (58%) of the 308 complaints we received were about DoCS. In relation to matters where we initiated complaint action, the resolution rate for DoCS complaints was 49 per cent.

We have achieved a consistent increase in the numbers of complaints handled by the Division that result in resolution of the complaint and/or services being improved. In 2006 ó 2007, 54 per cent of all formal complaints were resolved. This compares to 38 percent in 2003 ó 04.

Inquiries and systemic investigations

The Ombudsman has a number of broad monitoring and review functions under CS CRAMA, including:

- to monitor and review the delivery of community services and related programs, both generally and in particular cases (s.11(1)(c); and
- to inquire, on his or her own initiative, into matters affecting service providers and visitable services and persons receiving, or eligible to receive, community services or services provided by visitable services (s.11(1)(e))

We have also carried out systemic reviews using own-motion investigative powers under the *Ombudsman Act*.

We have conducted a number of inquiries and systemic investigations relevant to child protection services, including:

- Individual Funding Arrangements in out-of-home care (conducted prior to the Childrenøs Guardian becoming fully operational); and
- services for children with disabilities.

Most recently, in 2007, we completed project work around police reporting of risk of harm, arising from the reviewable death function. This work raised concerns about the consistency with which police were adhering to requirements for reporting of risk of harm. The outcomes of this work have been reported to NSWPF and discussed in follow-up meetings. NSWPF has subsequently established a working party, as described above, to address police compliance with risk of harm reporting requirements. [13]

We are also in the process of finalising a major project focusing on support for Aboriginal foster carers and non-Indigenous carers of Aboriginal children.[14] The project has involved interviews with over 100 foster carers, and consultation with DoCS. The project has examined issues relating to case management, including information provided to foster carers before a placement is made, financial entitlements, case planning and conferencing, health and development issues, education, carer training, carer support groups and other support systems.

We monitor the implementation of recommendations arising from inquiries and systemic investigations. Recommendations have, in the main, been accepted by agencies, and we have identified clear outcomes from this work. Our attached submission to the Parliamentary Joint Committee provides further details of these outcomes.

Official Community Visitors

Official Community Visitors (Visitors) are statutory appointees of the Minister for Community Services. Their role is to visit accommodation services for children and young people, and people with a disability, that are operated, funded or licensed by DoCS or DADHC.

The functions of Visitors are outlined in Part 4 of the *Community Services (Complaints, Reviews and Monitoring) Regulation 2004*:

a) to inform the Minister and the Ombudsman on matters affecting the welfare, interests and conditions of persons using visitable services;

b) to encourage the promotion of legal and human rights of persons using visitable services, including the right to privacy, confidentiality, adequate information and consultation in relation to those services and the right to complain;

c) to consider matters raised by persons using visitable services, staff of providers of visitable services and people having a genuine concern for the welfare, interests and conditions of persons using visitable services;

d) to provide information to persons using visitable services as to the advocacy services available to help them in the presentation of any grievance or matter of concern and, in appropriate cases, to assist such persons to obtain such services; and

e) to facilitate, wherever it is reasonable and practicable to do so, the early and speedy resolution of grievances or matters of concern affecting persons using visitable

[13] A copy of the report to NSWPF has been provided to the Special Commission.
[14] A copy of the report regarding support for Aboriginal foster carers and non-Indigenous carers of Aboriginal children will be provided to the Special Commission.

services by referring those grievances or matters to the providers of the relevant services or to other appropriate bodies.

At June 2007, there were 1,230 visitable services in NSW. Of these, 107 were out-of-home care services, accommodating 213 children and young people. In 2006/07, Visitors made 370 visits to these services. An additional 59 visitable services accommodate 204 children with a disability. In 2006/07, Visitors visited these services on 196 occasions.

Pursuant to s 8 (1) of CS CRAMA, Visitors may:

a) at any reasonable time, enter and inspect a place at which a visitable service is provided;
b) confer alone with any person who is resident or employed at such a place;
c) inspect any document held at such a place which relates to the operation of a visitable service;
d) provide the relevant Minister in relation to the provider of the visitable service and the Ombudsman with advice or reports on any matters relating to the conduct of such a place; and
e) exercise such other functions as may be prescribed by the regulations for the purposes of this section.

Visitors are independent of the Ombudsman. The Ombudsmanøs role in relation to Visitors is focused on general oversight and coordination. As part of this role, we:

- determine priorities for visiting and allocate visiting hours to Visitors;
- manage the Visitable Services Database. The database incorporates reports prepared for services by Visitors following their visit. The reports identify any issues or concerns noted by the Visitor;
- provide support, training and resources to assist Visitors in their work and promote the scheme to services and consumers; and
- handle complaints arising from individual and/or systemic concerns raised by Visitors.

The focus of Visitors is to facilitate and monitor the resolution of issues by services at the local level. Visitors may refer issues of concern to the Ombudsman. In 2006/07, 377 issues were reported by Visitors in relation to services for children and young people, and 221 issues in relation to services for children with a disability.

Education and promoting consumers' access to advocacy support

The Ombudsman has broad functions that extend to child protection services in relation to community education and promotion of access to advocacy support for consumers (s.11 (1) (a), (b), (j)). We have invested significant resources into community education, information and awareness activities to further promote our role in relation to community services, including child protection services. This includes roundtables with child and family and disability peak organisations every six months, regional visits across NSW, and ongoing provision of consumer and service provider training. Our work is described in the attached submission to the Parliamentary Joint Committee.

We also have a specific function to review the systems of service providers for handling complaints (s14). This is primarily focused on educating and supporting services in the development of good complaint handling systems. In 2007, we completed a complaint handling review of DoCS-funded Family Support Services. The review identified areas of the complaint handling process that required development and included specific recommendations to this end. DoCS and Family Services NSW have responded with appropriate training and resource support strategies.

2.3.2 Part 3A Ombudsman Act

In 2006/07, we received 1,995 notifications of reportable allegations and finalised 1,749 of these notifications. This represented an 11.7 per cent increase in notifications since 2005/06. Of these notifications:

- The most frequent notifier was the Department of Education and Training (DET) (41%), followed by DoCS (23.5%).
- The most frequently notified issue was physical assault (58%), followed by sexual offences (8%), neglect (9%), sexual misconduct (7%), and behaviour causing psychological harm (4%).

Scrutinising systems

Our role is primarily oversight and review of agency investigations, with the aim of assisting agencies to improve their own systems for responding to reportable allegations. Minimally, oversight includes assessment and provision of feedback on the adequacy of each investigation. In approximately 20 per cent of cases, we assess that a higher level of oversight is warranted and we monitor these cases closely. Monitoring can include requiring certain information at the outset of investigations and regular updates from the agency.

Our scrutiny of agency systems is an ongoing process, and part of our day-to-day oversight of agenciesøresponses to reportable allegations and recommendations arising from them. Where we have concerns, we may investigate. However, agencies typically respond well to feedback and suggestions made by us on a less formal basis, and investigation of specific reportable allegations is therefore infrequently required.

We may also investigate systemic concerns, and this has been the primary purpose of the majority of investigations conducted. We have initiated 55 direct investigations since the jurisdiction commenced.[15]

Audit

Pursuant to s 25B of the Ombudsman Act, we audit agenciesøsystems for preventing reportable conduct by employees, and for handling and responding to reportable allegations. Audits provide a systematic review of systems and result in comprehensive feedback and recommendations about systemic improvements to agencies. We have conducted 109 formal audits since June 2001, of which 16 are current.[16]

The majority of agenciesøhave welcomed the opportunity to be audited, and we monitor compliance with recommendations. Generally, agencies fully comply with our recommendations.

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[15] 40 investigations have been finalised, three are open and 12 discontinued.
[16] As at March 2008.

Complaint handling

Formal complaint handling is a relatively small portion of our overall work under Part 3A. Complaints about investigations of reportable allegations are often resolved at the informal ÷enquiryø stage by referring concerns to the relevant agency and monitoring the response as part of our oversight of the investigation. We generally provides an agency with the opportunity to respond to complaints about them in the first instance, as concerns can often be resolved more efficiently in this way than through formal intervention by this office.

The majority of formal complaints we receive in regard to our Part 3A jurisdiction are received post-investigation and relate to the investigation outcomes. We have finalised 377 formal complaints since June 2001 and have 16 open complaints.[17] The outcome of these complaints range from providing explanation or clarification to the complainant to having investigation findings amended.

Education

For most agencies, conducting investigations into reportable allegations is not standard business. Provision of education and information to assist agencies in this work is therefore an important component of our work.

In 2006/07, we delivered training and briefings to over 1,000 people, conducted 22 industry forums, and 10 regional visits.

We have been instrumental in educating agencies in the early identification of risk factors and in managing those risks, particularly in regard to 'grooming' behaviour, accessing child pornography and the exploitation of children using electronic devices including the internet.

Over time, we have observed a significant improvement in the systems agencies in our jurisdiction have in place for protecting children in the workplace from abuse.

Our work under Part 3A of the Act is a part of the broader statutory child protection scheme in NSW, and we play a role in ensuring compliance with other child protection legislation.

[17] As at March 2008.

3. The Ombudsman's relationship with other oversight agencies

3.1 The Office for Children: Commission for Children and Young People

Section 11 of the *Commission for Children and Young People Act 1998* identifies the principle functions of the Commission for Children and Young People (CCYP) as:

a) to promote the participation of children in the making of decisions that affect their lives and to encourage government and non-government agencies to seek the participation of children appropriate to their age and maturity;

b) to promote and monitor the overall safety, welfare and well-being of children in the community and to monitor the trends in complaints made by or on behalf of children;

c) to conduct special inquiries under Part 4 into issues affecting children;

d) to make recommendations to government and non-government agencies on legislation, policies, practices and services affecting children;

e) to promote the provision of information and advice to assist children;

f) to conduct, promote and monitor training on issues affecting children;

g) to conduct, promote and monitor public awareness activities on issues affecting children;

h) to conduct, promote and monitor research into issues affecting children;

h1) to determine or intervene in review applications concerning prohibited persons;

i) to participate in and monitor background checking for child-related employment in accordance with Division 3 of Part 7;

j) to develop and administer a voluntary accreditation scheme for persons working with persons who have committed sexual offences against children;

k) to support and assist the Child Death Review Team in the exercise of its functions under Part 7A;

l) to encourage organisations to develop their capacity to be safe and friendly for children;

m) to develop and administer a voluntary accreditation scheme for programs for persons who have committed sexual offences against children.

Section 12 prescribes that in exercising its functions, the Commission is to give priority to the interests and needs of vulnerable children.

3.1.1 Research, inquiry and advocacy

Due to the scope of the CCYPøs jurisdiction, there is little intersection between the CCYP and the Ombudsmanøs office in regard to our functions of promotion of access to advocacy support, and monitoring and inquiry.

The *Office for Children Annual Report 2006/07* notes that the Royal Commission into the NSW Police Service was a ÷major catalystø for the establishment of the CCYP.[18]

The Royal Commission recommended the establishment of a:

> *'new Commission with appropriate powers and capacity to oversee and co-ordinate the delivery of service for the protection from abuse (including sexual, physical and emotional abuse and neglect).ø*[19]

The Royal Commission indicated this would occur in the context of a rationalisation of the roles of existing agencies, including the Community Services Commission.

The *Office for Children Annual Report* notes that:

> *Children, young people and others who were consulted about establishing the Commission felt that it should broaden its focus to encompass the broad range of issues that affect all children and young people in NSW and should focus on their well-being.*[20]

This is reflected in the scope of the CCYPøs work focus and status as a stated advocacy organisation for children and young people in NSW. The work schedule of the CCYP presently ranges from the built environment, children at work, and mobile phone use to collaborative projects with external agencies on the experience of young carers and childrenøs experience and understanding of poverty.

While the Ombudsman has a broad jurisdiction that incorporates universal services such as child care and neighbourhood and youth centres, our work is clearly focused on children who are or may be at risk of harm are in statutory or voluntary care, or who have disabilities and require assistance from State agencies, or from those agencies licensed, funded or authorised by State agencies.

The research work of the CCYP ó for example, the experiences of children living in poverty ó can provide contextual information relevant to the work of our office.

3.1.2 The Child Death Review Team

The amended CS CRAMA that provided the foundation for the merger of the Community Services Commission with the Ombudsmanøs office also transferred responsibility for certain child deaths ó those now termed reviewable ó from the Child Death Review Team (CDRT) to this office.

Governmentøs rationale for the shift included that:

> *'These review functions sit more appropriately in a watchdog body like the Ombudsman's office, with its monitoring and investigation powers and its existing function of oversighting the child protection system than in a research team that considers all children.'*[21]

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[18] Office for Children *Annual Report 2006/07*. page 47

[19] Final Report of the Royal Commission into the NSW Police Service: Volume 5, Chapter 20, p.1234.

[20] Office for Children *Annual Report 2006/07*. page 47

[21] Hon Carmel Tebbutt, Minister for Community Services. Second Reading Speech for the *Commission for Children and Young People (Child Death Review Team) Bill* . 2003

Part 7A of the *Commission for Children and Young People Act 1998* provides for the CDRT, with the object of the Part being to prevent and reduce the deaths of children in New South Wales. The functions of the Team are prescribed in s45N:

a) to maintain the register of child deaths occurring in New South Wales that has recorded such deaths since 1 January 1996;

b) to classify those deaths according to cause, demographic criteria and other relevant factors;

c) to analyse data to identify patterns and trends relating to those deaths;

d) with the approval of the Minister, to undertake, alone or with others, research that aims to help prevent or reduce the likelihood of child deaths;

e) to make recommendations, arising from the Teamøs maintenance of the register of child deaths and from its research, as to legislation, policies, practices and services for implementation by government and non-government agencies and the community to prevent or reduce the likelihood of child deaths; and

f) to identify areas requiring further research by the Team or other agencies or persons.

The functions of the Ombudsman in reviewing deaths are prescribed by s. 36(1) of CS CRAMA:

a) to monitor and review reviewable deaths;

b) to formulate recommendations as to policies and practices to be implemented by government and service providers for the prevention or reduction of deaths of children in care, children at risk of death due to abuse or neglect, children in detention centres, correctional centres or lock-ups or persons in residential care;

c) to maintain a register of reviewable deaths occurring in New South Wales after a date prescribed by the regulations classifying the deaths according to cause, demographic criteria or other factors prescribed by the regulations; and

d) to undertake research or other projects for the purpose of formulating strategies to reduce or remove risk factors associated with reviewable deaths that are preventable.

Section 36(2) states that, for the purpose of exercising those functions the Ombudsman may:

a) keep under scrutiny systems for reporting reviewable deaths, and

b) undertake detailed reviews of information relating to reviewable deaths, and

c) analyse data with respect to the causes of reviewable deaths to identify patterns and trends relating to those deaths, and

d) consult with and obtain advice from any person or body having appropriate expertise.

In our view, the separation of child deaths reviews has worked well and is effective.

In this regard, we note that the functions are complementary and the legislation provides for procedures that minimise overlap in the conduct of research. The *Commission for Children and Young People Act* and *Ombudsman Act* contain provisions to protect against duplication or overlap. The CDRT may not undertake a review of a reviewable death, and while reviewable deaths may be included in CDRT research, research about reviewable deaths must be approved by the Minister, who must consult with, and consider the advice of, the

Ombudsman in granting such approval.(s 45N (2), (3)) *Commission for Children and Young People Act*. Adherence to these requirements is an effective way in which to enhance the specific roles of the CDRT and this office.

In connection with the annual reports produced by each agency on child deaths, we also note that they are distinct and complementary. The CDRT has not made new recommendations in its annual reports since 2001/02, when this office gained responsibility for reviewable deaths. The annual reports have been used to monitor earlier recommendations, and recommendations arising from special CDRT reports. The focus of current monitoring of its recommendations are those arising from the Teamøs 2005 report on Sudden and Unexpected Deaths in Infancy.

Furthermore, any new recommendations made by the CDRT through annual reporting would be likely to reflect the broad parameters of the Teamøs mandate.

The CDRT and this office also have a number of procedural arrangements that ensure good use of resources and effective outcomes for both bodies. For example:

- The CDRT codes cause of death for all child deaths according to the Australian modification of the International Classification of Diseases (ICD ó 10AM).[22] The CDRT then provides this office with the codes for deaths that are reviewable by the Ombudsman. In this way, resources are used effectively and are registers appropriately identical in relation to cause of death.
- We provide information to the CDRT regarding children who were known to DoCS prior to their death. This eliminates duplication and the need for the CDRT to access the KiDS system.
- We exchange other information as required. For example, each year we exchange information to ensure our data sets are comparable. This has been a useful process for verifying data. The CDRT also supported our recent work in reviewing causes of death for children whose deaths were reviewable (2003 ó 2006) through provision of a dataset of all children who died in that period.

Since the commencement of our reviewable death function, at least two sitting members of the CDRT have been concurrent members of this officeøs Reviewable Child Deaths Advisory Committee. This provides a good practical link between the two bodies.

3.1.3 Employment related child protection

The work of this office intersects with that of the CCYP on a number of levels:

- probity checking,
- notification of relevant employment proceedings, and
- complaints about CCYP notifications

Essentially, our work complements the role of the CCYP in child-related employment, and provides an avenue to promote the effective operation of employment screening and probity checking, as described below.

[22] This coding system is an international standard health classification published by the World health Organisation for coding diseases.

Probity checking

It is a requirement of the CCYP Act that all persons considered for child-related employment be the subject of a Working With Children Check (WWCC) prior to employment.[23]

As part of our role in scrutinising agenciesø systems for preventing reportable conduct, we can monitor agenciesø adherence to the WWCC requirement. For example, in agency audits, we include an audit of WWCC documentation.

Where we oversight or monitor investigations of reportable allegations and there is reason to believe the subject employee may not have been appropriately screened by the agency prior to employment, we will require information in respect of this and, dependent on the response, take follow-up action.

Notification of relevant employment proceedings

The CCYPøs scheme is broader than this officeøs, in that agencies not within the Ombudsmanøs jurisdiction will nonetheless fall within the CCYPøs jurisdiction for the purpose of employment screening and the notification of relevant employment proceedings.

All completed investigations of reportable allegations constitute relevant employment proceedings that require a notification to the CCYP, unless:

- the allegation is found to be false, vexatious , misconceived or not reportable conduct; or
- the employing agency has entered a class or kind agreement with the CCYP and the matter falls within the ambit of that agreement.

Where agencies do not notify the CCYP at the completion of investigations of reportable allegations that constitute relevant employment proceedings, we will, at minimum, advise the agency that a notification to the CCYP is required. We can require an agency to provide information about whether it has notified the CCYP, and in cases where agencies have not taken this action, we advise the CCYP.

Where an employee has been wrongly notified to the CCYP, we will advise the agency and pursue a withdrawal of the notification. If an employee is notified in too high a category based on the investigation findings, and without adequate and documented decision-making, we will pursue this with the agency until we are satisfied that the employee has not been treated unfairly. We will also follow up with agencies where too low a category of notification appears to have been made based on investigation findings and/or risk assessment.[24]

The CCYP provides this office with regular advice about notifications made and withdrawn to assist in our work.

Complaints about CCYP notifications

The CCYP will not handle complaints about relevant employment notifications, and refers such complaints to this office. We review these complaints, and determine appropriate action on a case-by-case basis. For example, we may decline to take any action on the basis that the

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[23] In some circumstances, employment can be offered conditional upon a satisfactory WWCC being returned.

[24] There is a two-tiered approach to notifying relevant employment proceedings to the CCYP: Category one and category two notifications. Category one indicates a higher risk.

notification was properly made. Alternatively, we may make representations to the employer about either withdrawing the notification or amending the category of notification. Employees may seek a review by our office of these decisions.

3.2 The Office for Children: Childrenøs Guardian

The Ombudsman and Childrenøs Guardian have roles and responsibilities in relation to children in out-of-home care.

Under s.181(1) of the *Children and Young Persons (Care and Protection) Act 1998*, (Care and Protection Act) the functions of the Childrenøs Guardian include:

b) to promote the best interests of all children and young persons in out-of-home care;[25]

c) to ensure that the rights of all children and young persons in out-of-home care are safeguarded and promoted;

e) to accredit agencies and to monitor their responsibilities under this Act and the regulations.

Providers of out-of-home care that are within the jurisdiction of the Childrenøs Guardian are also subject to oversight by the Ombudsman. This office can:

- handle complaints about, investigate the conduct of, and review the complaint handling systems of out-of-home care providers;[26]
- review the circumstance of children in care, either individually or as a group;
- review the deaths of children in care;
- conduct inquiries or monitoring activities in relation to the provision of out-of-home care services; and
- scrutinise, oversight and monitor out-of-home care agenciesø systems for preventing, handling and responding to reportable allegations.

As noted above, Official Community Visitors also visit the 107 visitable services providing out-of-home care.

There are a number of legislative and procedural measures in place to ensure that that the work of both agencies is complementary. These measures include:

- provisions in the Care and Protection Act to avoid overlap in review, investigation and dispute resolution (s 180);
- capacity for exchange of information to promote the interests of children and young people in care; and
- a Memorandum of Understanding between the Childrenøs Guardian and this office (September 2004). The MOU sets out principles and procedures to ensure an open and effective working relationship, and provides clarity around referral of complaints, and information exchange and consultation.

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[25] This applies to statutory care only.

[26] Under CS CRAMA, a ÷service providerø includes providers of voluntary out-of óhome care, as per Part 3 of the *Children and Young Persons (Care and Protection) Act 1998.*

In relation to our role in reviewing the circumstances of children and young people in care, our MOU provides for consultation with the Childrenøs Guardian in the event we conduct a group review. The Childrenøs Guardian can also refer requests to us to review a child or group of children. Sections 150 (6) and 181(1)(d) of the Care and Protection Act provide for certain review roles in relation to individual children for the Childrenøs Guardian. These have not been proclaimed. We note and concur with the view of the Childrenøs Guardian that should s.150 (6) be proclaimed in the context of the Childrenøs Guardian gaining a limited role in making parental responsibility decisions, there would be no conflict with CS CRAMA provisions.[27]

3.2.1 The Children's Guardian and access to Official Community Visitor reports

The Childrenøs Guardian has indicated that it would be of significant benefit for her office to be provided with reports from Official Community Visitors to assist her in her accreditation decisions.

We have no objection to this, but note that Visitors are independent of the Ombudsman, and would therefore need to consent to information being provided. A further issue that would need to be addressed in any information exchange arrangement is procedural fairness. In our view, agencies would need to be advised of, and be given opportunity to respond to, reports that have been forwarded to the Childrenøs Guardian. This should happen regardless of what action, if any, the Childrenøs Guardian takes in response to a report.

3.3 The NSW Coroner

The role of this office intersects with that of the State Coroner as a result of our responsibilities in reviewing deaths. The primary role of the Coroner is to determine cause and manner of death.

Section 13AB of the *Coroner's Act 1980* identifies deaths that are examinable only by the State Coroner or Deputy State Coroner. The definition of these deaths is identical to the categories identified as reviewable deaths in CS CRAMA.

Pursuant to CS CRAMA, the State Coroner is required to notify this office of any reviewable death notified to her (s 37(3)), and to provide ÷full and unrestrictedø access to records that the Ombudsman may reasonably require for exercising his functions under part 6 (s 38(1)(g).

The relationship we have with the Coronerøs Office is effective. Over time, we have developed clear administrative arrangements with that office that provide for exchange of relevant information about reviewable deaths. For example, we routinely advise the Coroner of the child protection status of children, where these deaths have not been reported to her office.

[27] Childrenøs Guardian ó submission to the Special Inquiry into Child Protection Services ó Oversight Agencies (draft)

3.3.1 Coronial inquests

Since this office assumed responsibility for reviewable deaths, the Coroner has conducted 36 inquests relating to the death of 46 children or young people who have fallen within our reviewable death jurisdiction.

Where the Coroner decides to conduct an inquest, we generally await the outcome of this process prior to finalising our review. We also advise the Coroner of all cases where we have determined to investigate a matter.

The difficulty we do have with the Coronial process is the length of time taken to complete post mortem reports, which has a subsequent impact on the timeliness of the Coroner's determination as to whether or not a matter will be subject to an inquest. Our understanding is that delays are due to a shortage of forensic pathologists, who are employed by NSW Health. Our experience is that it can take some months for this office to be advised of whether the Coroner proposes to conduct an inquest.

3.4 The Audit Office of NSW

The NSW Audit Office has a discretionary oversight role in relation to child protection services, particularly through performance audits.

The most recent child-protection focused performance audit was completed by the Office in 2005, and concerned the operation of the DoCS Helpline.

This office has a good working relationship with the Audit Office, and there has been effective consultation in relation to performance audits targeted to issues and agencies of interest to this office. The Audit Office prepares an annual audit schedule, and we keep this in mind when determining our priorities.

4. Issues raised about the role of the Ombudsman

Discussed below are a number of issues that have been raised about our role in the following submissions to the Special Inquiry:

- the Association of Children's Welfare Agencies (ACWA);
- the Office for Children: The Children's Guardian; and
- joint submission by Dr Judy Cashmore, Professor Dorothy Scott and Commissioner Gillian Calvert (*'Think Child, Think Family, Think Community'*).

Also of relevance to the Special Commission, the attached submission to the Parliamentary Joint Committee incorporates:

- responses to issues raised by stakeholders about our role as an oversight agency in community services; and
- proposals for amendments to CS CRAMA to enable this office to more effectively meet the objects and functions of that Act.

4.1 Reviewable child deaths

4.1.1 Oversight of child deaths

The agenda for the public forum on the role of oversight agencies raises the question of whether one agency should be responsible for oversighting the review of and research into all child deaths.

In our view, the current arrangements have resulted in an effective system of scrutiny of child deaths in NSW. The system enables a broad-based approach to understanding causes and patterns in child deaths, and the ability to undertake appropriate research. At the same time, the system ensures a particular focus on deaths resulting from abuse and neglect, and those that occur in the context of child protection concerns.

As noted above, one of the main reasons for transferring responsibility for reviewable deaths to the Ombudsman was to site this group of child deaths within an agency that had strong monitoring and investigation powers and an existing role in scrutinising the child protection system.

Critical to our role is the direct access we have to police and DoCSø databases. This office has remote access to the police COPS system and will shortly have direct access to KiDS for the purposes of our death review function.[28] In addition, we regularly use our broad-ranging powers, including our Royal Commission powers, to gain access to the information we require to effectively fulfil our responsibilities.

4.1.2 The focus of reviewable child deaths

In their submission to the Special Inquiry, Dr Judy Cashmore, Professor Dorothy Scott and Commissioner Gillian Calvert recommend:

> *'Extend the reporting time for the Ombudsman's report into reviewable deaths to every three years with a focus on deaths from child abuse and neglect and children who die in suspicious circumstances, with annual reporting on progress of recommendations.'*[29]

The submission notes that a longer reporting schedule would *'help to bring a wider perspective'* and that reporting that does not allow enough time for change can demoralise staff and *÷weaken the system'*.

The basis for this recommendation appears to be the largely negative media publicity surrounding child deaths, annual reporting not leading to new information, and annual reporting not allowing enough time for change to be implemented or measured. We note in relation to the latter point that the recommendation does, however, call for continued annual reporting of progress with recommendations.

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[28] There has been a long-term in-principle agreement by DoCS to enable remote access to KiDS. Delays in providing access have been technical in nature.

[29] Dr Judy Cashmore, Professor Dorothy Scott, Commissioner Gillian Calvert *Submission to the Special Commission of Inquiry into Child Protection Services in NSW*. March 2008

Reporting timeframes

Media reporting

Our annual reports are careful to ensure balance, accuracy and a focus on systemic issues. All agencies are provided with an opportunity to comment on a draft copy of the report, and their responses are fully considered and as appropriate, incorporated.

The release of our first report was in December 2004, and media coverage was extensive and in some cases simplistic. In the ensuing years, we have further developed our approach to releasing material related to child death reviews. In preparing our public reports, we give much consideration to ensuring the material does not lend itself to sensationalist media reporting.

Our most recent annual report devoted much of its focus to considering the underlying issues that present a challenge to child protection responses, such as drug and alcohol use, mental illness and domestic violence. Moreover, it articulated the positive gains made by agencies over the five years of our reviews.

Child deaths ó particularly those linked to abuse and neglect ó will always attract media attention. Release of both our 2006 and 2007 reviewable deaths reports followed a high level of media coverage of a number of child deaths. These deaths were the focus of the media reporting.

The example of the incorrect use of our figures provided in the submission is unfortunate, but not in our experience common. This one report aside, we have identified an increasing capacity in the media to understand the complex issues arising from child deaths. Reporting in the past two years about our work has been more balanced. We have certainly not seen *'media coverage resulting in the adoption of policies which are not based on evidence'*.[30] Each annual report is accompanied by briefings for journalists, a media conference and direct media access to the Ombudsman in order to put forward as balanced and clear a message as possible. We ensure the report, and all briefing material, clearly describes the jurisdiction and the fact that by definition, the majority of the children whose deaths we review will inevitably be known to DoCS.

New information

We have produced four annual reports to Parliament on child deaths. Each has taken a broad systems view of the operation of the child protection system. Core concerns ó for example, agency identification and reporting of risk of harm, DoCSø capacity to respond to reports, and the quality of risk assessment made ó have been consistently reported. Each report has built on the previous, particularly in regard to our reporting of issues and solutions about the role of NSWPF and NSW Health.

We now have a strong body of evidence, and will continue to monitor progress in core areas of practice. We also plan to focus our report on specific issues and/or areas of concern, in addition to monitoring progress on recommendations. The 2008 annual report, for example, will focus on the deaths of children not known to DoCS.

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[30] ibid. p. 14

While in our view, media reporting and ÷new informationø are not sufficient grounds to extend reporting timeframes, we note that the production of an annual report is a complex task that requires significant resources, and this does raise questions of the costs and benefits of annual reporting cycles. We have limited resources to apply in the reviewable death function, and producing an annual report as we have done for the past four years has opportunity costs. For example, we have had limited capacity to undertake significant research or related developmental activities. Consideration of extended reporting timeframes on this basis may be warranted.

It is also important, however, to note that the officeøs reviewable death function ó and the reviewable death annual report - also concerns people with a disability. We would anticipate significant concerns from stakeholders in that sector relating to a reduced reporting period.

Root cause analysis

The submission also notes that:

> *Adopting a root cause analysis model such as that operating in the fields of health and industrial safety would shift the focus on the last link in a chain of events to a broader view of the problems and of the multiple potential points of intervention.'*

The inference appears to be that our work is focused on the death incident and does not take a systemic approach to analysing the preventive aspects of child deaths. While we would be keen to consider proposals about improving our work, as we have detailed above, our work ó both on individual matters and in annual reporting ó is focused on risk to children and how this can be alleviated through a systems approach.

What also needs to be acknowledged is the role DoCS plays in conducting its own reviews of these matters. The department is well placed to look closely at specific types of systemic issues relating to its response to child protection concerns. For example, while both DoCS and the Ombudsman do adopt a systems perspective, as the employing body, DoCS will often be in the best position to obtain, assess and analyse more micro and location-specific systems issues.

Furthermore, our reviewable death function has been in place for a relatively short five years, and we are continually evolving our work in reviewing deaths. We have been involved in ongoing discussions with DoCS about how we perform our respective roles, including those areas where our review roles currently intersect.

More broadly, together with the Victorian Commission of Child Safety, we are working to bring together child death review functions in the Australasia region, to consider how each jurisdiction approaches their work, and to provide an opportunity for learning and development. The proposed forum is scheduled for June this year.

Focus on abuse, neglect and suspicious deaths

CS CRAMA requires us to review all deaths of children who deaths are defined as reviewable. The rationale for this is indicated in the second reading speech for the *Community Services Legislation Amendment Bill*:

> *'The Bill provides maximum opportunity for using information from individual deaths to target the monitoring and review of service providers and to influence changes to systems and practice.'*

As noted above, 90 per cent of children whose deaths are reviewable are in the category of ‘known to DoCS’. Of the 620 deaths we reviewed in the past five years, 180 resulted from abuse or neglect, or occurred in suspicious circumstances.

In reviewing deaths of children known to DoCS, it is apparent that risk factors evident in many of the histories of children who die as a result of abuse or neglect do not appear to differ significantly to the child protection histories of children who do not die in these circumstances. No child protection system can specifically identify those children who are likely to die as a result of abuse. However, our approach of systematically examining critical parts of the child protection system recognises that improving responses to children who are at risk is an important preventative measure.

It is also important to consider prevention of child deaths broadly. For example, work we completed in 2007 on the causes of death for children we have reviewed found that there was a higher likelihood of these children dying from certain natural and unnatural causes. These include epilepsy, preventable disease such as meningococcal and pneumonia, and accidental drowning. These findings raise important public policy questions about risk to vulnerable children.

Reporting on all reviewable deaths has also enabled us to raise significant issues that will help to minimise risk. For example, a significant number of deaths that we review involve children who never leave hospital following their birth (26 in 2007, 21% of all reviewable deaths). These deaths are generally not classified as abuse or neglect. Our capacity to report on these deaths, however, contributed to our recommendation for NSW Health to overhaul their drugs in pregnancy services. Improved pre-natal care for women using drugs can have the potential to lower child mortality, and improve the quality of life for many other children.

Similarly, our work reviewing and reporting on all child deaths within our jurisdiction has raised significant issues about, and elicited agency responses to, critical issues in child protection. These include young people with mental health issues reported to be at risk of harm, children at risk due to domestic violence, Aboriginal children at risk of harm, and interagency coordination and cooperation. A more limited focus would not promote this broader perspective.

For these reasons, we would not support a restricted focus on our reporting.

4.2 Part 3A Ombudsman Act

4.2.1 Focus of our work under Part 3A Ombudsman Act

In its submission to the Special Commission, the Association for Childrenøs Welfare Agencies (ACWA) states:

> *'There is a need to review of the functions of the operation and focus of the Child Protection Team, to refocus of the workplace child protection remit onto serious instances of reportable conduct, rather than the currently onerous regime for NGOs in investigating, managing and reporting reportable conduct which is of a minor or trivial nature, and some of which is based on malicious or disingenuous complaints.'*[31]

The Ombudsmanøs child protection scheme is allegation-based. If an allegation is made that meets the definition of a reportable allegation, the head of agency must notify us within 30 days of having become aware of it (s25C (2) *Ombudsman Act*). The allegation must then be investigated and the outcome reported to us along with all supporting documentation.

The scheme arose from recommendations from the Royal Commission into the NSW Police Service, which found, among other things, shortcomings and possible conflicts of interest when agencies were required to handle child abuse allegations against their employees. The Royal Commission had found that agencies tended to draw conclusions that allegations of child abuse had no substance simply on the basis of an employeeøs denial or the employerøs belief systems. In requiring agencies to notify reportable allegations on the basis of what is alleged, agencies can demonstrate transparency and accountability for their decision-making.

Changes to Part 3A in 2004 inserted several exemptions, including allegations that can be regarded as trivial. Section 25A of the Act makes it clear that certain conduct does not constitute reportable conduct, including:

(a) Conduct that is reasonable for the purposes of the discipline, management or care of children, having regard to the age, maturity, health or other characteristics of the children and to any relevant codes of conduct or professional standards; or

(b) the use of physical force that, in all the circumstances, is trivial or negligible, but only if the matter is to be investigated and the result of the investigation recorded under workplace employment procedures; or

(c) conduct of a class or kind exempted from being reportable conduct by the Ombudsman under section 25CA.

Employers are expected to obtain sufficient detail from the notifier about what is being alleged before determining whether or not the allegation is a reportable allegation.

In addition, the Act provides for the making of determinations that exempt agencies from the requirement to report certain classes or kinds of conduct (s 25 CA). This provision has been used extensively, with some agencies demonstrating investigative capacity to the degree that will enable us to exclude all but serious matters. However, some agencies have not been able to demonstrate a satisfactory investigative standard, even in regard to low risk matters. We continue to work with these agencies to improve practice. In our view, it is critical that the Act continue to provide for appropriate responses to the variance in agency capacity.

[31] ACWA *Submission to the Special Commission of Inquiry into Child Protection Services in NSW,* page 32

Since July 2007 to date, we have received 111 notifications from agencies providing out of home care to children. Of these:

- 10 have been received from agencies with class or kind determinations;
- 51 have been received from a large agency that we investigated and continue to monitor closely; and
- seven have been received from an agency that was offered a class or kind determination but requested our continued oversight of all matters.

Of the remaining 43 notifications, we have received 11 from another large agency, and either one or two notifications from a further 21 agencies.

Since commencement of the scheme in 1995, we have received approximately 15,000 notifications. Subsequent investigations determined that the alleged conduct either did not happen, or that there was no evidence of any weight that it occurred, in only 6 per cent of matters.

4.2.2 Duplication of the oversight role of the Ombudsman and DoCS

ACWA further states in its submission that DoCS and the Ombudsman's office oversight when an NGO is acting on a reportable matter, and 'there should only be one body monitoring agencies in this regard, not two watchdogs either monitoring the investigation of conducting their own investigation.

We have an investigation oversight role in regard to every reportable allegation notified to us. At a minimum, we assess and provide feedback on the adequacy of each investigation, ensure that risks to children have been properly assessed, and where appropriate managed, and ensure that the employee who is the subject of an allegation has been afforded procedural fairness. Where we assess that a higher level of oversight is warranted, we monitor the investigation (s 25 E *Ombudsman Act*). This involves closer scrutiny of the agency's investigation from planning through to completion of the matter. We monitor approximately 20 per cent of notifications from the outset, and escalate our involvement in a further 11 per cent of matters.

If available information suggests to us that an agency has not complied with its obligation to report a matter to DoCS, we will advise an agency that it needs to do so. In appropriate cases, we will also provide advice to agencies of their need to report to police, report to the CCYP, or complete appropriate probity checking.

At times, there may be some overlap in the material agencies need to report to various bodies. However, we do not believe this overlap is resource intensive or unnecessary.

In terms of reportable allegations, where either police or DoCS are involved in an investigative capacity, apart from reporting, there is minimal duplication. For example, in those cases where either DoCS or police (or both) decide to conduct their own inquiries into allegations that have been made, it would generally be inappropriate for the agency to conduct its own investigation at the same time. The agency would suspend its investigation but would be required to undertake a risk assessment at the time the allegations were made. It is only after the police and/or DoCS have finalised their inquiries that the agency concerned would need to establish what further information it needed to obtain, and how. Therefore, in these circumstances, good practice would usually avoid duplication.

However, we acknowledge that the types of matters that require agencies to notify this office, DoCS and police are inevitably of a serious nature, and may cause agencies to be legitimately concerned about whether they are handling the matter appropriately. In this context, and in light of the concerns raised by ACWA, we believe that there would be benefit in our office bringing together the relevant agencies, including ACWA, to discuss the development of practical guidelines to assist agencies in dealing with these types of matters. This can be facilitated through our regular quarterly forum for agencies providing out of home care.

Bruce Barbour
NSW Ombudsman

Steve Kinmond
Community and Disability Services Commissioner (Deputy Ombudsman)

Special Commission of Inquiry into Child Protection Services in NSW

Submission of NSW Ombudsman

Part 2B: Response to DoCS' submission on the role of oversight agencies

22 April 2008

Ombudsman ref: ADM/6124

1. Introduction

Our views on oversight arrangements are set out in our previous submission to the Special Commission.[1] In this submission, we respond to the claims and proposals made by DoCS in its submission about oversight agencies.[2] In relation to allegations against employees, we also address some issues that have arisen in the course of forums held by the Special Commission.[3]

This submission addresses three main areas subject to criticism by DoCS:

- The function and role of the Ombudsman
- The role of the Ombudsman in child death reviews
- The role of the Ombudsman in the management of allegations against employees.

It is disappointing that many of the claims and criticisms in the departmentøs submission are wrong or misleading, and not supported by any evidence.

2. The function and role of the Ombudsman

In regard to the general operation of this office, DoCS is critical of role delineation and the resources required to respond to oversight agencies.

2.1 DoCS' submission: Role delineation

DoCS asserts that:

> *'Responsibilities are blurred in current oversight arrangements and the proper role delineation between the executive and oversight agencies is not always clear.'*[4]

DoCS provides no particular evidence of this serious allegation, other than to note *'agencies are often faced with detailed recommendations from oversight agencies that effectively direct policy, operational practice and resource allocation.'*[5]

DoCS draws attention to the recognition of *'this potential tension between oversighting body and agency'* in the *Health Care Complaints Act 1993*, which requires the Health Care Complaints Commission to make recommendations in such a way that:

a) *Would not be beyond the resources appropriated by Parliament for the delivery of health services.*
b) *Would not be inconsistent with the way in which those resources have been allocated by the Minister and the Director-General in accordance with government policy.*[6]

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[1] NSW Ombudsman submission to the Special Commission of Inquiry into Child Protection Services in NSW: Oversight agencies March 2008

[2] NSW Department of Community Services submission to the Special Commission of Inquiry into Child Protection Services in NSW: The role of oversight agencies March 2008.

[3] Regional Forum Wagga Wagga, 11 March 2008; Oversight Forum, 28 March 2008.

[4] Op cit page 6.

[5] Ibid page 6

[6] *Health Care Complaints Act 1993* section 91

Our response

It is inaccurate to suggest there is blurred responsibility between this office and the executive. The Ombudsman has a clear role conferred by Parliament, both generally, and in relation to community services and child protection. Our work demonstrates that we fulfil our legislated role and do not exceed it.

- DoCS has provided no evidence of recommendations being made that inappropriately direct policy and/or resource allocation. Reference to child deaths in this commentary indicates the criticism is directed to this office: in relation to child deaths, this is discussed further in section 3 below.

- Recommendations made by this office, whether they result from an individual complaint or a systemic report, are not determinative and cannot be enforced by the Ombudsman. The Ombudsman does not determine policy directions or resource allocations for any agency.

- Section 5 of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (CS CRAMA) requires issues, decisions or recommendations under that Act to be commensurate with the resources appropriated by Parliament for the delivery of community services, to be consistent with the allocation of resources by relevant Ministers and Directors-General, and with government policy. This section, however, specifically excludes the exercise of any function of the Ombudsman. This exclusion recognises that such limitation would impose an inappropriate restriction on the independence of the Ombudsman.

- DoCS has provided no evidence that the Ombudsman has misused his role to adversely influence resource allocation or policy. Further:

  The HCCC has a tightly defined jurisdiction relating to the handling of complaints. The Ombudsman has much broader ambit which incorporates requirements to make recommendations that go to policy and practice.[7]

  The HCCC reports to the responsible Minister. The Ombudsman reports to Parliament and is accountable to a joint Parliamentary Committee. It would be inappropriate to place such restrictions on his role and capacity and any such restrictions would be strongly opposed.

2.2 DoCS' submission: Resource impacts

DoCS states that in addition to different oversight bodies:

> *'DoCS responds to matters from three separate parts of the Ombudsman's Office: the community services division which deals with issues like reviewable deaths; the child protection team which deals with reportable conduct issues; and the general team.'* [8]

DoCS also provides information about increases in *'Ombudsman related oversight matters'*.[9] In summary, these are that:

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[7] For example, s 11(1)(d), 13(4)(b), 14(1)(b), 36(1)(b) *Community Services (Complaints, Reviews and Monitoring) Act 1993.*

[8] Op cit page 7

[9] Ibid page 8

- In a two-year period, the average number of matters about which this office *÷made contact with DoCS in relation to general oversight'* increased from around 70 to 120 per quarter. DoCS states that *'Only three of these inquiries proceeded to finalised investigations by the Ombudsman.'*
- In a two-year period, 319 preliminary inquiries and 250 referrals for local resolution were made by this office.
- Between 2003 and 2007, the number of allegations increased from 170 to 848, with cases of reportable conduct increasing from 145 to 434. DoCS states that the increase is likely due to wider knowledge of the provisions, *'as well as the low threshold for reportable conduct.ø*[10]

Our response

- The inference in DoCSø submission is that responding to matters from different teams within the Ombudsmanøs office creates an unreasonable demand. There is no evidence provided that this is the case, and the department has not raised this as a concern to this office. This office also deals with a number of different units within DoCS. Any matter which is identified by us as requiring notification or action in more than one functional area ó for example, a child death that is also the subject of a complaint and involves a reportable allegation ó is managed internally within this office to ensure no duplication of effort on DoCSø part.

- In relation to DoCS, the General Team within this office handles only Freedom of Information requests. This is a highly specialised function performed under the *Ombudsman Act 1974* and the *Freedom of Information Act 1989* that is not related to direct oversight of child protection services.

- It is unclear what DoCS means by this office having *'made contact with DoCS in relation to general oversight'*. CS CRAMA incorporates an extensive range of functions that can result in different levels of contact with DoCS. ÷Contactø can range from inquiries related to complaints ó in 2006/07, we handled 1,037 formal complaints and inquiries about DoCS[11] ó to reportable allegations, to reports arising from reviewable deaths (many of which require no response), to provision of information relating to the work of Official Community Visitors.

- DoCSø statement that *'only three of these inquiries proceeded to finalised investigations'* appears to imply that the inquiries may not have been necessary. Apart from the fact that the figures, and what they relate to, is unclear, the statement is misleading. The department would be aware that CS CRAMA prioritises local resolution, with formal use of investigatory powers limited to the most serious matters. This enables the department ó or any agency ó to resolve matters themselves. This has been previously encouraged by DoCS.

- DoCS does not acknowledge increased complaint numbers following two high profile child deaths in 2007. DoCS is also aware that due to resourcing issues within its own complaints unit, the department has been unable to promptly finalise many matters. This has resulted in increased contact by our office in relation to delayed complaints, thereby

[10] Ibid page 8
[11] 321 formal complaints and 716 informal complaints/inquiries.

increasing the number of ÷contactsø we have had with DoCS. The absence of this information in DoCSø submission is both misleading and disappointing.

- DoCSø claim that the number of allegations of reportable conduct has increased to 848 in 2007 is misleading. The number of notifications did rise, however, this rise was from 352 in 2004/05 to 436 in 2005/06, and 469 in 2006/07. This is an increase of 10% and 7.6% respectively.[12] The figure put forward by DoCS appears to include inquiries that did not result in an allegation of reportable conduct. This was clarified later in the submission, where DoCS notes of the 848 *'intake reports', 'not all of these reports met the threshold of reportable conduct under the Ombudsman Act 1974.'* DoCS figures show that just over half (434) were accepted as reportable conduct.[13] The issue of increased workloads in managing reportable allegations is discussed further below in section 4.

3. Child death reviews

In its submission, DoCS contends that:
- The Ombudsman, particularly through child death reviews, has acted inappropriately in directing recommendations to policy and resource issues.
- Structural arrangements for the investigation, review and reporting of child deaths, and the way these functions are undertaken, do not promote effective reform of child protection practices.
- There is duplication in the review of child deaths in NSW, with ÷manyø key external bodies being responsible for these reviews.
- The approach to, and outcomes of, child death reviews is ó or has the potential to be ó punitive and destabilising to the department.

We strongly reject these claims and have serious concerns that the department has put them forward in the absence of any reasonable supporting evidence.

DoCSø submission also proposes a number of ways forward. Essentially, the elements of child death review that DoCS recommends are to vest child death reviews in one body, and to limit the definition of a reviewable death. The possible model put forward by the department gives primary responsibility for review to DoCS, with external review of the departmentøs subsequent report by a panel of experts and agencies.

DoCSø proposal for reform is poorly articulated. It would achieve the outcome of decreased oversight, but fails to demonstrate any clear benefit to the system for protecting children.

These issues are addressed in detail below.

[12] See NSW Ombudsman Annual Reports (Employment related child protection) 2005/06 and 2006/07.
[13] Op cit page 16. We note there is a minor difference in our figures and DoCS figures.

3.1 DoCS' submission: The role of the Ombudsman in child death reviews

Our reading of DoCSø submission on our role, particularly as it relates to child deaths, is that the department considers our role to be too broad and our recommendations too directive and/or *'nebulous'*.[14]

DoCS clearly implies that the Ombudsman has stepped beyond his role in oversighting child deaths, and that:

> *'It is inappropriate for any one oversight agency to determine the preferred policy direction on the broader areas for which DoCS is responsible. Decisions about how to best allocate resources for child protection and achieve service improvements are matters for the Minister and Parliament. In any event all the research indicates that child deaths are unpredictable events and it is particularly inappropriate to direct major policy and resource allocations on that basis.ø*[15]

DoCS alleges that:

> *'At present it is too common to be confronted with recommendations made in a public report which are either nebulous or unlikely to address the problem.''*[16]

In the departmentøs terms, reform would constitute institutional arrangements being *'modernised'* and structural arrangements being changed to make this function *'more rigorous and effective.ø*[17]

Our response

Our response to DoCSø assessment of the role of the Ombudsman is detailed in section 2 above.

- In 2002, the NSW Parliament conferred responsibility to the Ombudsman for reviewing the deaths of certain children and of people with disabilities in care, making annual reports to Parliament about these deaths, and formulating recommendations about policies and practices to be implemented by government agencies and service providers for the prevention or reduction of child deaths.[18]

- DoCS is not *'confronted'* with recommendations made by this office in a public report. DoCS receives a draft version of recommendations and is invited to make comment on them. This is the case with reviewable deaths annual reports, and has been since 2006, when DoCS requested that the department be provided with draft recommendations.

- Previous communication between this office and DoCS in relation to recommendations is at odds with DoCSø current claims. In 2006, DoCSø response to our draft reviewable

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[14] Ibid. page 6 and 13
[15] Ibid page 6
[16] Ibid page 13
[17] Ibid page 12 and 13.
[18] *Community Services (Complaints, Reviews and Monitoring) Act 1993*. section 36(1)(b)

deaths report recommendations noted the department was *'pleased that the draft recommendations directed to DoCS are generally in line with existing policy directions.'*[19]

- In 2007, Dr Neil Shepherd, the then DirectoróGeneral, provided a breakdown of recommendations made in our reviewable deaths annual reports from 2004 ó 2006, noting that:

  48 per cent related to DoCS providing advice, updated information or finalised documents to the Ombudsman.

  38 per cent were *'consistent with DoCS' existing work, initiative or reform'*, and

  13 per cent were about new initiatives.[20]

  Recommendations about *'new initiatives'* included a proposal that DoCS give priority for risk assessment to children reported to be at risk of harm and whose siblings had been previously removed by an order of the Childrenøs Court; a recommendation to undertake a systematic performance audit of each CSC in NSW; and a number of recommendations relating to thresholds for closing cases prior to full risk assessment, and DoCS ability to quantify the cases it closes due to resource constraints. In our view, these are entirely reasonable recommendations in line with our legislated role and responsibilities.

- Current recommendations are also entirely reasonable. The recommendations:

  seek progress on DoCSøproposed actions to address issues identified through our work;

  propose that the department develop capacity to report on the number of cases closed due to resource constraints;

  ask that, as part of a planned evaluation of the child protection program, a component consider the handling of reports referred to the early intervention program that are subsequently deemed ineligible due to risk to the child being too high;

  propose that DoCS and NSW Health develop clear arrangements for notifying methadone prescribers where their patientøs child is admitted to an emergency department as a result of methadone ingestions; and

  request DoCS and NSW Health to provide advice on any strategies planned to promote a coordinated response to adolescents at risk of harm where reported concerns include suicide risk and mental health issues.

- We understand that the CDRT has one current recommendation targeted to DoCS. This relates to a 2002 report and is that Families First be enhanced to enable the provision of sustained home visiting for all high risk families for up to two years.

- DoCS has, at no stage or in relation to any area of our work, indicated a view that a recommendation was either nebulous or unlikely to address the problem. If DoCS is of this view, it is important that the basis for this position be substantiated.

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[19] Email from Donna Rygate, (then) Executive Director Strategy, Communication and Governance, dated 27 October 2006.
[20] Correspondence from Dr Neil Shepherd, responding to the Ombudsmanøs request for views on the reviewable deaths work of this office, dated 19 September 2007.

- We note that this is not the position of other agencies subject to oversight through our reviewable deaths function. NSW Health, for example, has advised us that reviews of child deaths have been an effective catalyst for:

    improving interagency collaboration in child protection responses, in particular through joint recommendations and the review, implementation and evaluation of the Interagency Guidelines for Child Protection Intervention (2006);

    improving inter-branch collaboration within NSW Health and examination of intersections between child protection and other areas, such as drug and alcohol abuse;

    initiating reviews into important issues, such as the child methadone deaths review;

    legislative change, such as the recent changes to sections 23 and 25 of the *Children and Young Persons (Care and Protection) Act 1998* relating to prenatal reports; and

    policy change, such as the NSW Health policy *PD2006_084 Domestic Violence – Identifying and Responding* to help ensure child safety when working with victims of domestic violence.

- NSW Health has advised us that *'the power of the Ombudsman's office to lead the coordination of activities, and hence monitor progress and provide an accountability function, whether within an agency or between agencies is highly valued.'*[21]

- The NSW Police Force (NSWPF) has advised us that our reviewable deaths function is an important one, and that *'in response to findings of your investigations, NSWPF has issued guidance to police in relation to identifying and reporting risk of harm'*, and further that NSWPF is *'currently reviewing and updating its SOPS* [Standard Operating Procedures] *in relation to Domestic Violence and Child Protection, both of which will include updated advice for police taking into consideration the recommendations of your reviewable deaths reports.'*[22]

- It is unclear how DoCS considers that the current system fails to be contemporary, and we reject the inference that the work of this office lacks rigour. It is exceptionally rare that DoCS has questioned a fact or finding arising from our work. It is disappointing that the department has raised such issues without any substantiation.

3.2 DoCS' submission: Arrangements and responsibilities in reviewing child deaths

DoCS submission fails to clearly describe current arrangements and roles of oversight bodies involved in reviewing child deaths. The departmentøs core contention is that too many agencies are involved in child death reviews, and that there is resultant duplication and resource issues for the department. This is reiterated in DoCS submission to the Special Commission on the operation of the Childrenøs Court.[23]

DoCSø view is that *'many'* agencies are responsible for the review of child deaths:[24]

[21] Correspondence from Professor Debora Picone, Director-General NSW Health, responding to the Ombudsmanøs request for views on the reviewable deaths work of this office, dated 31 July 2007.
[22] Correspondence from Assistant Commissioner Mahoney, responding to the Ombudsmanøs request for views on the reviewable deaths work of this office, dated 13 July 2007.
[23] NSW Department of Community Services submission to the Special Commission of Inquiry into Child Protection Services in NSW: Operation of Courts in the child protection system. February 2008. Page 33
[24] Op cit page 3

> *'In relation to child deaths, for example, the Coroner, the Ombudsman and the CDRT will all look at the same matters. The Coroner will look at an agency's involvement with a family to determine culpability. The Ombudsman will be looking for maladministration, although it is the case that the Ombudsman has a much broader range of functions under s (11)(1)(d) of CS CRAMA. The CDRT will be looking at the death in terms of patterns and trends. An agency that was involved with the child or young person will be required to respond to the demands of all three.'*[25]

DoCS later notes, however, that:

> *'the reviewable deaths framework is not designed to address the question of culpability for a death. That issue is a matter for the Coroner and the police. Additionally, it is not designed to determine specifically whether there has been maladministration, as that function sits as one of the Ombudsman's more general responsibilities.'*[26]

The work of the CDRT is described briefly, and DoCS notes the Teamøs release of annual and special reports, quoting the CDRTøs 2003 *Fatal assault and neglect* report as an example.

DoCS further describes its own role reviewing child deaths and notes the Child Deaths and Critical Reports Unit (CDCRU) *'has an increasing capacity to provide a timely centralised, systematic and consistent response to deaths of children known to DoCS.'* [27] DoCS describes the strengths of this system as an understanding of organisational context; willingness of staff to talk ó presumably as the review is internal; capacity to make *'practical'* recommendations, and capacity to deliver on organisational learning and improvement.

Our response

- The department provides no evidence of the degree to which it is subject to unreasonable or duplicative requests by agencies. If there is duplication, DoCS has not brought this to our attention.

- Existing arrangements in relation to child death reviews have been clearly described in our submission to the Special Commission on Oversight Bodies.[28] Importantly, the relevant legislation provides for clear roles and responsibilities of each agency. The legislative framework incorporates clear provisions for managing any potential for duplication between the CDRT and this office. If duplication is an issue ó and again, we have received no indication that it is ó this is most likely to be an administrative, rather than structural, issue.

- In 2002, NSW Parliament determined a new regime of oversight of community services. The primary rationale for the change was to reform *'the most complex oversight arrangements of community service providers of any jurisdiction in Australia.ø*The reforms included the separation of child death reviews into a research function through the CDRT, and reviews of the deaths of certain children, including children known to DoCS, through the Ombudsman. This was because such reviews *'sit more appropriately in a watchdog body like the Ombudsman's office, with its monitoring and investigation powers*

[25] Ibid page 7
[26] Ibid page 11
[27] Ibid page 11
[28] NSW Ombudsman submission to the Special Commission of Inquiry into Child Protection Services in NSW: Oversight agencies March 2008 section 3

and its existing function of oversighting the child protection system than in a research team that considers all children'. [29]

- The roles ascribed by DoCS to the Coroner and this office indicate little understanding of the core role of each agency:

  Child deaths are examinable by the State Coroner, and may be subject to inquest. The role of the Coroner is primarily ó although not limited to ó determining cause and manner of death. In our view, and without speaking on behalf of the Coroner - determination of *'culpability'*, particularly outside of a formal inquest by the Court, is not the particular role of the Coroner in relation to child deaths. As we noted in our submission, of the 620 reviewable deaths we have reviewed since December 2002, only 46 have been subject to Coronial inquest.

  To describe the Ombudsmanøs role as simply *÷looking for maladministration'* ignores the broad range of functions Parliament requires the Ombudsman to perform.

- The submission makes minimal reference to the role of the CDRT, despite its important research role in the scheme of child death reviews.

- We note that DoCS provides reference to the CDRTøs 2003 *Fatal assault and neglect* report as an example of a special report. This is referenced without qualification, which in effect adds to the inference that there is ongoing duplication of responsibility between this office and the CDRT. Suffice to say, the production of the report related to the team finalising its role in this area, and related to deaths prior to the Ombudsman assuming responsibility for child death reviews. Any research about reviewable deaths undertaken by the CDRT requires Ministerial approval, following consultation with the Ombudsman.

- DoCS has described the focus of the departmentøs CDCRU as being on organisational learning and practical change.[30] In our view, this is a considerable strength. Peer review of cases, for example, are strategies that are clearly most effectively instituted by the responsible agency.

- Our reviews are described in detail in our oversight submission to the Special Commission. They draw from a range of sources. Often this includes police and health records, and may include records from other government and non-government agencies that have had contact with a child and / or their family. Section 24(1) CS CRAMA provides for the Ombudsman to apply section 19 (Royal Commission) powers to reviews of deaths. This enables us to access private recordsófor example, from general practitionersóthat can be essential for a holistic and proper review. As noted, our focus is to identify issues that are systemic in nature, and to formulate recommendations to address these issues and ultimately, reduce risk to and prevent deaths of children.

- We would be pleased to see the DoCS CDRCU expand its capacity and work more closely with this office to appropriately complement our review work. We have extended invitations to DoCS to do so.

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[29] Hon Carmel Tebbutt, Minister for Community Services. Second reading Speech for the Commission for Children and Young People (Child Death Review Team) Bill 2003.

[30] Correspondence from the Director-General, Dr Neil Shepherd, in response to a draft copy of the report of this officeøs *Report of reviewable child deaths in 2006*, received 15 October 2007.

- We also have questions about DoCSøcapacity. Since the CDRCU was formed, this office has received copies of 41 completed internal child death review reports relating to 43 child deaths. It is our preferred approach that where we are aware DoCS is conducting a review, decisions to take further action on a matter, or completion of investigations or other inquiries already in train, should await the outcome of DoCSøreview. However, timeliness is an issue. For example, the average time between our issuing of an investigation notice or a report under s 43(3) CS CRAMA, and receipt of a DoCS review report on the case, is around ten months. Timeframes have extended to 19 months. Such delay is unacceptable.

3.3 DoCS' submission: Purpose and outcomes of a child death review

DoCSødiscussion about the purpose and outcomes of child death reviews is unclear. However, the nature of DoCSøcriticisms would indicate that the model being addressed is the traditional UK model of child death inquiry.[31] This is not the model that operates in NSW.

DoCSøsubmission relating to the purpose of child death reviews clearly focuses on public reporting of child death reviews. In DoCSøview:

> *'At its best, a child death review can lead to a public debate about opportunities for systemic reform both of child protection practices and policies generally that will minimise the number of child deaths in the future. However, a review can also lead to destructive and destabilising consequences for individual workers and the child protection system.*[32]

Further:

> *'Experts such as Eileen Munro have argued that a punitive system of oversight can have very detrimental effect (sic) on worker morale and system performance. The consequences can include over-reliance on procedures, diversion of resources, and difficulty in attracting and retaining staff. It also prompts further investment in 'crisis' intervention rather than early intervention and prevention. The end result is loss of focus on clients and consequently poor outcomes.'*[33]

DoCS considers that child deaths should be examined *'in a manner that does not destabilise the child protection system'*.

Ombudsman's response

The departmentøs discussion about adverse consequences is misplaced and misleading. DoCS has at no point indicated to this office that either our individual work or annual reporting is punitive in approach, or has resulted in any adverse diversion of resources, or has led to a loss of client focus or staff retention.

- In our view, the reviewable deaths function identifies shortcomings in agency (not only DoCS) systems and practice that may have directly or indirectly contributed to the death of a child, or that may lead to children being exposed to risk in the future. This approach is two-pronged:

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[31] Munro, Eileen (2005) *Improving practice: child protection as a systems approach.* London: LSE Research Articles Online http://eprints.lse.ac.uk/archive/00000359
[32] Op cit page 11
[33] Ibid page 11

> We establish facts in individual cases. This may include issues or errors related to professional practice. It will also include facts relating to the context within which any problems arose.
>
> We identify systemic issues. This includes consideration of mitigating factors, for example, resource constraints, or vacant positions resulting in low levels of supervision, and so on. It also includes the consideration of common factors that arise across reviews that may point to systems problems. These are the issues reported to Parliament.

- This office has never, in relation to a child death, recommended disciplinary action against an individual.

- The current system does not conduct child death reviews publicly. Of the 620 reviews conducted by this office, and 66 investigations, oneóarising from a formal complaint to this officeóhas been the subject of a publicly released report.[34] Release of the report was in our view necessary and in the public interest. The report highlighted our concerns about agency responses to neglect and recommended that DoCS review its involvement with the child and his sibling. It is noteworthy that the departmentøs review of its practice in this case, conducted in response to our investigation, identified significant policy, procedure and practice issues. The department made recommendations to address these.

- We assume, therefore, that the main focus of DoCSø concerns is the reviewable deaths annual report. The annual report is fully de-identified and focused on systemic issues. Openness and transparency about how the child protection system operates, and the risks presented by systemic flaws in that system, should not be compared to major reports focused on an individual childøs death.

- Individual child deaths do and have resulted in high level media attention. In 2007, high profile media reporting of the deaths of Dean Shillingsworth and Shellay Ward placed significant pressure on DoCS. It should be noted there was also significant pressure on this office, in the context of the Ombudsmanøs role in reviewing child deaths. The media and the public will always have a direct interest in issues relating to child deaths, and such reporting will occur regardless of how a review process is structured. Our oversight submission to the Special Commission further addresses this issue of reporting.[35]

[34] 66 investigations relating to 37 individual matters. DoCS was the subject to investigation in 37 cases. Information current as at February 2008. The report was NSW Ombudsman (2004) *Improving Outcomes for Children at Risk of Harm : report arising from an investigation into Department of Community Services and NSW Police following death of a child* : special report to Parliament under s 31 Ombudsman Act 1974

[35] NSW Ombudsman submission to the Special Commission of Inquiry into Child Protection Services in NSW: Oversight agencies, March 2008.page 23

3.4 DoCS submission: proposals for change

DoCS has provided poor evidence to support its conclusions that:

- *'The structural arrangements for the investigation, review and reporting of child deaths and the manner in which these reviews are currently undertaken do not promote effective reform of child protection practices.ø*[36]
- *'The framework is in need of reform to make it more focused and efficient.ø*[37]
- *'Institutional arrangements should be 'modernised' and the function made 'more rigorous and effective'*[38]

The department has subsequently proposed a number of changes, some of which assume continuation of the current framework and others that do not. [39] DoCSø submission proposes:

- *'Refining'* the definition of reviewable deaths. DoCS proposes a definition of reviewable death being *'if the cause of death was, or may have been due to abuse or neglect or occurred in suspicious circumstances AND* [DoCSø emphasis] *the child, or the child's sibling who lives in the same household, was known to DoCS in the 12 months prior to the child's death.* The stated purpose is to *'ensure the focus of the reviewable deaths framework was on identifying causal links between the deaths and the child protection response, if they exist.'*
- Working toward a reporting framework consistent with those in other Australian jurisdictions.
- Having one key external body responsible for the review of child deaths.

DoCS has also suggested elsewhere that duplication could be avoided *'if the Ombudsman were to rely upon the Coroner's findings after an inquest and then incorporate the individual findings as part of a more systemic review of child deaths.'*[40]

The department further proposes a possible model, which DoCS identifies as being similar to the model operating in Queensland:

- DoCS would undertake a review where a child, or a sibling of a child, dies and was known to the department in the preceding 12 months. The review would be completed within 6 months.
- Findings and recommendations from the review would be considered by the DoCS Senior Executive.
- A panel would be responsible for the *'independent oversight'* of child death reviews, and for broader functions in relation to all child deaths. The panel would consist of relevant service agencies and child protection academics.
- The panel would receive, and review, the DoCS review, subsequent advice from the Coroner - as well as input from other agencies if relevant, and make recommendations in relation to systemic reform, if warranted.
- The panel could independently report directly to the Minister on the child death. It would not have the capacity to report directly to Parliament, as is the case with this office.

[36] Op cit page 12
[37] Ibid page 12
[38] Ibid pages 13 and 13.
[39] Ibid page 3
[40] NSW Department of Community Services submission to the Special Commission of Inquiry into Child Protection Services in NSW: Operation of Courts in the child protection system. February 2008. page 33

DoCS concludes that *‘the essential point of any reform of the system is that it is simplified, that it is adequately resourced and that it results in clear and practical recommendations that are capable of implementation.’*[41]

Our response

We have significant concerns about DoCSøproposals. In our view, the changes would do little more than:

- reduce oversight of the department;
- restrict the focus of reviewable deaths;
- reduce capacity to identify systems issues; and
- reduce our capacity to review the role of other agencies and interagency processes in relation to a child death.

- In the first instance, it is disappointing that DoCSøview of the *‘point of reform’* makes no reference to the role of oversight in improving outcomes for children at risk, and promoting better systems for the provision of child protection services. The grounds for reform indicate a reluctance to accept external advice, and demonstrate an approach quite contrary to an *‘organisational culture that is open, accountable, and self improving.ø*[42]

- DoCS provides no justification for its claims that the current system and the work of this office does not promote effective reform; that it is unfocused and inefficient; and that it lacks rigour. It is unacceptable that DoCS implies, without evidence, that recommendations made by this office are not clear or practical and are incapable of implementation (see 3.1 above). At the same time it fails to evidence failures in the current system, DoCS submission does not identify any demonstrable benefits likely to result from its proposed changes.

DoCS’ proposal to change the definition of a reviewable death:

- We strongly oppose the proposal that the definition of a reviewable death be limited to those occurring as a result of abuse or neglect, or in suspicious circumstances, with a focus on identifying *‘causal links between the deaths and the child protection response.’*[43] The system as it is currently structured provides well for identifying such causal links. Importantly, it also allows those causal factors to be seen in a broader systemic context. The level of change proposed by DoCS would pose significant restrictions to this office in carrying out the role and function conferred by Parliament.

- The figures put forward by DoCS to illustrate how its proposed definition would have minimal impact on the *‘identification of issues for organisational learning’* are misleading.

> DoCS states that, of the 114 child deaths known to DoCS in 2006, 81 (71%) of children and/or their siblings were reported to DoCS in the last 12 months, and only one of these cases *‘subject to a detailed DoCS review’* would fall outside the 12 months reporting parameter.

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[41] Ibid page 13
[42] Ibid page 5
[43] Ibid page 12

However, our analysis indicates that only 27 of the 114 deaths would have met the definition of deaths resulting from abuse or neglect or occurring in suspicious circumstances, and the child or their sibling being known to DoCS in the previous 12 months.[44]

Between December 2002 and March 2006, this office reviewed 620 child deaths. If DoCSø proposed definition had been in place, the number of deaths subject to review would have reduced to approximately 100. In other words, the proposed change would likely result in this office having capacity to review less than 20 per cent of the deaths currently subject to review.

- As we noted in our earlier submission on oversight, risk factors in the child protection histories of many children who die from abuse or neglect are not substantially different from the histories of children who die in other circumstances. Restricting the jurisdiction in the way proposed by DoCS would likely leave this office with a limited view of the child protection system, and inhibit our capacity to examine issues relating to improving service provision to children at risk. Given that ongoing systemic review of, and related improvements to, the child protection system are critical tools for both preventing deaths and protecting at risk children generally, we fail to see any grounds for narrowing our jurisdiction along the lines suggested.

- A key strength of having a jurisdiction that covers all children known to child protection authorities is that it enables a holistic view of responses to the whole population of children who are more likely to be at risk of abuse or neglect. This approach would appear to be supported by DoCSø own submission:

  The department states that: *'in any event, all the research indicates that child deaths are unpredictable events and it is particularly inappropriate to direct major policy and resource allocations on that basis.ø*[45] If this is DoCSø view, it is unclear why it considers a more restricted review would be useful.

  DoCS refers to literature that provides further reason not to restrict the definition: *'Identifying a potential child-killer from a caseload of at-risk parents is a very difficult task. Indeed, there is a general agreement that the only effective way to prevent child fatalities is to improve service provision to the entire at-risk population'*.[46]

  The views of Lord Laming, with which DoCS introduces its section on reviews of child deaths, also provide weight to the need to address the efficacy of the system. *'It is unrealistic to expect that it will ever be possible to eliminate the deliberate harm or death of a child – indeed no system can achieve this. However, there is great scope for services to be operated more effectively and efficiently.'*[47]

- DoCS view that the deaths subject to review should be restricted and the review framework focused on *' identifying causal links between the deaths and the child protection response, if they exist'* is unnecessarily limiting. It is our strong view that the brief to consider prevention or reduction of deaths of these children can be met in part, by

[44] Of the 114 deaths, 88 children or their siblings were the subject of a report to DoCS in the previous 12 months. Of these 88 children, 27 died as a result of abuse (6) or neglect (4) or in suspicious circumstances (14).
[45] Ibid page 6/7
[46] Ibid, page 9, quoting Wilczynski (1997) in Reder, P and Duncan S (1999) *Lost Innocents: A follow-up study of fatal child abuse*. Routledge, London.
[47] Op cit page 9

considering in the broadest sense, how we can better ensure their safety and improve our responses to the risks they face generally.

- Our current jurisdiction has enabled us to make informed observations about critical aspects of the child protection system. This has included issues pertaining to such matters as interagency practice, prenatal reports, responses to domestic violence and substance abuse, and responses to Aboriginal children and their families. Our capacity to do so would have been restricted if our jurisdiction was limited to deaths of children known to DoCS who dies as a result of abuse or neglect or in suspicious circumstances:

    The over-representation of Aboriginal children in our current reviewable death population has highlighted a range of critical challenges for the child protection and early intervention systems. NSW Health has advised this office that *'the over-representation of Aboriginal children amongst child deaths is a matter of significant concern and therefore an important issue for further consideration by the Ombudsman's Office.ø*[48] We have raised significant issues about the child protection response to Aboriginal children and their families. Over the past five years, we have reviewed the deaths of 89 Aboriginal children and young people. Under the DoCS proposed definition, we would have reviewed only 30 of these deaths.

    As noted in our earlier submission to the Special Commission, 21 per cent of all reviewable deaths in 2007 (26 deaths) were babies who died before leaving hospital. In 2005, 23 babies whose deaths were reviewable never left hospital. Our work in reviewing these deaths was instrumental in our identification of issues relating to maternal substance abuse, and resulted in NSW Healthøs subsequent decision to review drugs in pregnancy services. Unless there is a clear link between a motherøs substance use and a babyøs death, these deaths are not identified as abuse, neglect or suspicious. Of the 49 babies reviewed above, only one would have been reviewable under DoCSø proposed definition, and these issues would not, in all likelihood, have come to our attention.

    Another area to which we have drawn attention is adolescents reported to be at risk of harm, where reported concerns include suicide risk and mental health concerns. Reviewable adolescent deaths are from two major causes ó suicides and motor vehicle accidents. According to the model proposed by DoCS, these deaths would not be the subject of review because they would not fall within the proposed reviewable death definition.

    The NSW Police Force has referred to our work in the areas of domestic violence and substance abuse as examples of important contributions to practice.[49] Our reviews have enabled us to identify the disparity between the police SOPS and the mandatory reporting threshold; problems with referrals to and responses by JIRT; and the need to improve the quality of police child protection reports. Limiting our jurisdiction would limit our capacity to identify these issues.

- More broadly, our reviews have indicated that there may be important issues to explore in regard to deaths of children known to DoCS, where the deaths result from natural causes or accidents. In 2007, research commissioned by this office compared the causes of death

[48] Correspondence from Professor Debora Piccone, Director-General NSW Health, responding to the Ombudsmanøs request for views on the reviewable deaths work of this office. Dated 31 July 2007.
[49] Correspondence for Assistant Commissioner Mahoney, responding to the Ombudsmanøs request for views on the reviewable deaths work of this office. Dated 13 July 2007.

from our reviewable death population, with the trends from the general child death population.[50] This research found that there was a higher likelihood of children known to DoCS dying as a result of epilepsy, preventable disease such as meningococcal and pneumonia, accidental poisoning, exposure to smoke and/or fire, and drowning. As we noted in our report, the potential links between natural cause deaths for children whose deaths are reviewable, and environmental factors linked to social deprivation and subsequent child protection concerns, warrant further consideration in our reviews.

- We also have a clear interest in the deaths of children who were not known to DoCS, but who died in circumstances of abuse or neglect, or in suspicious circumstances. A focus of our forthcoming annual report will be a five year review of children *not* known to DoCS. We anticipate that this review will provide insight into the contact those children may have had with other government and non-government agencies, and whether there are lessons in this that may help to prevent future deaths. This group of children would be removed from our jurisdiction under DoCSø proposed definition.

DoCS' suggested model for child death reviews:

- Again, our strong view is that DoCS has not provided sufficient rationale to justify dismantling of the current system. As noted above, the expressed views of two other main agencies subject to scrutiny through our reviewable deaths function ó NSW Health and the NSW Police Force ó indicates the work is effective and adds value to the work of these agencies and the child protection system.

- The model proposed by DoCS is unclear. DoCS appears to have no view as to how, and where, this model would effectively sit within the current legislative framework for oversight.

- While the Ombudsmanøs office is nominated as a member of the panel, the role of this office in the proposed model is unclear. In particular, DoCS gives no consideration to the fact that this office also has the role of reviewing the deaths of people ó including children ó who die while in the care of disability accommodation services and licensed boarding houses. It gives no consideration to the fact that this office has a broader monitoring role in relation to child protection. Similarly, the role of the Coroner is not articulated, nor is consideration given to s 13AB of the Coroners Act, which includes deaths of people with disabilities.

- DoCSø submission argues that its staff should carry out all initial child death reviews. This proposal fails to take into account that, for many matters, DoCS simply does not, and should not, have the power to access the necessary information from all of the parties who may have had relevant dealings with a child and/or their family in the period leading up to their death. DoCS gives no consideration to how this model will incorporate review of the role of other agencies. As noted above, this office has the capacity to draw on all sources of information to inform a child death review, including private practitioners, non-government agencies and all state authorities. This is a critical part of an effective child death review framework and should not be ignored.

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[50] National Centre for Classification in Health (2007) *Causes of death of reviewable children in New South Wales from 2003 – 2006: A report for the office of the New South Wales Ombudsman*. Reported in NSW Ombudsman (2007) *Report of Reviewable Deaths in 2006: Volume 2: Child Deaths*. Pp 65ó74.

- The model gives no consideration to the detailed reasons behind the 2002 decision of the NSW Parliament to restructure oversight of community services. Parliament determined ó following significant review ó that the system it implemented through amended community service and child protection legislation would meet the needs of this state and draw effectively on the powers of, and expertise within, NSW oversight agencies. The amendments were also made on the basis of a number of fundamental principles. As explained by the then Minister to Parliament, these principles were:

  'that the independence of oversighting agencies, the transparency and independence of the review and reporting process and the potential to share information should be strengthened wherever possible; that any gaps or uncertainties in the current system should be remedied; that client access and complaint handling are to be improved; that none of the current protections in the review and monitoring systems of community services should be weakened.ø[51]

  In our view, any changes to the system would equally need to uphold these principles, and it is apparent that they would not be met in either DoCSø broad proposals or the model suggested.

DoCS' views on the reporting framework for child death reviews

- DoCS indicates there would be *'great value'* in working towards a framework more consistent with those in other Australian jurisdictions.[52] No reason is provided for this view. Moreover, we note that different jurisdictions report quite differently. This office has organised, with the Victorian Child Safety Commission, an Australasian seminar on child death reviews, scheduled for June 2008. The seminar is focused on promoting learnings from inquiries and reviews. Certainly, consistency of reporting is an issue that could raised.

- DoCS also gives support to the proposal by Dr Judy Cashmore et al that the reporting cycle for the reviewable deaths report should be extended to three years.[53] Our view of that proposal is detailed in our earlier submission to the Special Commission on oversight. As we concluded in that submission:

  'media reporting and 'new information' are not sufficient grounds to extend reporting timeframes, we note that the production of an annual report is a complex task that requires significant resources, and this does raise questions of the costs and benefits of annual reporting cycles.'[54]

  On this basis, we would consider extended reporting timeframes, but note that this will also affect stakeholders in the disability sector.

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[51] Hon Carmel Tebbutt, Minister for Community Services. Second reading Speech for the *Commission for Children and Young People (Child Death Review Team) Bill 2003.*
[52] Ibid page 3
[53] Dr Judy Cashmore, Professor Dorothy Scott, Commissioner Gillian Calvert Submisison to the Special Commission of Inquiry into Child Protection services in NSW. March 2008
[54] NSW Ombudsman submission to the Special Commission of Inquiry into Child Protection Services in NSW: Oversight agencies March 2008. page 24

Reliance on Coronial findings

- DoCSø suggestion, made elsewhere, that this office draw from inquest findings in order to prevent duplication, is not useful. As we have noted:
  - Just over seven per cent of child deaths that are reviewable are subject to inquest by the Coroner.
  - Coronial inquests may focus solely on cause and manner of death.
  - Coronial inquests may take up to two years to finalise.

4. Management of allegations against employees

DoCS submission highlights issues arising from the departmentøs role in managing reportable allegations.

The submission advocates for change *'in the way in which allegations of reportable conduct are managed and investigated to minimise risk to children, reduce delays in finalising investigations, and help ensure that authorised carers are fairly treated.'*[55] DoCS identifies two main areas for reform:

- The threshold for reportable conduct, and
- The way in which DoCS investigates and manages allegations.

In regard to investigations of reportable conduct, we note that the Special Commissionøs regional forum held at Wagga Wagga on 25 March 2008 canvassed the issue of removal of children during investigations. We also respond to this issue below.

4.1 DoCS' submission: increased workloads

DoCS indicates that the department has experienced increased workloads arising from allegations of reportable conduct. DoCS has previously stated that as a result of the NSW Ombudsman ÷escalatingø oversight of matters of reportable conduct during the 2006/07 year, there was an increase of approximately 79% in the number of requests for information[56]

DoCS also indicates that the class or kind agreement with the Ombudsman in September 2006 *'has not had an appreciable impact on the workload of investigating low level allegations'*.[57]

Our response

- As noted in 2.2 above, we have identified an increase in notifications of 10 per cent and 7.6 per cent in 2005/06 and 2006/07 respectively. Similar increases have been experienced by other large agencies and can be in part attributed to:
  - Previous under-reporting;
  - greater awareness of child protection issues following provision of staff training and information; and
  - more children entering care or receiving government support or services.

- Between 1 April 2007 to 1 April 2008 some 503 notifications were received by this office. Of these the majority related to allegations of physical assault (329 matters), followed by neglect (70) and psychological harm and ill-treatment (35). Sexual offences and sexual

[55] Ibid page 3
[56] http://www.community.nsw.gov.au/DOCSwr/_assets/annual_report07/build_capacity_governance.htm
[57] Op cit page 15

misconduct accounted for 39 matters. Approximately 22 (5%) of these matters were declined. In 19 cases, the person subject to the allegation was not an employee and in three matters, the alleged conduct did not reach the threshold of reportable conduct.

- The claim in DoCS 2006/07 annual report that there has been a 79% increase in requests resulting from *'the NSW Ombudsman escalating its oversight of matters during the year'* is disingenuous and misleading. This increase can be attributed to:
  - DoCS delays in investigating reportable allegations (see 4.2 below).
  - failures by DoCS to provide required information, resulting in the need for this office to make repeated requests for information in the majority of cases.
  - a change in the process for requesting information, at the request of the Allegations Against Employees Unit (AAE). The Unit will no longer accept requests for information from this office by telephone, and will respond only to written requests. This has resulted in a significant increase in written requests when telephone calls would have been more efficient.
  - inadequate systems for recording case-related information and information about employees. DoCS has previously advised that it is not confident that information held on KiDS is accurate, and therefore will not rely on it.

4.2 DoCS' submission: investigation and management of allegations

DoCSø submission acknowledged the departmentøs *'failure to investigate allegations efficiently and effectively.'* [58]

To achieve this aim, DoCS proposes to centralise its investigations and considers that

> *'Substantial improvements could be made to the management of reportable allegations by centralising the investigation of these allegations within DoCS. This will mean a fairer system with allegations being reviewed faster and in a more consistent manner.'* [59]

Further,

> *'by centralising the investigation of allegations and removing unnecessary work from the field, resources will be freed up at the local level to focus on crucial child protection matters. Risk assessment of children in the care of persons subject to allegations would still have to be conducted at the local level.'* [60]

Our response

- While the Ombudsman has previously acknowledged the pressures, time constraints and limited resources facing DoCS, it is our view that in the past 12 months, delays in DoCSø investigations and the departmentøs failure to provide required information in a timely manner has reached an unacceptable level. Of 450 matters currently open, 84 matters (19%) are now older than 12 months. Delays result in:
  - increased risk to children;
  - threats to the integrity of investigations; and
  - compromised procedural fairness for carers and employees subject to an investigation.

[58] Ibid page 15
[59] Ibid page 18
[60] Ibid page 18

- It has been our experience that when fully staffed, the AAE has been effective in fulfilling the departmentøs legislative obligations, although its work has been impeded by a lack of cooperation in some Community Service Centres.

- Where the Ombudsman is satisfied that an employer can demonstrate a high standard of investigative practice, he can make a determination to exempt certain types of matters from reporting requirements through class or kind determinations. This office was sufficiently satisfied with DoCSø systems that in 2006, a class or kind determination was made. This meant that certain low risk matters did not require notification, with the intent of broadening, over time, the class or kind determination so that only serious matters would need to be notified. This has not occurred, primarily due to the fact that, in the past 18 months, we have identified a number of concerns with DoCSø handling of reportable allegations, including:
  - delays in allocating cases for investigation; ÷
  - delays in finalising investigations; and
  - delays in providing this office with lawfully required information.

  In this context, it would be inappropriate to extend the class or kind agreement. We have raised these concerns with the department and discussed how these can be addressed in order to progress an expanded class or kind agreement.

- Centralising the investigations of reportable allegations may be an appropriate management strategy for DoCS, however, it will not necessarily provide an immediate solution to the current concerns. To be effective, a centralised unit would need to established with:
  - adequate staffing and resources;
  - increased capacity to manage reportable allegations at CSC level; and
  - sufficient clarity about responsibility for the prompt investigation of ÷low levelø matters and the completion of these matters within a reasonable period of time.

- We note that the Department of Educationøs centralised investigation unit, the Employee Performance and Conduct Unit (EPAC) completes approximately 34 per cent of matters within 30 days. DoCS completes approximately 8.5 per cent within 30 days.
  - DoCS handled 848 matters, including 434 matters involving reportable allegations.
  - DoCS AAE Unit incorporates around 9.6 positions.[61]
  - EPAC handled approximately 2,120 matters, including 740 matters involving reportable allegations. EPAC has 20 ó 25 investigating staff, excluding managers.

  In our view, the workload ratio between the AAE and EPAC is not entirely dissimilar.

- DoCS proposal that *'risk assessment of children in the care of persons subject to allegations would still have to be conducted at the local level'* is unclear.[62] Good investigation practice dictates that risk assessment is an integral early part of any investigation process.

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[61] Special Commission forum on Oversight, March 28, 2008
[62] Op cit page 18

4.3 DoCS' submission: definition of reportable conduct

In connection with the increase in workloads DoCS argues that too many ‑low levelø matters need to be either managed and/or reported: *'Further refinement is needed in defining what physical abuse is regarded as 'reportable conduct. This will assist in ensuring attention is not diverted to trivial or negligible matters.'*[63]

DoCS also refers to provisions under the *Children and Young Persons (Care and Protection) Regulation 2000, Code of Conduct for Authorised Carers, Schedule 2* which prohibits the use of physical punishment of a child in care. DoCS notes that *'this means that any physical punishment, no matter how trivial needs to be investigated.'*[64]

Our response

- We do not support the need for further review of definitions at this stage. Reportable conduct definitions apply not only to DoCS, but to a significant range of government and non-government services, numbering over 7,000. A review of definitions would involve all these agencies and could present significant confusion with agencies that are less experienced in managing reportable allegations.

- Definitions of reportable conduct were subject to relatively recent review, with subsequent legislative amendment, in 2003. Changes were made following extensive consideration and consultation. As noted in the second reading speech for the *Child Protection Legislation Amendment Bill 2003* in relation to the changes:

  'They are designed to balance the overriding principle of protecting children with the need to ensure that professionals working in child-related employment are not improperly hamstrung by the child protection system.'[65]

- The issues raised by DoCS can be addressed using existing provisions, that is, through exemptions and class or kind agreements. We are keen to use the legislative provisions of Part 3A of the Act to exempt from notification all reportable allegations against departmental employees, including foster carers, unless the allegations involve serious matters such as sexual offences, serious physical assaults and instances of neglect resulting in significant harm to children. The only current obstacle to achieving this outcome is DoCSø acknowledged unsatisfactory performance in investigating allegations.

4.4 Removal of children during investigations of reportable conduct

The issue of removing children during investigations of reportable conduct received wide attention at the Special Commission forum in relation to oversight agencies, and also at the regional forum in Wagga Wagga:

- At the oversight forum, Commissioner Wood noted:

  'We have found that one of the issues identified is that most kids are removed during that time and that also creates difficulties.'[66]

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[63] Ibid page 17
[64] Ibid page 15
[65] Dr Andrew Refshauge (then) Deputy Premier, Second Reading Speech *Child Protection Legislation Amendment Bill 2003*, September 2003.
[66] Commissioner Wood, Transcript 28 March 2008, page 54

- DoCS advised *‘I can get you specific figures. It is probably more than 50 per cent.ø*[67]

- At the Wagga Wagga forum, a participant noted:
  ‘The children are removed first and the allegations are then investigated’,
  ‘We have had a couple of occasions where it has been investigated while the children remain. That is few and far between. Mostly they are removed first and even if the matter comes back unsubstantiated, it’s not the same as a false finding’[68]

- Another participant at the Wagga Wagga forum raised an opposite view:
  ‘I would like to know: at what stage does DoCS decide these children are at risk and will they be taken out of the care of the parents?ø[69]

Our Response

- This office monitors the initial risk assessment and ongoing risk management by agencies in certain matters under s25E of the *Ombudsman Act*. It is our expectation that children will be removed from a placement pending investigation, in circumstances where high-risk/serious allegations have been made, and ongoing risks to any party cannot otherwise be managed. The removal of children as a risk management strategy should only happen when supported by a sound risk assessment. In such cases it is even more imperative that any investigation be completed in a timely manner.

- It is our experience that DoCS, in general, conducts reasonable risk assessments and determines reasonable risk management strategies when it becomes aware of allegations, but at times fails to reassess its strategies and the need for protective measures once the investigation process has commenced.

- It should be noted that despite the number of concerns raised at the Special Commissionøs Wagga forum, as noted above, this office rarely receives complaints from foster carers about the removal of children during or after investigations.

- We reviewed 91 DoCS notifications for the period 1 April 2007 to 1 April 2008, in order to objectively ascertain DoCSø practices in relation to removing children from carers who are subject to reportable allegations, and the reasons for the removals. The 91 matters represent the majority of closed DoCS notifications for this period. This review indicates that DoCSø claim that more than 50 per cent of children are being removed from carers subject to reportable allegations is considerably overstated and requires substantiation.

- Our review found that the reasons for removal varied. In 30 of the 91 matters (32%), DoCS removed the child, or the child left the placement or requested to be placed elsewhere. Of these 30 cases:[70]
  - In 16, children were removed specifically because of the notification(s) and risk assessment(s) by DoCS (17% of the 91 matters reviewed). In relation to these 16 matters:

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[67] Ms Donna Rygate page 54

[68] Special Commission transcript: Wagga Wagga forum, 11 March 2008, local area representative, Foster Carers Association, page 18

[69] Special Commission transcript: Wagga Wagga forum, 11 March 2008, participant page 36

[70] Reasons for removal by DoCS included placement breakdown, transition being part of a restoration or case plan, the carer requested the child be removed.

- o the allegations against the carers were predominantly allegations of physical abuse (12 matters), neglect (6 matters) and alleged sexual assault (one matter) and ill-treatment (one matter).
- o in 7 matters the carers had a history of previous allegations, usually between one or two previous allegations. In nearly all cases, the allegations of physical abuse and neglect related to multiple and often serious incidents.

Our review indicates that the removal of children usually occurs at the time the allegations are raised. Children were removed after additional allegations came to light or due to the allegation history of the carer in only three matters.

In the other 14 cases, reasons for removal included:

- o Placement breakdown (three matters)
- o Child removed on request from carer (two matters)
- o Child removed due to carers stress and workload (two matters)
- o Transition was part of a restoration/overall case plan (three matters)
- o Child (young person) left the placement (two matters)
- o Child requested to be removed (three matters)
- o Carers separated and child stayed with leaving carer (one matter).

The age range of children removed did not appear to be a significant factor, with children removed in all age ranges, with the exception of babies under 12 months. Of the children removed, approximately half were under the age of 10, and half were over 10 years of age.

4.5 Allegations of neglect involving professional staff (caseworkers) working with children

- During the Special Commission's Oversight forum, questions were asked in relation to a current matter involving discussions between DoCS and this office as to whether reportable allegations can be raised against employees for actions exercised as part of their professional duties.[71]

- DoCS specifically raised this issue in their submission: *'Clarification is also required that the abuse covered by the reportable conduct relates to the activities of the person with daily care of the child and not the actions of anyone whose actions might have presented abuse.'*[72]

Our response

- In the nine years since the commencement of Part 3A of the *Ombudsman Act*, we have received only a small number of allegations involving caseworkers. Of these, all but one involved alleged behaviour that has occurred in the employees' private capacity, for example, serious sexual or physical assault or neglect of a family member. There has only been one matter involving a caseworker in their professional capacity where we have believed it appropriate that a notification be made involving an allegation of neglect.

- The particular matter arose in 2007 when we received a notification that a foster carer had physically assaulted a child in her care and was subsequently charged and convicted of a criminal offence against the child. A Category One notification was made to the

[71] Special Commission forum on oversight, March 28, 2008 page 46
[72] Ibid pages 17, 18.

Commission for Children and Young People, and the foster carer was declared a prohibited person.

- The subject caseworker was aware of the details of the assault by the foster carer, who used a belt to inflict serious physical injuries to the child. Those injuries were observed by the caseworker who failed to assess the safety and wellbeing of the child, or to take any protective action to prevent any further injury to the child. The caseworker supported the foster carer, whom the caseworker knew had emotional and physical problems that contributed to her abusive behaviour. The child remained unprotected in the placement. Further, the caseworker sought to influence the police to withdraw the charges against the foster carer.

- We do not believe that caseworkers making professional decisions based on approved departmental procedures, where a child is subsequently harmed, should be notified to the Ombudsman. However, given that, in this specific case, it was our view that the caseworkerøs failure to properly protect the child constituted reportable conduct, we sought a notification from the department. The department has a different view about this matter, and both this office and DoCS are keen to develop an appropriate strategy to resolve this issue.

Wood Special Commission of Inquiry
into Child Protection Services in NSW

Submission of NSW Ombudsman

Part 3: Privacy and exchange of information

4 April 2008

Request for information

We note the letter from Counsel Assisting the Inquiry dated 27 February 2008 requesting that the NSW Ombudsman provide information to the Inquiry in order to assist it to better understand perceived obstacles to the exchange of information concerning the protection of children. In particular:

1. Our views on the legal impediment(s) which exist in relation to the proper exchange of information between agencies and non-government organisations in respect of information concerning child protection matters.
2. Our views on how those impediments might be overcome by way of legislative amendment or the use of Directions or Codes.
3. Our views on the operational, practical or cultural impediments which exist to the proper exchange of information between agencies including non-government organisations in relation to child protection matters.
4. Our views on the usefulness of developing a simple overall Code of Practice applicable to all agencies in relation to child protection matters which operates to exempt or modify the application of some or all of the Information Protection Principles set out in each privacy Act.

Executive summary

It is necessary to have a simple and practical system in place for the exchange of information between agencies of the kind that promotes the safety, welfare and well-being of children.

Section 248 of the *Children and Young Persons (Care and Protection) Act 1998* (the Protection Act) provides that the Director-General of DoCS may exchange with a prescribed body information about the safety, welfare and well-being of a particular child or a class of children. However, the section does not provide that any of the prescribed bodies can exchange information about the safety, welfare and well-being of a particular child or a class of children, with each other. (There are both public and private organisations listed as prescribed bodies.)

When the Director-General exchanges information with a prescribed body as permitted by section 248 of the Protection Act, neither the Director-General nor the prescribed body commits an offence or breaches any privacy rules.

But, subject to certain exceptions, a prescribed body is generally restricted from exchanging information about a childøs safety, welfare and well-being with another prescribed body, because of the following laws:

- section 254 of the Protection Act, which provides (with some exceptions) that it is an offence for a person to disclose any information obtained in connection with the administration or execution of that Act, and
- the NSW *Privacy and Personal Information Protection Act 1998* (PPIP Act), which applies in relation to the sharing of personal information about individuals by NSW public sector organisations, and

- the Commonwealth *Privacy Act 1988*, which applies in relation to the sharing of personal information (including health information) about individuals by private organisations, and
- the NSW *Health Records and Information Privacy Act 2002* (HRIP Act), which applies in relation to the sharing of health information about individuals by both public and private organisations.

We note that when both the Commonwealth Privacy Act and the NSW HRIP Act apply, agencies must comply with both.

Our view is that certain agencies with significant responsibilities relating to the safety, welfare and well-being of children, ought to be permitted to communicate directly with each other, without having to rely on DoCS to pass on critical information and without being restricted by privacy concerns. We feel that, at a minimum, the police, schools, health services and non- government organisations, including those providing major early intervention services and those providing out of home care services for children, should be able to do this.

We believe that through legislative amendments these agencies should be able to exchange information with each other without committing an offence or breaching any privacy rules. Expanding section 248 to allow for this would provide a strong foundation for creating the cultural and practical changes that are necessary to facilitate better exchange of information between a number of agencies that play a crucial role in protecting and caring for children.

We also note that in exchanging information with a prescribed body, the Director-General must act in accordance with any requirements prescribed by the regulations. This means there is some scope to restrict or regulate the ability under section 248 to share information.

As an alternative to expanding section 248, we also acknowledge that the current impediments may be able to be addressed through two sister Privacy Codes of Practice, one made under the PPIP Act and one made under the HRIP Act. However, in this submission we outline a number of concerns about this approach.

Introduction

We have made a number of public statements in the past expressing our concerns about the problems that can arise when agencies do not, or are unable to, properly share information about the children in their care. On the tabling of his annual report for 2005 ó 2006, the Ombudsman said:

> **A final and emerging theme touched on in my report, is the need for agencies to be able to communicate effectively. This is especially important where the wellbeing of the most vulnerable in our community is the purpose of the communication.**
>
> **It is sometimes a difficult task – to balance the right of privacy against the needs for agencies to share information about vulnerable persons. However, where there are real risks if information is not appropriately and expeditiously shared, arrangements should facilitate and not hinder free communication. The failure to**

communicate and share information is an issue in much of our work, from workplace child protection to the safety of children in homes where there is domestic violence or drug use. Part of the cause, in my view, is the complex and cumbersome array of privacy rules binding public and private sector agencies, which are in urgent need of review.

In this submission we set out our views on what we feel are the underlying causes of agencies failing to properly share information. This includes legislative and other impediments. We also set out our views on changes that may reduce the problem. This includes our views on changes to the law, the development of Privacy Codes of Practice and the possibility of using Privacy Directions.

In the Appendix we set out in full the legislative provisions that we refer to in this submission.

1 & 3: Legal and other impediments to the proper exchange of information

A. Sections 248 and 254 of the Protection Act

Section 248 of the Protection Act allows DoCS to share information with agencies including the police, schools, hospitals and private organisations providing services to children. In particular, the section gives the Director-General of DoCS the ability to ÷furnishø a prescribed body with certain information and the ability to ÷directø a prescribed body to furnish certain information to the Director-General.

For some years we have publicly stated our view that section 248 is too limited because certain agencies other than DoCS need to have the ability to exchange information with each other.

We note that together, section 248 (6)(f) and clause 7 of the Children and Young Persons (Care and Protection) Regulation provide that the following agencies are ÷prescribed bodiesø

- the Police Service, a government department or a public authority, or
- a government school or a registered non-government school within the meaning of the *Education Act 1990*, or
- TAFE establishment within the meaning of the *Technical and Further Education Commission Act 1990*, or
- a public health organisation within the meaning of the *Health Services Act 1997*, or
- a private hospital within the meaning of the *Private Hospitals and Day Procedure Centres Act 1988*, or
- any other body or class of bodies (including an unincorporated body or bodies) prescribed by the regulations for the purposes of this section.
- a private fostering agency within the meaning of the 1987 Act (whether or not it is authorised),
- a body that conducts a residential child care centre or a child care service within the meaning of the 1987 Act (whether or not it is licensed),
- a designated agency,
- a private adoption agency within the meaning of the *Adoption of Children Act 1965*,
- the Family Court of Australia,

- the Federal Magistrates Court of Australia,
- the Commonwealth Services Delivery Agency known as õCentrelinkö,
- the Commonwealth Department of Immigration and Multicultural and Indigenous Affairs,
- any other organisation the duties of which include direct responsibility for, or direct supervision of, the provision of health care, welfare, education, childrenøs services, residential services, or law enforcement, wholly or partly to children.

The listing of these agencies as ÷prescribed bodiesø recognises that these agencies all have some responsibilities for ensuring the safety, welfare and well-being of children and that DoCS may need to communicate with them to fulfil its child protection responsibilities. However, limiting the scope of section 248 to only communications between DoCS and other agencies fails to recognise the common scenario where various agencies have different responsibilities in relation to a particular child, and need to share information with each other to jointly support the child, without necessarily requiring DoCS to be involved.

Further, section 254 of the Protection Act provides (with some exceptions) that it is an offence for a person to disclose any information obtained in connection with the administration or execution of that Act. This limits the ability of agencies to directly exchange information about a childøs safety, welfare and well-being with each other.

B. Privacy laws

Without a specific legislative power or permission to exchange information with each other, both public and private organisations must act in accordance with section 254 of the Protection Act (as outlined above) and the privacy laws that apply.

In relation to the sharing of personal information about individuals, the NSW *Privacy and Personal Information Protection Act 1998* (PPIP Act) prevents NSW public sector organisations, and the Commonwealth *Privacy Act 1988* prevents private organisations, from sharing certain information with each other.

In relation to the sharing of health information about individuals, both public and private organisations are restricted by the provisions of the NSW *Health Records and Information Privacy Act 2002* (HRIP Act), and private organisations are also subject to the provisions of the Commonwealth Privacy Act.

This means that if a prescribed body exchanges with another prescribed body information about a child, they may commit an offence under section 254 and may also fail to comply with one or more of the three Privacy Acts referred to above.

There are exception provisions in the privacy legislation that allow for the exchange of information by certain bodies in certain circumstances. However, it is our experience that privacy is an area of the law that proves baffling to most people.

By way of illustration, each of the Privacy Acts has a different number of privacy principles (the HRIP Act has 15, the Commonwealth Privacy Act has 10, PPIP has 12). These principles do not cover identical concepts and are worded differently. A concept covered by one principle in one Act may be covered by two principles in the other Acts.

In addition, each public sector agency must have a privacy management plan in place, which outlines the business rules of that individual agency relating to privacy matters.

This means that in practice, an agency deciding whether or not certain information should be disclosed to another agency, needs to consider:

- sections 248 and 254 of the Protection Act
- the Privacy Acts and regulations that regulated its actions
- any Privacy Codes of Practice (under the PPIP Act and the HRIP Act) that may be applicable
- any Privacy Directions that may be applicable
- any privacy management plan that the agency has in place.

The current state of privacy laws understandably means that agencies tend to adopt a cautious rather than open approach in communicating with other agencies who also have responsibility for a childøs safety, welfare and well-being.

C. Cultural impediments

We have observed in our work cases where a proper risk assessment of a child was not carried out by DoCS because section 248 had not been used effectively to obtain all of the information available about the child.

We have previously published our observations on this issue. In our Report of Reviewable Deaths in 2005 Volume 2: Child Deaths (at page x), we observed that:

> **Our reviews and other work in 2005 again showed both the importance of good interagency cooperation and coordination, and that this is not consistently being achieved. Our reviews identified examples of ineffective communication between agencies, inadequate liaison between agencies to ensure full information was available to accurately assess risks to children, and concerns about effective use of section 248 of the *Children and Young Persons (Care and Protection) Act 1998.***

It appears to us that better education and training of front-line staff (both at DoCS and other agencies) may be necessary so that they are better aware that section 248 provides them with the tools to give and receive information about a child or family of concern.

However, we would argue that this issue is not only about education and training. It is our view that the current privacy regime has sent a powerful message which works against the exchange of information and that, where this has been combined with demanding workloads, has contributed to a culture in which critical information is not being passed on.

In making these comments, it is also important to acknowledge that there are other cultural factors in play. For example, in the policing field a strong message has been conveyed over the years about the unauthorised disclosure of confidential information. This has been an important message to deliver and has helped shape police culture. Similar cultural messages have also been delivered within human service agencies.

Against this background, we believe that a broader cultural perspective needs to evolve. The Government and the Parliament need to send a clear and strong message promoting the exchange of information in circumstances which serve to better protect children, and provide simple and practical tools to allow this to take place. In taking this position, we would also support strong sanctions against those who release information for an unauthorised purpose.

D. Impediments arising from a perception that permitting greater information exchange risks disclosure of information for purposes other than the protection of children

In supporting a culture that promotes greater information exchange, it is important to acknowledge concerns which have been expressed about the view we have been publicly stating over the past few years.

In particular, DoCSøGreen Paper raised the following concerns:

> **The Ombudsman has recommended a more open approach to sharing information...The specific proposal is that any "prescribed agency" should be able to supply information to other specified agencies where the supply of information related to the safety, welfare and well-being of children or young people.**
>
> **An even broader approach has been advocated in the context of police matters, where it has been suggested that all information held by DoCS should be available to a law enforcement agency investigating a matter of serious import. If this approach were applied it would enable, for instance, information that a child is at risk from parental drug use to support police action against the carer for drug offences.**
>
> **What we have to remember in this context is that a child protection report is an unsubstantiated claim at the time it is made and it is initiated by the reporter for the purpose of protecting a child, not for prosecuting the parent. ...**
>
> **The ability for several agencies to exchange information supplied to them by DoCS would make it very difficult, if not impossible, to restrict the use of that information to child protection purposes. The ability to exchange information that relates to safety, welfare and well-being will inevitably be interpreted much more widely and to do so would be to risk a serious strain on the integrity of the child protection system....**
>
> **[A]nother way forward would be to facilitate information exchange between specific agencies and in a more specific range of circumstances, and to place additional safeguards around that process.**

In our submission in response to the Green Paper, we made the following comments:

> **We acknowledge these concerns. However, we submit that the careful development and application of suitable business rules**

should serve to prevent or minimise the inappropriate use or disclosure of information.

Furthermore, even if there may be some legitimate concerns about the potential risks involved, these are not sufficient to outweigh the very significant public interest in ensuring the promotion of the appropriate exchange of information among prescribed agencies about the safety, welfare and well-being of children and young people, particularly that needed for their effective and timely protection.

In addition, it is important to acknowledge that no system is risk-free. Any system that allows the sharing of information carries the risk that information could be misused and shared for other reasons. Equally, a system of child protection that does not allow for the sharing of relevant information about an individual child carries the risk that agencies will fail to adequately support and protect children.

Further, it is our experience that there are effective practical measures available to help manage the risk that information will be used for improper purposes.

We support a shift in the culture towards certain agencies being actively encouraged to share with each other information which promotes the safety, welfare and well-being of children. As with most systems, this general principle can and should have business rules. These business rules should be used to restrict the use of information which is shared, and to provide that information should not be shared in certain circumstances.

In relation to DoCSøspecific concern about law enforcement agencies using information gained for child protection purposes to take criminal action, our view is that there will be circumstances where the disclosure and/or use of such information should be restricted. For example, where the apparent criminal activity is very minor and a criminal investigative response is likely to harm the capacity to deal with the child protection issues. However, there will also be situations where the disclosure of that information to police should be mandatory, for example, where the criminal activity is of a serious nature and directly affects the safety of the child. We note section 316 of the *Crimes Act 1900* makes it an offence to fail to report to the police knowledge that another person has committed a serious indictable offence.

In our view, the best way of helping workers from key agencies to decide when they should and should not disclose information to the police, and helping law enforcement officers decide when they should and should not take direct action in response to allegations they learn through child protection work, is for clear business rules to be developed around these issues.

E. Impediments arising from a perception that permitting greater information exchange risks disclosure of the identity of reporters

In our view, there is nothing inconsistent about allowing agencies responsible for the care and protection of children to exchange information to help them in their work, and ensuring that people can, in most cases, make a confidential report to DoCS that a child is at risk of harm. Section 29(1)(f), (2) and (3) set up a system which provides that the identity of a reporter will not be shared with another agency unless exceptional circumstances apply. Those

circumstances must be firstly, that there are court proceedings on foot, and secondly, that the court is satisfied that the evidence is of critical importance in the proceedings and failure to admit it would prejudice the proper administration of justice.

From our child death review work we are aware that this issue arose during an inquest into the death of a 6 month old baby. The Coroner directed the police to conduct a criminal investigation into the death of the baby, as there were suspicions the child may have been murdered. As part of the investigation they requested that DoCS produce all files, reports and documents relating to the babyøs mother and to the baby.

Six notifications had been received by DoCS about the babyøs welfare. Five of the notifications were made by mandatory notifiers. DoCS consulted with them and obtained their consent to release their identities (as per section 29(1)(f)(i)). DoCS offered to ask the sixth notifier for his/her consent, but the police did not want DoCS to do this because they were of the view that this may have jeopardised their investigation. As consent could not be obtained, DoCS refused to release the identity of the sixth notifier.

The police applied to the Coroner for leave to be granted for the identity of the sixth notifier to be disclosed, pursuant to section 29((1)(f)(ii).

The Deputy State Coroner at Westmead, Magistrate Milovanovich, analysed these issues thoroughly (on 28 April 2005). We agree with his reasoning, extracted below:

> **It would be in my view, a sad reflection on the legislation if it was ever intended to prohibit appropriate investigations that may or may not lead to the prosecution of a person, for, as in this case, possible murder or manslaughter.**
> **.....**
> **It is clear to me that the intention of the legislation is based on solid principles, that is to ensure that mandatory and non mandatory notifiers are protected in relation to their identity.**
> **.....**
> **The principles behind the Children and Young Persons (Care and Protection) Act is to ensure the safety and protection of children from abuse etc. It was clearly the intention of Parliament that in regard to notifiers, in order not to discourage reporting, they would be provided with some protection and anonymity. However, it is also clear from the legislation by virtue of the provisions of Section 29 Sub 2 that either with consent or by the order of a Court that protection can be overridden in certain circumstances....**
> **[It appears] that [for] the legislation to be effective it must involve the co-operation of other government departments and community agencies.**
>
> **Surely the Coroner and as in this case, the Police who are the Coroners agents are seeking to investigate and enforce laws that bind all citizens. The gathering of evidence and possible charging of a known person with an indictable offence in relation to the death of the child, must be seen as not being inconsistent with the intention of the Act. After all, what greater way to protect children is there than to gather evidence and place those responsible for perpetrating crimes against children before the Courts. This is what the Police are attempting to do in this matter, and to that extent I support them and it perhaps should be said, that the only person who can now protect [the child], although deceased, is the Coroner. Surely that can not be inconsistent with the Act and clearly in my view consistent with the tests required under Section 29 Sub 2.**

.....
I propose to order that the Department (DOCS) is to provide the particulars of all notifiers to the NSW Coroner or to the NSW Police as agents for the Coroner.

We agree that the identity of reporters should be kept confidential unless they consent or exceptional circumstances apply. However, we feel the system could be improved if the scope of those exceptional circumstances, and the decision-maker who decides whether those circumstances apply, were changed.

Currently the exceptional circumstances are that:

1. proceedings are being conducted relating to the report, and
2. the court or other body (before which the proceedings are being conducted) is of the view that identity of the reporter is of critical importance in the proceedings and that failure to reveal the identity of the reporter would prejudice the proper administration of justice.

We are of the view that the test in section 29(1)(f), (2) and (3) could be changed to allow for more timely exchange of information about the identity of reporters, without weakening the protection of reportersø identities as a general rule.

As the case of the 6 month old baby above illustrates, there will be circumstances where a police investigation into a serious offence cannot be conducted thoroughly without the police knowing the identity of the reporter concerned. In that case the police were conducting the investigation on behalf of the Coroner, but there may well be other cases where there are no current proceedings but the police are investigating for the purposes of possibly laying charges. In these cases, section 29 does not provide any mechanism through which police can gain access to that information (if the reporter does not consent, or the police do not want DoCS to seek the personøs consent, for operational reasons).

In our view, the exceptional circumstances should include situations where a law enforcement agency requires the information for the purposes of investigating a serious indictable offence, obtaining the consent of the reporter to the release of their details is impractical or has the potential to prejudice the investigation of the offence, and an appropriate person certifies that they are satisfied that these conditions have been met. We would also be of the view that the appropriate person would have to hold a very senior position and that this responsibility should not be able to be delegated.

2 & 4: Overcoming impediments through legislative reform or Privacy Codes of Practice

A. Expanding the scope of section 248 to allow agencies other than DoCS to share information

In our previous public statements about this issue, we have suggested that these issues may be best resolved through changes to the Protection Act. In particular, we support expanding the scope of section 248 to allow some other agencies, in addition to DoCS, to exchange information with each other.

Under the current scheme, the Director-General of DoCS faces no legislative impediments to exchanging information with prescribed bodies if he or she does so in accordance with section 248 of the Protection Act. In particular, he or she does not commit an offence under section 254, because subsection (1)(b) provides that a person is guilty of an offence ÷unless the disclosure is made:

(b) in connection with the administration or execution of this Act or the regulationsø

Neither does the Director-General breach the relevant privacy principles in the Privacy Acts that apply to public sector agencies (the PPIP Act and HRIP Act) because:

- Section 25(b) of the PPIP Act provides that a public sector agency is not required to comply with section 9, 10, 13, 14, 15, 17, 18 or 19 (which set out information protection principles) **if non-compliance is otherwise permitted** (or is necessarily implied or reasonably contemplated) under an Act or any other law.

- Section 23(b) (in Part 4) and Health Privacy Principle 10 (in Schedule 1) of the HRIP Act provide that a private sector person is not required to comply with a requirement of that Part or a provision of that Health Privacy Principle **if non-compliance is otherwise permitted** (or is necessarily implied or reasonably contemplated) under an Act or any other law.

In addition, section 248(5) provides that any legislative provision that prohibits or restricts the disclosure of information **does not operate** to prevent the exchange of information under section 248.

Also under the current scheme, when agencies (that are prescribed bodies) furnish information in compliance with a direction from the Director-General under section 248(1)(b), they face no legislative impediment. We note that the following provision of the Commonwealth Privacy Act applies in relation to personal information held by private organisations:

- Schedule 3, National Privacy Principle 2, paragraph 2.1, provides that an organisation must not use or disclose personal information about an individual for a purpose other than the primary purpose of collection **unless** (option (g)) **the use or disclosure is required or authorised by or under law**.

Our view is that certain agencies with significant responsibilities relating to the safety, welfare and well-being of children, ought to be permitted to communicate directly with each other, in the same way that the Director-General of DoCS is currently permitted to communicate directly with prescribed bodies.

We believe that the police, schools, health services, and large non-government agencies responsible for ensuring the safety, welfare and well-being of many vulnerable children, should be given explicit permission to exchange information for the purposes of fulfilling those responsibilities.

As to the detail of such a scheme, we submit that consideration be given to expanding section 248 to include a three tiered structure to allow more information exchange.

The first tier would be the current scheme, where the Director-General of DoCS has both the ability to furnish another agency with certain information and the ability to *direct* another agency to furnish him/her with information.

The second tier would give another group of agencies both the ability to furnish another agency with certain information and the ability to *request* certain information from other agencies, but not *direct* those agencies to furnish that information. Instead, those agencies receiving such a request would have the ability to furnish that information at their discretion, without obtaining the consent of relevant parties, and would not be in breach of any privacy laws or section 254 in doing so.

The third tier would include agencies who only have the ability to furnish certain information to agencies *in the first and second tiers* without breaching any privacy laws or section 254. In considering exchanging information with another third tier agency, these agencies would be subject to both privacy laws and section 254. However, if a third tier agency requested information from a first or second tier agency, the agency receiving such a request would not breach any privacy laws or section 254 if it provided that information to the third tier agency.

Careful consideration would need to be given to what bodies should be in tiers 1, 2 and 3. We do not believe that it is appropriate for the Ombudsman to outline each agency which should be included. However, it is our view that, at a minimum, the police, schools, health services and non- government organisations including those providing out of home care services for children and those providing major early intervention services, should be included in tier 2.

It is our submission that the lists of agencies that should be in tiers 1, 2 and 3 could be included in section 248 either through a regulation or by way of Schedule to the Act. One benefit of using one or more Schedules is that they could be amended by proclamation and would not need to be reviewed every 5 years, as do all regulations. This would make it a practical mechanism that could be updated as circumstances change.

We also acknowledge the need for clarity around the types of agencies that should be included in the Schedule or Schedules. For example, agencies in the first and second tiers would need to have significant involvement with vulnerable children and their families. Further, we believe that agencies should be required to have in place sound policies and procedures to govern the way information is to be exchanged, used and kept secure.
Our work has shown that in some circumstances, when agencies fail to exchange information, dire consequences can result. We believe that changes need to be made to the cultures within agencies that determine the attitudes of workers about the sharing of information with other agencies. We believe that changes need to be made to the policies and practices of agencies to encourage and facilitate the timely exchange of information about a childøs safety, welfare or well-being.

Allowing agencies with significant responsibilities for the safety, welfare and well-being of children to share information with each other without having to rely on DoCS or attempt to navigate their way through a complex maze of privacy issues, would be a good starting point.

We have publicly stated our views about the current problems with the exchange of information between agencies in a number of previous submissions. In particular, our focus has been on the need to remove these barriers to information exchange.

In our submission to the review of the Protection Act (dated 28 February 2006) we observed that:

> **Section 248 is critical in that it allows for information between DoCS and other agencies to be exchanged in relation to the safety, welfare and wellbeing of children. Accordingly, we believe the Act should clearly reflect this position.**
>
> **Effective information exchange is fundamental to good care and protection practice. However, our work has identified that there are significant problems with information exchange between agencies. Some of these problems appear to exist because of perceived legal impediments to information exchange, and poor understanding of what information can be exchanged, when it should be exchanged and who can exchange it.**

In our submission responding to DoCS Green Paper (dated 30 March 2007), a copy of which was attached to Part 1 of our submission to this Special Commission of Inquiry (Childrenøs Court), we put forward two alternative proposals ó the first being that all prescribed bodies should be able to exchange information, the second being that at least those prescribed bodies playing a critical role in childrenøs safety, welfare and well-being, should be able to. We made the following comments:

> **We strongly adhere to the position put forward in our previous submission [dated 28 February 2006]. In the alternative, we would recommend that, at the very least, key agencies whose work may often involve dealing with critical issues relating to the protection of children and young people – that is, DoCS, the NSW Police Force, the Department of Health, health organisations and hospitals, and the Department of Education and schools – should be clearly entitled to exchange information relating to concerns about the safety, welfare and well-being of a child or young person....**
>
> **Significantly, section 248 does not permit prescribed bodies to exchange information relating to safety, welfare or well-being of children and young people between or among themselves.**
>
> **Section 248 therefore seems to be proceed on an assumption that DoCS is at the centre or "hub" of all matters in relation to the care and protection of children and young people. As we discuss further below, this assumption is misconceived.**
>
> **It is section 254 of the Act which governs the circumstances in which prescribed bodies may exchange information. Significantly, that section has as its starting point a general prohibition on the disclosure of information "obtained in connection with the administration or execution of this Act". The section then goes on to provide for the exceptional circumstances in which information may be disclosed. One such circumstance is the provision to the prescribed body of the consent of the person from whom the information was obtained. In the absence of consent, the prescribed body will only be able to disclose the information "in connection with**

the administration or execution of" the Act or the regulations under the Act, or with "other lawful excuse".

Difficulties with the legislative scheme

In practice, the legislative scheme under section 254 means that a prescribed body will have to carefully examine whether, and to what extent, the other provisions of the Act and the regulations, as well as other legislation, permit it to disclose – or restrict it from disclosing – relevant information to other agencies. This is not necessarily an easy exercise. The meaning of some provisions of the Act or other legislation may not be clear or open to debate. There may be difficulties in the application of the provisions to the circumstances of the particular matter. One particular difficulty may be interpreting and applying the provisions of the *Privacy and Personal Information Protection Act 1998* and/or directions made under that legislation.

Furthermore, in circumstances where the improper disclosure of information under section 254 of the Act is a criminal offence, agencies will understandably be cautious – perhaps unduly so – in disclosing information where there are or may be problems in interpreting and applying the relevant legislative provisions.

As we have emphasised above, our work in reviewing the deaths of children and young people has revealed that a significant current failure in the system for the care and protection of children and young people relates to the need for the improved and timelier exchange of information relating to the protection of children and young people.

Against that background, it would clearly be desirable for there to be much greater clarity about whether, and to what extent, prescribed bodies can exchange information relating to the safety, welfare and well-being of children.

The significance of the principle in section 9

Given that the fundamental principle of the Act, as articulated in section 9 of the Act, is that the safety, welfare and well-being of children and young people must be "the paramount consideration", it is, on its face, difficult to understand why the Act should not specifically and clearly permit the exchange of information between and among DoCS and [certain] prescribed bodies where such exchange is necessary or desirable to ensure or promote the safety, welfare and well-being of children and young people. It is particularly difficult to understand why the legislation does not encourage information exchange between key agencies in those circumstances where critical child protection issues are at stake.

In the submission we also discussed the significance of section 29A of the Protection Act, and paragraph 3.1 of the revised Interagency Guidelines, and made the following comments:

> **[I]t appears to us that it is a necessary corollary of the obligations on, and expectations of, agencies responsible for the safety, welfare and well-being of children and young people that they should be able to provide appropriate information to – and receive appropriate information from – other agencies to assist them in the performance of their functions, and that the Act should clearly articulate their rights in this respect.**
>
> **As mentioned above, section 248 of the Act appears to proceed on the assumption that DoCS is at the hub of all care and protection matters involving children and young people. However, the reality is that, for many matters, other key agencies will be playing the central role, and will therefore need to be able exchange information with other players. Once again, it is important to emphasise that our perspective is informed by our reviewable deaths work, which highlights the need for the greater and more timely flow exchange of information about the safety, welfare and well-being of children and young people...**
>
> **It is also important to emphasise the increasing involvement of non-government organisations ("NGOs") in the system for the care and protection of children and young people. For example, the role of NGOs is critical to the early intervention program currently being rolled out by DoCS. Similarly, the responsibility for case management of children and young people in out-of-home care is increasingly being transferred from DoCS to NGOs.**
>
> **In these circumstances, it is our submission that there should be a clear capacity for DoCS and certain prescribed bodies to exchange information about the safety, welfare and well-being of children and young people.**

We note that in the Department of Educationøs recent submission to the Special Commission of Inquiry, they submitted that the Protection Act be amended to include a mandatory requirement that risk of harm notifications be transferred between principals of schools where there are ongoing concerns about the safety and welfare of students. It is the Departmentøs understanding that under the current legislation, when a student changes schools, any knowledge that the studentøs previous principal has about risk of harm notifications made about the student cannot be passed onto the principal of the studentøs new school. As the Department of Education submitted, having this kind of information may be crucial in determining how to support the welfare of the student.

We agree with the reasons for the Departmentøs submission that principals should not have to obtain the consent of reporters in order to pass onto a studentøs new school information about risk of harm reports about that student. We would suggest that these concerns would be addressed through the amendments to section 248 that we have suggested in this submission. It would not be necessary to introduce a new mandatory requirement.

B. Statement of principle

Taking away current legal impediments will give workers the *ability* to share information, but it may not, of itself, encourage workers to actually communicate and actively engage with other agencies.

We therefore submit that consideration be given to including a statement of principle, possibly in section 9 of the Protection Act, that makes it clear that it is important that agencies with significant responsibilities for ensuring the safety, welfare and well-being of children communicate with other agencies with the same responsibilities. This would send a clear message that the community *expects* agencies to include in their practice a responsibility to initiate contact with other agencies who may also be looking after the safety, welfare and well-being of a child.

C. Education and training

Expanding section 248 in the way we have suggested would provide a strong foundation for creating the cultural and practical changes that are necessary to facilitate better exchange of information between a number of agencies that play a crucial role in protecting and caring for children.

At a practical level, we have stated above that more education and training of front-line staff may be required so that they understand the tools (in particular section 248) that are currently available to them to give and receive information about a child or family of concern. If our legislative proposal were accepted, clearly education and training of all front-line workers with children would be required. The focus of such training should be helping workers understand the reasons why exchange of information is so important in relation to children, and explaining the tools that are available to them to do this.

D. Addressing concerns about misuse of information and protecting the identity of reporters

We are of the view that the concerns that allowing greater exchange of information may lead to information being used for improper purposes or the inappropriate disclosure of the identity of reporters, can and should be addressed through the introduction of specific threshold tests or requirements on agencies, in conjunction with expanding the scope of section 248.

We note that currently, section 248(1) states that:

> **(1) For the purposes of providing information to, or exchanging information with, a prescribed body, the Director-General may do either or both of the following:**
>
> **(a) the Director-General may, *in accordance with the requirements (if any) prescribed by the regulations*, furnish the prescribed body with information...**
> (b) **the Director-General may, *in accordance with the requirements (if any) prescribed by the regulations*, direct the prescribed body to furnish the Director-General with information...**

While currently there are no such requirements prescribed, clearly there is scope to restrict or regulate the ability under section 248 to share information.

We outlined above our suggestion that a Schcdule or Schedules be introduced to list those agencies that could use a three-tiered scheme of exchanging information under section 248. We are of the view that there may be merit in requiring an agency to meet certain conditions before being listed. In particular, an agency may need to demonstrate they have in place proper policies and procedures about the use of information shared under section 248. Such a requirement could be used to make sure information is only shared for the purposes of ensuring the safety, welfare and well-being of particular children or classes of children.

A separate but related issue relates to the criteria which should be met before information can be disclosed. We note that section 248 provides that the Director-General may share information for the purpose of ensuring the safety, welfare and well-being of a child or class of children.

We note that the Health Records and Information Privacy Code of Practice 2005 and Part 4 of the Privacy Code of Practice (General) 2003 require the decision maker to be satisfied that there are reasonable grounds to believe that there is a risk of substantial adverse impact on the individual or some other person if collection or use of the information, or disclosure of the information, does not occur. Our view is that such a test is complicated to implement in practice. It requires speculation of a possible outcome of not doing something. The starting point is non-disclosure and the test is quite strict. This would not be our preference.

In contrast, new provisions in the Queensland *Child Protection Act 1999* (Chapter 5A) require that the person sharing information must reasonably believe that the information will assist the agency to make certain decisions, assessments, plans and investigations relating to the welfare of a child. Although the starting point is also non-disclosure, the test is quite broad and would appear to be relatively easier to apply.

We believe that a simple test is the best option. A simple test related to promoting the safety and welfare of children would send the right message, encouraging information exchange while at the same time providing a solid ethical base to impose sanctions against those who act outside their mandate.

On the issue of sanctions or consequences for unlawful or inappropriate use of information, we would also make several other points. Firstly, the combination of departmental policy and straightforward legislation as to what is permissible, would provide a solid platform for action to be taken against government employees who act inappropriately in this area. In the main, the same could be said for the non-government sector. For any non-government agency with a lack of rigour in this area there should also be scope to address any shortcomings through vehicles such as funding agreements, accreditation requirements and, in extreme circumstances, the removal from the proposed Schedule or, for example, moving an agency from tier 2 to tier 3.

E. Codes of Practice and Public interest directions

The Commissioner has raised as a possibility for consideration the publication of a Privacy Code of Practice (under section 31 of the PPIP Act) and a related Health Privacy Code of Practice (under section 40 of the HRIP Act), or the publication of a public interest direction under the PPIP Act and health public interest direction under the HRIP Act.

Our preference is for legislative change, in the form we have outlined above. In our view the focus of the issue of information exchange should be about improving the current system of child protection, not about how far privacy laws should be limited in particular circumstances. We are of the view that a proposal to amend section 248 would provide an opportunity for public debate and consideration of this issue by the Parliament, representing the community. If the proposal is adopted, then it would send a powerful positive message to agencies that the community expects agencies to communicate with each other about their work with children.

As we have stated above, an important element of improving the current system is achieving cultural change. We believe a message from the Parliament would provide a strong foundation for creating those cultural and practical changes that are necessary to facilitate better exchange of information between agencies.

In addition, Parliament could consider whether or not it wants to include the statement of principle we have suggested. Again, this would send a clear message that exchanging information about the welfare of children is an essential part of working with those children.

We recognise that the legislation cannot address the nuances of practice, however we have suggested mechanisms through which practical details could be worked out.

However, we also recognise that legislative change may take time. In the interim we would not be opposed to using Codes of Practice, as in theory these should be able to be published more quickly. However, we would only support the use of Codes or Directions as a temporary measure. Further, we note that Codes of Practice have, in the past, taken several years to put in place.

We note that on the website of NSW Privacy it is stated that Directions are meant to be temporary in nature. We observe that a number of Directions have been extended past the date they were originally intended to expire. It would not be our preference to extend a Direction in lieu of legislative change. This problem needs a long-term solution that a Code or Direction cannot provide.

In your letter to our office, you drew our attention to the Health Records and Information Privacy Code of Practice 2005 and Part 4 of the Privacy Code of Practice (General) 2003. We note that the Codes of Practice mirror each other to, in combination, provide that public and private organisations providing ÷human servicesø can collect, use and disclose personal information about an individual to each other. The Codes provide for these activities to be appropriately authorised.

It may be that the current definition of ÷human services agencyø in these Codes could be expanded to explicitly include agencies providing childrenøs services and policing services.

This could give agencies with responsibilities for the safety, welfare and well-being of children scope to exchange information.

If these changes were made, or new Codes or Directions were published, we would suggest that the details of the system needs to be simple and clear. Only then will agencies be able to understand what they are and are not permitted to do, and accordingly change their practices around exchanging information.

We observe that the details in some of the Directions seem to be very complicated and are therefore difficult to follow in practice. We would be concerned if any new Codes were similarly complicated.

For example, we have examined the provisions in the Direction relating to the Anti-Social Behaviour Pilot Project, to see if it could provide a good practical model of a system that allows certain agencies to exchange information in certain circumstances. In our view it seems the decision-makers are required to undertake a very complicated process when deciding whether or not to refer cases. Such processes will not be easy to follow in situations where prompt and challenging decisions need to be made. Other elements of the system also seem unwieldly and difficult to follow. We therefore do not feel a system based on this particular Direction would be the best solution.

One example of where agencies may need to share information with each other without the involvement of DoCS and where the existence of a Direction does not appear to have completely resolved problems, is where agencies require information from the police to investigate allegations against an employee. Under Part 3A of *Ombudsman Act 1974* certain agencies that provide services to children must report and investigate any allegations (of which they become aware) against an employee that the person has behaved in ways that could be abusive to children (so called ÷reportable allegationsø).

The Privacy Commissionerøs ÷Direction on processing of personal information by public sector agencies in relation to their investigative functionsø includes a clause 4A which states:

> **4A. A relevant agency need not comply with sections 18 or 19(1) of the PPIP Act if non-compliance is reasonably necessary to assist another relevant agency exercising investigative functions or conducting a lawful investigation.**

Relevant agencies listed in the Schedule to the Direction include most, if not all, NSW public sector agencies including NSW Police, Department of Education and Training and the Department of Health, but no non-government organisations.

The existence of this Direction has not resulted in NSW Police sharing information with those public sector agencies, which are listed in the Schedule, trying to comply with their Part 3A obligations.

NSW Police generally refuses to provide information about a person whom they have investigated, or are investigating, directly to that personøs employer, where Part 3A of the Ombudsman Act would apply to the situation. They have advised us that their view is it is more appropriate for an agency that becomes aware of allegations about an employee to put a request for information to DoCS, and for DoCS to use section 248 to require NSW Police to

furnish that information to DoCS. DoCS may then make a decision to pass the information onto the agency.

In a situation where NSW Police know of allegations about a person who works with children, but the personøs employer is unaware of the allegations, NSW Police are of the view that it is more appropriate for them to make a risk-of-harm report to DoCS, if this is warranted, and, if Part 3A applies, DoCS may then make a decision to pass the information onto the personøs employer under section 248. We note that in these circumstances clause 4A of the Direction would not apply, because the other ÷relevant agencyø(which would be the employing agency) would not, at the time the police wanted to share the information, be ÷exercising investigative functions or conducting a lawful investigationø

Our experience has been that the current system has resulted in information not being shared in a timely way, and, sometimes, information not being transferred to the employing agency at all. As a consequence, agencies have not been able to finalise investigations, make proper risk assessments or informed findings.

Unduly delaying investigations puts stress on the alleged victims and the person who is the subject of allegations. More troubling, agencies that do not have the relevant information from the police can make the wrong decision in relation to the employee. This puts children at further risk from the employee.

We note that NSW Police has recently indicated support for a proposal from DoCS that an amendment be made to section 248 to facilitate the exchange of information between the Department of Education and Training and NSW Police. As we have discussed in this submission, we agree that an amendment to section 248 is the appropriate solution to the current situation.

Finally, we would make the point that the simpler a system, the more likely agencies will comply with it, and the easier it is to hold agencies to account when they fail to comply.

Conclusion

Our work has shown that people responsible for ensuring the safety, welfare and well-being of children need to be able to easily access complete, accurate and timely information about those children.

In our submission changes need to be made to the current child protection system to both allow and encourage agencies to communicate effectively with each other. These changes need to be clear, simple, and be able to be implemented in practice.

Bruce Barbour
NSW Ombudsman

Steve Kinmond
Community and Disability Services Commissioner (Deputy Ombudsman)

Appendix: Relevant legislative provisions

In this Appendix we set out in full the legislative provisions that we refer to in our submission.

Children and Young Persons (Care and Protection) Act 1998

9 What principles are to be applied in the administration of this Act?

The principles to be applied in the administration of this Act are as follows:

(a) In all actions and decisions made under this Act (whether by legal or administrative process) concerning a particular child or young person, the safety, welfare and well-being of the child or young person must be the paramount consideration. In particular, the safety, welfare and well-being of a child or young person who has been removed from his or her parents are paramount over the rights of the parents.

(b) Wherever a child or young person is able to form his or her own views on a matter concerning his or her safety, welfare and well-being, he or she must be given an opportunity to express those views freely and those views are to be given due weight in accordance with the developmental capacity of the child or young person and the circumstances.

(c) In all actions and decisions made under this Act (whether by legal or administrative process) that significantly affect a child or young person, account must be taken of the culture, disability, language, religion and sexuality of the child or young person and, if relevant, those with parental responsibility for the child or young person.

(d) In deciding what action it is necessary to take (whether by legal or administrative process) in order to protect a child or young person from harm, the course to be followed must be the least intrusive intervention in the life of the child or young person and his or her family that is consistent with the paramount concern to protect the child or young person from harm and promote the childøs or young personøs development.

(e) If a child or young person is temporarily or permanently deprived of his or her family environment, or cannot be allowed to remain in that environment in his or her own best interests, the child or young person is entitled to special protection and assistance from the State, and his or her name, identity, language, cultural and religious ties should, as far as possible, be preserved.

(f) If a child or young person is placed in out-of-home care, arrangements should be made, in a timely manner, to ensure the provision of a safe, nurturing, stable and secure environment, recognising the child or young personøs circumstances and that, the younger the age of the child, the greater the need for early decisions to be made in relation to a permanent placement.

(g) If a child or young person is placed in out-of-home care, the child or young person is entitled to a safe, nurturing, stable and secure environment. Unless it is contrary to his or her best interests, and taking into account the wishes of the child or young person, this will include the retention by the child or young person of relationships with people significant to the child or young person, including birth or adoptive parents, siblings, extended family, peers, family friends and community.

29 Protection of persons who make reports or provide certain information

(1) If, in relation to a child or young person or a class of children or young persons, a person makes a report in good faith to the Director-General or to a person who has the power or responsibility to protect the child or young person or the class of children or young persons:
(a) the making of the report does not constitute a breach of professional etiquette or ethics or a departure from accepted standards of professional conduct, and
(b) no liability for defamation is incurred because of the report, and
(c) the making of the report does not constitute a ground for civil proceedings for malicious prosecution or for conspiracy, and
(d) the report, or evidence of its contents, is not admissible in any proceedings (other than care proceedings in the Childrenøs Court, or any appeal arising from those care proceedings), and
(e) a person cannot be compelled in any proceedings to produce the report or a copy of or extract from it or to disclose or give evidence of any of its contents, and
(f) the identity of the person who made the report, or information from which the identity of that person could be deduced, must not be disclosed by any person or body, except with:
(i) the consent of the person who made the report, or
(ii) the leave of a court or other body before which proceedings relating to the report are conducted,

and, unless that consent or leave is granted, a party or witness in any such proceedings must not be asked, and, if asked, cannot be required to answer, any question that cannot be answered without disclosing the identity or leading to the identification of that person.

(1A) A certificate purporting to be signed by the Director-General that a document relating to a child or young person or a class of children or young persons is a report to which this section applies is admissible in any proceedings and, in the absence of evidence to the contrary, is proof that the document is such a report.
(2) A court or other body cannot grant leave under subsection (1) (f) (ii) unless the court or other body is satisfied that the evidence is of critical importance in the proceedings and that failure to admit it would prejudice the proper administration of justice.
(3) A court or other body that grants leave under subsection (1) (f) (ii):
(a) must state the reasons why leave is granted, and
(b) must ensure that the holder of the report is informed that evidence as to the identity of the person who made the report, or from which the identity of that person could be deduced, has been disclosed.
(3A) The protections given by this section to a person who makes a report apply to:
(a) any person who provided information on the basis of which the report was made, in good faith, to the person, and
(b) any person who otherwise was in good faith concerned in making such a report or causing such a report to be made,

in the same way as they apply in respect of the person who actually made the report.

(4) Subsection (1) (f) does not prevent the disclosure of information from which the identity of a person may be deduced if the prohibition on the disclosure of that information would prevent the proper investigation of the report.
(5) A report to which this section applies is taken to be an exempt document for the purposes of the *Freedom of Information Act 1989*.
(6) In this section:

court includes a court exercising federal jurisdiction.

report includes a report under sections 24, 25, 27, 120, 121 and 122.

29A Person who makes report is not prevented from helping child or young person

For avoidance of doubt, it is declared that a person who is permitted or required by this Part to make a report is not prevented, by reason only of having made that report, from responding to the needs of, or discharging any other obligations in respect of, the child or young person the subject of the report in the course of that personøs employment or otherwise.

248 Provision and exchange of information

(1) For the purposes of providing information to, or exchanging information with, a prescribed body, the Director-General may do either or both of the following:
(a) the Director-General may, in accordance with the requirements (if any) prescribed by the regulations, furnish the prescribed body with information relating to the safety, welfare and well-being of a particular child or young person or class of children or young persons,
(b) the Director-General may, in accordance with the requirements (if any) prescribed by the regulations, direct the prescribed body to furnish the Director-General with information relating to the safety, welfare and well-being of a particular child or young person or class of children or young persons.
(1A) Information about the following may be furnished under this section in the same way as information about a child or young person or class of children or young persons may be furnished:
(a) an unborn child who is the subject of a pre-natal report under section 25,
(b) the family of an unborn child the subject of such a report,
(c) the expected date of birth of an unborn child the subject of such a report.
(2) It is the duty of a prescribed body to whom a direction is given under subsection (1) (b) to comply promptly with the requirements of the direction.
(3) If information is furnished under subsection (1) or (1A):
(a) the furnishing of the information is not, in any proceedings before a court, tribunal or committee, to be held to constitute a breach of professional etiquette or ethics or a departure from accepted standards of professional conduct, and
(b) no liability for defamation is incurred because of the furnishing of the information, and
(c) the furnishing of the information does not constitute a ground for civil proceedings for malicious prosecution or for conspiracy.
(4) A reference in subsection (3) to information furnished under subsection (1) or (1A) extends to any information so furnished in good faith and with reasonable care.
(5) A provision of any Act or law that prohibits or restricts the disclosure of information does not operate to prevent the furnishing of information (or affect a duty to furnish information) under this section. Nothing in this subsection affects any obligation or power to provide information apart from this subsection.
(6) In this section:

prescribed body means:

(a) the Police Service, a government department or a public authority, or
(b) a government school or a registered non-government school within the meaning of the *Education Act 1990*, or

(c) a TAFE establishment within the meaning of the *Technical and Further Education Commission Act 1990*, or
(d) a public health organisation within the meaning of the *Health Services Act 1997*, or
(e) a private hospital within the meaning of the *Private Hospitals and Day Procedure Centres Act 1988*, or
(f) any other body or class of bodies (including an unincorporated body or bodies) prescribed by the regulations for the purposes of this section.

254 Disclosure of information

(1) A person who discloses any information obtained in connection with the administration or execution of this Act is guilty of an offence unless the disclosure is made:
(a) with the consent of the person from whom the information was obtained, or
(b) in connection with the administration or execution of this Act or the regulations, or
(c) for the purposes of any legal proceedings arising out of this Act or the regulations, or of any report of any such proceedings, or
(d) in accordance with a requirement imposed under the *Ombudsman Act 1974*, or
(e) with other lawful excuse.

Maximum penalty: 10 penalty units or imprisonment for a period not exceeding 12 months, or both.

(2) It is not an offence under this section for the Director-General to disclose information to a person who has made a report concerning any action taken as a consequence of the report if the Director-General is of the opinion that disclosure of the information is not inconsistent with the objects and principles of this Act.

Children and Young Persons (Care and Protection) Regulation 2000

7 Prescribed bodies: sec 248

For the purposes of section 248 (6) (f) of the Act, the following are prescribed as a ***prescribed body***:
(a) a private fostering agency within the meaning of the 1987 Act (whether or not it is authorised),
(b) a body that conducts a residential child care centre or a child care service within the meaning of the 1987 Act (whether or not it is licensed),
(b1) a designated agency,
(c) a private adoption agency within the meaning of the *Adoption of Children Act 1965*,
(d) the Family Court of Australia,
(d1) the Federal Magistrates Court of Australia,
(e) the Commonwealth Services Delivery Agency known as õCentrelinkö,
(e1) the Commonwealth Department of Immigration and Multicultural and Indigenous Affairs,
(f) any other organisation the duties of which include direct responsibility for, or direct supervision of, the provision of health care, welfare, education, childrenø services, residential services, or law enforcement, wholly or partly to children.

Privacy and Personal Information Protection Act 1998

23 Exemptions relating to law enforcement and related matters

(1) A law enforcement agency is not required to comply with section 9 if compliance by the agency would prejudice the agencyøs law enforcement functions.
(2) A public sector agency (whether or not a law enforcement agency) is not required to comply with section 9 if the information concerned is collected in connection with proceedings (whether or not actually commenced) before any court or tribunal.
(3) A public sector agency (whether or not a law enforcement agency) is not required to comply with section 10 if the information concerned is collected for law enforcement purposes. However, this subsection does not remove any protection provided by any other law in relation to the rights of accused persons or persons suspected of having committed an offence.
(4) A public sector agency (whether or not a law enforcement agency) is not required to comply with section 17 if the use of the information concerned for a purpose other than the purpose for which it was collected is reasonably necessary for law enforcement purposes or for the protection of the public revenue.
(5) A public sector agency (whether or not a law enforcement agency) is not required to comply with section 18 if the disclosure of the information concerned:
(a) is made in connection with proceedings for an offence or for law enforcement purposes (including the exercising of functions under or in connection with the *Confiscation of Proceeds of Crime Act 1989* or the *Criminal Assets Recovery Act 1990*), or
(b) is to a law enforcement agency (or such other person or organisation as may be prescribed by the regulations) for the purposes of ascertaining the whereabouts of an individual who has been reported to a police officer as a missing person, or
(c) is authorised or required by subpoena or by search warrant or other statutory instrument, or
(d) is reasonably necessary:
(i) for the protection of the public revenue, or
(ii) in order to investigate an offence where there are reasonable grounds to believe that an offence may have been committed.
(6) Nothing in subsection (5) requires a public sector agency to disclose personal information to another person or body if the agency is entitled to refuse to disclose the information in the absence of a subpoena, warrant or other lawful requirement.
(7) A public sector agency (whether or not a law enforcement agency) is not required to comply with section 19 if the disclosure of the information concerned is reasonably necessary for the purposes of law enforcement in circumstances where there are reasonable grounds to believe that an offence may have been, or may be, committed.

25 Exemptions where non-compliance is lawfully authorised or required

A public sector agency is not required to comply with section 9, 10, 13, 14, 15, 17, 18 or 19 if:
(a) the agency is lawfully authorised or required not to comply with the principle concerned, or
(b) non-compliance is otherwise permitted (or is necessarily implied or reasonably contemplated) under an Act or any other law (including the *State Records Act 1998*).

Health Records and Information Privacy Act 2002

23 When non-compliance authorised

A private sector person is not required to comply with a requirement of this Part applying to the person if:
(a) the private sector person is lawfully authorised or required not to comply with it, or
(b) non-compliance is otherwise permitted (or is necessarily implied or reasonably contemplated) under an Act or any other law.

Privacy Act 1988 (Cth)

SCHEDULE 3

National Privacy Principles

Note: See section 6.

1 Collection ....

2 Use and disclosure

2.1 An organisation must not use or disclose personal information about an individual for a purpose (the ***secondary purpose***) other than the primary purpose of collection unless:

(a) .... or

(b) .... or

(c) .... or

(d) .... or

(e) .... or

(ea) .... or

(f) .... or

(g) the use or disclosure is required or authorised by or under law; or

(h) .....

Special Commission of Inquiry
into Child Protection Services in NSW

Submission of NSW Ombudsman

Part 4: Mandatory reporting

30 April 2008

Ombudsman ref: ADM/6123

1. Introduction

The *Children and Young Persons (Care and Protection) Act 1998*, consistent with similar legislation in other States in Australia, provides for mandatory reporting by certain professionals and employees.

Mandatory reporting reinforces the duty of professionals that have contact with children to respond to concerns they may have about a childøs safety, welfare and wellbeing.

While acknowledging there is significant debate about the merits or otherwise of mandatory reporting, we agree with DoCSøview that the legislative framework for mandatory reporting is not in need of significant reform.[1]

2 Demand on the child protection system

It is well established that the number of risk of harm reports to the DoCS Helpline continues to steadily increase. DoCS received 286,022 risk of harm reports in 2006-07 ó an increase of 19% on the total number of reports received in 2005-06.[2]

Growing demand for child protection services is not unique to NSW. Most jurisdictions, both nationally and internationally, have experienced substantial increases in child protection notifications, irrespective of whether mandatory reporting has been in place, or reporting thresholds have been altered.[3] A recent report by the Australian Institute of Health and Welfare (AIHW) concludes that whilst differences in the way various state jurisdictions handle child protection notifications makes direct comparison problematic,

> *'…nationally, notifications, substantiations, and the number and rates of children under care and protection orders in out-of-home care are all rising.'* [4]

Factors identified by the AIHW as influencing a rise in notifications included an actual increase in the number of children who require a child protection response, and increased awareness of child protection issues in the wider community leading to a greater reporting of welfare concerns to child protection authorities.[5]

Changes to the scope of mandatory reporting in NSW introduced with the 1998 child protection legislation undoubtedly impacted on the volume of reports to DoCS, and the corresponding administrative burden for DoCS in processing and assessing these reports. We note, however:

- the proportion of reports assessed by the Helpline as requiring further assessment (approximately 67%) has remained relatively constant with the expanded mandatory reporting requirements; and
- the rate of growth in reports by non-mandated reporters is in line with that of mandated reporters.[6]

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[1] Department of Community Services ó Submission to the Special Inquiry into Child Protection Services ó Mandatory Reporting. Page 21

[2] Ibid. Page 6

[3] Department of Community Services (2006). *Statutory child protection in NSW – Issues and options for reform.*

[4] Australian Institute of Health and Welfare (2008). *Child Protection Australia 2006-07.* Child welfare series no. 43. Page 10.

[5] Ibid at page 21.

In this context, there is some question as to the degree to which changes to current mandatory reporting arrangements would resolve issues about DoCSø capacity to manage the volume of reports it receives.

3 Reporting thresholds

Within debates about mandatory reporting, there is varying opinion regarding reporting requirements. One view is that having a broad range of matters which have to be reported can promote early signalling of, and intervention for, children at risk of harm, and can enable identification of compounding risk where there are ongoing concerns, particularly in relation to neglect. A different perspective is that a broad mandatory reporting regime will inevitably result in overóloading of the statutory child protection system with reports that do not warrant a statutory response, resulting in less capacity to identify and respond to higher risk cases.

It is clearly important to strike a balance to ensure that mandatory reporting requirements result in greater capacity to meet the objects of the legislation: To ensure that children receive the care and protection necessary for their safety, welfare and well-being; that services are provided appropriately and with positive outcomes; and that appropriate assistance is provided to families in order to promote a safe and nurturing environment for children.

The opening address of Counsel Assisting the Special Commission posed the following question:

> *'is the threshold for reporting, namely risk of harm appropriate? Some jurisdictions require only actual or likely harm, some require only sexual abuse or non-accidental physical injury to be reported'*[7]

Currently, the threshold in NSW for determining when a risk of harm report should be made to DoCS is when a person forms ÷reasonable grounds to suspectø that a child is at risk of harm.[8] Most state jurisdictions in Australia have a reporting threshold that involves a ÷beliefø or ÷suspicionø raised on ÷reasonable groundsø.[9]

DoCS has submitted that the current threshold of ÷reasonable grounds to suspectø involves two parameters that are open to subjective interpretation by reporters. The department has argued that there may be merit in introducing a greater onus on reporters to provider clearer evidence of risk to accompany a report. For this reason, DoCS has suggested õlegislative amendments that introduce a higher standard í such as a requirement for ÷reasonable evidenceø of a risk of harmö. According to DoCS, the benefit of this approach would be in its potential to improve the prospects of reliably filtering out reports that do not have a firm basis in fact. DoCS considers this may also assist in improving the quality of information conveyed

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[6] DoCS report a 51% increase in reports from mandatory reporters and a 50% increase in reports from non-mandated reporters since 2001-02. Figures cited in DoCSø *Annual Statistical Report 2005-06,* November 2007. Page 14

[7] Special Commission of Inquiry into Child Protection, Opening address by the Counsel Assisting, 17 December 2007

[8] Section 27 (2) of the *Children and Young Persons (Care and Protection) Act 1998* in relation to mandatory reporters.

[9] Bromfield, L & Higgins, D. (2005). ÷National comparison of child protection systems,ø *Child Abuse Prevention Issues,* Published by the Australian Institute of Family Studies, No. 22, Autumn 2005. Page 6.

by reporters, as there would be a greater impetus to provide sufficient information to support concerns they raise.

DoCS also considers there would be merit in requiring õa higher level of probabilityö that a risk to a child is present. To achieve this, it has proposed introducing the term õreal likelihoodö. [10]

÷Reasonable evidenceø

A threshold such as ÷reasonable evidenceø would impose on the reporter the need to consider what constitutes evidence of a risk of harm. While the concept of evidence may be well understood by certain professionals, including lawyers and those involved investigative work, it may not be clear to practitioners outside of these fields. Furthermore, it is unclear to us what is meant by the proposed additional requirement that the evidence must be õreasonableö. We believe that it would be more appropriate for the Commission to consider supporting a legislative amendment requiring a reporter to have õreasonable grounds to believeö, rather than only suspect, risk of harm.

÷Real likelihoodø

In our view, mandatory reporters may also take differing views as to both the meaning of ÷likelihoodø and whether that likelihood is ÷realø. Should an amendment to the legislation be considered necessary, to provide a greater focus on the degree of perceived risk, we believe that ÷substantial riskø is more likely to be easily understood and consistently applied by practitioners.

Grounds for reporting risk of harm

At the public forum on mandatory reporting, the Commissioner expressed interest in examining whether section 23 should be expanded.[11] In our view, section 23 as it currently stands generally provides a clear framework for appropriately identifying the range of circumstances that may warrant a statutory response.

DoCS has raised the possibility of including specific reference in section 23 to the identification of serious and persistent parental drug use as behaviour with the potential to cause harm. DoCS suggests the inclusion of a statement along the lines of:

> *'the child or young person is living in a household where there is evidence of serious and persistent parental use of illicit drugs and, as a consequence, the child or young person is at risk of serious physical or psychological harm.'* [12]

It is arguable that inclusion of this specific ground is not strictly necessary, since it is already covered in substance by the broad definitions of ÷at risk of harmø under paragraphs (a), (b), (c) and (e) of section 23. However, given the significance of illicit drug use as a risk factor to children, there may be merit in focussing particular attention on this concern.

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[10] Department of Community Services ó Submission to the Special Inquiry into Child Protection Services ó Mandatory Reporting. Page 21-23.

[11] Special Commission Forum Transcript. *Mandatory Reporting.* Page 35.

[12] Department of Community Services ó Submission to the Special Inquiry into Child Protection Services ó Mandatory Reporting. Page 23.

A further issue which has come to light from our work concerns truancy. While we would oppose any suggestion that occasional truancy should be included within section 23, habitual non-attendance at school of a child of mandatory school age means that the child is being deprived of a fundamental right relating to their development. For this reason, there may be merit in also focusing particular attention on this issue through an appropriate amendment to section 23.

Strengthen focus on neglect or ÷cumulative riskø cases

We understand that the Special Commission is keen to explore the possibility of including an explicit reference to the word ÷neglectø in section 23 and/or a specific reference to the deleterious impact of cumulative harm.[13]

In this regard, we note that Victoria has recently amended the stateøs child protection legislation to reference the harmful effects of cumulative exposure to risk. The *Children, Youth and Families Act 2005* states that the:

> *'…harm identified in the various grounds may be constituted by a single act, omission or circumstance or accumulate through a series of acts, omissions or circumstances'*.[14]

It may be appropriate to consider a similar provision in the NSW legislation.

4 Agency policy and practice

In considering the scope of mandatory reporting, it is important to note the policies and practices of relevant agencies that are intended to complement and support mandatory reporting requirements.

NSW Police Force

According to DoCS, mandatory reporters were responsible for approximately three-quarters of all reports made to the department in 2006-07. Further, between 2003 and 2007, NSW police have consistently been the single biggest reporting group by a substantial margin. Domestic violence continues to be the most frequently reported risk factor identified in reports.[15]

NSW Police Force (NSWPF) policy requires police to *'immediately notify the Department of Community Services when a child has been present at a domestic violence incident…'*.[16] This policy directive is reflected in both the *Domestic Violence Standard Operating Procedures (DV SOPS) and the Child Protection Standard Operating Procedures (CP SOPS).* We note that NSW Police are currently reviewing both policies.

This requirement goes beyond legislative provisions for mandatory reporting and does not provide for professional judgement about whether a child is at risk. Police have noted that this

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[13] Special Commission Forum Transcript. *Mandatory Reporting.* Page 35.
[14] Section 162(2) *Children, Youth and Families Act 2005* (Vic)
[15] Department of Community Services ó Submission to the Special Inquiry into Child Protection Services ó Mandatory Reporting. Page 9.
[16] NSW Police (2000) *Domestic violence policy and standard operating procedures.* Page 31.

approach was designed to ensure no child ‘missed out’ and to remove subjectivity from reporting.[17] In section 5 of this report we discuss the potential scope for a proposed risk assessment tool to assist police in exercising their professional judgement in this area.

Department of Education and Training

The Special Commission has questioned: *‘Should institutions such as hospitals and schools be obliged to report, rather than individual workers?’*[18]

Centralised reporting arrangements at a policy level, such as those currently in operation within the within the Department of Education and Training (DET), and the Memorandum of Understanding between DoCS and DET may assist in the quality and consistency of information reported to DoCS.

We note that the process whereby reports or risk of harm are made by DET principals and executive officers is administrative and provides for no discretion on the part of the principal or executive officer in regard to whether or not a report should be made. Staff members are required to inform these senior officers if they have grounds to make a report.[19] Once the staff member has reasonable grounds to suspect a child may be at risk of harm, they must inform the principal or executive officer, who must make a risk of harm report to DoCS. There is also continued onus on the staff member to ensure that a report is made. As DET has advised this office:

> *‘there is no option for opinions to be provided or considered by the principal or the staff member in the making of a report where there are reasonable grounds to suspect risk of harm.’*

In our view, this is an appropriate approach to centralised or institution-based reporting. We would consider centralised reporting in other agencies should be based on similar clear principles that reinforce the responsibility of individual staff to ensure a report is made.

5 Quality of information

It is reasonable to assume that the better the quality of information conveyed to DoCS, the more effective the mandatory reporting system will be in terms of assisting DoCS identify and assess children and young people at risk of harm and who may be in need of a statutory response. As DoCS has noted:

> *‘any changes to the definitions, grounds for reporting, or persons required to report may have the effect of reducing the volume of reports, however, it will not improve the quality of information contained in reports.’*[20]

We have undertaken significant work around the need for improved quality of information in relation to risk of harm reports, particularly in relation to reports made by police.[21] Given the volume of reports that NSW Police will make to DoCS, there is a significant onus on police

[17] Detective Superintendent Begg, Special Commission Forum transcript *Mandatory Reporting*. Page 25.
[18] Special Commission of Inquiry Agenda and Fact Sheet on mandatory reporting.
[19] Department of Education and Training (2000) *Protecting and Supporting Children and Young People.*
[20]Department of Community Services – Submission to the Special Inquiry into Child Protection Services – Mandatory Reporting. Page 3
[21] NSW Ombudsman (2007) *Report of Reviewable Deaths in 2006, Volume 2, Child Deaths,* Page 36.

officers to provide comprehensive information to the department about the childøs circumstances and associated risks. This issue is related to the need for police to make consistent decisions concerning the types of matters which should be reported to DoCS. Research we have conducted into this issue has clearly identified the need for improved practice in this area.

We note there are a number of initiatives in train that will assist to improve reporting, including joint work between DoCS and NSW Police to develop strategies to enhance the quality of information communicated between NSWPF and DoCS[22], finalisation of a DoCS / Police Memorandum of Understanding, and use of a standardised Helpline ÷intakeø form for faxing risk of harm reports.

In our view, there is merit in the use of structured risk assessment tools to assist identification of risks to children. We have elsewhere recommended that the NSWPF and DoCS develop a shared risk assessment model to assist in alerting either agency about children and young people at risk of harm, particularly in situations of domestic violence. We have also recommended that the NSWPF develop a shared risk assessment model to guide the decision-making of police in responding to individual domestic violence incidents.[23]

In this regard, we note that a cross-agency-risk-assessment (CARA) reference group has been established to address the development of a shared risk assessment tool to guide agencies in responding to domestic violence incidents. The groupø members are NSWPF, DoCS, NSW Health and Attorney Generaløs Department.

We have held several meetings with a number of these agencies to discuss the tool and the reporting of domestic violence matters by police to DoCS. While we accept that the proposed tool will be used for domestic violence matters generally, we are firmly of the view that its development provides an opportunity to guide police and other agencies to make consistent and well informed decisions about when to report domestic violence matters to DoCS. The tool could also assist in improving the quality of reports made to DoCS. Given the importance of this issue, we would be keen for the Commission to strongly encourage the prompt completion and rollout of this initiative. According to recent advice we have received, it is currently unlikely that the tool will become operational within the next 12 months.

6 Feedback to reporters

In their submission on mandatory reporting, DoCS notes that:

> *'it is anticipated that with better feedback to reporters, some of the unnecessary re-reporting of children will be avoided and more constructive relations built with other service providers.'*[24]

We are aware of evidence which indicates that, due to a perceived lack of response by DoCS, some mandatory reporters have indicated that they may re-report children at risk to elevate the

[22] Ibid. Page 78

[23] NSW Ombudsman (2006) *Domestic violence: improving police practice.* Page 87.

[24] Department of Community Services ó Submission to the Special Inquiry into Child Protection Services ó Mandatory Reporting. Page 4

likelihood of a statutory child protection response. The other side of this is that mandatory reporters may stop making reports, in anticipation that DoCS will be unlikely to respond.

Effective feedback of relevant information to mandatory reporters may address the issues of re-reporting and non-reporting, and moreover, assist agencies to better meet their own obligations to children at risk of harm. This is particularly relevant in the context of the recent introduction of a legislative notation at section 29A of the *Children and Young Persons (Care and Protection) Act 1998* that reinforces that the making of a report to DoCS does not prevent agencies from responding to the needs of children and their families.

Appropriate feedback to reporters assists agencies to:

- plan the level and nature of ongoing service provision to families, against an informed background of the services already being provided, or not being provided;
- identify any gaps in service provision and provide an appropriate response to fill these gaps for example by providing a service, or making referrals as necessary; and
- inform agency decisions about if (and when) it may be appropriate to escalate a case, for example by making another report to DoCS, or initiating a case planning meeting.

The current level of feedback provided to mandatory reporters is outlined in the *NSW Interagency Guidelines on Child Protection Intervention*. The guidelines state:

> *÷when a report is made, the Helpline will inform the reporter about the initial action to be taken. Mandatory reporters, except NSW Police, will be advised in writing either that a report has been closed at the Helpline or transferred to a Community Services Centre of a Joint Investigation Response Team (JIRT).'*[25]

NSW Police are provided with an automatic receipt of their report, including a reference number.

For those reports referred to a CSC, the provision of further feedback about DoCSøintended course of action is discretionary. Feedback at this stage may include for example, the identity of the allocated DoCS caseworker, whether or not a home visit will occur, or that, on the information available, no further action will be taken by DoCS. At a minimum, the guidelines dictate that:

> *'the CSC will provide feedback to mandated reporters who request it and who have an ongoing role with the child, young person or family and the feedback will enable that work to continue.'*[26]

There is considerable value in strengthening systems to allow routine and comprehensive feedback about the status of reports and the planned nature and extent of DoCS assessment and intervention.

We acknowledge that current limitations, particularly in relation to DoCSøIT systems, may hinder DoCSøcapacity to provide such feedback. We understand that DoCS has also completed a cost/benefit analysis of the provision of routine feedback to mandatory reporters about the outcome of their reports. The analysis identified a number of challenges and significant resource implications in moving towards a system that provides a greater level of

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[25] NSW Interagency Guidelines for Child Protection Intervention. Page 21

[26] Ibid.

feedback.[27] We consider these to be critical issues to resolve in order to allow the department to enhance its capacity to provide effective feedback to reporters.

On a separate, but related issue, we note that DoCS is currently trialling electronic reporting with certain agencies. As part of this initiative we believe it is important to explore providing electronic feedback to reporters. DoCS have already indicated that they are keen to develop this capacity but have identified increased resources as necessary in order to pursue this possibility.[28]

DoCS have raised a number of valid concerns about the capacity to provide feedback within the current system. However, we consider that appropriate feedback to reporters is an essential factor in agencies working together to protect children.

7. Management of reports

Irrespective of any changes to the mandatory reporting system, there will still be a very large number of risk of harm reports made to the Helpline. In this regard, DoCSø has acknowledged that:

> '*notwithstanding any legislative amendments* [to the threshold for reporting] *there will still remain practical challenges in assessing the significant volume of information provided to it under the mandatory reporting system, linking the information supplied with the delivery of appropriate services and providing proper feedback to reporters on the risk assessment process and, where appropriate, action taken.'* [29]

In our view, it is essential to give greater consideration to how reports can be more effectively managed to ensure resources are properly targeted. In particular:

- information about child protection concerns should be treated as ÷intelligenceø that can be built on to provide effective risk profiles; and
- IT systems need to provide easy access to child protection histories, and enable identification of ÷high riskø families.

We will address this issue in detail in our forthcoming submission on assessment of child protection reports.

Bruce Barbour
NSW Ombudsman

Steve Kinmond
Community and Disability Services Commissioner (Deputy Ombudsman)

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[27] Department of Community Services ó Submission to the Special Inquiry into Child Protection Services ó Mandatory Reporting. Page 19
[28] Ibid. Page 12.
[29] Ibid. Page 3.

Wood Special Commission of Inquiry into Child Protection Services in NSW

Submission of NSW Ombudsman

Part 5: Out of Home Care

8 May 2008

Ombudsman ref: ADM/6122

Out of Home Care

Introduction

This submission concerns the Special Commission of Inquiry term of reference:

The adequacy of arrangements for children in out of home care.

The roles and responsibilities of the Ombudsman as they relate to out of home care services in this state are prescribed by the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (CS CRAMA) and the *Ombudsman Act 1974.* The specific responsibilities conferred upon the Ombudsman that relate to child protection and out of home care are set out in our previous submission to the Special Commission.[1]

This submission:

- canvasses a number of issues relating to the delivery of out of home care services in general;
- provides some broad observations about practice issues relating to DoCSøcare placements; and
- summarises the key findings from specific out of home care reviews and investigations conducted by the Ombudsman over the past five years. We also summarise our findings in relation to our work concerning children with disabilities at risk of entering care.

General issues relating to the delivery of out of home care services

At the outset, we acknowledge the constructive work of the department, the non-government sector and the Childrenøs Guardian in achieving practice improvements in the out of home care field in recent years.

However, a significant issue which has emerged for the Commission to consider relating to the provision of out of home care services in NSW relates to the future roles of the department and the non government sector in providing services of this type. While we note the evidence relating to better support for children and carers within the NGO sector, we believe this fact cannot be divorced from caseworker allocation rates and placement costs. While we would support ongoing expansion of the NGO sector in providing out of home care services, this shift in the government/non government service delivery mix, will present a number of challenges.

In this regard, we note that rapid expansion of non government services in the past has not always guaranteed the delivery of quality services. For this reason, we are of the view that a move towards a greater proportion of out of home care placements being under the umbrella of the non government sector needs to be carefully managed

[1] NSW Ombudsman submission to the Special Commission of Inquiry into Child Protection Services in NSW: Oversight agencies March 2008

and closely monitored. In particular, any rapid expansion of individual services ó particularly those without well established practice in this field ó may pose a risk to the quality of the services provided.

A shift in placements to the non government sector is also likely to raise particular challenges relating to the recruitment by the sector of sufficient numbers of well qualified staff. A rapid structural shift towards the non government sector is likely to make this challenge even more acute. Therefore, any shift towards a higher proportion of non government service delivery in relation to children in out of home care, should ideally occur through a gradual process which enables capacity and quality issues to be tested as this shift in practice is rolled out.

A related issue which has been raised with the Commission concerns whether DoCS should ultimately play any role in directly providing out of home care placements. We note DoCSø argument that there are benefits in the principal funder of out of home care services maintaining a role in also providing these services. In this regard, there would appear to be some merit in DoCSø argument that it will be better placed to be an informed purchaser of services if it also remains a supplier.

However, perhaps a more critical issue in relation to whether DoCS should continue to have a role in directly providing these services relates to whether it is realistic and desirable that all children in care could and should be accommodated by the non government sector. Leaving aside potential workforce capacity constraints - and the challenges associated with providing the range of care models required to meet children and young peopleøs needs - there is the question as to whether DoCS may need to retain responsibility for certain young people whose behaviour and/or circumstances places them in need of specialist care services. In this regard, we note the improved service delivery arrangements that DoCS has put in place to meet the needs of this group over the past four years.

The projected growth in the number of children in out of home care brings with it a number of challenges. One of these concerns the need to recruit sufficient numbers of carers. We support the departmentøs plans to examine ways of reducing the period of time it takes to assess its foster carers. Ongoing foster carer recruitment campaigns will also be vitally important and need to be dovetailed with efficient follow up and carer assessments. Within Aboriginal communities, our recent work identified that õword of mouthö ó as opposed to large campaigns ó was seen by a number of Aboriginal carers as one of the best recruitment strategies. However, for õword of mouthö to be an effective recruitment strategy, it requires carers to strongly endorse the merits of fostering to those within their communities. For this to happen, it requires carers to feel that they are being well supported.

Our report on young people with disabilities leaving care clearly indicates that vulnerable young people who are exiting care need additional support. On this issue, we acknowledge the comprehensive report by Dr Joseph McDowall õCREATE Report Card 2008: Transitioning from Careö (March 2008), which outlines the types of supports which need to be considered to strengthen our support for young people leaving care.

Our reports on services for children with disabilities and their families have highlighted deficiencies in the service arrangements in place to meet the needs of children with a disability who are voluntarily placed in care by their parents. While the actual number of children entering care as a consequence of their disability is relatively small, we believe that it is vitally important that recent initiatives by the Department of Ageing, Disability and Home Care (DADHC) to support families caring for disabled children ó and to support those children with disabilities who enter care ó are evaluated.

We note that an evaluation of the outcomes of the 2003 Memorandum of Understanding between DoCS and DADHC on children and young people with a disability is currently underway and that a report on the evaluation is due to be finalised in late June 2008. We believe that it is vitally important to establish if the MOU objectives of coordination and collaboration between DoCS and DADHC are being achieved.

Finally, we would like to make some broad observations about Aboriginal out of home care ó Aboriginal children represent over 30% of all young people in out of home care.

We note that the current capacity of the Aboriginal out of home care sector is very limited with Aboriginal out of home care services currently only able to place around 200 of the 3812 Aboriginal children in care. Furthermore, while 52 percent of all children in the Western Region are Aboriginal, there is currently no Aboriginal out of home care service in that region.

A separate but related issue is the shortage in the number of authorised Aboriginal carers. Although DoCS is unable to provide out of home care figures on the Indigenous/non Indigenous carer ratio for Aboriginal children in care, our review showed that, of the 100 carer placements we reviewed, over 30% of Aboriginal children were in non Indigenous placements.

There is a critical need to expand both the number of Aboriginal out of home care services and the number of placements available for Aboriginal children with Aboriginal carers. In response to these challenges, DoCS has outlined its plans in its submission to the Commission. While these plans represent important initiatives, they are unlikely to have a significant impact on substantially lifting the ratio of Aboriginal carers.

Against the background of these challenges, we would refer to the role of AbSec as the peak body in this area. We would be keen to see a review take place of AbSecøs current capacity against a clearly articulated vision about what role AbSec might play in the future. While we are pleased to note that AbSec has received recent advice about additional funding, there would appear to be scope for significantly expanding Absecøs activities.

As part of that review, there would also be merit in considering the potential for further co-operative arrangements between well established non Aboriginal service providers, DoCS and AbSec, to help build the capacity of the Aboriginal out of home care sector into the future. In this regard, we are aware of Burnsideøs work in

providing care to Aboriginal children in the Western Region and future plans for Barnados to build service capacity in this critical area.

In connection with the quality of Burnsideøs service delivery, we have spoken with a number of Burnsideøs Aboriginal carers and were encouraged to hear them speak in very positive terms about the support Burnside provides to both them and the Aboriginal children in their care.

We support the Commissionøs consideration of flexible accommodation models for Aboriginal children. In particular, we believe that, at the very least, short term residential accommodation for Aboriginal children and young people needs to be considered, particularly if it provides a means of keeping these children close to their families and communities.[2] Regarding this issue, we note recent attempts within the Bourke community to explore the possibility of providing a safe house environment.

In a later submission we will discuss in more detail our views on child protection issues pertaining to Aboriginal communities.

DoCS' care placements – broad observations

DoCS is the largest provider of care placements in NSW. Through our complaint and review work over recent years, we have observed the changing out of home care landscape. In general, it has changed for the better.

Particular improvements that we have observed include care planning consultation and permanency planning; casework support and improved care planning for those on short term orders and those identified with high needs; and aspects of carer support.

However, our recent work indicates that children in DoCSø placements, who are with relatives and/or on long term orders, often miss out on adequate support.

The transfer of cases from one Community Service Centre (CSC) to another, and from the child protection team to the out of home care team within the same CSC, is an area of practice which needs to be improved. Our work has shown that delays in case transfers can have negative consequences for both children and their carers.

Another area requiring attention is the health and development needs of children in care. At this time, there is no guarantee that children entering out of home care will

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[2] Regarding important contributions to the debate around the potential role of residential care see:

- Frank Ainsworth, Patricia Hansen (2005) *A dream come true – no more residential care. A corrective note*; International Journal of Social Welfare, Volume 14 Issue 3, pages 195-199
- Michael Little, Amelia Kohn, Ronald Thompson (2005) *The impact of residential placement on child development: research and policy implications*; International Journal of Social Welfare, Volume 14 Issue 3, pages 200-209
- Richard P. Barth (2005) *Residential care: from here to eternity*; International Journal of Social Welfare, Volume 14 Issue 3, pages 158-162
- Anne M. Libby, Anita Saranga Coen, David A. Price, Karen Silverman, Heather D. Orton (2005) *Inside the Black Box: what constitutes a day in a residential treatment centre?* International Journal of Social Welfare, Volume 14 Issue 3, pages 176-183
- James P, Anglin, *Pain, Normality and the Struggle for Congruence: Reinterpreting Residential Care for Children and Youth*, Haworth, 2003.

have their health, developmental and dental needs assessed and followed up in a thorough and timely manner. By not identifying and addressing these needs as early as possible, behavioural, social and educational problems will often develop or become exacerbated.

For this reason, in our recent work we have looked not only at the problems in this area, but have also referred to a number of promising health initiatives focused on health assessments and follow up for children in out of home care.

The adequacy of support to ensure children in care receive appropriate educational opportunities has been an area of concern for many years. In our most recent report, we looked at some of the challenges in ensuring agencies better identify and address the educational needs of Aboriginal and other children in out of home care.

Another area that we considered in detail in our recent review work concerns carer support initiatives. In this regard, we have found a relatively low level of awareness by carers of local and regional carer support groups. Carers involved in these groups told us they have found them to be of significant benefit. We also noted the range of agencies which provide carer support groups and have recommended that DoCS and the peaks work in partnership on a range of initiatives focused on maximising benefits that can be derived from these groups.

On an individual carer level, there are several practical issues the department needs to address to better support its carers.

Firstly, the department needs to promptly and effectively resolve complaints made by and against carers. Consistently in meetings between carers and this office, carers have spoken of their anger and distress over allegations that have been made against them which have remained unresolved for many months ó these concerns are supported by our own data. On this issue, we note the departmentøs stated commitment to improve the turnaround times for these matters.

Our general complaint jurisdiction also demonstrates why disputes between the department and foster carers need to be handled promptly and effectively. The ongoing differences between the department and the Foster Care Association over the attendance of FCA representatives at case conferences (referred to in the FCAøs submission to the Commission) arose in the context of a longstanding dispute between an FCA representative and the department.

Secondly, while noting the symbolic significance of the 2007 *Partnership Agreement Between DoCS and Carers*, it is clear that this document needs to be backed by solid practical support. In our report *Supporting the Carers of Aboriginal Children*, we provide a range of examples of how the department can demonstrate this kind of practical support for carers.

Key findings from systemic work

Our systemic work in relation to children in out of home care over the past five years includes:

- an inquiry into individual funding arrangements in out of home care (2003);
- two reviews of children under five years of age (2002 and 2007);
- an investigation into the implementation by DADHC of aspects of its policy for children and young people with a disability (2004);
- a review of young people with disabilities leaving care;
- a review of children under the parental responsibility of the Minister who are placed in SAAP services;
- a review of 100 DoCS carers who are providing care for 185 Aboriginal children in statutory care. Our report will be finalised in the near future and be provided to the Commission;
- a review of the circumstances of a group of children in care who are aged from 10 to14 years. We expect to complete this review in the second half of this year;
- an investigation concerning DoCSø systems for dealing with allegations of child abuse against departmental foster carers; and
- an investigation that we have recently initiated concerning the departmentøs screening processes in relation to authorised carers.

Copies of completed reports are attached. The following observations highlight the major findings from each of these investigations and reviews:

An investigation of DoCS' systems for dealing with allegations of child abuse against departmental foster carers

In 2001, this office initiated an investigation into DoCSø systems for dealing with allegations of child abuse against departmental foster carers and for preventing the abuse of children in out of home care.

Our investigation found a number of inadequacies. Specifically:

- not all departmental foster carers were authorised and/or trained;
- children placed with foster carers often did not have adequate case plans and their placements were poorly monitored;
- foster carers the subject of ÷abuse in careø allegations were not necessarily afforded procedural fairness when the department investigated these allegations;
- the departmentøs record keeping during the course of the investigations was often inadequate; and
- the requirements of s25C of the *Ombudsman Act* ó regarding advice to this office of the allegations ó were not adhered to in all matters.

In response to out recommendations, DoCS:

- developed and implemented procedures across the department for the assessment and approval of authorised carers;
- developed and implemented procedures for responding to allegations against DoCS employees, authorised carers and staff of other agencies;

- funded ACWA to develop a foster carer assessment tool and foster care training modules; and
- took steps to ensure departmental staff are aware of their legislative obligations to notify this office of allegations and convictions of child abuse against employees, and to notify the Commission for Children and Young People of the completion of relevant disciplinary proceedings concerning employees.

An inquiry into Individual Funding Arrangements in Out of Home Care (IFA)

The need for the inquiry arose from concerns raised by Official Community Visitors and information obtained from complaints and reviews of children and young people placed in individually funded care arrangements. Most of the children in these arrangements had significant needs.

The main findings from the inquiry were:

(1) There was a lack of permanency planning associated with service provision under IFAs.

(2) A significant number of IFA placements were residential care with rostered staff ó this raised questions about the appropriateness of residential care, particularly for children under 12.

(3) DOCS had inadequate information about the children and young people in individualised funding arrangements and the contracts relating to their care. This raised concerns about DOCSø capacity to adequately plan and monitor such arrangements.

(4) The contractual arrangements failed to adequately clarify respective responsibilities for casework and case management between the service providers and DOCS.

(5) IFAs contained no reference to the need for an agency to have policies and procedures consistent with the *NSW Out of Home Care Standards.*

As part of its reform agenda, DoCS has put in place a range of strategies to ensure that children with high needs receive the services they require, including case management services.

2002 and 2007 reviews of children under 5 in care

In 2007, we reviewed a number of very young children in out of home care. We prepared the results of our review with a similar review that we conducted in 2002. We found:

(1) Improvements in the quality of care planning, permanency planning and care management to support children who are the subject of short term orders.

(2) Improvements in the support provided for contact arrangements and life story work.

(3) Improvements in the support provided to carers, including the provision of information about the child placed in their care and relevant health information.

(4) Ongoing concerns about the adequacy of support provided to children the subject of long term care orders and placed with either relatives or foster carers. (Children placed with relative carers and in long term foster care were less likely to have an allocated caseworker.)

(5) Ongoing concerns about the adequacy of general health and other screening (developmental and dental) when children enter care.

(6) Ongoing concerns about the transfer of case management responsibility within and between CSCs.

(7) Ongoing concerns about the adequacy of placement reviews and compliance generally with the requirements of section 150 of the *Children and Young Persons (Care and Protection) Act.*

(8) Ongoing concerns about carers not being provided with the childøs case plan and case conferences not occurring.

(9) Concerns about the adequacy of the arrangements to ensure children appropriate for adoption receive the appropriate adoption services.

(10) Concerns that section 82 orders by the Childrenøs Court are often not complied with by DOCS and that this will not generally trigger any response by the Court.

Given DoCS is about to embark on a quality review program, we have asked DoCS to tell us whether the practice weaknesses identified through our most recent review of very young children will be addressed by the departmentøs quality review program or by other initiatives.

Services for children with a disability and their families

In 2004 we reported on the findings of our investigation into DADHCøs administration of its childrenøs policy, with particular attention to:

- arrangements to support families at risk of giving up care of a child or young person with a disability;
- arrangements to support children and young people with disabilities placed in voluntary care; and
- arrangements to monitor the quality of accommodation services provided on a fee-for-service basis.

In relation to these key areas, we found that the departmentøs implementation of its childrenøs policy had been characterised by:

- a poor implementation strategy;
- lack of clarity about the departmentøs role in supporting families in crisis;
- uncertainty about which sections of the department had responsibility for providing such support;
- inadequate guidance to staff about how to implement the policy;
- an inadequate operational framework to underpin the policy;
- lack of clarity about the respective responsibilities of DADHC and DoCS;
- conflict between policy requirements; and
- subsequent inconsistent service delivery.

We also found that, for families seeking support to care for children and young people with disabilities, there was:

- lack of clarity about how to obtain access to services;
- no clearly defined or consistent decision making processes about access to services;
- a fragmented service system for those able to access it;
- poor coordination of services; and
- no clearly defined avenue for review or appeal where services were denied or considered inadequate by the family.

In response to our investigation, DADHC developed an ÷Action Plan for Improving Services for Children, Young People and Familiesø. This plan outlined key strategies to address the problems identified by the investigation. The plan included a commitment to review and report on the impact of departmental initiatives to address the findings of the investigation. This review was completed in 2005. The review and this office found that DADHC had made progress in significant areas but also identified where significant work was yet to be completed. Specifically:

- While the department had developed a range of training packages and programs in relation to how families can be supported to care for their children, all relevant staff had not yet completed the training.
- The training needed to be expanded to provide for a comprehensive approach to improving the responsiveness of childrenøs services to the needs of families from Aboriginal and culturally diverse backgrounds.

- More needed to be done in the area of collaboration between DoCS and DADHC.
- More needed to be done to build on existing initiatives to improve coordination between DADHC and NSW Health, local area health services and the Department of Education and Training.
- DADHC needed to ensure that it had a policy and implementation strategy for individual planning for children living at home and supported by services.
- Services provided by DADHC needed to receive the same level of monitoring as that required of services funded by the department.
- More needed to be done to ensure that families, including families from culturally diverse backgrounds and Aboriginal families, are not only aware of how they can access available support options, but also that they are encouraged to do so.
- More needed to be done to ensure guidelines gave staff sufficient direction as to how families are to be assisted to resume the care of their child or if this does not happen, to move to a stable long term placement.
- More needed to be done to ensure appropriate long term placements are available for children with disabilities entering care on a permanent basis.
- DADHC needed to clarify for the community when and how its intensive family support services would be available, and to evaluate the effectiveness of the new services.
- DADHC needed to establish protocols to ensure that that support packages through its Family Assistance Fund are appropriately targeted to families with the greatest need for support.
- DADHC needed to finalise its family based care strategy for ensuring the majority of children and young people in out-of-home care and all children less than 12 years of age are in family based placements.
- At the time of the review, it was not clear how DADHC and DoCS were collaborating to use existing mainstream foster care services. Additionally, many of the newly funded family based placements were not yet available
- It was unclear how DADHC planned to monitor whether the quality of placements conformed to the principles of the departmentøs childrenøs policy. This is a significant issue given that the departmentøs monitoring framework monitors the adequacy of systems for individual and group home planning, but did not monitor the quality of out of home care support for individual children.

DADHC undertook to address these and other issues as they emerge, through the creation of an expert advisory group on children and young people and establishing a departmental steering committee responsible for identifying, monitoring, managing

and responding to issues that may result in inadequate service provision for children with disabilities and their families. On our part, we are currently considering what further review work we should undertake in this area.

Young people with disabilities leaving care

In February 2004, the Ombudsman initiated reviews of young people identified by DoCS as having an intellectual disability or autism, who were under the parental responsibility of the Minister and who would be leaving care in 2004. DoCS identified 27 young people who met those criteria. On review of these young peopleøs circumstances, we found:

(1) The majority of the 27 young people presented with complex support needs associated with their disabilities.

(2) The reviews highlighted that eligibility for DADHC services was no guarantee of seamless transfer from statutory care arrangements to supported accommodation funded or provided by DADHC. We found that this was particularly so for young people with disabilities in contact with the criminal justice system.

(3) In November 2003, DoCS and DADHC agreed that DoCS would notify DADHC at least two years prior to a young person leaving care where the young person has a disability and is likely to have significant support needs. Our reviews confirmed the need for such an arrangement and the importance of early and effective planning.

(4) The reviews highlighted particular challenges associated with young people leaving care who have a disability, but who are not eligible for DADHC services.

Many of these young people will require ongoing assistance to access and use the services offered at the time they leave care. We found that, in some instances, caseworkers addressed this situation by linking the young person to a disability support service or adolescent service at the time of discharge. We also found examples of departmental caseworkers engaging a range of support services for the young person prior to their discharge from care. These arrangements, including drop-in support and mentoring, can provide for a gradual transition to independence and some form of safety net for the young people. Our reviews identified that for many of these young people, DoCSø support did not cease when the young people turned 18.

For some, however, the only support arrangement was referral by their DoCS caseworker to a service funded to provide after care support. As these after care agencies were not funded to provide longer term or intensive casework, they were not well placed to meet the needs of this group.

(5) The quality of leaving care planning, and the documentation of these plans, varied greatly for the 27 young people. We found many examples of flexible,

innovative leaving care plans that were effectively implemented by the department and other service providers.

The planning process for these young people had in common:

- engagement of the young person in the planning process;
- an inter-agency approach to the planning;
- timely engagement of specialist support and/or adolescent services prior to discharge from care;
- a focus on assessment to determine the young personøs skills;
- leaving care plans that address skills/knowledge deficits identified through assessment;
- documentation of the leaving care plan with clear reference to goals and strategies, roles and responsibilities; and
- review dates.

Where these elements were not in place, opportunities were often lost to ensure the best possible outcomes for the young people.

(6) Against the background of these observations, in our final report in December 2004, we made the following recommendations:

- The Department of Community Services should take proactive steps to ensure that leaving care planning occurs in accordance with the departmentøs practice guidelines. These require planning to commence 12 months prior to leaving care.

- The Department of Community Services should provide clearer guidance to its caseworkers about the departmentøs expectations concerning the documentation of leaving care plans.

- The Department of Community Services should consider the scope for, and potential benefit of, funded after care services providing intensive case management to young people with disabilities who require assistance to develop skills to live independently, or to be linked to appropriate support services.

In March 2005, in response to the group review report, DoCS advised us that it was developing an aftercare policy. We asked the Department to provide us with a copy of the policy once it was developed and endorsed.

In February 2006, DoCS presented a draft policy to the Out of Home Care Partnerøs Reference Group (PRG) for comment. ACWA advised us that they made comment on the draft that month.

In December 2006, the department published out of home care financial guidelines. These guidelines outline the type of aftercare assistance that can be provided.

DoCS advised us in late December 2006 that the aftercare policies and procedures had been endorsed and a copy would be forwarded to us. In February 2007, DoCS provided us with a copy of the paper presented to the PRG in February 2006. The

department said it was working towards rolling out relevant policy and procedures from July 2007.

In May 2007, the department advised it was still developing procedures and information for rollout in July and preparing ministerial guidelines, regarding an amendment to section 165 of the *Children and Young Persons (Care and Protection) Act* 1998, specifying the circumstances in which assistance to young people leaving care may be granted.

In August 2007, we were advised that DoCS was still developing draft ministerial guidelines, for consultation with ACWA and the NGO sector. ACWA was consulted and provided comments on the draft ministerial guidelines in November 2007.

To date, we have received no further information from DoCS on the progress of the after care policy. We understand that the guidelines are still in draft format.

In terms of the needs we identified for additional services for young people with disabilities leaving care, we were pleased to see that the May 2006 release of the disability services plan, Stronger Together, specifically referred to õthe introduction of new approaches for young people [with a disability] leaving foster and other care at 18 years of age who may need to move into other forms of support or accommodation.ö

More generally, Stronger Together also identified additional supports for people with a disability exiting the criminal justice system ó our review had shown that this was an area of particular need.

In January 2008, DADHCøs progress report on the rollout of *Stronger Together* referred to 74 long-term accommodation on support arrangements having been put in place for young people [with a disability] leaving the care of DoCS.

Supporting the carers of Aboriginal children

In 2007, we undertook work specifically examining issues affecting carers of Aboriginal children and the adequacy of services and supports in place to help them to provide quality care. In relation to this work we made a number of observations:

(1) The most significant issue highlighted by carers relates to the regularity and quality of carersø communication with caseworkers. We found that carers generally did not have unrealistic expectations of DoCSø ability to assist them in providing quality care. In this regard, for the most part, carersø primary need was for regular contact with the childøs caseworker and for caseworkers to acknowledge and respect carersø efforts to provide a healthy and nurturing home environment.

(2) We met a number of carers who indicated that they had regular and supportive contact with caseworkers. Carers who believed that their caseworker understood and appreciated the important role they played tended to feel adequately supported by DoCS.

(3) There are critical deficiencies in DoCSøcollection of data for carers of Aboriginal children. For example, while DoCS can provide figures on the number of Aboriginal children in out-of-home care, it is unable to provide reliable data on the ratio of non indigenous and indigenous carers of Aboriginal children.[3]

(4) On a related issue, in its 2006/07 *Annual Report* DoCS states that õMore than 3000 Aboriginal and Torres Strait Islander children were placed *in accordance with [the Aboriginal placement] principle* as at 30 June 2007, or 85 per cent of all Indigenous children in out-of-home care [our emphasis].ö We tested this by looking closely at placement practice and found that guidance is needed regarding what constitutes ÷proper consultationøin relation to placement decisions for Aboriginal children.

(5) We found that cultural planning was not taking place for the vast majority of Aboriginal children we reviewed. Against this background, we examined the cultural care planning process in Victoria and, in our report, noted a number of positive features about the Victorian system.

Following our draft report, we were pleased to note DoCSøannouncing it would be piloting cultural support plans in a number of its Community Service Centres and that the plans will be õloosely basedö on the Victorian system.

(6) Our review examined a number of the carer support initiatives which have been introduced by DoCS over the past five years. We found that local carer support groups were well-regarded by carers who are participating in them: 89% of those who participated in these groups rated them as effective or very effective. However, half the carers we surveyed had no information about these groups, dropping to only 17% for relative carers.

Regional carer advisory groups have also been established. However, our surveys found that only 25% of carers were aware of these groups.

We have made a number of recommendations about carer support initiatives. The Department, AbSec, the Foster Care Association (FCA) and the Foster Parent Support Network (FPSN) are all involved in carer support groups across NSW. Given the potential of these groups to play a pivotal role in assisting carers we have recommended that:

"there would be merit in the Department, in partnership with AbSec, the FCA and the FPSN, continually tracking the location of these groups; the types of groups in place (for example, Aboriginal/non-Aboriginal); the level of Departmental and/or other agency involvement; the number of participants; Aboriginal carer participation numbers; the nature of the concerns raised and action taken to resolve these concerns. Consistent with this exercise of better

[3] Based on data provided by DoCS, the Australian Institute of Health and Welfareøs annual survey, *Child Protection 2006-07,* reported that there were 11,843 children in out-of-home care in NSW as at 30 June 2007 (although we understand there are different counting rules used by AIHW and DoCS). The departmentøs 2006-07 *Annual Report* put the total number of children in out-of-home care in NSW at that date at 12,712. Data provided by the Department on 19 February 2008 put the number of children in out-of-home care on that date at 12,403 (not including children living in residential care).

coordinating and tracking the Department's and peaks' carer support group activities, there would also be merit in improved coordination of the identification of carers' training needs and the delivery of training. Regular meetings of this kind would also provide the opportunity to share information about good practice initiatives."

(7) As part of our review, we examined initiatives underway to improve health outcomes for children in out of home care, including the MOU with NSW Health.

We also considered the out of home care health screening initiatives carried out by the Sydney Childrenøs Hospital in Randwick and Liverpool Hospital. Both of these initiatives appear to have worked well and underscore the importance of good health screening and co-ordinated follow up for children in out of home care.

The involved practitioners advised us that research indicates that carers are generally quite good at detecting basic health issues of children in their care. However, they are not well-placed to identify difficulties early on in a childøs life with speech, vision and hearing. As these difficulties are prevalent for children in out of home care, early health care screening is critical.

DoCS is currently negotiating with Catholic Health Care to provide health assessments for DoCS placed children in out of home care in each region. In our report we note that it is unclear whether or not the services under this proposed arrangement will compare favourably with the public health models provided by Sydney Childrenøs Hospital and Liverpool Hospital. In any case, we note that these current models can õprovide a potentially useful benchmark against which the proposed service by Catholic Health Care can be measuredö.

Aside from this broader issue of health care assessments, our review found a number of practical health issues which need to be addressed, including:

- children and young people having prompt access to a Medicare card upon entering out of home care;
- ensuring that information is provided to carers about childrenøs health needs at the earliest opportunity;
- ensuring that childrenøs health records are kept up-to-date and that where a NSW Health Personal Health Record or ÷Blue Bookø is lost, requests for a new book are made promptly through relevant local child and family health services;
- ensuring that carers understand their role in maintaining health records and in facilitating their childøs access to services;
- ensuring that carers are made aware of the most efficient and effective ways to access particular types of health services, including Medicare-funded allied health services when appropriate; and

- making clear the role of caseworkers in relation to monitoring health checks and referrals, especially in connection with children with particular health problems which are identified through screenings.

(8) As part of our review, we also looked at aspects of the educational needs of the children we reviewed. A significant number of carers spoke very positively about the attempts made by schools and caseworkers to deal with the ÷special needsø of their child. However, we found that few carers had regular discussions with DoCS caseworkers about their childøs education.

The recommendations that we made in our final report reflect the major educational issues we focused on. In this regard, we recommended that consideration should be given to:

- promptly finalising a project plan for the collecting, analysing and reporting on comprehensive information about the education participation and performance of *all* children in out of home care, and tracking performance over time to provide much more reliable indicators of effective strategies to enhance learning outcomes;

- ensuring that there is ongoing evaluation of the practical impact of recently developed systemic supports, such as memoranda of understanding and the implementation of individual education planning for children in out of home care; and

- developing strategies that give effect to the principle that carers, caseworkers and schools should work in partnership to address any learning impediments or schooling problems, and ensure that the broader educational needs of children in their care are met.

Children under the parental responsibility of the Minister who are placed in SAAP services and aged 15 years or under

In 2006, we reviewed the circumstances of a number of young people is statutory care who were accommodated in SAAP services. According to a January 2006 telephone survey of youth SAAP services, there were only 21 young people in out of home care living in SAAP services at that time who were aged 15 years or under. However, anecdotal information from peak agencies suggested that the numbers may be higher. On this issue, we are of the view that it is critical for there to be clarity.

(1) From our review of 15 of these 21 young people, it was pleasing to find that all but one had an allocated DoCS caseworker. While not all of the children had a documented caseplan, the practical casework to meet their needs was, in the main, appropriately responsive.

(2) In our final report in this matter we recommended that DoCS should provide a report to the Ombudsman containing:

- detailed advice about the scope for collecting centralised data about the use of SAAP for children and young people for whom the department

has care responsibility for the purposes of monitoring the circumstances of individual children and monitoring trends in the use of SAAP for this group;

- options for making any such data publicly available to enable informed discussion about issues concerning unaccompanied children in SAAP; and

- detailed evidence of progress made by the department in the development of policy and protocols for unaccompanied children in SAAP and a timeframe for the finalisation of the policy. (This policy initiative related to a 2004 undertaking by DoCS that it would clarify policy and practice for responding to this particularly vulnerable group of young children.)

(3) In response to these recommendations, DoCS has not yet committed itself to actively tracking data about the use of SAAP by children under its care. However, we will be having further discussions with the department about this issue.

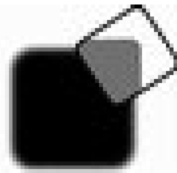
(4) DoCS has also advised that the policy on unaccompanied children in SAAP should be finalised by July 2008. Given the time which has already elapsed since the 2004 undertaking by DoCS to develop this policy, we are keen to see the policy finalised and we will monitor its rollout.

An investigation concerning the department's screening processes in relation to authorised carers - 2008

As a consequence of our concerns about the departmentøs systems for preventing and responding to allegations against departmental employees, we have recently initiated an investigation into the matter. The investigations will consider the adequacy of the departmentøs screening of authorised carers, its processes for handling information arising from the screening of authorised carers, the adequacy of its policies and procedures for the screening of authorised carers, and the adequacy of the departmentøs dissemination and application of these policies and procedures.

Bruce Barbour
NSW Ombudsman

Steve Kinmond
Community and Disability Services Commissioner (Deputy Ombudsman)



Special Commission of Inquiry
into Child Protection Services in NSW

Submission of NSW Ombudsman

Part 6: Assessment and Early Intervention and Prevention

12 May 2008

Ombudsman ref: ADM/6177

1. Introduction

This submission concerns the following Special Commission of Inquiry terms of reference:

ii. Management of reports, including the adequacy and efficiency of systems and processes for intake, assessment, prioritisation, investigation and decision-making;
iv. Recording of essential information and capacity to collate and utilise data about the child protection system to target resources efficiently;
v. Professional capacity and professional supervision of the casework and allied staff;
iii. Management of cases requiring ongoing work, including referrals for services and monitoring and supervision of families;
ix. The adequacy of resources in the child protection system.

The views expressed in the submission are based on our work in oversighting services for children and young people at risk of harm, in need of care and protection, or in statutory care.

The roles and responsibilities of the Ombudsman as they relate to child protection services in NSW are prescribed by the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (CS CRAMA) and the *Ombudsman Act 1974.*

Since 2003, following the amalgamation of the Community Services Commission into the Office of the Ombudsman, we have:

- conducted 73 investigations into 44 matters that have raised child protection issues;
- reviewed the deaths of 620 children and young people;
- conducted 12 group or service-based reviews of children in care;
- handled a significant number of complaints and inquiries related to child protection and out-of-home care services. In 2006/07, we dealt with 174 formal complaints about child protection services, and 137 about out-of-home care services; and
- conducted a number of inquiries and projects related to child protection and out-of-home care services, including services for children with disabilities and support for Aboriginal foster carers and non-Indigenous carers of Aboriginal children.

2. Assessment models and processes

The Risk of Harm Assessment Framework

In discussing the assessment framework, we note that it has two stages:

- initial assessment (carried out at the Helpline); and

- secondary assessment, carried out by local Community Service Centres (CSC) or Joint Investigative Response Teams (JIRT).[1]

Initial Assessment

Through our child protection reviews and investigations, we have made a number of observations about the process at the Helpline for obtaining information from, and conducting analysis of, information received from reporters. This initial assessment is intended to make an initial judgement about the level of risk and a timeframe for response to the child or young person the subject of the report.

From our work we have generally found that the Helpline assessments accurately reflect the level of risk associated with the concerns reported. However, our work has identified that, on occasions, there have been inadequate assessments of the level of risk, and delays in the transfer of reports from the Helpline to CSCs and JIRTs.

DoCSø 2006-07 data concerning referral of matters from the Helpline to the CSCs indicates the following:[2]

Total number of reports received by DoCS	**286,033**
Reports closed at the Helpline or referred elsewhere	31,464 (11%)
Reports forwarded to a CSC/JIRT as ÷info onlyø	51,486 (18%)
Reports forwarded to a CSC/JIRT for further assessment	200,223 (70%)

A particular issue highlighted through our work relates to the importance of accurate and thorough consideration of the previous child protection history of a family. Our work has consistently identified cases where there has been incomplete or inaccurate gathering and interpretation of such history. This includes:

- assessments that have failed to identify critical child protection issues, such as serious and chronic parental substance abuse or mental health issues; and
- assessments that have not accurately identified relevant links to previous incidents or familial relationships. In some cases, assessments have not uncovered the previous removal of children due to child protection concerns.

The adequacy of history checks has a direct impact on a caseworkerøs judgements about the level of risk to a child, and whether intervention to protect the child is necessary.

[1] We note that in some circumstances, such as when an urgent after business hours response is required, the Helpline Crisis Response Team can undertake secondary assessments.

[2] Note that the percentages in the table do not add up to 100%. However, the figures are based on data provided to the Special Commission by DoCS and reported in the Commissionøs Fact Sheet on Mandatory Reporting.

In identifying these particular issues and as noted above, in the majority of cases we have reviewed, initial assessments have accurately identified risk and made appropriate recommendations to CSCs and JIRTS. [3]

Furthermore, in recent years the Helpline, as a central intake unit, has been involved in a process of continual business improvement. We have referred to a number of these important quality improvement initiatives in our reviewable child death annual reports. For example, DoCS has introduced ÷rolling quality reviewsø of the Helpline in order to support the continual improvement of initial assessment practices. These reviews provide an opportunity to identify problems and develop strategies to improve the accuracy and consistency of initial assessments. The findings are used to improve training and supervision of Helpline staff.[4]

Despite the strengths of the initial risk assessment process at the Helpline, the need for holistic analyses of child protection histories by the Helpline will continue to remain a challenge as long as problems remain with the current reporting capacity of KiDS. In this regard, a root cause analysis conducted by the Helpline found that *'the current structure of KiDS did not make it easy for Helpline workers when conducting history checks.'* [5]

DoCS has advised us that these findings will inform the Business Process review of the Helpline and the KiDS Core Redesign projects. Later in this submission we will discuss further concerns relating to the KiDS system.

Secondary risk of harm assessment

In looking at secondary risk of harm assessments, it is important to distinguish the different types of action which can be taken. Reports which are referred from the Helpline for further assessment can be sent to either a CSC or JIRT.

JIRT

Through our child death review work and related investigations, we have raised a number of concerns about referrals to and from JIRT.

We have identified concerns about the need for more consistent practice in connection with DoCSø referral of reports indicating possible criminal offences to JIRT or police. In this regard, we have noted that there is some ambiguity in DoCSø policies and procedures about which matters should be referred to JIRT and/or police.[6] We have also raised concerns about the response by DoCS to matters that have not been taken up by JIRT: these concerns include matters that have been referred back to the CSC for a child protection response, but result in no further action.

[3] NSW Ombudsman, (2007) *Report of Reviewable Deaths in 2006, Volume 2: Child Deaths.* Page 46
[4] NSW Department of Community Services, correspondence to the Ombudsman, 31 July 2007.
[5] NSW Department of Community Services, correspondence to the Ombudsman, 20 February 2008.
[6] NSW Ombudsman (2005) *Report of Reviewable Deaths in 2004.* Page 63.

Based on these concerns, we have made the following recommendations to DoCS:

- That in those cases where JIRT rejects referrals, JIRT should clearly document the reasons for this decision, including details about any information that would be required to enable JIRT to take up the matter.
- That there is a need to clarify the types of reports that DoCS should refer to JIRT and/or police, including reports that raise allegations of criminal offences that are not covered by the JIRT criteria.
- That there is a need to ensure DoCS provides appropriate child protection responses for children who are the subject of reports referred to, but rejected by, JIRT. [7]

While we acknowledge that there has been a number of initiatives that have been designed to improve practice in this area (including a draft MOU between DoCS and Police; a new policy for case plans that are rejected by JIRT; and a joint review of JIRT by its three partner agencies), recent reviews we have carried out indicate that there are issues which warrant further attention.

CSC assessments

The types of responses which may be made by a CSC after a report is received from the Helpline include:

- the closure of a case based on an assessment that the report does not warrant further action;
- allocation for a secondary assessment stage 1 (SAS 1) ó this may involve seeking more information from the reporter, an agency or the family;
- following SAS 1, allocation for a secondary assessment stage 2 (SAS 2) ó this may involve discussions with agencies and other sources of information as well as face-to-face contact with the child and their family; and
- the closure of a case at any stage on the basis of competing priorities, regardless of whether the information at the time indicates that a child may be at risk of harm.

Data that DoCS has provided for 2006-07 provides a breakdown of these options:[8]

Total number of reports referred to a CSC/JIRT	**200,223 (70% of all reports)**
Reports closed without any assessment	77, 229 (27% of all reports)
Reports closed after limited additional inquiries (SAS1)	77, 229 (27% of all reports)
Reports that receive face-to-face contact (SAS2)	42, 906 (15% of all reports)

[7] NSW Ombudsman (2006) *Report of Reviewable Deaths in 2005.* Page vi.
[8] Note that the percentages in the table do not add up to 100%. However, the figures are based on data provided to the Special Commission by DoCS and reported in the Commissionøs Fact Sheet on Mandatory Reporting.

DoCS has a range of tools to assist staff in making risk assessments about a child. The assessment tools relating to initial assessments and secondary assessments (including õjudgements and decisionsö), when viewed as a whole, provide reasonably solid guidance about the issues which need to be considered as part of a thorough assessment. Furthermore, the department has provided its staff with other tools to assist their decision making in relation to particular types of matters. For example, DoCS is piloting a number of assessment tools specifically targeted at cases that raise child protection concerns in relation to neglect and parental substance abuse, including the Parental Drug and Alcohol Information Gathering Tool and the Hearth Tool.[9] Assessments can be conducted using these tools and the results can be incorporated into comprehensive secondary assessments. Following a 12-month trial, DoCS intends to evaluate these two assessment tools to determine their suitability for routine use by caseworkers.

The department ÷*has finalised its negotiations with the PSA on... Intake and Assessment Guidelines. DoCS will be implementing these guidelines commencing July 2008.'* [10]

Despite the benefits of these tools and policies, we believe that the current assessment practices have two significant weaknesses.

1. Poor application of risk assessment tools

Our work over the past five years has identified a number of issues relating to the quality of secondary assessments, including:

- Secondary assessments being unduly limited in scope. In a number of cases, we have found that secondary assessment was focused on specific events or issues that may have been referred to in a particular report, at the expense of assessing the circumstances of the child and their family in a holistic way. In some cases, we have found that action taken by the department has resolved immediate risks ó such as homelessness or safety in the context of domestic violence - but has failed to address the serious and ongoing chronic child protection concerns.
- The inadequate gathering and analysis of information to inform assessments. Sometimes, essential questions have not been asked, or necessary information has either not been sought or taken into account.
- Children not being sighted, or persons alleged to have caused harm, not being interviewed ó even in circumstances involving serious allegations.
- The assessment of multiple reports simply on an incident-by-incident basis without adequate recognition of the totality of those reports indicating escalating risk.

In our reviewable child death annual reports we provide further details of these types of practice problems.

[9] NSW Department of Community Services, correspondence to the Ombudsman, 27 February 2008.
[10] In correspondence of 27 February 2008, the department advised us that the Intake Assessment Guidelines are due to be rolled out in July 2008.

The department has sought to respond to these problems in a number of ways, including through policy and training initiatives. For example, over the last few years, the department has invested in specialised training in critical areas such as substance abuse and neglect. In 2006, the department also revised its secondary assessment procedures and completed a policy on neglect.

With the recruitment of a large number of new staff over the past five years, and the overhaul of its business practices, it was inevitable that the department would face significant challenges in delivering consistently high quality assessment decisions at the CSC level, at least in the short to medium term.

Given the challenges faced by the department in delivering quality services, we were keen to see the department implement measures to identify the degree to which practices were improving over time. For this reason, in our report of *Reviewable Deaths in 2004*, we recommended that:

> **DoCS' practice improvement strategies should incorporate a systemic performance audit of each CSC in NSW. Specific areas of consideration should include:**
>
> - **Efficiency of resource allocation.**
> - **Whether responses to Helpline recommendations adequately consider both recommended response time and initial assessment of risk level.**
> - **Whether secondary risk assessment practices reflect the requirement for holistic assessment.**
> - **Whether other agencies are being effectively engaged in risk assessment and response to confirmed risk of harm.**
> - **The degree to which secondary assessments result in judgements and decisions.**
> - **The overall adequacy of secondary assessment reports and judgements and decisions.**
> - **The overall adequacy of case plans, and their implementation, where risk of harm is substantiated.**
> - **Case closure decisions, including the basis for decisions.**[11]

The department has recognised quality as a critical issue. In response, over the past few years it has been developing a quality assurance program that aims to measure performance in relation to a number of key business areas. As the department continues to roll out this program, it will be important to establish how well it is able to be used as a tool to improve assessment and other key business practices.

[11] NSW Ombudsman, *Report of Reviewable Deaths in 2004,* Page 96

2. Weaknesses associated with current resource capacity

It is important to understand the relationship between the capacity of DoCS to obtain the necessary information to conduct thorough risk assessments and the adequacy of the assessments carried out.

While we are of the view that DoCSø current assessment tools are potentially useful, a fundamental problem is that, for many matters requiring a comprehensive assessment, such an assessment is not able to be undertaken because of resource constraints. DoCSø own data, referred to above, demonstrates the small number of matters which result in face-to-face contact ó the implications of this from an assessment perspective are obvious. For the relatively small number of matters which get to the õjudgements and decisionsö stage of DoCSø secondary assessment tool, a practitioner should be in a position to make a well founded assessment. However, it is simply not practical, under the resources of the current system, for many matters warranting this kind of thorough assessment to receive one. Instead, there are a very large number of matters which are closed at various stages within the current assessment framework, not on the basis of a determination that the matter warrants closure or that there is no ongoing risk, but rather on the basis of ÷current competing prioritiesø. This issue presents one of the greatest challenges for this state in achieving a strong child protection system.

What needs to be recognised about many of the cases closed on the grounds of ÷competing prioritiesø is that they may still be matters relating to significant risk to a child at the time the decision is taken for the department to take no further action.

Since the commencement of our review and investigative work relating to the child protection system, we have expressed concerns about this issue. For example, in our *Reviewable Deaths Annual Report 2003-2004* we recommended that:

> **A key principle in child protection intervention should be that where a report raises issues of safety of a child, or a failure to adequately provide for a child's basic physical or emotional needs, it should not be closed until adequate steps have been taken to resolve the issues. In this context, DoCS should work towards a framework for case closure that includes a risk threshold above which cases should not be closed without protective intervention.**[12]

It is clear that this recommendation caused some difficulties in our relationship with the department. For example, in correspondence from the departmentøs then Director-General to the Ombudsman of 19 September 2007, the Director General said that this recommendation has ÷continued to be controversialø.

[12] NSW Ombudsman, *Reviewable Deaths Annual Report 2003-2004,* Page 67.

The department has taken the position that all child protection systems require *'procedures to assist the agency to manage service demand when demand for assessment and casework services exceeds organisational capacity.'*[13] In this regard, we support the departmentøs position.

However, it is critical that our child protection system should strive to meet the principle outlined in our recommendation.

More recently, we have focused our resource-related recommendations on the department developing measures to report accurately on its capacity to meet demand. For example, in our 2006 reviewable child death annual report we recommended that the department develop the capacity in KiDS to enable the collection of, and reporting on, data (including cases closed due to competing priorities).[14]

We also recommended that DoCS should advise the Ombudsman of the way in which it intended to measure improvements resulting from the reform initiatives. (In correspondence of 19 September 2007, the departmentøs then Director General noted that this was ÷surely a matter for accountability to Government rather than accountability to the Ombudsmanø).

Notwithstanding the then Director Generaløs views, in last yearøs reviewable child death annual report we made the following recommendation:

> **DoCS should develop the capacity to report on the number and proportion of child protection reports in which assessments and inquiries are not able to be commenced or completed due to resource constraints (as opposed to the evidence warranting further action).** [15]

A fundamental problem with assessment is that decisions to close cases on the basis of ÷competing prioritiesø are not made within a framework that provides adequate guidance to decision makers. This lack of adequate guidance exists in an environment in which staff are being constantly required to make extremely difficult judgements about the closure of certain high risk matters over others. Therefore, while we would support the current risk assessment framework if it were the case that the vast majority of matters warranting a full secondary assessment were able to receive one, this is simply not available under the current system. Instead, as we have noted, decisions to close certain high risk matters over others are being made by case workers in high volume, high pressure environments without a sophisticated tool to help them determine the relative risks between matters.

The department has sought to assist its staff when making these very difficult decisions by refining its case closure policy. Despite a number of amendments to this policy over

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[13] Department of Community Services, correspondence to the Ombudsman, 21 February 2005.
[14] NSW Ombudsman, *Report of Reviewable Deaths in 2005, Volume 2: Child Deaths.* Page VIII
[15] NSW Ombudsman, *Report of Reviewable Deaths in 2006, Volume 2: Child Deaths.* Page VIII

recent years, the situation remains that cases which involve high levels of risk can be closed on the basis of ÷competing prioritiesø

In our report of *Reviewable Deaths in 2004,* we recommended that DoCS should give priority to allocating for secondary assessment those reports referred to a CSC or JIRT for further assessment, where:

- A risk of harm report is made for a child living in a family where a sibling has been previously removed by an order of the Childrenøs Court.
- A pre-natal report is made concerning an unborn baby and the baby is born into a family where a child has been previously removed by an order of the Childrenøs Court.[16]

In response, DoCS advised us in 2006 that it would add the previous removal of a sibling to the amendments it was proposing to make to its Intake Assessment Guidelines.[17] As previously noted, in February 2008, the department advised that it expects to begin implementing the guidelines in July 2008**.**[18] In relation to these amended guidelines, the department has also identified a range of other additional risk factors that would warrant a case being given priority for a SAS 1 assessment. However, these proposed amendments to the guidelines will not provide any guarantee that cases meeting the amended criteria will receive a secondary assessment, as they will still be able to be closed due to competing priorities.

Therefore**,** although the Intake Assessment Guidelines do provide an important tool for promoting more consistent assessment and allocation decisions, they do not deal with the problems that we have outlined relating to case closure.

While this policy work is important, it is unlikely to adequately resolve the fundamental difficulties associated with DoCS caseworkers having to make extremely difficult judgements about which high risk cases should be pursued over others. For this reason, we believe that it is appropriate to consider the adoption of a structured decision making assessment tool of the kind which the department has proposed in its submission to the Commission. Support for such a tool can be found in the argument that it may provide caseworkers, particularly those at the Helpline, with much greater clarity in relation to making assessments about the relative risk of certain matters over others.

A separate but related question is whether the guidance provided by the tool would lead to better decision making.

On this point, we note the lack of evidence provided by the department in its submission to the Commission regarding the effectiveness of the tool in guiding assessment decisions. We also note the evidence provided by Dr Leah Bromfield before the Commission in which she stated that there is a very limited independent evidence base

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[16] NSW Ombudsman, *Report of Reviewable Deaths in 2004,* page 96
[17] NSW Department of Community Services, correspondence dated 27 July 2006
[18] NSW Department of Community Services, correspondence dated 27 February 2008

against which to assess the effectiveness of structured decision making (SDM).[19] Dr Bromfield also indicated that preliminary results of an evaluation by Deakin University into the implementation of SDM in Queensland suggest that overall, *'…it did not promote consistency in decision making.'* [20]

In these circumstances, we would favour an initial trial of the tool to ascertain whether it improves assessments, and addresses some of the fundamental weaknesses associated with the current assessment system. We also believe that there should be a considered analysis of the results of Deakin Universityøs evaluation of the tool.

Better assessments through the use of intelligence

Over recent years, the department has been undertaking significant work in relation to analysing the frequency and nature of the reports it receives. For example, the departmentøs data indicates that 11 percent of sibling groups generate close to 50 percent of the total reports received by the department. In this regard, DoCSø research has shown that in 2005-06, fifty percent of the 241,003 risk of harm reports made to DoCS related to around 7,200 sibling groups. [21]

We are also aware of research the department has undertaken in relation to re-reporting rates for Aboriginal children, as well as other work around the characteristics of particular types of reports. This type of analysis can be beneficial from both a policy and practice perspective.

However, while we understand that local CSCs will have some idea as to the high risk families within their area, there is nothing in place to ensure that there is a systematic collection and analysis of the information obtained from child protection reports to identify these families. The departmentøs own research demonstrates why it is essential that each CSC is fully aware of the relatively small percentage of families within their area who generate approximately half of the reports received.

By way of contrast, it is worthwhile considering the policing profession. Like DoCS, police receive hundreds of thousands of reports each year. Police data also demonstrates that there are a limited number of individuals and sub groups within our community who commit most of the crimes.

Over the past 10 ó 15 years, the policing profession has changed dramatically in terms of how it carries out its business of crime reduction and prevention. Increasingly, police have used their information holdings to drive their operational practice.

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[19] Dr Leah Bromfield, transcript of public forum on assessment models and processes. Page 56.
[20] Ibid. Page 57.
[21] Data reported in a presentation to the Australasian Conference on Child Abuse and Neglect, *Breaking Down the Barriers between Prevention, Early Intervention and Child Protection,* 31 October to 2 November 2007.

In particular, the police use their information systems to assist in identifying patterns of criminal activity and the high risk offenders who are behind much of this activity. From the corporate level down to the local level, the data is analysed and then applied to inform the deployment of police resources.

If we take domestic violence matters as an example, police use their data holdings to develop profiles of both high risk offenders and high risk victims. Informed by these profiles, police can then make ÷evidence basedø decisions about which matters should be prioritised, and what kinds of crime prevention strategies should be employed.

This shift by police towards a much more sophisticated intelligence based practice provides a blue-print for DoCS. Some of the excellent data analysis which DoCS has already carried out supports this proposition.

Such practice would allow the department to better utilise the vast amount of information it receives to make more informed decisions about those who are most in need of support. Intelligence driven child protection practice would also allow better identification of many of those families who require a coordinated interagency response.

In order to develop intelligence based practice, the department would need to provide its frontline staff with the capacity to run reports which identify families subject to multiple reports. A further prerequisite for the development of more intelligence based practice would involve providing frontline staff with the reporting tools that provide real time, consolidated child protection history reports. On this issue, we would note that, as an organisation with an operating budget of around $22 million, the Ombudsmanøs IT system can quickly provide us with consolidated police officer histories which draw on data holdings from five separate police databases.

Given that DoCS is projected to receive around 300,000 risk of harm reports this financial year, and that holistic assessments are integral to effective child protection practice, it is essential that the department be provided with the necessary funding to enhance the utility of its information system in this way. Under the current KiDS system, for a user to apprise themselves of a familyøs child protection history, they may need to spend hours navigating their way through numerous data fields. We note that the departmentøs submission, refers to the development of its Corporate Data Warehouse. For the reasons we have outlined, we fully support this initiative, as it has the potential to provide the department with substantially enhanced reporting capacity.

However, in discussing intelligence based practice, it is important to also recognise that possessing the necessary IT capacity represents only one component of this type of practice. The other elements concern the need for ongoing sophisticated analysis of information holdings, and the ability to translate this analysis into well informed decisions about which families are most in need of a response and the nature of the response which should be provided. For these essential elements to be embedded in practice requires:

1. a sound intelligence policy framework;
2. structural and governance arrangements capable of driving the departmentøs intelligence practices, particularly at the corporate and local CSC levels; and
3. skilled staff at the corporate and local level dedicated to use and develop the departmentøs intelligence practices.

Finally, in supporting this move towards intelligence driven child protection practice, we would argue that this should occur regardless of which particular risk assessment framework the department ultimately adopts.

3. Expanding service capacity and early intervention and prevention.

Even if the department is able to strengthen its assessment practices and adopt sophisticated intelligence based practices, it will not be able to meet demand. For this reason, we support the departmentøs view that there is a need to expand service capacity.

We also support the departmentøs view that NSW would benefit from a differential system for responding to risk of harm reports. There will always be reports that require a forensic investigative approach by the department. However, for many reports, the best response will be one that is focused on providing support. With these matters, there is considerable scope for the non-government sector to play an expanded role over time.

DoCSø submission to the Commission, divides the reports it receives into three categories:

- Level A refers to children with identified support needs, but not necessarily at risk of harm. DoCS estimate that this group of children currently represents around 25 ó 35 percent of all children and young people reported to the department each year.
- Level B refers to children and young people who enter the child protection system and are generally the subject of multiple reports, often over a long period of time. Reports of this kind indicate the presence of chronic, unresolved child protection concerns for these children and their families. DoCS estimates that this group comprises approximately 45 ó 60 percent of children currently in the system.
- Level C refers to those children and young people who require an immediate forensic investigatory response to protect them from abuse and/or neglect. The department estimates that approximately 10-20 percent of children in the system currently fall into this category.

There is merit in conceptualising the reports that the Department receives in this way. However, in saying this, it is important to acknowledge that there is a certain artificiality in any conceptual construct of this type. The departmentøs figures regarding the percentage of matters which would fall into the three different categories should only be viewed as broad estimates. For this reason, any future system would need to test the

accuracy of these estimates and have the flexibility to adjust the service mix should this be required.

The departmentøs proposed system keeps the Helpline as the hub of all reports received. By way of contrast, we note that the Victorian system has a dual reporting scheme. In Victoria, child protection notifications are made to the department and child wellbeing reports are made to regional centres, known as Family Information and Referral Support Teams. These regional teams are principally staffed by non-government employees, although departmental child protection workers to assist in the assessment of child wellbeing reports.

We support maintaining the Helpline as the central intake point for all reports because it provides a reasonably high quality service that produces a level of consistency in the initial assessment of reports.

What the departmentøs submission seeks to both acknowledge and address, is the position that we have been strongly arguing for some time, that there are a large number of reports involving vulnerable families which receive no significant response.

To illustrate the capacity constraints of the current system, it is worthwhile to consider the limited reach of the Brighter Futures program. Our work has highlighted a number of cases in which families have been referred to Brighter Futures but were rejected from entering the program on the basis that the presenting risks were too serious. However, when these cases were referred back to child protection, they were closed by the department on the basis of competing priorities.

These cases highlight a service gap involving matters deemed too low a risk for a child protection response and too high a risk for the Brighter Futures program. While we acknowledge the existence of other programs, services within these programs are generally not well placed to adequately support these higher risk families.[22]

It is also of concern that, in a matter we are currently investigating, a large family support service that is not a part of the Brighter Futures program, referred to a significant increase in the number of high risk families that have been referred to them since the commencement of Brighter Futures. In a subsequent discussion with Family Services Inc, that agency, as the peak body for family support services, confirmed that other family support services were experiencing a similar trend. In connection with a complaint handling review of Family Support Services that we conducted last year, a number of the services also expressed similar concerns.[23]

[22] For example, there are a range of universal and targeted services which can potentially provide some support to high risk children and their families: including those funded under Families NSW, Better Futures, the Aboriginal Child, Youth and Family Strategy, the Area Assistance Scheme and the Community Services Grants Program (CSGP).

[23] NSW Ombudsman (2007), Family support services complaint handling review.

Furthermore, while the current system does have a number of intensive family based services (IFBS), the numbers of these services are so small that only a limited number of these higher risk families can be supported by them. By contrast, Victoria has a more comprehensive range of these services.

Our concerns around the limitations of the current system to meet this area of unmet need led to us making the following recommendation in last yearøs child death annual report:

> **The DoCS evaluation of the child protection program under the Child Protection Major Project should include a component to consider referrals to the Brighter Futures program that are subsequently deemed ineligible due to high risk. The evaluation should consider:**
> - **The nature of reports referred to Brighter Futures that are subsequently deemed ineligible due to high risk**
> - **The nature of response by DoCS to these reports and outcomes for the child and family**

In response to this recommendation, in February 2008 DoCS advised us that they are *'focusing on better identification and targeting of high risk children and families for appropriate intervention and services, through the Child Protection Major Project. Also, the Special Commission of Inquiry into Child Protection Services in NSW will contribute to DoCS planned improvements.'* The department further advised that *'when DoCS develops an evaluation framework for the child protection program, the response to children and families who are not accepted into Brighter Futures may be considered, if appropriate.'* [24]

Given the lack of specific details provided by DoCS in response to our recommendation, we have arranged to meet with the Department to discuss this and other matters. However, upon reading the departmentøs submission to the Commission, it was pleasing to note that the department has acknowledged the need for service expansion.

Challenges of service expansion

Having noted our general support for the departmentøs proposals around service expansion, it is also important to acknowledge a number of the challenges that will need to be faced.

One of the most important challenges concerns identifying which types of services will be best suited to responding to the areas of greatest need.

Related to this challenge is the need to avoid the õpendulum effectö. In this regard, we recognise the ongoing debate around whether the pendulum should now swing towards building universal and targeted support services to vulnerable families, over further investment in strengthening the Stateøs forensic investigative response to child protection. From our work, we are convinced that a system that does not seek to strengthen both

[24] Correspondence from Dr Neil Shepherd, Director-General. Dated 27 February 2008.

approaches will be fundamentally flawed. This view has been stated elsewhere, for example, during the key note presentation by Dr Michael Little, Research Director at Dartington Social Research Unit, UK, at the Australasian Conference on Child Abuse and Neglect, on 31 October 2007.

On the other hand, it is important to acknowledge that public reports of child abuse, particularly those involving serious abuse and/or deaths, often result in calls to examine whether DoCS, or some other agency, may have failed to take action to protect a child. In turn, the public policy response, tends to focus on providing DoCS, and other agencies, with more powers and resources to investigate and take action ÷to protect childrenø While these narrowly focused responses are understandable, there is a real risk that, over time, investment in õchild protectionö can tend to become narrowly focused and lead to an over emphasis on the investigative forensic side of the issue and an under emphasis on the early intervention and prevention side. For this reason, it is positive that the Commissionøs terms of reference allows scope for considering the need for broadening service capacity in this critical area of early intervention and prevention.

Over recent years, the department has undertaken significant research into the most effective types of early intervention and prevention programs.

What emerges from the research is evidence supporting programs that can target the needs of vulnerable families by providing a comprehensive and multi-layered response. By contrast, programs which are limited in their focus, and in the services they provide, have often been found to be of limited benefit. For example, research into occasional home visiting suggests that these programs produce only limited benefits. However, when combined with other services ó such as child care, parenting programs, supported playgroups ó and delivered in a planned and integrated fashion, the evidence suggests better outcomes.[25]

An illustration of this general principle would appear to be the Aboriginal Maternal and Infant Health Strategy (AMIHS). This program targets a particularly vulnerable group in our community by coordinating a range of services for Aboriginal women during pregnancy and in the early weeks after birth. Teams of midwives, and Aboriginal health workers work with GPs and specialists to provide community based care; antenatal and postnatal education; social and emotional support; and referral to community services. The teams also provide home visiting and transport services.
Clearly, a strength of the program lies with the broad range of services provided in a coordinated way in recognition of the disparate needs of the service receivers. In this regard, we note the recent evaluation of the strategy which found a significant reduction

[25] See for example, Sweet, MA & Applebaum, MI (2004). Is home-visiting an effective strategy? A meta-analytic review of home-visiting programs for families with young children. *Child Development,* 75(5), 1435-1456; Reynolds AJ, (2004). Research on early childhood intervfentions in the confirmatory mode. *Children and Youth Services Review,* 26: 1- 14; Gomby, D., Culross, P., & Behrman, R. (1999) ÷Home Visiting: Recent Program Evaluations- Analysis and Recommendations,ø*The Future of Children, 9(1).*

in the number of babies born preterm. Other positive findings include that significantly more women received antenatal care and were choosing to breastfeed their babies.[26]

What is pleasing to note is that in April 2007, DoCS and NSW Health entered a partnership to link Aboriginal children and families more effectively with existing prevention and early intervention programs. Under this partnership, Aboriginal families will have streamlined access to the Brighter Futures program. Again, this step is consistent with the research literature that points to the benefits of multi-layered strategies and ongoing comprehensive support, particularly for those most vulnerable. With Aboriginal child deaths representing around 20% of the child deaths that we review each year, and with around 70% of Aboriginal child deaths occurring within the first 12 months of a childøs life, we are encouraged by both the results of the evaluation and the plans to expand this initiative.

Through our review of the literature and our direct knowledge of services provided, we have also noted the growth of those services seeking to adopt the principles behind the Pathways to Prevention model. A core element of this model is the need for comprehensive and multi-layered responses when addressing the needs of vulnerable children and their families.[27]

In particular, programs that replicate the Pathways to Prevention model take a developmental perspective in relation to children and young people that focuses on the nature and timing of interventions in connection with key transition periods in a childøs life.[28] In particular, Pathways programs seek to involve targeted and universal services working together in a planned way to support children and young people in negotiating critical transition points in their lives. [29]

Some of these key principles have also been highlighted in research which DoCS has carried out into child care. DoCSø research has shown that high quality child care is a successful intervention for improving child outcomes, including significantly enhancing the prospects of vulnerable children commencing school on a more equal footing with their peers.[30] Given that entry to primary school is a critical transition point for a child, it is not surprising that high quality childcare which addresses initial disadvantage, including those associated with early learnings, has been shown to be of benefit. Also consistent with the Pathways principles, is DoCSø finding that the positive effects of high quality childcare are further enhanced by the provision of other targeted services; such as

[26] NSW Health (2006). Evaluation of Aboriginal Maternal and Infant Health Strategy.
[27] A major federally funded project conducted by the Attorney Generaløs department looked at ÷pathwaysø in the context of crime prevention ó its conclusions however, are broadly relevant to child protection. For a general overview of the developmental perspective underlying the principle of intervention at key transition points, refer to the report by the National Anti-Crime Strategy(1999) *Pathways to Prevention: Development and early intervention approaches to crime in Australia.* National Crime Prevention, Attorney-Generaløs Department: Canberra.
[28] Ibid.
[29] Homel, R (2004) ÷The *Pathways to Prevention Project:* One model for working in disadvantaged communities throughout Australiaø, Griffith University, page 7.
[30] NSW Department of Community Services (2005) *Prevention and Early Intervention Literature Review.*

home visiting and parent education programs. This finding is consistent with other research which emphasises the importance of programs which can address the circumstances of the child and their family within a broader community context.

In terms of maximising the capacity of early intervention and prevention work within this state, a further challenge which needs to be addressed relates to the current situation in which we have a range of federally and state funded initiatives targeting vulnerable families. For example, there are various Commonwealth programs which seek to support families and/or have a strong õchild protectionö focus. Some of the services caught by the different program streams include:

- A broad range of services provided under the Communities for Children Program stream.[31]
- Family relationship services such as counselling and the provision of advice and referrals to families in need of support.
- Parenting education programs such as the Responding Early Assisting Children (REACh) program. REACh has an emphasis on promoting successful transitions through key periods in the lives of vulnerable children and young people.
- Early intervention services to young people and families experiencing conflict; for example, the Reconnect Program which aims to link young people who are homeless, or at risk of becoming homeless, with appropriate support services.
- Intensive support playgroups aimed at assisting vulnerable families with multiple needs who often face a range of social, economic and other challenges. A 2007 Federal Budget initiative to expand supported playgroup services to vulnerable indigenous families in remote areas has provided an addition $13.8 million over four years to the playgroup program.
- Strengthening community based early childhood programs and resources, for example, the Child Care Links initiative uses child care centres in disadvantaged areas as community õhubsö to link families to local support services and to strengthen existing community networks.

This list of federal initiatives does not include a range of other universal and targeted programs (in areas such as domestic violence, substance abuse and mental health) that are also relevant to vulnerable children and their families.

In addition to these federal programs there is also an array of local government initiatives which are relevant to this area of early intervention and prevention.

In noting these programs, it is important to acknowledge both the strengths and potential weaknesses of a system which involves such a diverse range of government and non-government service types. One of the potential strengths of the diversity of these services is that they can reflect the diversity of the local communities they are seeking to serve. The benefits of diversity and flexibility of service types can be particularly evident in the

[31] We note that the Communities for Children program stream is only one of the streams linked to the Stronger Families and Communities Strategy.

case of locally generated initiatives. However, diversity and flexibility can come at a cost. To illustrate this, it is interesting to note the 2001 Prime Ministerøs Youth Pathways Action Plan Taskforce report, Footprints to the Future which noted that there were more than 500 different youth programs in Australia that were often ÷*so fragmented that conflicting objectives are being pursued, resources are being wasted and…many young people are receiving only partial support and some are slipping through the cracks altogether.'*[32]

We would argue that the findings from this report are relevant to the field of ÷child protectionø generally. In our opinion, it would be desirable for there to be a close alignment, at least at the State and Federal level, in the core elements of the early intervention and prevention programs supported by both levels of government. In order to achieve this, it would require a cooperative approach in the planning, funding and delivery of programs. Having said this, it is important to acknowledge work that has been carried out over recent years to improve State/Federal planning in this area. For example, there is general consistency in the objectives relating to children in the NSW State Plan, and the Council of Australian Governmentøs (COAG) desired outcomes for children outlined in its National Reform Agenda.[33]

If a closer alignment can be achieved over time, it is likely to result in more efficient use of the resources that can be employed to address family vulnerability. However, in suggesting a joint approach to the core elements of these programs, we are not advocating for conformity and uniformity of programs. To do so, would ignore the need for innovation and flexibility in program delivery, particularly at the local level, to meet the needs of the varied communities across the state.

A further challenge associated with DoCSø proposal for significant expansion of early intervention and prevention services, would be the need for the NGO sector, in particular, to recruit sufficient numbers of adequately qualified staff to perform this important work. On this issue, we note that the system which is now established in Victoria has come about as a result of years of service development.

Apart from the issue of recruiting sufficient numbers of qualified staff, there will be the need to establish excellent and efficient working arrangements between the department, other government agencies and the NGO sector. In this context, it is worthwhile considering emerging issues around the roll out of the Brighter Futures program.

Rolling out Brighter Futures was always going to involve some õteething problemsö. Initial feedback that we have received from certain agencies within the NGO sector suggests a number of practical issues around referrals from DoCS to their NGO partners. For example, one of the larger NGO agencies has raised with us the fact that the number

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[32] Prime Ministerøs Youth Pathways Action Plan Taskforce report, (2001) *Footprints to the Future.* Page 8.
[33] NSW Government State Plan (2006) State Plan ó A new direction for NSW; refer to Council of Australian Governments, *Communiqué,* for details about the Human Capital Project of the National Reform Agenda, accessed from http://www.coag.gov.au

of DoCS referrals they have received to date is much lower than expected. This raises questions about whether the referral process is as streamlined and efficient as it could be.

A separate issue relates to the role of the DoCS early intervention workers. In particular, some non-government agencies have expressed concerns over whether these positions are being employed in a way that enhances the efficiency of the program. For example, we have been advised by services that the referral practices between DoCS and NGO agencies could be improved. In this respect, agencies have indicated a lower than expected referral rate from DoCS. We note that similar concerns were put before the Commission by a Barnados representative at the public forum on Assessment Models and Processes.[34]

While these kinds of issues will no doubt be worked through over time, they highlight the need to identify, and to minimise, as many of the potential structural impediments as possible up front to avoid problems down stream. For this reason, DoCSø discussion in its submission to the Commission around the need for better referral processes and a carefully planned change management strategy.

A further issue that will need to be addressed regardless of whether DoCSø proposals are adopted, relates to the exchange of information between both the government and non-government sector. As the repository of all child protection reports, DoCS needs to ensure that the NGO agencies providing supports to vulnerable families have available to them the information they require. In relation to the NGO sector, it needs to develop a very clear understanding of the type of information it requires. Services within the NGO sector also have to ensure that they have well established and consistent practices regarding those circumstances in which information will need to be provided back to the department, or to some other agency, for the purpose of protecting a childøs safety.

Related to this issue, will be the challenge for the NGO sector in properly resolving circumstances in which it may be critical to shift its response from supporting a family to playing a role more akin to a forensic investigative approach. While it could be asserted that this role should only reside with DoCS, the reality is that greater involvement by the NGO sector with high risk families will mean that certain NGO service providers will increasingly have to be prepared to move from a strong support focus to one which involves the careful collection of evidence for the purpose of placing critical information before the department as part of consideration of whether care proceedings should be initiated. This shift in practice would not only bring with it a skills challenge for certain services; it will also present a significant cultural challenge.

This issue is connected to what future role DoCS and other government agencies should play in directly providing and/or funding support services. The views expressed in our Out of Home Care Submission are apposite in this regard.

[34] Ms Hamill, Barnados, Special Commission of Inquiry Transcript of Public Forum on Assessment Models and Processes. Page 49.

Conclusion

Clearly, there will be a greater burden shared by the NGO sector for responding to children at risk of harm in this state if DoCSøproposed vision is adopted. Whether this shift in responsibility is desirable will depend on how some of the challenges we have outlined are met. There is a risk that, if they are not responded to effectively, then the outcome will be a weaker system for protecting children. On the other hand, if the associated challenges can be met in a way that allows sufficient time to build the necessary NGO service capacity and the related partnership with the department and other key government agencies, there would appear to be considerable scope to improve child protection in NSW.

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NSW Ombudsman

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Community and Disability Services Commissioner (Deputy Ombudsman)

Wood Special Commission of Inquiry
into Child Protection Services in NSW

Submission of NSW Ombudsman

Part 7: Young people at risk

26 May 2008

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A. Terms of reference and focus on young people at risk

This submission focuses on the adequacy of arrangements specifically for at risk young people, having regard to concerns raised by the Commissioner as to a possible gap in services for adolescents, particularly homeless adolescents, and whether any oversight agencies are reporting on this problem.

During one of the forums held by the inquiry the Commissioner said:

> **There are a couple of areas which seem to me at the moment to be areas to be aware of where there is a gap in service. I'm not quite sure who is looking at that or reporting on it… but the first of those is a situation of adolescents, some of whom have been in care, others of whom should probably be in care but who are homeless. From what we hear around the country, the services, the refuges or the residences… for these people are substantially lacking.**[1]

At the outset, we should note that while we have had an ongoing interest in this area, we do not profess to know the answers. However, we make some broad observations about key practice issues at the end of this submission.

B. Introduction

Adolescence is a risky period. It is a time when people tend to take greater risks, and be more impulsive and less considered in making decisions. It is a time where people have increased opportunity to make dangerous decisions.

Adolescence can also be a period of emotional vulnerability. Feelings of insecurity and uncertainty are common as people transition from childhood dependency to adult independence.

During this period, individuals can remain at risk from issues such as family violence, neglect and parental substance abuse, but additional risks can be posed by their own mental health and their behaviour.[2] For agencies working with adolescents, an additional challenge is that young people may decline the assistance offered, making it difficult to respond to risk.

Over recent years a number of reviews have been undertaken, at both State and Federal levels, looking into how our society currently supports young people who are particularly vulnerable. The National Youth Commissionøs April 2008 report into *Australia's Homeless Youth* and the NSW Commission for Children and Young Peopleøs report of January 2003 (outlining their research into the deaths of 187 people aged 12-17 years, who died from suicide or risk-taking behaviour) are but two examples.

This office has undertaken a significant number of investigations, reviews, audits and projects that focus on services and systems that are responsible, in some way, for supporting young people who are particularly vulnerable.

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[1] Forum ó Oversight Agencies, Transcript of proceedings, 28 March 2008, page 33

[2] McDonald, J., & Hayes, L. (2001) ÷Strengthening welfare services for young peopleø *Youth Studies Australia*, 20(1); Australian Institute of Criminology (2002) ÷Pathways from child maltreatment to juvenile offendingø *Trends and Issues*, No. 241.

Our work has identified a number of subgroups of particularly vulnerable young people, for whom service delivery continues to be an issue, including:

- those who commit criminal offences
- those who are the victims of crime or other abuse
- those who are addicted to illegal substances
- those with mental health conditions including depression
- those with a disability
- those who are not living in stable accommodation
- those who are not regularly attending school
- those in out of home care who have significant emotional and behavioural problems.

In most cases, particularly vulnerable young people fall into more than one of these subgroup categories.

C. The role of the Ombudsman

The Ombudsman has a wide range of functions, with jurisdiction over both government and non-government agencies. This gives the office a level of awareness of a number of the services available to young people, particularly those who are vulnerable. Currently we perform our functions under more than 20 pieces of legislation. Of those, the critical Acts are:

- *Ombudsman Act 1974*
- *Community Services (Complaints, Reviews and Monitoring) Act 1993 No 2* (CS CRAMA)
- *Police Act 1990.*

The role and responsibilities of the Ombudsman as they specifically relate to child protection services were outlined in detail in Part 2 of our submission to the Wood Commission, on Oversight Agencies.

Through these Acts we oversee the work of the following agencies, which may, at some stage in a young personøs life, provide them with services or have a duty of care towards them:

- The Department of Community Services (DoCS)
- NSW Police
- The Department of Juvenile Justice
- Agencies from the non-government sector that provide services to young people, such as mental health support, accommodation, recreational activities, counselling, mentoring services, emergency assistance and emergency accommodation (eg SAAP)
- The Department of Education and Training
- Public, private and independent schools
- The Department of Health
- The Department of Housing
- The Department of Ageing Disability and Home Care.

D. The work of the Ombudsman in this area and observations

Part 2 of our submission to the Wood Commission, on Oversight Agencies, provides a summary of the work we have carried out in relation to child protection services since 2003, and some of the outcomes of that work.

Three of our specific functions under CS CRAMA, that are relevant to this submission, are:
(a) To review the deaths of certain children and people with a disability (Part 6)
(b) To review the situation of a group of children in care (section 13), and
(c) To monitor and review the delivery of community services, and inquire into matters affecting service providers and consumers (section 11).

In this document we outline some of the work we have carried out and are currently undertaking in relation to young people at risk.

1. Reviews of deaths of young people and associated investigations

As to the whole spectrum of high-risk activities by young people that can lead to death, in January 2003, the NSW Commissioner for Children and Young People, handed down a report based on research relating to 187 young people aged 12-17 who died in NSW from suicide and risk taking behaviour during the period January 1996 to December 2000.[3]

In terms of the ÷at riskø profile of these young people prior to their deaths, the Commission found particular risk indicators such as:

- low year 12 completion rates
- high rates of drug use, particularly among those who died from risk taking behaviours
- high rates of offences among those who died from risk-taking behaviours
- a much higher than average rate of this group not living with intact biological families.

Our statutory role in reviewing the deaths of children and young people generally focuses on those whom the child protection system endeavours to protect. We aim to identify shortcomings in agency systems or practice that may have directly or indirectly contributed to a childøs death, and make recommendations to prevent and reduce the risk of deaths in the future. The vast majority of our reviews have involved children and young people who have been notified to agencies within the child protection system as being at risk. (Please see Part 2 of our submission to the Wood Commission, on Oversight Agencies, for more detail about our child death review work generally.)

Since commencing this function we have reviewed 21% of all child and youth deaths in the state. Over 100 deaths fall within our jurisdiction annually.

[3] NSW Commission for Children and Young People, *Suicide and risk-taking deaths of children and young people* (2003)

In 2007 we analysed the cause of death for 496 children and young people reviewed between 2003 to 2006.[4] Of this group 87 were young people between the ages of 13 to 17 years. In 69% of cases, the young person died from their own actions or in a motor vehicle accident (26% committed suicide, 21% died in motor vehicles accidents and a further 22% died from causes relating to other risk taking behaviour).

Over the past four years we have identified a number of key issues and subsequent challenges for agencies working with these young people, particularly those engaging in high risk taking behaviour, or with mental health problems. These include:

1. *Early intervention*

Some of the young people who died had been known to various agencies since childhood. Our review of a number of these matters raised issues about the adequacy of early intervention in their lives.

As an example, in one matter we handled concerning 10 and 12 year old siblings, one sibling had been the subject of 79 risk of harm reports and the other, 58. The reports included allegations that the children had been assaulted and their basic needs were not being met. There was some response to some of the earlier reports, but over a six year period, every one of the 60 reports received during that time about the children was closed without allocation for secondary risk of harm assessment. Following our involvement DoCS recognised the need to look at the history of neglect and to provide a comprehensive response to the needs of these children as they approached adolescence.

In another case involving a family with five children, there had been 27 risk of harm reports about the children which, when seen in totality, outlined a pattern of ongoing parental neglect, domestic violence, drug and alcohol abuse, truancy and juvenile offending. The family lived in a disadvantaged area characterised by long term unemployment, poverty, poor education levels, a high incidence of public housing and a range of social problems. Despite being known to a number of agencies, no steps were taken early in the childrenøs lives to provide the specific support services this family needed. The case came to our attention after one of the children, 16 years old, died while driving a stolen car being chased by police.

2. *Interagency coordination*

In many of the cases we have handled where young people were reported to be at risk and were engaging in risk taking behaviour, there did not appear to be effective interagency coordination. For example, in an investigation following the murder of a 15 year old girl by her violent boyfriend in 2004, we found that the girl had been known to five different agencies, including child protection, education and health authorities, and the police. We found that none of the agencies had individually recognised the profound risk to which she was exposed, none of them made a commitment to providing her ongoing support in an attempt to reduce that risk, and none of them initiated any cooperative cross-agency response.

[4] National Centre for Classification in Health, *Causes of death of reviewable children in NSW 2003-2006: A report for the NSW Ombudsman* (June 2007)

Following our investigation, DoCS indicated greater interagency work was being undertaken with all agencies including NSW Police. Our work provided some impetus for the implementation of a coordinated interagency partnership that allows police and other agencies to share information and develop intensive case management plans for young people and families at risk. Further details of this initiative are provided in Part 8 of our submission to the Wood Commission, on Interagency practice.

We have also found there to be inadequate interagency coordination in a number of matters concerning young people at risk, where suicide or mental illness was known or documented. Since 2005 we have identified a number of systemic deficiencies in the support provided to this particularly vulnerable group of young people at risk. In particular, we found that most of the young people who had committed suicide (6 of 22 reviewable deaths in 2004) had had contact with a number of agencies, but in some cases there was limited communication or coordination between services, including between mental health services and DoCS.

In one matter we investigated, a young person who committed suicide had just been discharged from a mental health facility without a formal discharge plan being in place and without any post-discharge support services being arranged. In another matter, we found that the young person, who had a child protection history and had recently harmed herself and experienced suicide ideation, received hospital treatment in response to her deteriorating mental health, but was not provided with the support she required once she left hospital. While we were looking into this matter, significant supports were put in place and it was pleasing to note that she responded well to the supports provided.

Over the past three years we have made a series of recommendations[5] directed to DoCS and NSW Health regarding this issue of improving supports to young people with mental health problems. Our recommendations were firstly, for them to determine which of them should take the lead for ensuring ongoing improvement to the level of service provided to young people at risk of suicide and secondly, to consider strategies for improving:

- the systems for assessing the particular needs of individuals
- effective and coordinated interagency responses to those needs
- the systems for actually meeting the needs of individuals.

In December 2007 we asked for advice about any specific strategies planned to promote effective and coordinated child protection and health responses to adolescents reported to be at risk of harm, where reported concerns include suicide risk and mental health.[6]

[5] See NSW Ombudsman, *Report of Reviewable Deaths in 2004* (tabled December 2005), p.98, *Report of Reviewable Deaths in 2005, Volume 2* (tabled November 2006), p.xi, *Report of Reviewable Deaths in 2006, Volume 2* (tabled December 2007), p.x.

[6] Ibid. p. x

Over the past two years, DoCS and NSW Health have advised us of a number of steps they have taken relating to our concerns, at a local and regional level, including:

- the Child Protection Senior Officers Group (which comprises representatives from DoCS and NSW Health) is undertaking a project to identify assessment tools currently being used to assess the needs of children and young people reported to be at risk of harm, and consider whether the system can be streamlined.[7] We were advised in February 2008 that interim findings reveal a proliferation of assessment tools used by agencies to assess the needs of young people.
- DoCS finalised a research project that looked at issues for practice in engaging with young people and aimed to identify serious suicide and self-harm patterns in vulnerable young people and promote models for successfully delivering services to young people in care[8]
- DoCS has established a panel to meet on a quarterly basis to focus on the suicide/risk taking deaths of young people known to DoCS[9]
- DoCS met with the Child and Adolescent Mental Health Services Network to develop a draft framework aimed at ensuring appropriate services were provided to children and young people.[10]
- DoCS and NSW Health have signed a Memorandum of Understanding to ensure priority access to health services for children and young people under the parental or care responsibility of DoCS or the Minister. An addendum is being developed to improve linkages between the departments in the care of young people with a key consideration being risk management and suicide prevention.[11]

In relation to improving mental health services for young people, we are also keen to see the impact resulting from the rollout of the Federal governmentøs Headspace program.

In light of the positive findings from the evaluation of the HASI program, there would also appear to be scope for extending this program to strengthen supports for young people with mental health needs who also require accommodation and other supports.

3. Adequacy and availability of services for young people

The child protection system struggles to meet demand, and young children requiring immediate protection are generally considered to be the most urgent cases. All agencies are limited by the resources available to them. One consequence of this is less support is available for young people, including those with complex needs and who may be difficult to engage.

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[7] *Report of Reviewable Deaths in 2006, Volume 2* (tabled December 2007), p.101
[8] *Report of Reviewable Deaths in 2005, Volume 2* (tabled November 2006), p.55, *Report of Reviewable Deaths in 2006, Volume 2* (tabled December 2007), p.31
[9] *Report of Reviewable Deaths in 2006, Volume 2* (tabled December 2007), p.31
[10] *Report of Reviewable Deaths in 2006, Volume 2* (tabled December 2007), p.101
[11] Ibid. p.31, 102

From our review of thousands of child protection reports over the past five years and related discussions with DoCS staff, it is apparent that young people are given a lower priority within the child protection system. In this regard, we note the following observations made by the National Youth Commission report on youth homelessness:

> **In every hearing, the systems of care and protection in the different jurisdictions were reported as being under-resourced and under-staffed. This resulted in priority allocations that focus on younger children, creating major issues of access for older youth.**[12]
>
> **....**
>
> **Despite positive work in many areas, there remain many indicators that care and protection systems are both under-resourced and suffering an acute workforce crisis. Early intervention and prevention in child protection, while laudable, is being prioritised at the expense of support for older children who are being regarded as 'less vulnerable'. In another practical sense, they often seen as too difficult to deal with and manage and a drain on limited resources. As a result of what can only be described as system neglect, these children and young people are experiencing homelessness and reliant on the SAAP system for support. This is despite legislation that is meant to give responsibility to the state and territory child protection authorities for young people under the school leaving age.** [13]

2. Reviews of the circumstances of children and young people in statutory care and/or living away from 'home'

We have conducted a number of reviews relating to the accommodation needs of young people at risk. Our work has included:

- examining issues that face young people relying on supported accommodation under the Supported Accommodation Assistance Program (SAAP)
- looking at young people living in statutory out of home care
- reviewing the situation of young people with a disability leaving statutory care
- investigating accommodation issues facing young people with a mental illness.

(a) Access of young people to SAAP services

In May 2004 we tabled a special report to Parliament, Assisting homeless people ó the need to improve their access to accommodation and support services. The report detailed the findings of our inquiry into access to, and exit from, SAAP services. One key finding was that certain groups of homeless people faced a high possibility of exclusion from these services based on global policies of turning away people with particular personal characteristics, including groups of young people, without assessing each person as an individual.

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[12] National Youth Commission, *Australia's Homeless Youth*, Executive Summary p. 9

[13] National Youth Commission, *Australia's Homeless Youth*, p 139

We recommended that individuals should only be excluded from a SAAP service after an agency assesses the personøs actual circumstances and makes a reasonable attempt to manage any risks that are identified. In response:

- DoCS provided funding to peak SAAP agencies (including the NSW youth accommodation association) to revise their policies, develop access and equity plans and develop a risk assessment tool for SAAP services
- DoCS revised its agreements with services to emphasise that global exclusions were not in line with policy
- SAAP services responded to the findings of the report and a majority were using the risk assessment tool by 2007.[14]

From this and other work, the overwhelming feedback we received from the SAAP sector was that, while accommodation service providers can provide a range of services, to effectively support homeless people, including young people, SAAP services need expert assistance from other agencies, such as those specialising in substance abuse and mental health, and that more work is needed to improve links between SAAP services and those other services.

A related issue relates to services (including accommodation) for young people whom, due to behavioural and other difficulties, it is difficult to accommodate within SAAP services.

We note that a broad range of issues associated with youth homelessness have been canvassed in the National Youth Commissionøs April 2008 report on youth homelessness and that, in response, the Federal government intends to release a green paper on these issues later this year. Given the breadth of the issues that the green paper is likely to canvass relating to at risk young people generally, Federal initiatives will be likely to have an impact on any State response.

(b) Young people living in out of home care

(i) Foster care

From our complaint and review work it has become apparent that the period leading up to and following adolescence is a time of heightened risk for out of home care placements. For example, during our recent review of 185 Aboriginal children in DoCSø foster placements, a number of carers expressed difficulties in dealing with fairly extreme behaviours by the children and young people in their care who had either entered or were about to enter adolescence. In recent discussions with the peak bodies who support foster carers, they also noted an increased risk of placement breakdowns and other serious placement challenges during this period in young peopleøs lives. Given that long term placements are less likely to receive active case management support from DoCS, there is merit in considering whether additional placement support may need to be considered from the time young people in out of home care are moving towards adolescence.

[14] NSW Ombudsman annual report 2006-2007, p 91

(ii) SAAP

Young people under 16 in SAAP services represent a particularly vulnerable subgroup. Over a number of years we have made representations to DoCS about this group of young people. In 2005 DoCS advised that it was holding discussions with the SAAP sector around this issue with a view to developing a policy position.

In 2006 we reviewed the circumstances of 15 young people who were in statutory out of home care and living in SAAP services.[15] We found that a number of them had a history of placement breakdowns, and were disconnected from family and other social networks in the period leading up to their entry into SAAP. However, we found that good outcomes had been achieved for a number of them through good planning and service coordination by the SAAP services working with DoCS. Some of the young people were able to achieve stability, engage in positive activities, such as attending school, and develop some important stable relationships.

However, our review highlighted for us the need for DoCS to finalise its policy on providing supports to all young people under 16 who are in SAAP services. For this reason, one of our recommendations required DoCS to advise on the progress it had made on the development of this policy.

In response, in March 2008 DoCS advised that its policy/protocol on *Assisting unaccompanied children under 16 years in SAAP youth accommodation services* would be finalised by July 2008.

(c) Investigation into the Joint Guarantee of Service for People with Mental Health Problems and Disorders Living in Aboriginal, Community and Public Housing

Stemming in part from concerns that have been brought to our attention by the SAAP sector, we recently commenced an investigation of the implementation of the Joint Guarantee of Service for People with Mental Health Problems and Disorders Living in Aboriginal, Community and Public Housing (JGoS). The focus of the investigation is examining the steps taken by the Departments of Housing and Health to meet the objectives of the JGoS, which are to:

- better assist and enhance the wellbeing of existing social housing tenants whose tenancy may be otherwise at risk, and
- assist housing applicants who may be homeless or at risk of homelessness to successfully establish a tenancy.

[15] We discuss this review in our Part 5 of our submission to the Special Commission of Inquiry, addressing Out of Home Care, at p 17

An important group of people who are affected by the JGoS are young people who are homeless or who are at risk of becoming homeless. In the investigation we will be looking at how well the support issues relating to this group of young people have been addressed.

(d) Young people leaving care

In 2004 we conducted a review of 27 young people identified by DoCS as having a disability and who had left or were about to leave statutory care. We discuss this review in more detail in a previous submission.[16]

For the purpose of this submission, we would observe that the findings from our review illustrated the importance of good planning, well ahead of time, and of adequate supports being in place for young people leaving care.

We found that the quality of leaving care planning varied greatly for the 27 young people. In our view more needed to be done to ensure consistency of the quality of leaving care planning, particularly for the most vulnerable young people. We were also concerned that young people with a disability exiting the criminal justice system experienced difficulties in transitioning to alternative accommodation.

Another significant observation was that, although DoCS policy stated that planning should start 12 months before a person was due to leave care, in 19 cases planning only started 6 months or less before the person was due to leave.

On the positive side, however:

- Our review found that many of the individuals who were not eligible for DADHC services received continuing support from DoCS on leaving care. Some caseworkers connected the young person with a disability support service or adolescent service prior to, or at the time of discharge. These arrangements can provide for a gradual transition to independence and some form of safety net for the young people.
- We also found many examples of flexible, innovative leaving care plans that were effectively implemented by the department and other service providers.

In response to our report, DoCS advised us that it was developing an aftercare policy. Through 2006 and 2007 DoCS advised us of the progress on the policy, but to date it has not been finalised.

We also observe that Stronger Together, the disability services plan released in May 2006, specifically referred to ‑the introduction of new approaches for young people [with a disability] leaving foster and other care at 18 years of age who may need to move into other forms of support or accommodationø and identified additional supports for people with a disability exiting the criminal justice system. In January 2008, DADHCøs progress report on the rollout of Stronger Together referred to 74 long-term accommodation on support arrangements having been put in place for young people with a disability leaving the care of DoCS.

[16] Please see part 5 of our submission, addressing Out of Home Care, at p 11

While our review focused on young people with disabilities, most young people leaving out of home care will need ongoing support. In this regard, the observations and recommendations made in the CREATE Foundationøs *Report Card 2008: Transitioning from Care* are relevant in considering the support needs of young people leaving care.

3. Education and children and young people

Engagement in the school system can be critical to a young person's emotional development and well being.

In relation to engagement at school, we are currently examining the implementation of the requirements of the Department of Education and Training's (DET) long suspensions procedures. A long suspension can be for up to 20 school days, a considerable period for a student to be out of school. It is not uncommon for students with particularly challenging behaviour to be given more than one long suspension in a school year, returning to school for a period but then behaving in a way which leads to a further period of long suspension.

One of the issues we have looked at is the availability of support and assistance to maintain students with difficult behaviour in school. We have expressed our concern to the department that the nature of the information it collects about suspended students and the lack of analysis of long suspension data appears to mean it has limited knowledge about the needs of students who are being suspended. In order to better ensure the needs of students are being met, we have suggested the department review the adequacy of support available to students identified as having behavioural and emotional problems and/or disorders. Our views have been well received by the department and we expect to report on this investigation within the next few months.

On the separate issue of non-attendance at school, we are aware of plans to strengthen the response to children of mandatory school age habitually failing to attend school. In a recent investigation we have undertaken, the DETøs failure to take decisive action notwithstanding the very poor attendance record of the children involved highlighted the need for improved response in this area. Against this background, in Part 4 of our submission to the Wood Commission, on Mandatory reporting, we have asked the Commission to consider whether habitual non attendance should be a specified ground for a risk of harm report to DoCS.

From our extensive work with Aboriginal communities, we have also become concerned over apparent high rates of non-attendance by Aboriginal children in particular locations. This problem often emerges late in primary school, as children are making a transition from childhood to adolescence. The issue is of particular significance to young people because they are not only being deprived of a fundamental right relating to their development but they also lose the social support network and structure that the school community can provide.

We note the DET Home School Liaison Officers currently work with identified families to encourage them to send their children to school and prosecutions are limited to between 60 and 100 a year. Therefore, if more rigorous work to ensure children are enrolled and attending school is to be effective, it will need to be adequately resourced and supported.

4. Oversight of NSW Police, including audits of Aboriginal Strategic Direction policy

One risk that young people face is the risk of engaging in criminal behaviour and the consequences that can follow from contact with the criminal justice system. While not all young offenders have a child protection history, there is evidence to show that there is a link between being at risk of harm as a child and committing offences as an adolescent. Our work in auditing the implementation by the NSW Police Force of their Aboriginal Strategic Direction policy (2003-2006) allows us to make some observations about the current programs and systems-approaches that currently exist to manage and support young people (in general) at risk of offending.

By way of background, the policy aims to improve criminal justice outcomes for Aboriginal communities as well as make positive changes in the relationship between police and those communities. Since 2003, we have conducted detailed reviews of measures local area commands across NSW have introduced to implement this policy. In particular, we have looked at local police strategies to ÷divert Aboriginal youth from crime and anti-social behaviourø, one of the six objectives underpinning the Aboriginal Strategic Direction policy.

(a) Young offenders with child protection histories

The link between people who were at risk of harm as children and juvenile offending is supported by ample evidence. For example, a 1997 review by the Bureau of Crime Statistics and Research reported that child neglect was more likely to lead to juvenile delinquency than drug use or poor school performance.[17] In 2004, the police undertook an analysis of Aboriginal offenders aged 10 and 11 years.[18] The review examined criminal charges against 10 and 11 year old Aboriginal and Torres Strait Islander offenders in the six months to 31 December 2003.

It identified 23 children who were charged with a total of 91 offences in this period. Analysis of police information relating to the 23 children charged found that:

- Every child charged had child / young person at risk reports, and 15 of the 23 had 5 or more reports of this nature.
- All 23 had been the subject of DoCS referrals, and 16 of the 23 had been the subject of DoCS referrals on 5 or more occasions.
- At age 10 or 11, every child charged with an offence in the six-month review period had previously been charged.
- Every child had faced between 2 and 53 charges before this six-month period.

In the six-month period reviewed, one child accrued a further 23 charges.

[17] Please see page 19-20 of Part 1 of the Ombudsmanøs submission to the Special Commission of Inquiry on the Childrenøs Court, for more details.
[18] ÷Reasons for charge: Aboriginal and Torres Strait Islander Young Persons aged 10 and 11 yearsø, Operations Support Command, NSW Police, 11 October 2004.

The analysis illustrates the correlation between high levels of offending behaviour and indicators of risk among very young offenders. It highlights the importance of agencies such as police and community services working closely with each other ó and with education, housing and other government and non-government services that have close contact with children, young people and their families ó to give people support as children, or, if more support is necessary when a child reaches adolescence, devise interventions with sufficient intensity to address underlying factors that contribute to a personøs offending or risk-taking behaviour.

(b) Findings from our initial Aboriginal policy audits

In 2003 and 2004 we audited 14 local area commands. Our special report to Parliament, *Working with local Aboriginal communities,* set out the main findings from those early audits. A copy of this report will be provided with our submission on Indigenous communities.

Through the reviews we gathered information on local police crime prevention planning, diversion schemes and other activities aimed at young people generally, which are also available to Aboriginal young people, as well as information about programs aimed at Aboriginal communities.

We commended police for the apparent surge in youth-related activities and other initiatives. A particularly effective strategy was Police Community Youth Clubs (PCYCs) programs targeting young offenders. We found the role of officers in these clubs had changed significantly, with priority given to case managing known young offenders, engaging with young people at risk of offending, and engaging in high visibility policing in juvenile crime or anti-social behaviour ÷hot-spotsø There are 58 communities with PCYC facilities and police are using mobile PCYC vans to extend this approach to high-need locations such as Walgett, Bourke, Brewarrina and Enngonia for the first time.

PCYCs seemed to be the exception rather than the rule, however. Our audits found that generally, even where specific ÷programsø existed for young people at risk, most were one-off activities, rarely lasted longer than a few weeks, were generally not closely aligned with measures to reduce young peopleøs involvement in crime, and often did not reach priority offenders. In our special report to Parliament, we observed:

> **Through our audits we have seen a number of positive programs and strategies being implemented across commands. We have also met some dedicated and enthusiastic youth liaison officers, community safety officers and PCYC officers. Because so many creative strategies already exist, the biggest challenge for NSW Police is to ensure that commands are measuring the success of local diversionary initiatives by closely tracking the offending patterns of both high-risk and at risk young people exposed to local programs. The frequency with which commands are using diversionary options needs to be monitored and where use of such options is minimal without good reason, commanders should be held to account and given guidance to improve their performance.**

> **Longer term strategies to reduce offending and steer young people away from the criminal justice system depend on factors such as better education and job opportunities, improved health and a safe home environment. Police have a critical role to play in keeping other service providers and communities focused on strategies to achieve these broader social improvements and tackling underlying contributors to crime.**[19]

(c) Findings from recent audits

During 2006 and 2007 we conducted a further 22 reviews ó consisting of follow-up audits of police work at the 14 initial locations and audits at eight other commands whose Aboriginal Strategic Direction initiatives had not been previously reviewed.

At 12 of the commands we originally audited, we found marked improvements in the quality and effectiveness of police work with young people. The police had made significant attempts to replace ad hoc activities with properly planned strategies. Although progress was less apparent in the two other commands, they had introduced important new crime prevention initiatives. At the commands being reviewed for the first time, we found quality police work with young people. This seemed to indicate that improvements were being made throughout the police force generally.

In general terms, our follow-up auditing found:

- Much broader police recognition that young people with complex needs require carefully targeted and sustained interventions, sometimes from several agencies.
- Examples of quality local level police work with young people are now common. More commands effectively use diversions under the Young Offender Act, have Youth Liaison Officers working closely with the Crime Management Units in their commands and have strong police links with local youth programs and services.
- The more active commands supplement established programs with a mix of targeted strategies to address specific issues ó usually to prevent particular types of juvenile offending and encourage longer term changes in behaviour.

This recent progress was very encouraging. The challenge for the police is to build on successful programs and maintain a long-term focus. We are of the view that corporate-level support and leadership is needed to strengthen and sustain the strategic focus of police work with young people in relation to:

- monitoring to promote the wider police use of existing youth diversionary options,
- better targeting and more sustained interventions, and
- better coordinated and systemic strategies, including police developing closer ties with other services that work with the same high-need young people and families.

[19] NSW Ombudsman special report to Parliament, *Working with local Aboriginal communities* (April 2005), p 23

(d) Diversionary programs involving police

Through our police audits and other work concerning young people, we are aware of a broad range of diversionary programs for adolescents at risk of offending or re-offending. They include:

- The Anti Social Behaviour Pilot Strategy (ASBP) is being trialled in several locations and managed by the Department of Premier and Cabinet. The aim of ASBP is to build on the successful elements of early programs run in Dubbo (Integrated Case Management), and Redfern-Waterloo (Case Coordination Project), by bringing together and better coordinating various services that can help address the needs of high-risk families in particular localities.

- In the Lake Illawarra local area command (LAC), Project Energy is a scheme established by police and funded by private sponsors that aimed to identify, engage and turn around the lives of young offenders aged 13-15 years engaging in car theft and other high-risk behaviours. The project actively identified offenders on the verge of ÷graduatingø to a career in serious and violent crime.

  The intervention was consistent, with weekly activities and frequent contact over a period of several months that was designed to foster regular contact with participants and change patterns of behaviour by rewarding them for regular school attendance and other achievements. It engaged frontline officers who actively enforced compliance with bail conditions, regular school attendance and other conditions, making program participants accountable for their actions. Any breaches led to exclusion from the weekly rewards until the young person was back on track.

  Importantly, there was a rigorous evaluation of project outcomes, which led to significant revisions for subsequent programs.

  As many of the participants were Aboriginal and the initial trial led to a sharp drop in motor vehicle theft, the successes achieved by Project Energy helped underpin a dramatic shift in the local police relationship with Aboriginal community leaders and organisations. We found that police ties with Aboriginal leaders became much stronger and relationships and engagement between Aboriginal young people and police officers improved markedly.

  The success of Project Energy has paved the way for a number of other youth-related programs in the Lake Illawarra and Wollongong commands, including Project Murra, a Commonwealth funded school-based police traineeship program for Aboriginal high school students in the Illawarra area. The initial pilot began this year and aims to provide mentoring, paid work experience and training for up to 10 potential young police recruits throughout the final two years of their high school education.

As the first group progresses through the scheme, trainees will take on responsibility for helping mentor the next intake, giving them a chance to develop their skills as leaders while extending the available supports for new trainees. If successful, the program could be extended to other commands, and to assist Aboriginal recruitment to other emergency services, such as the Ambulance service and fire brigade.

- NSW Police have been trialling an integrated case management framework in several LACs. Originally this project was designed to specifically target Arabic and Pacific Islander communities. Due to the success of the program in addressing social, environmental, economic and familial issues, a generic model for all young people is intended to be rolled out across selected areas.

- In the Macquarie Fields LAC, strategies include mentoring and case management of young people at risk of offending, and a range of residential camps for certain selected young people to build relationships between them and police, and to develop self esteem and motivation.

- Tirkandi Inaburra is a program for Aboriginal boys aged between 12 and 15 years who demonstrate potential but are just starting to get into trouble or showing signs of being at risk of contact with the criminal justice system. The aim is to assist young people at risk before they become involved in offending behaviour, by providing them with training opportunities to develop the skills and confidence to make positive life choices. A feature of its work is a ÷pathwaysø program that closely involves Aboriginal Elders and uses case planning to provide young participants with ongoing community and family support after graduating.

  Tirkandi and its interventions are currently being evaluated. If evaluated as successful, the program could provide a model for similar interventions in other parts of the state.

5. NSW Police’s use of the Young Offenders Act

The risks to young people associated with criminal behaviour not only stem from the harmful nature of the behaviour itself, but the negative effects of contact with the criminal justice system. At present, the only comprehensive state-wide program to divert young people from being brought before a court, and possibly convicted and serving a prison sentence, is the scheme of warnings, cautions and youth justice conferences established under the Young Offenders Act 1997 (YO Act). Under the Act, police can issue warnings and cautions to young offenders, and police and courts can identify and refer more serious or repeat young offenders for youth justice conferencing.

Various aspects of this scheme have been reviewed and evaluated in the past decade, including three key reports from the NSW Bureau of Crime Statistics and Research[20] and a monograph published by the Sydney Institute of Criminology.[21] Significantly, researchers

[20] An Evaluation of the NSW Youth Justice Conferencing Scheme (2000), Reducing juvenile crime: Conferencing versus court (2002) and Reoffending among young people cautioned by police or who participated in a youth justice conference (2006).
[21] Reshaping Juvenile Justice: The NSW Young Offenders Act 1997 (2005)

have concluded that the scheme is an innovative and effective juvenile justice reform, which meets the needs of all participants, reduces or delays reoffending, and reduces the likelihood of young Aboriginal first offenders being taken to court. The research also reveals certain shortcomings in the scheme and impediments to its wider use.

Much of our own work has focused on encouraging the police to address impediments to the effective use of diversions. In 2003 our office conducted a project evaluating how police were implementing the YO Act. The police were very receptive to our recommendations, which related to staffing and training, the use of community members to issue cautions, access by young people to legal advice, and engagement with local service providers to identify and address youth issues. As a result, we have worked with police on a number of specific areas including a police Youth Liaison Officer (YLO) training and induction package, increasing the availability of police YLOs for young people in custody, increasing the use of alternatives available under the YO Act, and encouraging police YLO contact with community organisations.

A related initiative was our review of arrangements to ensure the provision of timely legal advice to young people in custody. Our *Working with local Aboriginal communities* report (April 2005) highlighted factors that can limit the use of diversionary options, particularly with respect to Aboriginal young people. These included the requirement that a young person has to admit that he or she committed the offence to be diverted under the scheme, which can involve making a complicated legal decision, meaning that the person is reliant on the quality of the legal advice available.

We observed one approach used by in some commands that gave some young people (who are not a flight risk) a cooling off period of up to 14 days after the offence to seek appropriate legal advice. After this time a number of young people made admissions and were able to be dealt with under the YO Act.

We found significant discrepancy in the use of diversionary options between commands, and on occasion, between different sectors within the same command. This suggests that use of the YO Act depends very heavily on the views of an individual officer rather than the application of more general criteria. In our view, this issue should be closely monitored by NSW Police to identify how referral rates might be improved.

In 2005 we sought to address widespread concerns raised by police and youth advocates about the quality of legal advice provided to young people in police custody.[22] We became aware that young people were often advised not to make admissions, leaving police with few options other than to press charges, except where a ÷cooling offø period system was in place.[23] Following our involvement, the police and Legal Aid took some steps to improve communication flow but some time later we were advised that there were continuing problems in certain locations. High staff turnover, lack of resources and lack of corporate level support were all contributors. Legal Aid are taking steps to improve the service provided

[22] Section 7(b) of the ***Young Offenders Act*** requires that young offenders be given an opportunity to seek legal advice. This often means calling the Legal Aid Youth Hotline or, in the case of Aboriginal people in police custody, the ALS Hotline especially if the arrest occurred outside of business hours and local solicitors are unavailable to assist.

[23] The ***Young Offenders Act*** allows police to defer decisions on how to proceed in order to give the young person up to 14 days to seek legal advice. In practice, this generally requires local commands to establish arrangements with local ALS solicitors or other legal services provide that advice. Although there is potentially some scope for the Legal Aid Youth Hotline and ALS hotline to provide advice during the cooling off period, this has not been a common practice to date.

by the Hotline. In contrast, it appears the ALS service is considering shutting down some of its services, including its telephone advice line, because of expected funding shortfalls.[24] Unless the Legal Aid Youth Hotline takes over this role, such a change would potentially further reduce the number of young offenders able to be diverted through the YO Act.

These difficulties illustrate that, even with a scheme that appears to be able to achieve its goals and enjoys support from all affected parties, corporate level leadership, sufficient resources, good inter-agency cooperation and appropriate monitoring are absolutely critical to its success. We note that in New Zealand a similar youth diversionary scheme was extended in late 2002 to create a nation-wide network of Youth Offending Teams jointly managed by police, welfare, education and health agencies.

6. Work around the Children's Court, including young offenders

As we have outlined above, a large proportion of young people who commit offences come from situations of neglect and abuse, or experience some other form of vulnerability, for example, a disability or homelessness. A disproportionate number have been removed from their parents and live in statutory care. Even with community support programs in place, some of these vulnerable young people will still engage in offending behaviour. It is our view that when these young people are brought before the court system, it is nevertheless important that their underlying vulnerabilities are recognised and they are provided with the support they need (in addition to facing criminal justice consequences).

(a) DoCS assessment of young people with child protection histories

In its submission to the Special Commission of Inquiry, the Childrenøs Court seeks the power to require the Director General of DoCS to prepare reports to the court on the care and protection issues of a child or young person, and the actions to be taken to address those issues, or the reasons why no action will be taken. The court believes these powers will allow magistrates to assure themselves that the department is aware of what services are needed to support the young people concerned.

We set out in some detail our views on this proposal in our Childrenøs Court Discussion Paper (at pages 45-47), a copy of which was forwarded to the Commission on 4 April 2008. We made additional comments at pages 17ó21 of Part 1 of our submission to the Wood Commission, on the Childrenøs Court. In summary, we are of the view that there is merit in the Court receiving timely information from DoCS about the circumstances of any particular young person about whom the Court has concerns. Such referrals should, however, be limited to those matters where a high risk of harm appears to exist. In this regard, we note in our Childrenøs Court Discussion Paper that only 32 children were reported to DoCS in 2005 through the system devised for magistrates to report such cases to the department.

(b) Young people in statutory care

The Childrenøs Court also raised the lack of DoCS involvement in court matters involving juvenile offenders who are under the parental responsibility of the Minister. While the court may require parents of accused to attend court under section 7 of the *Children (Protection and*

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[24] legal aid cuts ***Sydney Morning Herald,*** 31 March 2008.
threat ***Central***, 7 May 2008

Parental Responsibility) Act, this does not extend to the Minister for Community Services or the Director General.

We understand DoCS does not appear in court in the majority of cases involving offenders who are under the parental responsibility of the Minister. It is our understanding that the parental responsibility of the Minister does not cease once a young person is criminally charged, nor does that responsibility transfer to the Minister for Juvenile Justice at any part of the proceedings, even if the young person is committed to a juvenile justice facility. We are of the view that children and young people who are under the parental responsibility of the Minister should receive the same support and informal advocacy from DoCS in any criminal proceedings, as would be provided by an active, caring and responsible parent in the same circumstances.

(c) Young offenders and accommodation

We understand there is a growing challenge for the Childrenøs Court in making bail decisions for young people facing criminal charges who do not have stable accommodation. Generally, the Court would release a person on bail if they did not pose any flight risk and were not a danger to the community. However, where a person is homeless, the Court may be forced to consider the welfare of the person and how he or she will be supported if he or she is released back into the community.

Through our work we have become aware that juvenile detention centres are experiencing overcrowding with detainees being accommodated in holding rooms and on mattresses on the floors of other detainee's rooms. We have been advised that in some regional areas the accommodation options available are very limited.

We are aware that in the past there have been proposals to set up so-called ÷bail housesø, to accommodate young people released on bail. Such initiatives would give the Court an option other than detaining a person in a juvenile justice centre where the Court is of the view that the person does not have a stable home to go to, or a sufficient support network to ensure their appearance at their court hearing.

It appears to us that there is a gap in the provision of accommodation to accused young people without stable homes in which to live. We would suggest that further research should be done to quantify and further clarify the extent of the problem.

(d) Young people who have mental health issues

We are aware that young people charged with offences who appear before the Childrenøs Court can be referred to Justice Health for an assessment if it appears to the Court that they may have mental health issues. Justice Health can link the young person up with a mental health service, and report back to the Court. It is our understanding that Justice Health is playing an increasingly important role in this area and this has provided assistance to increasing numbers of young people appearing before the Court. Ongoing expansion of this type of support would be a positive initiative.

E. Models of service delivery

Over recent years we have considered a number of models for delivering services to groups of vulnerable young people. We are encouraged by some of the models that are being offered to support young people in NSW, other States and at a Federal level. From our analysis it seems that the following programs from other countries, at the Federal level and in other States, contain particularly noteworthy features.

International

- The **Wraparound** process, which has been running since the early 1990s, is a collaborative, team-based approach to service and support planning to improve the lives of children and youth with complex needs and their families. The Wraparound process can be described as one in which the team:
  - creates, implements and monitors an individualised plan using a collaborative process driven by the perspective of the family
  - includes within the plan a mix of professional supports, natural supports, and community members
  - bases the plan on the strengths and culture of the youth and their family, and
  - ensures that the process is driven by the needs of the family rather than by the services that are available or reimbursable.

  The Wraparound model is the basis for a number of projects across Australia, including the Turnaround model in the ACT, the Youth at Risk Alliance in Queensland and the OOHC support model in NSW.

Federal

- **Headspace**, the Federal governmentøs national youth mental health initiative which aims to better coordinate and integrate the activities of mental health services, general practitioners, drug and alcohol services and vocational support.
- The **Youth Pathways Program**, administered by the Department of Education, Science and Training, which aims to assist young people aged 13-19 who are the most at risk of not making a successful transition from school into employment or training.
- **Reconnect**, a Commonwealth-funded program for young people aged 12-18 (and their families), who have recently left home or are at risk of leaving home early, and where there are mental health concerns within the family. It aims to support young people to stay with their families. We note in its report on youth homelessness the National Youth Commission recommended expansion of this program.

Queensland

- **EVOLVE** Interagency Services in Queensland, which were developed to increase mental health, behaviour support and participation in education for children and young people in the care of the Department of Child Safety. The program aims to coordinate services so as to maximise the resources and systems that are available to meet the needs of the target group.
- The **Youth-At-Risk Alliance** in the Gold Coast, which focuses on long term, sustainable outcomes for young people at-risk of homelessness or offending, their

families and the broader community. Benefits include addressing individualsø needs that were not being addressed by individual agencies, identifying systemic issues, improved relationships and communication between agencies and improved outcomes for young people.
- **CRYPAR** (Coordinated Response to Young People At Risk), which is an early intervention/prevention initiative based in North Brisbane aimed at targeting young people 12 to 25 years old who are ÷at riskøof involvement in the justice system. During contact with a young person, police may identify an underlying problem placing them at risk and then offer to refer the young person to one of the 17 local services on the CRYPAR referral list. The services have signed an agreement to contact the young person within 48 hours of receiving the referral from police.

Victoria

- **Creating Connections** ó Youth Homelessness Action Plan Stage 2: 2006-2010, a whole of government strategy that has a strong focus on early intervention and interdependence, tailors accommodation support options for each homeless young person, aims to provide greater access to complementary services for homeless youth with complex needs and aims to increase capacity of services for young people who are homeless.
- **Frontyard** Youth Services in Melbourne CBD, which is a collection of services that work together to address the needs of young people aged 12 to 25 years who are homeless or marginalised. It features high levels of commitment, collaboration and dialogue between the individual services who are co-located at the service. There is also a common critical incident response procedure, a single point of entry and waiting area, and shared procedures and protocols relating to integrated service delivery. The service works closely with Centrelink, state government agencies and NGOs.

Locally in NSW, in addition to initiatives such as the Anti-Social Behavioural Pilot and Tirkandi, described earlier, some other noteworthy initiatives include:

- **Out of home care Wraparound** support services, based on the American model, run by DoCS, which focuses on comprehensive, coordinated, community based service delivery programs.
- **Case Coordination Project (CCP), Redfern-Waterloo**, a pilot project established in November 2005 to bring together and better coordinate various services and use case management techniques to address the needs of a small number of high-risk and complex families living in the Redfern Waterloo area of inner Sydney. Key features include active involvement of non-government services as partners in the formal case coordination process, specific funding for secretariat and case management support, and formal exemptions from privacy laws to facilitate sharing of information between participating agencies.
- **Kings Cross Youth At Risk Project**, which coordinates services in the area to address the needs of 18ó25 year olds who are in crisis. It involves collaboration between government and non-government agencies. Outcomes include improved coordination between outreach service providers, reduced ÷service surfingøand ad-hoc service delivery, enhanced coverage of existing services (both geographic

coverage and hours of operation), enhanced the use of resources and funding, provided clear pathways for referral, and better communication between services.

- **Better Futures** is the NSW Governmentøs prevention and early support strategy for children and young people aged 9-18. It aims to improve outcomes for children and young people by encouraging their development, improving family and community support and getting them involved in the community. This is done by coordinating and building on existing networks, making sure services meet the changing needs of children, young people and their families and developing evidence-based service models.

F. General observations

From our examination of young people at risk, we make the following general observations.

1. Early intervention

The best outcomes can be achieved through early intervention. Vulnerable children who are appropriately supported at any early age are in a much better position to navigate adolescence. From our work we have seen lost opportunities to intervene early in the lives of particular children and the resulting impact that this has had on them as they entered adolescence.

2. Adequacy and availability of support for young people

Notwithstanding our belief that early intervention in the lives of children is the best response, we believe that there is currently insufficient priority given to young people at risk. As a starting point, we believe a clear policy position needs to be developed giving greater commitment to supporting this group. Understandably, the current child protection focus is on children, particularly the very young, but the lack of an overarching policy position regarding at risk young people means that there is an inadequate framework for determining our response to those young people who are most vulnerable.

However, we also recognise that good policy does not guarantee good practice. For this reason, any policy development must be accompanied by a clear implementation strategy. In this respect it is also important to acknowledge the potential resourcing implications, particularly in areas of need such as:

- accommodation
- mental health, and
- substance abuse.

Notwithstanding the concerns we have expressed about the level of response to particularly vulnerable young people, we would acknowledge that the landscape is changing. We also note that resourcing is but one part of the equation; it is also important to closely examine how services are delivered.

In this regard, it is pleasing to note the work of the Federal Government in considering how to best respond to the challenges raised by the National Youth Commission report. While increased accommodation places is clearly an issue, equally critical issues to consider are the

types of accommodation and other services homeless young people require and how best to promote the take up of these services by at risk young people.

It is important to recognise that accommodation is but one area where NSW would need to consider the Federal Governmentøs response as part of developing its own policy and practice framework for supporting at risk young people.

On the mental health front, it will also be important to consider the impact over time of the Federal governmentøs Headspace program and its capacity to effectively deliver services to young people with a mental illness. This important Federal initiative is particularly relevant in considering the potential for the State governmentøs HASI program to be extended to provide support for young people with mental illnesses needing accommodation and other supports. Another significant Federal Government program that would need to be considered is Reconnect both in terms of its current and potential reach for responding to at risk young people.

3. Interagency response

Related to this issue of how services are delivered, we note the evidence of an increasing trend towards a coordinated, multi-agency approach for responding to young people at risk and their families. This type of approach has considerable merit because at risk adolescents are often exposed to a number of different risk factors that require a multi-agency response. In Part 8 of our submission to the Wood Commission, on Interagency coordination, we examine in more detail particular multi-agency models that have been used for at risk young people and related structural and governance issues.

4. Role of education

In addition to these broad policy and multi-agency challenges, we also note the important role played by schools as a provider of a universal service to children and young people. Schools have a very important role in identifying and supporting vulnerable children and young people.

In this submission we have mentioned two vulnerable groups ó the chronic truants and those students who face suspensions. As our recent investigation into suspension demonstrates, there is the need to better identify and address the underlying vulnerabilities for this group of children.

While it is pleasing to note the recognition by DET to better identify and address the needs of these two groups, we will monitor its ongoing work to better support these and other vulnerable young people within the school environment.

5. At risk young people in out of home care

In the context of the current out of home care system, we acknowledge that current resourcing levels mean that children in long term DoCSøplacements are less likely to receive active case management support. However, given the challenge carers often face when the children for whom they are caring reach adolescence, there would be benefit in the Department

considering what additional supports and/or placement assessment activities it may be able to provide when children in care approach and enter this stage of their lives.

In terms of other specific issues relating to at risk adolescents in care, we refer to the comments we made in Part 5 of our submission to the Wood Commission, on Out of home care, about the tracking and monitoring young people in out of home care who are in SAAP services, and the need to improve support for young people leaving care.

6. Children's Court

Where a high risk of harm appears to exist, we support giving power to the Childrenøs Court to request a report from DoCS on the care and protection issues of a child or young person. We also suggest work needs to be done to strengthen the availability of accommodation options for young people accused of committing offences.

Bruce Barbour
NSW Ombudsman

Steve Kinmond
Community and Disability Services Commissioner (Deputy Ombudsman)

Special Commission of Inquiry into Child Protection Services in NSW

Submission of NSW Ombudsman

Part 8: Interagency Cooperation

Overcoming challenges in service delivery

26 May 2008

1. Introduction

The Special Commission's terms of reference include provisions requiring the Commission to *'examine, report on and make recommendations in relation to…the adequacy of arrangements for interagency cooperation in child protection cases.'*

The Special Commission's *Interagency Cooperation Facts Sheet* sets out numerous examples of interagency mechanisms and notes that they constitute a significant proportion of DoCS' annual expenditure. In 2006-07, almost 60 per cent of DoCS' budget ($667.5 million) was used to purchase services for clients, mainly from the non-government sector. While some of this spending involves multi-agency programs or complex decision-making, much of it involves DoCS identifying and defining client needs and commissioning other organisations to provide the services. This includes funding organisations to provide accommodation, health, education and other services to DoCS clients, or interventions such as home visits, playgroups, school programs and other community development or capacity building aimed at high-need groups or locations.

In discussing interagency practice, it is important to understand its different dimensions. Good interagency practice should operate on both case management and systemic levels.

At a basic level, effective interagency practice from a case management perspective involves agencies at a local level having a good understanding of what information and advice they need to obtain from or provide to other agencies. Sound practices in relation to mandatory reporting are but one example.

Effective interagency practice at this level requires there to be legislation, policy and procedures that are easily understood and applied, together with associated supervision and training. This submission does not propose to canvas this aspect of interagency practice in any detail. However, we note that with the expanding role of the NGO sector, we need to ensure that from both a knowledge and skill perspective, individual agencies and services are well equipped to fulfil their obligations in this area of practice.

We would also note that recent investigative work we have carried out demonstrates the need for this issue to be addressed, particularly in relation to NGO bodies that are increasingly being called upon to work with particularly vulnerable families. Without a good understanding of when there is a need to either obtain or pass on information to other bodies, there is a significant risk that poor judgement calls will be made, with potentially very serious consequences for the children involved. For example, a community service provider failing to promptly advise DoCS of a rapid escalation in the level of conflict within a family environment can have tragic consequences.

Interagency practice – case management

A major focus of this submission concerns the more complex models of interagency practice involving agencies making good decisions about those matters where it is critical that there be some detailed joint agency discussions on individuals or families with complex needs in order to ensure a planned, coordinated and high quality agency response.

With these matters, there has often been – or at least may need to be – multi-agency involvement with the individual or family. Without effective joint planning and coordination of service delivery in these cases, there is a real risk that resources will be ineffectively employed by individual agencies. This more complex interagency case management practice needs to operate effectively at the local level. In addition, in exceptional circumstances, case management planning of this type may need to take place at a more senior level.

In this area of practice, one of the major challenges is to identify those cases which require a jointly planned and coordinated response. If the net is cast too wide, significant resource problems may arise because of the potentially resource-intensive nature of this kind of response.

Interagency practice – systemic

Effective interagency practice at a local level should also include the involved agencies continually reviewing the strengths and weaknesses of local practice between agencies with a view to strengthening the systems and processes for working together over time.

In addition, at the regional level there should be a strong systemic focus and a capacity to both monitor and drive local interagency initiatives. If the regional interagency focus is well-directed, then it will include identifying and responding appropriately to significant systems issues and ensuring that models of best practice are both promoted and rolled out more widely. In addition, a functioning regional interagency response will also include providing sound advice about interagency performance and initiatives across the region, to the senior executives who have corporate responsibility for leading and developing their organisations' interagency practices.

While our submission principally focuses on local and regional interagency case management practices, we also discuss some of the structural and governance arrangements required to drive interagency child protection work from both within and across agencies.

2. Legislative, policy and practice framework

In terms of interagency practice from a case management perspective, it is important to acknowledge the overarching legislative and policy framework in NSW.

Legislation

Interagency cooperation is a legislative requirement. The *Children and Young Persons (Care and Protection) Act 1998* sets out the principles of joint agency work, including requirements for government and non-government agencies and services with responsibilities under the Act to play their part in developing coordinated strategies for the delivery of effective services.

State Plan priorities

The NSW State Plan provides a broad framework for government decision-making and service delivery. Any strategies to improve interagency cooperation among government and non-government agencies should have regard to the State Plan and the mechanisms associated with implementing the plan. In the area of child protection cooperation this should include State Plan priorities relating to *'Rights, Respect and Responsibility'* and *'Fairness and Opportunity for the most vulnerable'*, especially *'F4: Embedding The Principle of Prevention and Early Intervention'*, *'F6: Increased proportion of children with skills for life'* and *'F7: Reduced rates of child abuse and neglect'*.

In late 2007 the NSW Government published a 'Policy Framework on Prevention and Early Intervention' to be trialled over 12-18 months. The framework has two components: embedding the principle of prevention and early intervention into agency decision-making through changes in agencies' policies and practices, and practically implementing the

principle of prevention and early intervention through targeted action on particular issues. Implementation of proposed actions will be managed within existing agency resources.[1]

Other departmental plans, policies and strategies

There are layers of other interdepartmental plans, policies and strategies to promote the use of interagency cooperation in the area of child protection. The Special Commission's *Interagency Cooperation Facts Sheet* highlights some of the principal instruments used in NSW, including the NSW domestic violence interagency guidelines, the Interagency guidelines for early intervention, response and management of drug and alcohol misuse, and the Interagency action plan for better mental health.

Many of these mechanisms include strategies to address the over-representation of Aboriginal children in the child protection system. In this regard, we note the release in 2007 of the *NSW Interagency Plan to Tackle Child Sexual Assault in Aboriginal Communities*, a five-year, whole-of-government response to child sexual assault within NSW Aboriginal communities. It essentially outlines the NSW Government's strategic policy response to the Aboriginal Child Sexual Assault Taskforce's 2006 report, *Breaking the Silence: Creating the Future.* The plan focuses on four main areas:

1. Law enforcement: primarily involving police, juvenile justice and the Attorney General's Department.
2. Child protection: primarily DoCS and health.
3. Early intervention and prevention: primarily DoCS, health, education and housing.
4. Community leadership and support: primarily the Department of Aboriginal Affairs (DAA).

The DAA is responsible for monitoring agencies' implementation of the actions attributed to each agency. An implementation committee has been established and reports to the Human Services and Justice Chief Executive Officers forum.

The DAA is also the lead agency responsible for monitoring the implementation of *Two ways Together*, the NSW Government's 10-year plan to improve the well-being of Aboriginal people and their communities. This plan requires government agencies to work together with Aboriginal communities on four priority areas, including 'families and communities'.

Agencies such as the Department of Premier and Cabinet and the Attorney-General's Department also play an important role in bringing government and non-government organisations together to work on various crime prevention strategies which focus on addressing violence, anti-social behaviour and other related issues. These include trials of relatively complex or ambitious joint service delivery arrangements, some of which are supported with dedicated staffing and at least some level of funding.

As a principal sponsor of many interagency strategies, DoCS has established numerous memoranda of understanding and agreements with other agencies and services. These include agency-to-agency arrangements that primarily aim to ensure other government agencies recognise and respond to the needs of particular DoCS clients. Examples include established agreements to provide children and young people within the child protection system with access to essential health services (DoCS MOU with health), disability services (with DADHC), and education for children living in out-of-home care (with DET).

There are also MOUs and agreements associated with more complex interagency arrangements such as those that clarify the respective roles and responsibilities of services in

[1] Premier's Memorandum *M2007-20 State Plan Priority F4: Embedding the principle of prevention and early intervention*, 13 December 2007.

jointly investigating child abuse (DoCS MOU with police and health), and coordinated approaches to reducing violence against women (with health, police, juvenile justice, housing and the Attorney-General's Department).

Non-government organisations (NGOs) are parties to a number of these agreements, sometimes as a partner but more often as a contracted service provider. The importance of NGOs was formally recognised in the *Working Together for NSW Agreement* (2006), which was jointly developed by the non-government sector, through the Forum of Non-Government Agencies, and by the NSW Government, through the Premier's Department and the Human Services Chief Executive Officers Forum. The agreement provides a framework for human services delivery for the people of NSW by providing a set of shared goals, values and principles that guide working relationships between the two sectors.[2]

Interagency guidelines

On a day to day level, the primary policy document relating to interagency child protection practice is the *NSW Interagency Guidelines for Child Protection Intervention 2006*, which provide a framework for government and non-government organisations to put interagency cooperation into practice. The guidelines recognise that no single agency or organisation has all the knowledge, skills and resources necessary to respond to children and young people in need of care and protection. As with the legislation, the guidelines are based on the principle that government agencies will work in partnership with each other, with non-government organisations and with the child or young person and their family to secure and sustain their safety, welfare and well-being.

In the lead-up to the finalisation of these guidelines the department initially released a discussion paper canvassing issues relating to the development of the revised guidelines. At *Attachment A* is a copy of our submission to the discussion paper.

The department subsequently provided us with a copy of the draft guidelines. On 9 June 2006, we provided a response to the draft – see *Attachment B*.

On 16 August 2006, the then Director General of DoCS wrote to us enclosing the new guidelines, and thanked us for our contribution – see *Attachment C*.

The Commission will note that a number of the matters raised in our advice on the guidelines are relevant to matters the Commission is currently considering.

Without canvassing all of the issues that we raised in our correspondence with the department, we would draw attention to our comments regarding:

- The value of the guidelines *'articulat[ing] the circumstances under which interagency work is essential'.*

- The need for *'cases that suggest a high child protection risk, a strategic and coordinated response is often essential. Agencies need to be proactive in identifying those vulnerable families where risks are such that a coordinated interagency response is required to effectively address them*.'

  Against this background we recommended that '*in reviewing the Guidelines:*

  - *the Child Protection Senior Officers Group should give consideration to the outcomes from the Integrated Case Management Response group operating in the DoCS Western Region and the applicability of the model more broadly. In*

[2] See the Special Commission's *Interagency Cooperation Facts Sheet.*

addition, the results of interagency work in areas such as Redfern and Mt Druitt should be considered.[3]

The revised Guidelines should:

- *strongly encourage the development of local networks and protocols that are responsive to the needs of the local community.*

- *describe what good interagency networks look like, including the essential elements of local interagency practice.'*

In addition, we also made a number of observations regarding the need to deal with issues around the exchange of information, providing feedback to reporters and providing clear pathways for interagency partners to escalate matters, particularly if they have concerns about the planned closure of a case.
It is clear that the revised guidelines provide improved guidance to practitioners around interagency practice. We also note that the guidelines list a range of circumstances in which case meetings may be called. While we note that the guidelines are currently being evaluated, we believe an important issue for the Commission to consider is whether there is adequate guidance for practitioners in relation to those matters which should be the subject of cross-agency work.

Through our work we have identified a range of 'at risk' situations or vulnerabilities which would be very often suitable for a cross-agency intervention including those cases involving:

- serious and chronic neglect
- parental substance abuse, particularly in circumstances of heavy substance abuse in households with infants and young children
- high-risk adolescents
- serious mental health issues, by the parents and carers and/or young person, and
- high-risk domestic violence matters involving serious or escalating assaults.

In many matters of this kind that we have reviewed there has been involvement by a range of agencies without any or minimal joint planning taking place. Furthermore, the problems in many of these situations are quite complex and require the involved agencies that are providing support to be alert to a range of information to assist them to make informed decisions about the nature of support required. Without the agencies coming together to consider these matters, there is a real risk that significant resources will be expended in an inefficient and ineffective manner.

We also note the potential scope for using information holdings more effectively to identify the individuals and families which warrant an interagency response. In this regard, we refer to our submission on *Assessment and Early Intervention and Prevention*, and in particular our discussion of intelligence-driven child protection practices.

However, we believe that an even more fundamental issue is whether there are adequate structural and governance arrangements in place to ensure good interagency practice. Linked to this is the need to have individual staff whose core responsibilities include making this happen. Recently, DoCS hosted a presentation by Dr Helen Buckley on assessment practices in Ireland. She delivered a very clear message that, with busy practitioners, good interagency practice will not happen unless you build it into your operating framework in such a way as to keep this issue firmly in the mind of practitioners.

[3] The Integrated Case Management Response Group has since been merged into the Anti-social Behavioural Pilot Project.

3. Ombudsman work in the area of interagency practice

As an independent oversight agency with broad responsibilities for scrutinising the services and systems of many state government agencies and some non-government organisations, our role gives us access to detailed information about child protection systems and practices. Our investigations of certain child deaths, domestic violence prevention initiatives and police work with Aboriginal communities include examinations of various agencies' contributions to important interagency programs and trials across the state. This often involves discussions with and regular feedback from frontline staff, managers and community partners about their involvement in interagency work. These discussions have provided us with insights into some of the strengths and weaknesses of the various models.

In late 2002 we commenced a program to audit NSW Police against its *Aboriginal Strategic Direction* policy. Our audits had a particular focus on police initiatives to work with other agencies and with Aboriginal communities to divert young people from crime and respond more effectively to Aboriginal family violence and sexual abuse. While the focus of the audits was on the role of police, the need for shared responsibility and improved coordination between other government agencies and community service providers became obvious over time. Many police and community members expressed their concerns to us about the lack of coordination of services, with many overlapping programs often attempting to address similar issues.

In our 2005 report to Parliament, *Working with Local Aboriginal Communities*, we noted the significant demands placed on police, particularly in isolated rural locations, who often provide support in areas that are the core responsibility of other agencies. This is because police are often the first to respond to incidents of domestic violence, child sexual assault and families rendered dysfunctional by alcohol or drug abuse. At that time, interagency cooperation was mostly ad hoc, but we were encouraged by the efforts made by police in some locations to build effective operational partnerships with local service providers and other agencies. These initiatives included:

- police working closely with health and other services to tackle substance abuse in areas without established treatment facilities or programs
- police and local women's refuges working together on the quality and availability of domestic violence support services
- partnerships with DoCS to identify children at risk at an early stage, and
- police work with housing authorities to relocate certain families in an effort to reduce ongoing crime or conflict.

Our report emphasised that strong interagency cooperation between police and other government and non-government agencies was essential if genuine progress was to be made in improving relationships with Aboriginal communities.

Through our reviewable child death function, we have also encouraged and tracked agencies' progress in this area. In connection with a number of recommendations made by us since 2004 we note that:

- the *NSW Interagency Guidelines on Child Protection Intervention* have been reviewed and are currently being evaluated
- memoranda of understanding have been developed between DoCS and NSW Health, Department of Ageing, Disability and Home Care, Department of Juvenile Justice and Department of Education and Training
- integrated case management projects are being trialled in a number of sites across the State, and
- NSW Health and DoCS have developed an information sharing protocol in relation to opioid treatment and collaborated in writing the child protection chapter of the Clinical Guidelines for Methadone and Buprenorphine Treatment.

In our *Annual Report of Reviewable Deaths 2004 we recommended* that the Child Protection Senior Officers' Group should ensure the revised *Interagency Guidelines on Child Protection Intervention* be released with an evaluation framework to assess agency take-up and the guidelines' overall effectiveness. DoCS advised us that the then Human Services Chief Executive Officers Forum would examine frameworks to evaluate interagency practice and assess the 'best approaches for ensuring the ongoing effectiveness of the guidelines'. Subsequent to this, DoCS consulted us around the framework for the evaluation process.

Our December 2006 report to Parliament on the policing of domestic violence also flagged the need for high-level support and clear direction when developing fresh approaches to interagency work. Our reviews of domestic violence programs, many of which include a significant child protection component, found that too much interagency work in this area was still too dependent on the goodwill of key individuals. For this reason, in our report we recommended creating a framework to support a more strategic approach to domestic and family violence interagency initiatives.

We believe a similar framework to the one which has been developed for domestic violence could be used to bring together various interagency initiatives in the child protection area.

Another important outcome from our domestic violence report was to prompt moves to develop structured risk assessment tools for agencies dealing with children exposed to domestic violence. We recommended that police and DoCS develop a shared risk assessment model to assist in alerting either agency about the presenting risks to children and young people, particularly in situations of domestic violence. A cross-agency risk assessment (CARA) reference group consisting of representatives of police, DoCS, health and the Attorney General's Department is currently developing a model to guide agencies in responding to domestic violence incidents. When implemented, there is scope for CARA assessments to form the basis of decisions about, inter alia, whether risk of harm reports should be made to DOCS, and to improve the quality of information contained in risk of harm reports.

In recent months our monitoring of interagency cooperation has extended to the Department of Health and Department of Housing's implementation of their 'Joint Guarantee of Service',[4] an interagency initiative established by health and housing in 1997, and expanded in 2003 to include DoCS, Aboriginal housing and other government and non-government service providers. The policy is the cornerstone of a framework designed to coordinate the work of partner agencies in providing timely and effective assistance to people with mental health problems and disorders who live in Aboriginal, community and public housing. Our investigation will involve visits to 25 locations and will include interviews with agency staff and local service providers, about their views on what aspects of these agreements work well, and what could be improved.

We continue to closely monitor developments in relation to interagency work in high-need areas though a number of strategies, including regular discussions with key staff involved in various integrated case management projects, directly observing case management meetings, seeking community input on how the schemes could be improved and providing advice to participating agencies.

In the context of this work, it is worthwhile considering a number of the multi-agency models that we have observed through our work.

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[4] *Joint Guarantee of Service for People with Mental Health Problems and Disorders Living in Aboriginal, Community and Public Housing.*

4. Models of interagency practice

Multi-agency or multi-component mechanisms for interagency cooperation are typically aimed at identifying and assisting families whose needs are too complex and diverse for one service to manage effectively. These mechanisms can involve multiple parties and/or complex decision-making frameworks. [5]

NSW has trialled the use of several multi-agency mechanisms to improve client access to a suite of services, either by co-locating teams of service providers or through some form of comprehensive case management. Collocation schemes include the trial of Domestic Assault Response Teams to coordinate police, DoCS and other assistance to families experiencing domestic violence, and more established schemes such as Joint Investigation Response Teams (JIRTs). Examples of case management programs include the Domestic Violence Intervention Court Model trialled at Wagga Wagga and Campbelltown; the Redfern Waterloo Case Coordination Project; the former Integrated Case Management trial in Dubbo, and its successor the Anti-Social Behavioural pilots being trialled in locations across the state. Examples of these are set out in our reviewable deaths reports and in our special reports to Parliament on police work with Aboriginal communities (April 2005)[6] and the policing of domestic violence (December 2006).[7]

The Special Commission's *Interagency Cooperation Facts Sheet* also outlines a number of the initiatives that were highlighted in our domestic violence report, and in that regard, noted that our domestic violence report stated that local cooperation between agencies in responding to domestic violence was still largely ad hoc and often dependent on the goodwill of individuals. Our report also highlighted that although there are a number of promising interagency models that incorporate impressive features, no one model included all of the core elements that we identified as being fundamental to good practice in this area.

Additionally, our domestic violence report noted that although a number of pilot programs had been in place for several years, there was very limited formalised cooperation between government and non-government agencies. Although valuable lessons had been learned, at that time no decisions appeared to have been made about developing a set of minimum standards to be applied across the state, particularly in locations identified as high risk for domestic violence. For this reason, we recommended that:

> The Commissioner of Police provide a copy of our report to the Human Services Chief Executive Officers Forum, and that the forum c**onsider the benefits of implementing specific domestic violence interagency models and/or practices in NSW, particularly in locations identified as high risk, such as:**
>
> - **integrated case management and/or case-tracking**
> - **wider implementation of the DVPASS[8] mechanism, and**
> - **collocation of police officers, child protection workers and domestic violence victim support workers.[9]**

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[5] These can take the form of 'multi-component service delivery' arrangements to provide easier access to a suite of services, either by co-locating various service providers or some form of comprehensive case management. J Watson et al, *Prevention and Early Intervention Literature Review*, Department of Community Services, May 2005. See Chapter 7 for a detailed discussion of multi-component service delivery models.

[6] *Working with local Aboriginal communities,* NSW Ombudsman, April 2005.

[7] *Domestic violence: improving police practice*, NSW Ombudsman, December 2006.

[8] In 2003 NSW Police developed a Domestic Violence Proactive Support Service (DVPASS) Protocol and Resource Manual to guide local area commands in implementing referral arrangements. Thirty-three (33) LACs were initially involved. The DVPASS model is known by a variety of names in different LACs, including "yellow card", "sticker" and "fax-back", reflecting the different methods police use in different LACs to record victims' personal information and pass it on to support agencies.

[9] *Domestic violence: improving police practice*, NSW Ombudsman, December 2006, Recommendation 24.

Our work with communities, agencies and non-government service providers has given us access to detailed operational information about a number of these important interagency programs and trials across the state. This includes discussions with and feedback from frontline staff and managers on the strengths and weaknesses of different modes of interagency practice. In this section, we discuss several multi-agency collaborative models which involve a range of human service agencies and service-providers.

Collocation

The two best-known collocation interagency models in NSW are Joint Investigation Response Teams (JIRTs)[10] and the Domestic Assault Response Team (DART) trial. The more established model is JIRT, which brings together staff from police, DoCs and health to undertake joint investigations of child protection matters where there is a possibility that the abuse is a criminal offence. The role of these teams is summarised in Appendix 1 of DoCS' *Interagency Cooperation* submission to the Special Commission. It has also been the subject of a major review and the changes resulting from this review are currently being implemented.

The DART model is a joint project initiated by DoCS' Wyong office and the Tuggerah Lakes local command. In reviewing interagency practice in the context of our domestic violence investigation, we met with frontline workers and managers from police and DoCS who were involved in developing and implementing the DART model.

Domestic Assault Response Team

DART is a joint police-DoCS project funded by DoCS' Community Solutions program. It aims to provide more coordinated responses to families experiencing domestic violence. Its key feature is the collocation of police and DoCS caseworkers. The DoCS component of the DART comprises a casework manager, six caseworkers including specialist caseworkers (drug and alcohol; mental health and child health) and a part time clerical worker. The police component consists of a team leader (the LAC's DVLO), two police officers focused on early intervention and two arrest team officers. Tuggerah Lakes LAC receives no direct funding, with its component of the DART staffed from existing resources (they have use of a vehicle funded by DoCS). The DART works general office hours between Monday-Friday.

The DART model has two main elements: early intervention and intensive case management. The DART is alerted when police apply for an Apprehended Domestic Violence Order (ADVO) on behalf of a victim of domestic violence. It completes an extensive background check on the involved parties. Associated charges, prior history and conditions sought in the ADVO are ascertained. If children are involved, the DART also conducts a history check of previous child protection interventions and outcomes. It also determines if there are any current Family Law Court Orders in place, or if any are being sought (this precaution is taken in case the defence objects to a condition of an ADVO on the basis of a Family Law Court Order).

Where there are children involved, a DART caseworker and police officer visit the family home to explain the ADVO and court process and answer any questions the PINOP may have. At this visit, any child protection issues are discussed and referrals to services arranged. Where there are no children involved, the DVLO contacts the victim and/or conducts a home visit. The DART identifies the support needs of the PINOP and her/his family and provides appropriate referrals and information. Where possible, the DART also seeks to speak with the defendant about the same issues. At this time, his/her obligation to cease behaving violently is reinforced. The ADVO matter then proceeds to court.

[10] *Not all JIRTs are co-located*.

Intensive case management targets high-risk families with chronic histories of domestic violence. These cases are identified though joint meetings between DoCS and police, and the team focuses on the victim and any children as well as the offender. DART purchases support services for the family using brokerage funds and supports them through legal procedures and court hearings.

The other elements of DART are the arrest team that targets domestic violence offenders with outstanding arrest warrants, and ADVO compliance operations. Compliance operations involve police targeting offenders who have previously had an ADVO made against them. Police check to see if they are abiding by the conditions of the ADVO. If not, the person is charged with breaching the ADVO. During compliance operations, DoCS workers are 'on call' to assess any reported child-at-risk incidents that may necessitate the removal of a child.[11]

The police involved in the team told us that they strongly support the collocation of police and child protection workers in areas with high levels of domestic violence and child protection reports. When appropriately implemented, collocation can facilitate:

- the natural development of trusting interagency relationships
- more efficient communication and information sharing
- increased understanding of each agency's mandate, procedures, knowledge and skills
- integrated, streamlined service provision
- greater focus by police and improved investigation and customer service; and
- 'on-the-spot' negotiation of services – workers always know who to talk to and have access to that person.[12]

An evaluation of DART indicated the value of the model by achieving an increase in the number of victims pursuing ADVOs and not withdrawing them; a reduction in the reporting of high–risk families and improved court efficiency making it easier for victims and their children to appear before the court, resulting in better use of resources.

We believe multi-agency collocation models should be considered in the context of establishing 'hub sites' in high risk regional locations where agencies have faced significant challenges in attracting suitably qualified staff. This issue will be discussed in further detail in our submission to the Special Commission on Aboriginal Communities.

Our domestic violence report also acknowledged that these models require significant levels of resources. For example, at the time of our review DART employed eight DoCS staff and local police contributed five officers. Nonetheless, one way to address resource shortages is for agencies to share resources, including shared management arrangements to ensure more efficient coordination and delivery of service.

Multi-agency case management forums

In recent years several multi-agency pilot programs have been developed to apply the principles of case management to provide coordinated supports to young people and families with complex needs. These include trials of the:

- Case Coordination Project (CCP) at Redfern-Waterloo; and

[11] *Domestic violence: improving police practice*, NSW Ombudsman, December 2006, p50-51.

[12] McKinney, C., Spark, J. and Dixon, J., *"Successes and challenges in the development of an integrated 'One Stop Shop' for women escaping family and domestic violence in Perth, Western Australia"*, Paper presented at the conference Home Truths, Melbourne, September 2004. p.6.

- Anti-Social Behavioural Pilots (ASBP) at Dubbo, Bourke, Orange, Lake Macquarie and Sydney's eastern suburbs.

The first metropolitan trial of multi-agency case management was in Redfern. In 2003, the Redfern Waterloo Partnership project, guided by the Redfern Waterloo Human Services Senior Officers' Group, developed a business case for the establishment of the Redfern Waterloo case coordination project. In 2004, the NSW Premiers Department sought exemptions to allow agencies participating in the project to collect, use and disclose, personal and health information related to approved clients with other agencies if it was relevant and reasonably necessary for the purpose of meeting the objectives of the project.

Following a riot in early 2004, a subsequent Parliamentary inquiry examined policing and other service delivery by government agencies and non-government organisations in the area. The inquiry recommended that the NSW Government, through the Redfern Waterloo Authority and the Redfern Waterloo Partnership Project, ensure that strategic plans for the area allow for active involvement of local, state and Commonwealth agencies, and take steps to develop genuine partnerships between government and non-government organisations in the area. In response, the NSW Government established a Case Coordination Project (case management trial program, now known as the CCP), for high-risk young people and families. The trial formally commenced in November 2005.

Case Coordination Project (CCP), Redfern Waterloo

The CCP was established to bring together and better-coordinate various services using case management techniques to address the needs of a small number of high-risk and families with complex needs living in the area. An evaluation of the CCP noted that it was established to explicitly overcome three key issues or barriers:

a) Some at-risk children and young people in the area with complex needs were 'falling through the (human-services) net'.
b) Agencies involved with at-risk children and young people were often unaware of the involvement of other agencies. This at times led to duplication of services, a blurring of roles and responsibilities, plus a lack of clear direction regarding the way specific client outcomes would be delivered.
c) An absence of shared and coordinated case planning for at-risk clients that allows agencies to coordinate their interventions, and collaborate to more effectively address complex needs in a timely and outcome-orientated way.[13]

The CCP is overseen by the Redfern Waterloo Human Services Senior Officers Group. However, much of the day-to-day case management work is the responsibility of the operational managers' group, with assistance and support from project staff employed by the project.

Features that set CCP apart from some other case management and place management projects include its active involvement of non-government services as partners in the formal case coordination process, its specific funding for secretariat and case management support, and its formal exemption from NSW laws relating to client privacy and health record confidentiality in the context of interagency case coordination.[14]

One of the early challenges faced by the CCP was around defining the 'target group'.

> **The CCP target group was 'at-risk' young people and children who fell outside priority criteria for existing services and agencies because of the nature of their behaviour, age or family situation.**
>
> **Four selection criteria were set for acceptance of children/young people into the CCP:**

13 *Final Report: Redfern Waterloo Case Coordination Project Evaluation*, EJD Consulting and Associates, November 2007, p2-3.
14 *Final Report: Redfern Waterloo Case Coordination Project Evaluation*, EJD, November 2007.

1. **The child/young person resides in the Redfern, Darlington or Waterloo area or has strong links to the area through school, relatives or another significant connection.**

2. **The child/young person is at high risk or engaging in behaviour that places them and/or the community at risk.**

3. **Multiple agency collaboration is necessary due to the complexity of the case.**

4. **Agency intervention has failed to reduce the risks so far.**[15]

Recent feedback from the Redfern Waterloo project staff and participants is that this screening is more effective now than it was when the scheme began. This is largely because the group has become more adept at identifying matters that would be better-managed by a primary agency without the CCP's assistance. Agencies will generally exhaust other possibilities before turning to the CCP and, once a matter is referred to the CCP for help, the lead agency and co-agency partners involved in the particular intervention are now less reliant on the CCP coordinator for problem-solving advice.

It is also important to distinguish the issues that might be apparent at the point of referral from the issues and information that might be needed to bring about a successful intervention. The evaluation of the Redfern Waterloo Case Coordination Project found that the most common 'presenting issues' at the time young individuals, siblings or families were referred to the project for assistance were child neglect, poor school attendance, substance misuse, behavioural issues and criminal activity (almost all referrals had three or more issues noted among the reasons for referral). Interestingly, 'housing' was noted as an issue at the time of referral in just 10 of the 54 referrals during the review period. However, we have been advised that underlying housing issues had to be addressed in the majority of cases and that this was very often pivotal to achieving a lasting outcome.

The CCP was initially funded for 12 months and employed three full-time staff to establish the case coordination framework and provide hands-on support to human service agencies working in the Redfern area. The trial has since been subject to a detailed evaluation which concluded late last year. The evaluation's primary recommendations were that the CCP should be maintained for at least a further two years subject to annual performance reviews and that at least one full-time staff member should be employed in the role of CCP project coordinator.

Other key recommendations relate to:

- enhancing case management monitoring and reporting arrangements to provide a greater focus on results

- revising client referral forms to better reflect the reasons for the referral, the client's case history and suggested intervention options

- improvements to coordination processes and client plans to better capture agreed goals, timeframes, outstanding actions, review dates and how the success of the intervention will be measured

- formally recognising the role of NGOs and developing associated procedures to facilitate this

- the privacy exemption, including the development of guidelines, training and monitoring arrangements for its operation

[15] *Final Report: Redfern Waterloo Case Coordination Project Evaluation*, EJD, November 2007, p5.

- streamlining the governance arrangements of the CCP and clarifying the roles of the operational managers' group, senior officers' group and the Redfern Waterloo Human Services Senior Officers' Group

- continued funding for at least one full time coordinator position to facilitate the case management process.

The evaluation of the CCP highlights that clear governance structures and case management processes must be in place to sustain this kind of interagency work. The report on the evaluation is a valuable document and should be considered in the context of any broader rollout of multi-agency case management models. The recommendations are practical and we understand that they have mostly been implemented by the CCP. The evaluation also provides valuable lessons about what is needed to make case management models work effectively.

In early 2005, West Dubbo community leaders held a crisis meeting involving 200 residents, elders, police and government representatives to look at ways of dealing with high levels of crime on the Gordon Estate. The meeting led to a number of outcomes, one of the most significant was that agencies agreed to conduct integrated case management of 'at-risk' families identified collectively by services and justice agencies. Representatives agreed to meet every week for three months to develop individual case plans. Police were initially responsible for the project before DoCS took the lead. In our 2005 report to Parliament, *Working with Local Aboriginal Communities*, we noted that this model appeared to have many of the elements of solid interagency engagement focused on vulnerable members of the community.

Integrated Case Management (ICM), Dubbo

ICM was founded as a coordinated interagency partnership to allow police and other agencies to share information and develop intensive case management plans for young people and families at risk. The various strategies used included an interagency agreement to coordinate interventions aimed at 'at-risk' families identified by police, community services, housing, health and juvenile justice officials.

ICM's core strategies were for local government agencies to work collectively to improve the quality of life for West Dubbo residents, to identify and intensively case manage targeted individuals and their families, to improve the education and living standards of case managed families, and to map the movement of problematic families to maintain intensive management throughout the Western Region. Its referral process focused on profiles prepared by the referring agency and included interagency discussion about individuals and families. Individual and family case management was at the heart of the ICM approach. This included creating an action plan, tasks for relevant interagency partners, action plan reviews to update outcomes, coordinating information exchange, and tracking movements of individuals subject of case management.

During its establishment phase, the Dubbo ICM wrestled with various issues, including mechanisms associated with privacy and exchanging information. In early 2007, we asked the group to identify the core elements needed to make integrated case management work and they identified the following:

- agencies need to be honest and open about what they know about families they work with

- case plans need to travel with a family when they move to another location

- decision makers who can commit resources need to be in the room

- agencies and service providers need to be properly resourced so they can actually handle the cases being referred

- legislative change needs to be enacted to facilitate the exchange of information between agencies without having to go through too many hurdles

- there is a need to define successes and capture failures, and

- there is a need to capture overall improvements for a whole family rather than focus on a particular individual.

The Dubbo ICM was recently incorporated into the current Anti-Social Behavioural Pilot project, which is being trialled in several locations and managed by the Department of Premier and Cabinet. The NSW Premier announced the Anti-Social Behaviour Pilot Strategy in September 2006. The project is currently being trialled in five locations and eight further locations have been proposed.[16]

Anti-Social Behavioural Pilot (ASBP)

Although the ASBP model is still being developed, it aims to build on the successful elements of both ICM and CCP, and improve case coordination across participating agencies regarding the management of complex cases or crises involving children, young people and families who live in, or are habitual visitors of identified locations. It is also intended to improve case coordination across the ASBP participating agencies regarding the management of individuals and families referred for assistance. The target age group is 0 to 25 years. However, we understand that the ASBP mostly deals with young people aged 10-15 years and their families.

As with the Redfern trial, the ASBP was established with exemptions under the *Privacy and Personal Information Act 1998* to facilitate the exchange of information between partner agencies without consent, where the senior officers group responsible for overseeing the project believed there were reasonable grounds that seeking consent could 'unreasonably prevent or delay necessary service being provided with the result that the child/young person or third parties might suffer harm'. According to the evaluation of the Redfern trial, the structure and operations of the ASBP are largely modelled on the CCP.

In light of what we have observed from the Dubbo case management group, we believe that the ASBP project has the potential to provide a clear process for coordinated planning and support to vulnerable young people. For this reason, there is a need to closely monitor its progress and outcomes. However, we also make the following additional observations:

1. In practical terms, there are dangers in any multi-agency intervention focusing primarily on 'high-risk' adolescents with significant offending profiles as this may effectively exclude other vulnerable young people, including those on a trajectory of escalating offending behaviours but who do not yet have a significant history of criminal offending. Ideally, cross-agency program models should also target vulnerable children and their families as early as possible. If this model is shown to be effective, consideration should be given to the target group being expanded to include high-risk children more generally.

2. We believe that there has been a lack of consultation with, and involvement of, the NGO sector in relation to the ASB framework. Given the fact that NGO agencies are often much better placed to garner broad community support and client engagement than government agencies, and will be called on to provide varying levels of support to young people engaged with the program, we believe that consideration should be given to expanding the model to provide for greater input by relevant NGO agencies as genuine partners. The success of the Redfern CCP in harnessing this source of

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[16] Current ASBP locations are Orana (Dubbo), Canobolas (Orange), Eastern Beaches (Eastern Suburbs, Sydney), Lake Macquarie, Darling River (Bourke). Proposed locations include: Castlereagh (Walgett), Lachlan (Parkes), Macquarie Fields, Parramatta, Richmond (Lismore), Tuggerah Lakes, Lower Hunter and Wagga Wagga.

expertise and assistance demonstrates that difficulties associated with bringing NGOs to the table can be overcome, and that NGOs can play a vital role in working with government agencies to support vulnerable individuals and families. One of the recommendations of the Redfern evaluation was that the role of NGOs should be recognised formally and that procedures be put in place to facilitate their involvement.

3. The creation of integrated case management at Dubbo came about largely due to the commitment and perseverance of certain individuals who had a passion for this initiative and in direct response to a crisis. While it is pleasing to see that this commitment has been maintained by participants in Dubbo during the transition to the ASBP project, we understand that the take up of the ASBP model in other locations has been variable and slow to get off the ground. According to those we have spoken to, one of the reasons for the slow take up is because there is no individual responsible for making it happen from an agency-level in each location or region.

5. What's needed

The case management trials that we have considered provide valuable pointers regarding challenges in applying a multi-agency case management approach to assist individuals and families with complex needs. Our examination of each of the projects to which we have referred have highlighted a number of issues that we believe must be addressed for multi-agency forums to succeed. The most significant of these relate to the need to:

- clearly define the 'target group'
- make changes to the current child protection system to allow and encourage agencies to more readily exchange information
- involve non-government agencies as partners
- allocate additional and dedicated resources to coordinate and drive this type of work, and
- establish an overarching structural framework that includes clear governance and performance monitoring arrangements.

These issues are discussed in further detail below:

Identifying the target group

Appropriate gate-keeping processes can make or break multi-agency case management work. For this type of collaborative scheme to work effectively, groups should avoid taking on matters that could be better managed by a single agency. In carrying out this coordinated work it is important for agencies to have clear parameters around client selection.

As previously noted, there are certain downsides to multi-agency case management forums which only focus on 'high-risk' adolescents with significant offending profiles at the expense of younger children who may be more vulnerable. This is clearly an issue worth considering in terms of the development of any future models of this type. Our preference for child protection matters, is for multi-agency models supporting those who are most vulnerable and require a co-ordinated response.

It is also important to consider the variety of information sources available to government agencies and NGOs to inform decisions about identifying children and families in need of this kind of support. In this regard, we refer to our submission on *Assessment and Early Intervention and Prevention*, and in particular our discussion of intelligence-driven child

protection practices. However, while DoCS has extensive information holdings, there are many other valuable information sources held by other government agencies and NGOs that should be used to identify those most in need.

Furthermore, the experience of the Redfern CCP trial has shown that participants become more adept at identifying those individuals and families who can benefit from this approach.

Careful targeting and sustained effort is essential if multi-agency case management models are to hit their mark and effectively prevent clients from falling through the gaps. Responding using this kind of multi-agency response must also be integral to the day-to-day child protection work of each agency, and not merely an adjunct to their work.

Information exchange

Participants involved in these coordinated case management forums have cited issues associated with information privacy as one of the most significant barriers to the initial identification and ongoing case-management of families with complex needs. Privacy issues generate a great deal of confusion and uncertainty on the part of both government and non-government agencies. Many individual workers lack adequate knowledge of the privacy laws. In addition to legislative change, appropriate training and procedures need to be developed so that workers have a clear understanding of the types of information they can exchange. In this regard, we note that the Redfern evaluation recommended developing guidelines, training and monitoring arrangements in connection with the operation of the privacy exemption.

The Redfern CCP and ASB pilots are the only case coordination models operating with privacy exemptions in NSW. However, there are many other integrated case coordination projects which target at risk groups and are operating without privacy exemptions.

Our work has shown that people responsible for ensuring the safety, welfare and well-being of children need to be able to easily access complete, accurate and timely information about those children. Our submission on *Privacy and exchange of information* to the Special Commission argues that changes need to be made to the current child protection system to both allow and encourage agencies to communicate effectively with each other.

Involving NGOs and other community groups as partners

It is important to emphasise the increasing involvement of non-government organisations (NGOs) in the child protection system. For instance, the role of NGOs is critical to the early intervention program currently being rolled out by DoCS. Similarly, the responsibility for the case management of children and young people in out-of-home care is increasingly being transferred from DoCS to NGOs.

For this reason, it is important to include NGOs in local interagency committees and structured processes around case-management. In this regard, we note that NGOs are involved in a range of interagency joint planning initiatives, including in the area of domestic violence. Excluding NGOs from these forums can lead to a perception that government agencies have a ‘closed shop’ approach and are not prepared to work in partnership with the NGO sector. There is also the danger that the absence of NGOs in these multi-agency forums may deprive government agencies of information and advice to assist them in their decision- making. Furthermore, it is the NGOs who are very often best placed to deliver case management support to vulnerable clients.

The following reasons are sometimes given for excluding NGOs:

- legislative obstacles around exchanging information
- perceptions that NGOs are reluctant to share sensitive case information

- conversely, that NGOs would be less protective of information they received from agencies, and
- NGOs would be unlikely to provide information that government agencies would not already possess.

We also need to consider how to effectively involve key community groups, for example, Aboriginal community working parties, in providing advice and support to multi-agency case management forums. These groups can play an important role in representing and shaping the views of communities about key child protection issues, so we need to carefully consider the nature of the relationship which should be developed between these groups and the multi-agency case forum.

Additionally, local councils have a range of community programs that may need to be considered by case management forums when planning client interventions. Related to this issue, local multi-agency forums need to establish strong work relationships with local government employees responsible for delivering community services.

Resourcing

A fundamental issue in this area is that most of the multi-agency case management work is meant to be carried out without the provision of extra resources. DoCS' *Interagency Cooperation* submission argues that interagency programs, such as those primarily aimed at child sexual assault or domestic violence, work best given specific funding and dedicated staff resources, and clear agreements on the program's purpose, objectives, governance, reporting and other operational issues. These views are strongly supported by other agency and NGO staff that we have consulted – and are supported by this Office.

We believe there is a need for dedicated resources to be attached to these initiatives. At the very least, there is the need for cross-agency coordinators whose job is to work across agencies within a particular area to make sure that this kind of work is developed in a consistent and efficient way. Precedents for allocating specific resources for this kind of work include the funded coordinator position at Redfern. When the project was established it initially had funding to employ a senior case coordinator and two other case coordinators. This was later reduced to one full-time position. The Redfern evaluation recommended that funding should continue for at least one full-time coordinator to facilitate the case management process, document outcomes and provide secretarial support to the senior officer and operational managers' groups.

Other precedents for specifically funded positions include:

- the funding of regional coordinators for the Violence Against Women program;
- the network of 10 Regional Coordination Program staff whose roles include facilitating Regional Coordination Management Groups; and
- the network of coordinators employed by the Department of Juvenile Justice to recruit, establish and maintain a network of Youth Justice Conferencing convenors across NSW.

In employing staff to extend the use of child protection focussed coordinated case management across the state, the aim would be to use coordinator positions to provide secretariat support and specialist advice, program record keeping and maintenance, 'program continuity', and the identification of factors to support overall systems improvement. Coordinators could be employed by a partner agency or by an agency independent of the case management process. There may also be advantages in aligning the coordinator positions with DoCS in order to provide them with good access to key child protection information and advice. However, regardless of where these positions are placed, they will need to be equipped to drive improvements to local interagency practice from both a case management and systemic perspective.

Furthermore, there is also the need to ensure that their accountability is not just to their host agency. Reporting and monitoring arrangements should be put in place to ensure that the Department of Premier and Cabinet and the Human Services and Criminal Justice CEOs are kept abreast of local and regional interagency practice and systemic issues.

Structural framework

At a local level, each of the multi-agency local coordinated case management trials have had to address important structural issues. Early in each of the trials, the multi-agency committees have tended to serve a dual purpose: to bring local managers together to coordinate decision-making about the interventions needed to assist high-need individuals and families who would otherwise fall through the gaps; and to make strategic decisions about agency processes and local service-provision generally. The latter includes decisions about re-aligning programs and processes to complement the multi-agency work and address obvious gaps in service provision.

As each of the trials became established, these two functions have tended to split. In the case of the Redfern CCP, much of the case management work is conducted out of session by nominated service-providers. Brief updates on cases are then provided to a monthly meeting of operational managers. These updates enable participants who are not directly involved in the case management of a particular matter, to alert involved agencies in that case of any important developments. This relatively streamlined reporting process also prevents the forums becoming bogged down in the details of individual case management. If the operational managers encounter particular difficulties or 'blockages' that cannot be resolved at the case management level, they can refer these issues to a higher-level senior officers group whose responsibilities include managing the strategic direction of these and other local programs.

Less clear is the extent to which each of the various location-specific case coordination projects such as the Anti-Social Behavioural Pilots currently report to or are guided by wider governance and monitoring arrangements, such as the framework of local, regional and state-wide committees used to implement NSW State Plan priorities. However, the Department of Premier and Cabinet's submission to the Special Commission (April 2008) indicates what such a framework could look like in its description of a proposed '*whole-of-government coordinating structure for violence against women and domestic and family violence, which was announced in February 2008*':

> **The new violence against women approach involves a three-level, multi-agency structure: a strategic policy unit within the Department of Premier and Cabinet; five state-wide project officers (in NSW Health, the Attorney-General's Department, and the Department of Community Services) to deliver five key domestic and family violence projects; and a network of nine regional coordinators within the NSW Police Force to improve service coordination and integration (particularly between human service and criminal justice responses) in key regions of NSW. There will also be improved engagement with the non-government sector and the community through a new Premier's Council on Preventing Violence Against Women.[17]**

The submission notes that this approach is aimed at delivering consistent, strategic direction and coordination across government and across the state, and will emphasise agencies' shared responsibility for tackling domestic and family violence. For the reasons outlined above, we believe that a similar, tiered framework is needed to strengthen interagency cooperation in the area of child protection and provide more consistent direction to the many local-level committees and initiatives across the state. It would also provide more consistent reporting to higher level bodies including the Human Services and Criminal Justice Chief Executive Officers forum, and the Government Ministers they report to.

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[17] Department of Premier and Cabinet, Submission to the Special Commission, April 2008.

Finally, against the background of this discussion on the necessary structural framework, it is worthwhile considering the results of a recent evaluation of Young Offender Teams in New Zealand. This is a nation-wide scheme jointly managed by NZ police, welfare, education and health agencies. The aim of the Youth Offending Teams was to bring together managers and frontline practitioners from each of the four key agencies to better-coordinate interventions aimed at providing a more comprehensive and effective response to juvenile offending and its underlying causes. An evaluation report found that:

> **The chair is a critical role to the YOT and a motivated chair is considered very important to the success of the YOT… The success of a particular YOT is currently directed to a large extent by the involvement and input of individual members rather than the structure and processes of the YOT. The driving force can be the person who is the chair, but it can also be a motivated member of the YOT other than the chair. Youth Offending Teams are therefore vulnerable to changes in membership and the absence or departure from the YOT of a key member who is a driving force and can have a considerable effect on the performance of that YOT. Funding for projects is considered important for the success of YOTs…** [18]

The solution in New Zealand, as it is here, is to build this type of work into systems rather than being overly reliant on enthusiastic individuals to be the driving force.

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[18] *Evaluation of Youth Offending Teams in New Zealand*, NZ Ministry of Justice, November 2007.

Special Commission of Inquiry
into Child Protection Services in NSW

Submission of NSW Ombudsman

Part 9: RESPONDING TO ISSUES OF SERIOUS CHILD PROTECTION AND NEGLECT IN ABORIGINAL COMMUNITIES

June 2008

Ombudsman ref: ADM/6125

1. INTRODUCTION

This submission addresses issues raised by the Special Commission of Inquiry in its *Aboriginal Communities Facts Sheet* and the questions posed in the agenda for its public forum of 24 April 2008 regarding:

- Aboriginal workforce development in government and non-government child protection
- enhancing the capacity of Aboriginal organisations
- the practical application of Aboriginal Child Placement Principles
- Aboriginal children and young people in out-of home care and attracting and retaining carers to provide that care, and
- the adequacy of current and planned strategies to address the child protection needs of Aboriginal people and communities.

The views expressed in the submission are based on our work with Aboriginal communities across NSW, our Aboriginal Unitøs efforts to help police address a legacy of distrust and develop genuine partnerships with Aboriginal communities, and in monitoring services for vulnerable children and young people. Given the breadth of our powers and jurisdiction, we are in a unique position to make observations about the practices of individual agencies and interagency practice in providing services to Aboriginal communities.

We have also been mindful of a range of recent Federal and State initiatives that are particularly relevant to Aboriginal disadvantage and child protection issues.[1]

The extent of Aboriginal disadvantage and over-representation in the child protection system were underlined by the Commissionerøs opening remarks to the Special Commissionøs public forum on Aboriginal community issues on 24 April 2008. The data the Commissioner cited on significantly lower Aboriginal life expectancy, poorer health, disproportionate representation in reviewable death inquiries, poor school retention, significantly higher rates of incarceration, unemployment and homelessness, and the relatively high incidence of reported domestic violence incidents, highlight the entrenched nature of the problems affecting Aboriginal communities.

These challenges are particularly evident in a number of communities across NSW which have large Aboriginal populations and limited access to services, resources and opportunities. They are also becoming apparent in regional centres with better access to services, but which are experiencing rapid demographic change. A recent Centre for Aboriginal Economic Policy Research study noted that while the overall population growth between 1996 and 2001 in six regional centres, including Broken Hill, Dubbo, Orange and Tamworth,[2] was just 2%, the Aboriginal population in those centres grew by 28%. As the prominence of Aboriginal residents in these larger regional centres grows, this will have major implications for the role they play in the governance and economy of those centres, and for service delivery across the region generally.[3] The challenge for government is to address the complex social problems

[1] We have had regard to the Federal Governmentøs child protection discussion paper, Australiaøs children: safe and well, which is being used to inform the development of a national child protection framework. We have also reviewed submissions made to the NSW Parliamentøs Standing Committee on Social Issues in connection with its ÷Inquiry into closing the gap ó overcoming Indigenous disadvantageø, the Productivity Commissionøs National Framework of Principles for Delivering Services to Indigenous Australians and its three Overcoming Indigenous Disadvantage reports and the NSW Interagency plan to tackle child sexual assault in Aboriginal communities (2006-2011).

[2] The other two centres were Port Augusta and Kalgoorlie.

[3] *Population and Diversity: Policy Implications of Emerging Indigenous Demographic Trends*, CAEPR 2006.

that go along with this demographic shift, coupled with difficulties in attracting and retaining suitably qualified staff.

In many ways, the measures needed to address child protection issues are the same for both Aboriginal and non-Aboriginal communities. In the short term, Aboriginal and non-Aboriginal communities both need ready-access to quality services with the capacity to support families and respond to those children and young people who are most at risk. At the same time, the potential to foster longer term positive change and develop preventive solutions will depend on the availability of regular employment, quality education, cohesive families and other protective factors. The needs of Aboriginal people are no different from other Australians in this respect.

Yet there are also crucial differences. In addition to significant cultural and historical factors that distinguish Aboriginal people, it is important for child protection services to have regard to issues that are specific to Aboriginal communities when working in this area, including the following:

- as significant numbers of Aboriginal families are affected by child protection issues, there is a need to prioritise Aboriginal access to existing services and for services to be responsive to their needs

- Aboriginal people are more likely than non-Aboriginal people to reside in high-need rural locations, where general service-provision is often stretched, skill shortages are common and small numbers of staff must cover vast distances, making systems more susceptible to failure

- the differing availability of protective factors that lead to positive child protection outcomes in each community ó stable family environment, a safe home environment, good parenting, a steady income, employment, aspirations, self-esteem and the like, and

- current service deficiencies, Aboriginal over-representation in the child protection system and high rates of Aboriginal incarceration can reinforce and perpetuate low Aboriginal expectations of or even antipathy towards frontline service-providers.

In addressing Aboriginal child protection issues, an obvious starting point is to undertake a frank assessment of the needs of Aboriginal communities, whether those needs are being adequately addressed through either mainstream or Aboriginal specific services or programs, and to look for opportunities to build on positive initiatives already in place. Conducting such an assessment requires accurately determining the nature and extent of the need and evaluating which programs actually work.

An important step in assessing the adequacy of our child protection responses is to consider whether essential services are available where and when they are needed. Through our auditing and other review work, we have found that the delivery of policing, health, welfare, housing and other essential services in high-need areas can be hampered by skill shortages and high staff turnover. In many cases, these can be successfully addressed by providing better incentives to attract and retain suitably qualified and experienced staff, especially in remote locations where vacancies can take time to fill. This is critical if agencies are to prioritise Aboriginal access to mainstream services.

What has been consistently recognised in reports, is the challenge in making services more responsive to and accessible by local Aboriginal people. Meeting this challenge does not involve a ÷one size fits allø approach in the design and delivery of services. Instead, service delivery needs to be tailored to suit the needs of particular communities. Enhancing services

to Aboriginal communities should also involve establishing or extending the capacity of Aboriginal-specific or community-controlled organisations, and for those bodies to collaborate with other agencies to deliver a coordinated suite of services.

Clearly, a key challenge for agencies is to build genuine partnerships with Aboriginal communities and develop community-specific solutions.

2. ADAPTING MAINSTREAM SYSTEMS TO ABORIGINAL PEOPLE

In this section we discuss the following issues, a number of which were specifically canvassed by the Commission in its *Aboriginal Communities* facts sheet:

2.1 Aboriginal children and young people in out-of-home care
2.2 The practical application of the Aboriginal Child Placement Principles
2.3 Cultural support case planning
2.4 Enhancing the capacity of Aboriginal organisations
2.5 Attracting and retaining suitable carers of Aboriginal children, and
2.6 Aboriginal participation in care and protection decisions.

Many of these issues have been addressed in our earlier submissions and reports. This section highlights a number of the key issues that should be considered in delivering improved child protection services to Aboriginal children and families. Section 3 of this submission considers some of the building blocks which we believe need to be in place for responding to child protection issues within Aboriginal communities.

2.1 Aboriginal children and young people in out-of-home care

In 2007, we undertook a detailed review of issues affecting carers of Aboriginal children and the adequacy of services and supports in place to help them to provide quality care. Our report entitled *Supporting the carers of Aboriginal children,*[4] noted issues based on interviews with carers and service-providers, and feedback from face-to-face surveys of 100 Aboriginal and non-Aboriginal carers of Aboriginal children in care.

As more than 30% of all children and young people living in out-of-home care in NSW are Aboriginal, many of the issues and observations regarding Aboriginal children and young people in care will apply to out-of-home care generally.

The following observations were among the key issues highlighted in our report:

- Carers emphasised the value of regular, quality contact with caseworkers. We found that carers generally had realistic expectations of DoCSøability to assist in providing quality care. For the most part, their principal need was for regular contact with the childøs caseworker and for caseworkers to acknowledge and respect carersøefforts to provide a safe and nurturing home environment.

- Providing good support to carers not only encourages their retention, but well-supported carers are an effective, if not *the* most effective, recruitment tool through their word-of-mouth advice and encouragement to potential new carers.

[4] Drafts of this report were provided to DoCS for comment, and to the Special Commission of Inquiry.

- Providing good support to carers from the outset enables the early identification of problems and of any specific supports required for the child or carer, reducing the risk of placements breaking down. A closer and more supportive relationship between carers and case workers also enables the early identification of placements that are either inappropriate or have the potential to cause harm.

- Good health screening and coordinated follow-up is critically important as poor health and well-being, undiagnosed sight, hearing and other impairments and other health issues disproportionately affect children in out-of-home care. As Aboriginal children in care are particularly susceptible to certain health problems, we found significant benefits in the Department of Community Services (DoCS) establishing formal agreements with services such as the Aboriginal out-of-home care service provider, KARI Resources Inc, in conjunction with public health services, to coordinate comprehensive health assessments of all Aboriginal children entering out-of-home care placements with KARI carers in South-West Sydney.

- Few of the carers that we interviewed considered that caseworkers have an active interest in meeting the educational needs of children in care, except to assist in responding to particular incidents or crisis that threaten the viability of a school placement. Early educational supports are essential, as children in out-of-home care are disproportionately affected by health problems, behavioural issues, lack of resources, frequent absences from school and other issues with the potential to undermine learning outcomes. The traumatic circumstances associated with many children coming into care and, in some cases, the ongoing impacts of placement instability while in care, can also compromise their studies. Unless these problems are addressed early, the problems accumulate and put these students at a distinct disadvantage. We suggested that urgent consideration be given to:
    - individual education case planning
    - strategies to bring carers, caseworkers and schools together to address any learning impediments or schooling problems, and plan for the broader educational needs of their children
    - collecting, analysing and reporting on the education participation and performance of *all* children in out-of-home care, and
    - tracking performance over time to determine the effectiveness of strategies to enhance learning outcomes, including ongoing evaluation of the recently developed memoranda of understanding and other systemic supports.

- DoCS needs to address critical deficiencies in its data on carers of Aboriginal children. For example, although DoCS can provide figures on the number of Aboriginal children in out-of-home care, it could provide no reliable data to this Office on the ratio of non-Aboriginal and Aboriginal carers of Aboriginal children.

The Federal Governmentøs discussion paper, *Australia's children: Safe and well*,[5] outlines a range of options for developing national standards and monitoring of the out-of-home care system, including the development of a strategy to ÷build the capacity, status and performance of foster care nationallyø Due to the ÷emerging evidenceø about the particularly poor results for Aboriginal children in out-of-home care, the paper also proposes the development of specific national standards for Aboriginal children with a focus on securing safety and wellbeing, health and educational development, and connection to culture and community. We believe there is merit in the development of national standards and monitoring in this area to help ensure greater consistency across jurisdictions in providing for the safety and wellbeing of children in out-of-home care.

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[5] *Australia's children: safe and well – A national framework for protecting Australia's children. A discussion paper for consultation.* Australian Government, May 2008.

2.2 The practical application of the Aboriginal Child Placement Principles

Although DoCS claims that 85 per cent of all Aboriginal and Torres Strait Islander children in out-of-home care are placed ÷*in accordance with [the Aboriginal placement] principle'*, our review of the adequacy of supports provided to carers of Aboriginal children revealed that guidance to DoCSø staff and related work with communities is needed around what constitutes ÷proper consultationø in relation to placement decisions concerning Aboriginal children.

There are real challenges for DoCS and for communities in determining what constitutes proper consultation in making placement decisions. It is clear from DoCSø responses to our requests for information about current policy and procedures regarding ÷consultationø that little guidance is provided to staff about what consultation should look like in practice.

Emergency placements must continue to be made without any or significant consultation. This is recognised in section 13(8) of *Children and Young Persons (Care and Protection) Act.* Yet consultation should still take place as soon as practicable, and the references in section 12 to involving families, kinship groups, representative organisations and communities through ÷means approved by the Ministerø, makes it clear that the legislators intend meaningful consultation to take place.

It is important for DoCS to address the issue of what constitutes proper consultation from both a policy and practice perspective. While a ÷one size fits allø approach will not work, a solid policy platform would guide CSCs in developing local consultation strategies in partnership with their communities. Getting this process right would go some way to building bridges between DoCS and local Aboriginal communities. It is also inextricably linked to the development of cultural support plans for Aboriginal children in out-of-home care.

The Federal governmentøs discussion paper, *Australia's children: safe and well,* outlines an option for including ÷compliance with the Aboriginal Child Placement Principleø in a national framework for protecting children, with a focus on why jurisdictions have varying experiences of implementing the principle. This approach has the potential to identify innovative models of care for Aboriginal children and successful practices around consultation. However, we firmly believe that more effective consultation practices need to be adopted by DoCS as a priority, and that this should not be difficult to achieve.

2.3 Cultural support case planning (CSCP)

The proper application of the Aboriginal Child Placement Principles, including a serious and sustained effort to place children with extended family or kin, is related to helping Aboriginal children in out-of-home care retain their cultural connections and establish a confident understanding of their place in the world. If children must be placed with carers with no kin connection, then care planning, especially cultural care planning, is crucially important for carers expected to help the children in their care connect with their family, community and culture to the maximum extent possible.

DoCS says it expects all care plans to address factors such as identity, culture and religious awareness. For Aboriginal children and young people, care plans should also include information on family and social networks and placement arrangements.[6] Yet based on our consultations with carers, there appears to be very little evidence of cultural support planning

[6] Response by DoCS (provided on 16 November 2007) to our request for information dated 19 October 2007.

for Aboriginal children and young people in out-of-home care. Rather, the onus seems to be on carers to identify and access relevant supports. This is consistent with the advice provided in the *Foster Carer Resource Guide*. This lack of cultural support planning is a significant concern for children who are placed with non-Aboriginal carers. Having said this, Aboriginal carers may also require appropriate supports in this area, especially if they have no direct connection with the kin or country of the children in their care.

In our surveys of carers, we took any involvement by DoCS in arranging regular cultural activities to indicate evidence of current cultural support planning, irrespective of whether a formal plan was in place. Even so, against this benchmark carers indicated that just 8% of children had been provided with some type of ÷cultural supportø Also, although most carers appeared to appreciate the importance of cultural support planning for children, they clearly needed DoCS guidance about what this type of planning should involve and the respective responsibilities of carers and caseworkers.

We have examined cultural care planning in Victoria and noted a number of positive features about that process. DoCS has since announced it plans to pilot cultural support plans in a number of areas and that the plans will be ÷loosely basedø on the Victorian system. This is a welcome development as it has the potential to provide a catalyst for bringing DoCS closer to Aboriginal communities.

In developing and implementing a CSCP tool and guidance, in our report on *Supporting the carers of Aboriginal children*, we suggested DoCS consider the following issues:

- There would be value in involving the peak body, AbSec, as this may go some way towards helping to raise and address community concerns. AbSec could also help evaluate outcomes and develop a template for applying CSCPs more broadly.

- The proposal to involve a ÷major non-government out-of-home care serviceø in the trial has merit, especially a service with experience in supporting Aboriginal programs. This might also provide an important practice benchmark.

- As the Western region no longer has an Aboriginal out-of-home care service yet still has large numbers of Aboriginal children in care, there would be value in DoCS extending the trial to involve a non-Aboriginal service in the Western region, notably a service with a demonstrated commitment to cultural support such as Uniting Care Burnside.

- Given advice from Victoria about the difficulties in integrating CSCPs into case practice, DoCSø proposal to build the plans into the existing case management system is worth trialling.

- Any evaluation should include an assessment of compliance with the Aboriginal Child Placement Principles and compare consultation regarding placement decisions in the trial sites with the consultation processes used elsewhere.

- In addition to training case workers in the trial sites, there is also a need to train carers about their responsibilities to implement these plans.

- Consideration needs to be given to the ongoing role that AbSec and Aboriginal out-of-home care services should play in relation to providing input into the ongoing development of cultural support plans.

2.4 Enhancing the capacity of Aboriginal out-of-home care organisations

While DoCS, the non-government sector and the Childrenøs Guardian have achieved improvements in out-of-home care practices in recent years, including practices relating to Aboriginal children in care, the *capacity* of the Aboriginal out-of-home care sector remains very limited. Aboriginal services can currently place around 200 (5%) of the 3,812 Aboriginal children in care.

Our report on *Supporting the carers of Aboriginal children*, noted that there is a critical need to expand both the number of Aboriginal out-of-home care services and the number of placements available for Aboriginal children with Aboriginal carers to address current constraints and continuing growth in demand. In response to these challenges, DoCS has outlined its plans in its submission to the Commission. DoCSø goal is to increase the proportion of Aboriginal children placed with Aboriginal out-of-home care agencies from 5% to 10%. Even if it succeeds, at best this will only restore the proportion to around the level that existed prior to the demise of the Aboriginal Childrenøs Service.

Yet there are significant challenges for DoCS in meeting even its 10% target. Firstly, although 52% of all Western Region children in care are Aboriginal, there is currently no Aboriginal out-of-home care service in that region. Nor are there Aboriginal out-of-home care services in the New England and Metro Central regions. DoCS initiated an expression of interest process in March 2007 as part of a major ongoing program to enhance out-of-home care services. However, no Aboriginal agencies from the Western region were selected, nor did the process identify any new agencies.

The shortage of Aboriginal NGOs applying for funding enhancements to provide additional out-of-home care services, and the apparent failure of those that did apply to meet the standards required, indicates that current capacity constraints are likely to continue into the future unless action is taken now. DoCS acknowledges this is a concern, and has indicated it will try alternative approaches:

> *The [EOI] process has identified some gaps in the OOHC service system which will be filled by direct negotiation with Aboriginal and other specialised OOHC service providers.*[7]

As part of this process, our report on *Supporting the carers of Aboriginal children*, suggested that there would be merit in considering ways for successful non-Aboriginal services to mentor staff from Aboriginal services, both to build the capacity of existing Aboriginal services and support the establishment of new services. These kinds of cooperative partnerships would help build the capacity of the Aboriginal out-of-home care sector into the future. In this regard, we are aware of Burnsideøs success in recruiting significant numbers of Aboriginal staff and carers, and in providing care to many Aboriginal children in the Western Region. In speaking with a number of Burnsideøs Aboriginal carers we were encouraged to hear very positive feedback about the support Burnside provides to both them and the Aboriginal children in their care. Barnados also has plans to build service capacity in this critical area. Harnessing the support of experienced services is critical if Aboriginal NGOs are to play a more active role.

Following recent discussions with AbSec and service providers, we have no doubt about the willingness of key players to explore this issue of cooperative partnerships. In this constructive environment we see no reason why successful initiatives along these lines cannot

[7] ÷Out-of-home care funding rolloutø, http://www.community.nsw.gov.au/DOCS/STANDARD/PC_100986.html - accessed 30 May 2008.

be rolled out over the next few years. Furthermore, we believe that there is scope for these partnerships to develop Aboriginal agencies that can provide a suite of services.

In evidence to the Special Commissionøs public forum on Aboriginal Communities on 24 April 2008, Mr Julian Pocock, executive director of the Secretariat of National Aboriginal and Islander Child Care (SNAICC), outlined his reasons for supporting cooperative partnerships:

> í .*if we want to see smaller Aboriginal organisations increase their capacity to deliver a broad range of holistic services, of which out-of-home care is a part, and, secondly, if we want to see new agencies emerging where we don't have agencies, which is in most of the state, is that government actually needs to make the formal decision that it wants it to happen.*
>
> *.....it will always be the case that very small agencies, whether they are Indigenous or not, will struggle to compete against larger, more well-resourced organisations that already have a strong foothold in the sector. I think recent experiences in New South Wales largely bear that out.*
>
> *So the most fundamental thing that has to change is that government and the department have to actually make the decision that they want to develop the capacity of existing agencies to provide a whole range of programs, not just out-of-home care.*
>
> *The reason that we argue so strongly that out-of-home care should be situated within a broader suite of services for an agency is because if we continue in New South Wales to segment these things off, rather than having integrated funding agreements and agencies having one funding agreement to do a whole range of things, at a point in time when we need critical information about a child's circumstances, when there are care and protection issues to deal with, an agency that has a broad suite of programs will have had a history of engagement with families and will have the knowledge you need about who is important in that child's life, what their family and kinship network systems are and who can actually step up to the plate to protect kids. The more you fragment the service system, the more difficult it is, in our view, to get that critical information when you need it.*
>
> *So that's why we argue that all State and Territory governments – but particularly this one, because they are probably a bit further behind than other States, need to actually make a formal policy decision that we want to develop Aboriginal agencies to provide that continuity of service of which out-of-home care is a part. Until you make that mind shift, little will change.*[8]

We also support the Commissionøs consideration of flexible accommodation models for Aboriginal children. In particular, we believe that, at the very least, short-term residential accommodation for Aboriginal children and young people needs to be considered, particularly if it provides a means of keeping these children close to their families and communities, and is part of a broader suite of services. What also needs to be understood is that placing an Aboriginal child within a family environment close to the childøs own family can potentially raise major problems if the placement is not with the childøs kin. For this reason, we understand AbSecøs general support for trialling short-term residential care as a means of keeping at-risk Aboriginal children within their communities. We also acknowledge recent attempts within the Bourke community to explore the possibility of providing a ÷safe houseø environment. In this regard, we also note that the Federal Governmentøs discussion paper, *Australia's children: Safe and well,* canvasses potential innovative models that combine elements of family-based care with residential care. For example, proposals which combine a boarding school approach with more intensive support and permanently assigned respite parents. The paper also notes the growing interest in international developments in this area.

A related challenge is ensuring that any increase in the number of Aboriginal placements in out-of-home care is coupled with high quality service delivery. Past attempts to rapidly

8 Transcript, Aboriginal Communities forum 24 April 2008, p27-28

expand non-government services have not always guaranteed the delivery of quality services. For this reason, we believe that any accelerated expansion of individual services, particularly those without a proven track record in this field, must be carefully managed and closely monitored. Also, in order for AbSec to effectively perform its role in monitoring the quality of care, it needs easier access to critical information about Aboriginal children in care and the carers of these children. For this reason, improved systems for sharing the information and data are essential if DoCS is serious about building a more meaningful partnership with AbSec and helping it to strengthen its strategic focus.

2.5 Attracting and retaining suitable carers of Aboriginal children

As noted earlier, well-supported carers are an effective ó arguably *the* most effective ó recruitment tool through their word-of-mouth advice and encouragement to potential new carers. Aboriginal out-of-home care services affiliated with AbSec also confirmed that this strategy generally works best, and is much more effective than large campaigns. However, for word-of-mouth to be an effective recruitment strategy, it requires carers to strongly endorse the merits of fostering to those within their communities. For this to happen, it requires carers to feel that they are being well-supported.

In the Special Commissionøs recent Aboriginal Communities forum, Burnside UnitingCare manager, Mr Reg Humphreys, commented on the value of ÷word of mouthø in attracting interest from new carers:

> *Over the last 10 years we [Burnside] have been involved in a journey by developing relationships of mutual respect and trust with significant groups of individuals in our immediate vicinity, to the extent that, today, out of 44 permanent staff, 22 are Aboriginal people, and out of 49 carers, 29 are Aboriginal people, and a couple of things have become obvious along the way. One is the business of 'vouching'... they don't want to come and work for us unless they have had people recommend us.*[9]

Through our work with carers, we were advised that recruitment strategies that tap into the fabric of Aboriginal community life, including key cultural events such as NAIDOC, ÷community and family gatheringsø and sporting events, are also potential opportunities to spread the word about fostering. [10]

DoCS also plans to examine ways of reducing the period of time it takes to assess its foster carers. Ongoing foster carer recruitment will need to be dovetailed with efficient follow-up and carer assessments. Both DoCS and out-of-home care agencies will need to attract greater numbers of Aboriginal carers to meet the increased demand for suitable placements. DoCS and out-of-home care agencies will each be targeting the same potential pool of people in each region. For this reason, recruitment strategies need to be complementary and reflect a genuine partnership between DoCS, AbSec and out-of-home care service providers.

In this regard, it is pleasing to note that AbSec recently announced the launch of an Aboriginal foster care recruitment and training film, *Have a Heart – become a Carer.* The film will be formally launched by the Minister for Community Services at NSW Parliament House on 3 July 2008.

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[9] Transcript, Aboriginal Communities forum 24 April 2008, p17-18.

[10] We note that a recruitment campaign launched by DoCS in August 2006 attracted interest from 2000 potential foster carers. It is unclear how many of these people were Aboriginal or whether Aboriginality was identified. This campaign was linked to the launch of the centralised Foster Carer Recruitment Line in August 2006. After the initial inquiry is made, a caseworker makes contact with the potential carer and provides more detailed advice about authorisation, training and assessment processes. The second phase of the program involves a long-term approach targeting potential Aboriginal and multicultural carers.

Our review of issues affecting carers of Aboriginal children noted that most jurisdictions tend to collect little data about foster carers in general, particularly in relation to why carers commence or leave fostering. Our report suggested that there would be merit in systematically collecting this type of information, including issues specific to Aboriginal carers.[11]

2.6 Aboriginal participation in care and protection decisions

Our 2006 Childrenøs Court Discussion Paper noted the need for greater innovation in finding ways to facilitate more meaningful Aboriginal participation in child care and protection decisions. This includes developing more effective ways to genuinely engage Aboriginal families, kinship groups, representative organisations and communities in child care and protection decisions, as envisaged by the *Children and Young Persons (Care and Protection) Act*. NSW has started to explore options for putting this principle into practice, but this work is very much in its initial stages. On this issue, it is important to recognise that although the Act refers to ÷consultationø, it understandably does not elaborate on the complexities associated with this process. At least in theory, consultation should be addressed in policy. However, there are some very difficult challenges in applying this concept in practice. It also needs to be recognised that some community ÷leadersø may not be appropriate to consult in relation to child protection issues.

The issue of identifying appropriate and respected community members is currently being considered in the context of the ÷Care Circleø trial about to be piloted in Nowra. This trial has the potential to provide DoCS with guidance on this consultation issue. It may also highlight some challenges, including managing community expectations and difficulties that might arise from involving Aboriginal community leaders in a process that may result in decisions to remove children from their parents. For example, this trial should determine whether suitable members from within Aboriginal communities in the Shoalhaven area are prepared to participate in making decisions of this type and, if so, the level of acceptance by affected families and the local Aboriginal communities. It is also important to recognise that there will need to be different approaches used in different communities to resolve the ÷consultation issueø and for each child involved there will need to be specific consideration given to the particular family and community members who should be consulted. However, irrespective of whether the trial leads to the permanent establishment of Care Circles, a well-supported trial could provide valuable insights into the mechanisms needed to support better community input into decision-making about child protection issues.

Another approach is the ongoing Family Group Conferencing work being done by UnitingCare Burnside in relation to matters at the pre and post court stages. This model is based on the conferencing approach used for child protection matters across New Zealand, and has a strong emphasis on the concept of ÷extended familyø.[12] This emphasis makes this model a potentially useful and culturally appropriate tool to apply in resolving certain child protection issues affecting Aboriginal ÷familiesø.

Consistent with the Act, these kinds of initiatives need to be promoted and, if their evaluation demonstrates that they are successful in addressing key issues, rolled out more broadly. In

[11] The kind of data that might be useful to collect in relation to Aboriginal carers includes: Indigenous status; age; carer type ó foster, authorised kinship; date of commencement/exit; the reasons why person became a carer; the reasons why person ceased care-giving role (exit interviews); the number of potential carer inquiries (the carer hotline records this to a limited extent); the number of people assessed as unsuitable; the number of people who withdrew from initial training, and the method by which carer was introduced to fostering/kinship care.

[12] Burnside Uniting Care introduced Family Group Conferencing as a pilot program for care and protection matters in NSW from 1996 to 2000. When the project ended, facilitators continued to facilitate cases that were referred to them. Burnside Uniting Care continues to operate a conferencing program and some small-scale pilot projects that use, or draw on principles of, conferencing are planned in regional areas. Burnside has also developed an accredited training course for facilitators. See Harris N, ÷Family group conferencing in Australia 15 years onø, *Child Abuse Prevention Issues* No.27, Australian Institute of Family Studies, 2008.

this context, while noting the relative lack of use of alternative dispute resolution to date, we are encouraged by the commitment to alternative dispute resolution expressed by the major parties at the Commissionøs recent public forum on the Role of the Courts.

In supporting alternative dispute resolution, we acknowledge that it will not be appropriate for certain matters. However, given that the need for ÷care and protectionø is often not disputed in care proceedings, there would appear to be considerable scope for alternative dispute resolution techniques to be used to canvass what might be in the best interest of a child relating to decisions such as the allocation of parental responsibility, placement, specific care arrangements and contact. If these issues can be explored through a resolution process which focuses on a childøs best interests, this would appear to be more consistent with the legislatureøs intentions and appropriate within an Aboriginal context.

3. DELIVERING COORDINATED SERVICES

Since the creation of our specialist Aboriginal Unit in 1996,[13] Aboriginal communities have been a specific focus of our work. In recent years, this has also included our role in reviewing child deaths. Through our child death review work we have identified a range of issues and subsequent challenges for agencies working with Aboriginal children who may be at risk, including:

Limited capacity to respond to issues of neglect, parental substance abuse and domestic violence in particular Aboriginal communities. We have had concerns about child protection and related problems in Western NSW and other remote and/or ÷isolatedø communities.

Ineffective interagency coordination and collaboration and the need to improve interagency approaches.

This part of our submission considers the following building blocks that we believe need to be in place in order for progress to be made in responding to child abuse and neglect within Aboriginal communities:

3.1 building partnerships with community to address child protection issues
3.2 frameworks to guide planning and service delivery
3.3 building an evidence base, and
3.4 workforce development measures needed to enhance frontline capacity.

3.1 Building partnerships with community to address child protection issues

In 2006, the Productivity Commissionøs Steering Committee for the Review of Government Service Provision (SCRGSP) carried out an extensive community consultation process with Aboriginal communities across the country to seek feedback about its report, *Overcoming Indigenous Disadvantage: Key Indicators 2005*. As part of this process, the steering committee identified a range of ÷success factorsø behind the ÷things that workø when government agencies interact with Aboriginal communities and organisations. In this regard, there was strong endorsement for cooperative approaches between government and community, as well as community involvement in program design and decision-making.

[13] Although this Office had Aboriginal liaison officers before 1996, the Royal Commission into the NSW Police Serviceøs first *Interim Report* (Feb 1996) recommended the establishment of a unit to provide a specialist focus on Aboriginal issues.

On this issue of consultation, it is worthwhile noting the Productivity Commissionøs views on the factors that contribute to successful program implementation in Aboriginal communities consisted of the following four key components:

- cooperative approaches between Indigenous people and government (and the private sector)
- community involvement in program design and decision-making ó a ÷bottom-upørather than ÷top-downøapproach
- good governance
- on-going government support (including human, financial and physical resources).

In relation to these factors, it is worthwhile noting the importance placed on quality consultation.

While current attempts to increase Aboriginal participation in care and protection decisions have tended to focus on Childrenøs Court care proceedings and other acute interventions, it is important to consider the opportunities for involving communities in dealing more broadly with problems relating to child abuse and neglect within their own communities.

A significant development in relation to Aboriginal community consultation mechanisms occurred with the introduction of community working parties in NSW. In 2002, the Council of Australian Governments (COAG) selected eight sites across the country to examine the delivery of a ÷whole of government approach in partnershipøwith Aboriginal communities. The Far Western NSW region known as Murdi Paaki was one of the eight sites chosen. One of the key elements of the COAG trial was the establishment of community working parties as a primary mechanism for consultation and representation at the community level.

In 2006, the Australian Government commissioned an independent evaluation of the eight COAG trial sites. The evaluation found that the Murdi Paaki trial ÷has been highly successful to date, largely because of the Aboriginal communityøs commitment to improving governance and establishing community decision-making forums across the region, and Government support for these structuresø[14] The evaluation of the Murdi Paaki trial also noted the following positive outcomes:

- Murdi Paaki is regarded as one of the more advanced COAG trial sites in Australia in relation to its community capacity and governance;

- Representatives from the two lead government agencies selected to participate in the trial have developed strong relationships with communities and have a ÷visible presence in the regionø

- Consultations in the Murdi Paaki region revealed strong support for the ÷refreshedø community working party model and community action plans;[15]

- The governance capacity of communities has improved and many communities appear better able to articulate their priorities to government in a constructive fashion; and

- 18 shared responsibility agreements were signed during the trial.

The NSW Government submission to the Inquiry into Overcoming Indigenous Disadvantage outlines data in relation to indicators in the areas of housing, health, educational attainment,

[14] NSW Government submission to the Inquiry on Overcoming Indigenous Disadvantage, p82
[15] Although it has taken a long time to complete, the community action plan process was regarded in a positive light by the majority of stakeholders.

and law and justice for the Murdi Paaki region during the trial period. The submission notes that there has been ÷substantial improvementsø across these indicators, and while also noting that it is not possible to draw direct causal links between the trial initiatives and these improved outcomes, the submission does attribute the improvements to the success of the partnership approach in the region.[16]

From our work, we have been impressed by Aboriginal community working parties across the state. However, it is also important to note that we have been told on a number of occasions about significant concerns held by respected members of communities about particular working party members or others in key positions of responsibility. In circumstances where there are broadly held negative perceptions about individuals performing these roles, this can fundamentally undermine the effectiveness of the working parties and/or the agencies they represent. For this reason, there may be merit in considering the current processes around the selection and membership requirements relating to these types of committees and agencies. In this regard, the selection processes for community justice groups in Queensland may provide useful guidance on this issue.

While it is important to acknowledge the critical role of Aboriginal community working parties in the local consultation process, it is also worth noting the presence of Aboriginal womenøs groups in particular communities and, more recently, the emergence of menøs groups. These groups often focus on dealing with social problems within communities. In particular, groups tend to have a strong focus on domestic violence, substance abuse and parenting. Over the past few years, community leaders have increasingly raised concerns about at-risk children and young people within their communities. Against this background, we believe the time is ripe for agencies to begin to explore ways of strengthening the focus on child protection issues within community forums. In this regard, we note that the *Interagency plan to tackle child sexual assault in Aboriginal communities* has a strong consultation focus. We will be keen to see whether meaningful consultation resulting in real outcomes can be generated through this process.

Our four-year program of 36 detailed local area command audits to assess police work with local Aboriginal communities has provided us with a solid platform for commenting on Aboriginal community and agency partnerships. Our work has included consulting more than 3500 Aboriginal people from about 90 communities and representatives from over 400 agencies and services ó as well as local police commanders, other senior police and specialist liaison officers from the commands we audited. Our reports to Parliament in 2005, *Working with local Aboriginal communities*, and 2006, *Domestic violence: Improving police practice*, highlighted a number of local strategies and initiatives across NSW involving police, other government agencies and NGOs working with local Aboriginal communities to develop practical ways to address local community concerns. We formed the view that the most impressive of these schemes included small but effective youth diversion, school retention and youth mentoring programs, holistic models of coordinated domestic and family violence investigation and prevention initiatives, and linking Aboriginal employment and training programs with targeted crime prevention strategies and other police priorities. Since the release of our reports, we have continued our work in examining community and agency partnerships.

Although most of the schemes that appeared to have some evidence of success were limited in scale, unfunded or only modestly funded, they demonstrate the potential for government agencies, NGOs and communities to create genuine partnerships that improve practical outcomes. In most cases, the strength of these initiatives is that each involves agency partners successfully finding ways to:

[16] NSW Government submission to the Inquiry on Overcoming Indigenous Disadvantage, p83

engage with Aboriginal communities, even where that might involve having to negotiate community divisions or entrenched attitudes

clarify priority concerns and get consensus on a course of action

deliver on agency promises to implement practical measures that respond to priority community concerns

use the outcomes from these schemes to inform and improve agency practice, and adapt programs to better-meet the needs of Aboriginal families, and

use the subsequent growth in community confidence to tackle more complex issues.

In building strong partnerships with community to address child protection issues, it is important to take into account the developments unfolding at a State and Federal level in relation to attempts to address Aboriginal disadvantage and related child protection issues. In our view, overarching State and Federal objectives need to be taken into account when developing programs aimed at responding to the needs of individual communities. The need to align community level planning with State and Federal policies and approaches is discussed in detail in the next section.

3.2 Frameworks to guide planning and service delivery

In terms of constructing a response to Aboriginal child protection issues within this State, it is critical that we build on and effectively utilise related work which has been undertaken over recent years around Aboriginal disadvantage.

Overcoming Indigenous Disadvantage

In 2002 the Council of Australian Governments (COAG) commissioned the Productivity Commissionøs Steering Committee for the Review of Government Service Provision (SCRGSP) to produce a series of regular reports on the effectiveness of government spending on programs to address issues of Aboriginal disadvantage. The *Overcoming Indigenous Disadvantage: Key Indicators* reports ó published in 2003, 2005 and 2007 ó not only provide information about outcomes, but are also intended to act as strategic documents ‑*to assist governments to identify the focus for policy attention, and to measure whether these policies are working*ø (SCRGSP 2007: at 1.1). It is critical that this work is taken into account in considering child protection challenges as they relate to Aboriginal communities.

The steering committee established a framework for its assessments, identifying three priority outcomes for all sectors and jurisdictions working towards improving outcomes for Aboriginal and Torres Strait Islander people (see Figure 1):[17]

[17] *Framework for reporting on Indigenous disadvantage*, Steering Committee for the Review of Government Service Provision, at 2.1

Figure 1: Priority outcomes

These three priorities are expected to guide all Federal and State/Territory initiatives to engage with and respond to the needs of Aboriginal communities. The framework also identifies seven *Strategic areas for action*, and points to so-called *Headline indicators* that provide measures of major social and economic factors that need to improve if we are to effectively tackle Aboriginal disadvantage over time. The headline indicators include reporting on life expectancy at birth, rates of disability, school retention and attainment, post-secondary education, employment, income, home ownership, suicide and self harm, substantiated child abuse and neglect, victim rates for crime, and imprisonment rates. As we noted earlier in this submission, we see significant child protection problems as symptomatic of these broader issues of disadvantage.

The logic behind the framework of priorities, indicators and actions is that measurable short and medium-term actions will contribute to longer-term improvements. That is, implementing strategic areas for action (measured by the strategic change indicators) will, over time, lead to improvements in the headline indicators. Improvements in the headline indicators will, in turn, indicate progress towards the three priority outcomes.

The strategic areas for action draw on research indicating the kinds of short-term steps that, over time, can make a difference to longer term outcomes. Each is linked to a set of *strategic change indicators* designed to show whether actions are making a difference, and to identify areas where more attention may be needed. The seven strategic areas for action and the associated change indicators are:[18]

STRATEGIC AREAS FOR ACTION	STRATEGIC CHANGE INDICATORS
Early child development and growth (prenatal to age 3)	˝ Injury and preventable diseases ˝ Infant mortality ˝ Birth weight ˝ Hearing impediments ˝ Children with tooth decay
Early school engagement and performance (preschool to Year 3)	˝ Preschool and early learning ˝ School attendance ˝ Year 3 literacy and numeracy
Positive childhood and transition to adulthood	˝ Years 5 and 7 literacy and numeracy ˝ Retention at year 9 ˝ Indigenous cultural studies in school curriculum and involvement of Indigenous people in

[18] *Framework for reporting on Indigenous disadvantage*, Steering Committee for the Review of Government Service Provision, p66

	development and delivery of Indigenous studies ˝ Juvenile diversions as a proportion of all juvenile offenders ˝ Transition from school to work
Substance use and misuse	˝ Alcohol consumption and harm ˝ Tobacco consumption and harm ˝ Drug and other substance use and harm
Functional and resilient families and communities	˝ Children on care and protection orders ˝ Repeat offending ˝ Access to primary health care ˝ Mental health ˝ Proportion of Indigenous people with access to their traditional lands ˝ Participation in organised sport, arts or community group activities ˝ Engagement with service delivery
Effective environmental health systems	˝ Rates of diseases associated with poor environmental health (including water and food borne diseases, trachoma, tuberculosis and rheumatic heart disease) ˝ Access to clean water and functional sewerage ˝ Overcrowding in housing
Economic participation and development	˝ Employment (full-time/part-time) by sector (public/private), industry and occupation ˝ Self employment and Indigenous business ˝ Indigenous owned or controlled land ˝ Governance capacity and skills ˝ Case studies in governance arrangements

In promoting good child protection outcomes in Aboriginal communities, all seven strategic areas for action could be expected to influence the key headline indicator, ÷Substantiated child abuse and neglectø Similarly, progress in reducing abuse and neglect can only be achieved in conjunction with progress on other headline indicators such as family and community violence, incarceration rates and assault-related injuries. As the most recent *Overcoming Indigenous Disadvantage* report states:

> *This report recognises that many factors bear on change – no one action is going to eradicate Indigenous disadvantage. A key message from consultations with Indigenous people was that the report should not imply that the efforts of governments acting alone would be enough to achieve fundamental, long-term change. The drivers of change must include actions on the part of the private sector, the general community and, not least, Indigenous people themselves.*[19]

This highlights the inter-connected nature of strategies needed to tackle the entrenched issues that give rise to Aboriginal disadvantage.

'Closing the Gap'

In April 2007 the Aboriginal and Torres Strait Islander Social Justice Commissioner, Mr Tom Calma, announced a campaign involving more than 40 organisations advocating for government commitments to ÷Close the Gapø in life expectancy and other key differences between Indigenous and non-Indigenous Australians within a generation. As part of improving life expectancy, the Commissioner noted there would need to also be a focus on the social determinants of health ó living conditions, overcrowding in housing, education and employment. He said this was not just a health sector responsibility, but would require a ÷whole of governmentø, cross-departmental approach.

[19] *Framework for reporting on Indigenous disadvantage*, Steering Committee for the Review of Government Service Provision, at 1.3

By April 2008, the Commissioner reported that the Close the Gap partnership had put the crisis in Indigenous health under the national ÷spotlightø. For example, the Prime Minister included commitments to closing the gap in his ÷Apology to Australiaøs Indigenous Peoplesø in February 2008:

> *Our challenge for the future is to embrace a new partnership between Indigenous and non-Indigenous Australians. The core of this partnership for the future is closing the gap between Indigenous and non-Indigenous Australians on life expectancy, educational achievement and employment opportunities. This new partnership on closing the gap will set concrete targets for the future: within a decade to halve the widening gap in literacy, numeracy and employment outcomes and opportunities for Indigenous children, within a decade to halve the appalling gap in infant mortality rates between Indigenous and non-Indigenous children and, within a generation, to close the equally appalling 17-year life gap between Indigenous and non-Indigenous when it comes to overall life expectancy.*[20]

In May 2008, as part of its ÷Closing the Gapø commitments, the Federal Government announced $1.2 billion of funding over five years to be spent on a broad range of programs in areas such as literacy and numeracy, child and maternal health, drug and alcohol services, chronic diseases, early development and parenting support, and employment.

In making this announcement, the government indicated that the COAG had adopted its targets, and had established a working group ÷to develop a detailed work plan for meeting the targetsø.[21]

In addition, the Federal Government has established an Indigenous Affairs Committee of Cabinet. This committee will be chaired by the Prime Minister. The Prime Minister has also committed to reporting to parliament on the first working day of each parliamentary year on the progress against specific ÷closing the gapø targets. In order to report against these targets, the Government acknowledges that there needs to be ÷transparent monitoring to measure progress across government.ø

National framework for protecting Australia's children

There are also other changes currently taking place at the Commonwealth level that are likely to impact on State/Territory child protection policies and programs. Later this year, the Federal Government plans to finalise its ÷National framework for protecting Australiaøs childrenø. The recently published *Australia's children: safe and well* discussion paper has invited comment on a proposal to base the framework on six key measures:

1. Stronger prevention.
2. Better collaboration between services.
3. Improving responses for children in care and young people leaving care.
4. Improving responses to Indigenous children.
5. Attracting and retaining the right workforce.
6. Improving child protection systems. Although these measures or indicators could change or be refined as the final framework is developed, it is important to note that each is linked to, and builds on, the other five and none should be considered in isolation.

The discussion paper proposes various strategies in relation to each of the six key measures. There is a strong emphasis on Aboriginal child protection. Under the measure relating to *÷Improving responses to Indigenous childrenø* the paper sets out a number of potential options for dealing with a broad range of issues. Importantly, the paper also recognises the Working

[20] Prime Minister Kevin Rudd, Apology to Australiaøs Indigenous Peoples, 13 February 2008

[21] Media release, Minister for Families, Housing, Community Services and Indigenous Affairs, 13 May 2008.

Group on Indigenous Reform established by COAG in December 2007, including its role in identifying duplication and overlap between the Commonwealth and States/Territories. It is also worth noting that the working group should finalise its work program by the end of 2008 (with implementation timetables) covering the following critical areas:

- basic protective security from violence for Indigenous parents and children
- early childhood development interventions
- a safe home environment
- access to suitable primary health services
- supporting school attendance
- employment and business development opportunities
- involving local Indigenous people in the formulation of programs, and
- optimal service delivery for small remote communities.[22]

In developing a national framework, the Federal Government aims to clarify its role in child protection and to outline ÷concrete actionsø to be undertaken by all levels of government and other players. Some of these actions are already being implemented; others would require a change in approach or new commitment.

State Plan and Two Ways Together

As noted in our earlier submission on *Interagency Cooperation,* NSW is developing local, regional and state-wide committees and processes to support the implementation of State Plan objectives. These are emerging as the primary framework for the delivery of government services generally in NSW. The principal Aboriginal policy framework for the government sector in NSW is *Two Ways Together,* a ÷whole of governmentø plan developed by the Department of Aboriginal Affairs (DAA) and adapted in light of the State Plan.

The DAA has responsibility in relation to coordinating the implementation of *'Priority F1: Improved health and education outcomes for Aboriginal people'*. Additionally, the State Plan includes a number of other priorities of direct relevance to Aboriginal people, these are:

R1 Reduced rates of crime, particularly violent crime
R2 Reducing re-offending
R3 Reduced levels of antisocial behaviour
R4 Increased participation and integration in community activities
S3 Improved health through reduced obesity, smoking, illicit drug use and risk drinking
S4 Increasing levels of attainment for all students
S5 More students complete Year 12 or recognised vocational training
F3 Improved outcomes in mental health
F4 Embedding the principle of prevention and early intervention into Government service delivery in NSW
F6 Increased proportion of children learning with skills for life and learning at school entry
F7 Reduced rates of child abuse and neglect
E4 Better environmental outcomes for native vegetation, biodiversity, land, rivers and coastal waterways
E8 More people using parks, sporting and recreational facilities and participating in arts and coastal waterways[23]

In presenting the NSW Governmentøs submission to the NSW Parliamentøs Standing Committee on Social Issues in connection with its ÷Inquiry into closing the gap ó overcoming Indigenous disadvantageø, the Minister for Aboriginal Affairs, the Hon Paul Lynch, indicated

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[22] *Australia's children: safe and well – A national framework for protecting Australia's children. A discussion paper for consultation.* Australian Government, May 2008 p24.
[23] *Two Ways Together report on Indicators 2007,* p7

that Priority F1 ÷aims to address disadvantage in a holistic manner across five objectivesø He listed these as:

- Safe families: ensuring Aboriginal families are supported to live free from violence and harm;
- Education: increasing the readiness to learn of Aboriginal children prior to school entry;
- Environmental health: ensuring that all Aboriginal communities have equitable access to environmental health systems;
- Economic development: increasing Aboriginal employment; and
- Building community resilience.

According to the submission, this approach builds on that established under *Two Ways Together*. As part of its coordinating role, DAA produces a biennial report using both national indicators of disadvantage developed by COAG and NSW-specific measures. DAA describes the production of these reports as ÷a key element of accountabilityø by which progress can be measured against each of the priority areas.[24]

In order to ensure that government agencies improve service delivery at the regional level, the DAA established a network of Regional Engagement Groups (REGs). REGs include representatives from NSW and Commonwealth Government agencies and regional representatives of peak Aboriginal organisations. REGs are coordinated through the regional DAA offices and are sub-committees of the Regional Coordination Management Groups (RCMG), which are supported by the Department of Premier and Cabinet and have a key role in implementing State Plan objectives at regional level. In 2007, the REGs developed regional action plans that identified a small number of cross-agency focused goals for each region and the agency responsible for leading the work towards each goal. (The goals between regions varied, but each sought to address the State Plan Priority F1.)

These REG action plans are meant to take account of information collected and published by the DAA in the previous year. These reports seek to bring together data about Aboriginal people and the government services for each RCMG region to provide a snapshot of demographic and service information about communities in each region. The DAA works directly with 40 communities across NSW, mostly through local Community Working Parties established as part of the DAAøs Aboriginal Communities Development Program. These communities were identified by looking at indicators of need, community strengths and their willingness to work with government. In these partnership communities, local-level representatives groups are being established to assist with planning and delivering services to address community needs.

While the arrangements referred to above appear to be sound in a structural sense, whether they translate into effectively producing results on the ground is a separate issue. In this regard, we believe that a thorough evaluation of whether the existing governance arrangements are effective in garnering action by agencies across communities is needed. In making this suggestion we are particularly interested in whether the DAA staff who have an important role in coordinating agency/community action get the ÷buy-inø and commitment from key agencies which is necessary to make things happen. While the Director General of the DAA is now a member of the Chief Executiveøs Council, this does not necessarily mean that DAA staff working at the community level will necessarily have the requisite influence to get the necessary support for, and action on, important initiatives.

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[24] *Two Ways Together report on Indicators 2007,* p6

Observations on aligning state and federal policy approaches

As the above discussion illustrates, there are a broad range of state and federal planning initiatives directed towards addressing Aboriginal disadvantage, which also have relevance to Aboriginal child welfare. What is pleasing to note is that there is a reasonably close alignment between the broad areas which are being targeted through all of these endeavours. From a planning perspective, it is also important to note that there are initiatives underway which have the potential to provide an even closer alignment, in relation to both the issues which need to be addressed and how they should be responded to, across all States and Territories. For example, the national framework discussion paper refers to the COAG Working Party on Indigenous Reform seeking to identify duplication and overlap between the Commonwealth and the States. And the Working Partyøs targeted areas have much in common with the indicators in the *Overcoming Indigenous Disadvantage* reporting scheme. Furthermore, Mr Lynchøs submission on behalf of the NSW Government to the Inquiry on Closing the Gap acknowledges the need for specific alignment between NSWøs planning processes in this area and the work being done by COAG.[25]

One illustration of the importance of better Federal-State alignment is the Federal Governmentøs commitment to:

> … implementing its *New Directions: An equal start in life for Indigenous children* policy in collaboration with State and Territory governments. The policy includes child and maternal health services with comprehensive motherøs and babies services, nurse-led home visiting and Indigenous mothers accommodation fund; early development and parenting support; and early years literacy and numeracy. Local Indigenous leadership, participation and ownership are essential parts of this work.[26]

This commitment to state-federal collaboration in developing and rolling out this policy has particular benefits in NSW given the existing *NSW Aboriginal Maternal and Infant Health Strategy (*AMIHS*)*.

The AMIHS was initially funded to run in seven rural locations around NSW. The model has been subject to an extensive three-year evaluation. The evaluation found:

> significantly more women attended their first antenatal visit before they were 20 weeks pregnant
>
> more women initiated breath feeding, and more were still breast feeding when asked again at six weeks after the baby was born
>
> there was a significant reduction in the number of babies born preterm, and
>
> Aboriginal women were very satisfied with the services provided.

In light of these positive (and measurable) results, a further 17 sites had been established as of 1 January 2008.[27]

This NSW program is significant not only because it illustrates the critical need for alignment in state and federal planning, but also because it illustrates another important issue that needs to be addressed ó namely, the need to build a solid evidence base to enable effective planning to take place. This issue of building a solid evidence base will be discussed in section 3.3 of this submission.

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[25] NSW Government submission to the Inquiry into Overcoming Indigenous Disadvantage, p 6

[26] *Australia's children: safe and well – A national framework for protecting Australia's children. A discussion paper for consultation.* Australian Government, May 2008 p24.

[27] NSW Department of Health (2006), *NSW Aboriginal Maternal and Infant Health Strategy evaluation. Final report 2005.*

Planning and service delivery at the local community level

Aboriginal communities across NSW are diverse. Individual communities often have very different levels of need and access to basic services. Individual communities have different strengths and some have shown a greater willingness to work with government. Therefore, while it is important to align local community planning and service delivery with broad State and Federal objectives, at the local level, it is equally important to tailor programs and service delivery in a way that responds to the specific needs of local communities.

It has been broadly recognised that a ÷one-size-fits-allø approach will not work. In making this point, we are not suggesting that, at a local level, there is a need to depart from the broad Federal priority outcomes outlined on page 14 of this submission. However, what is required at the local level is to identify the extent to which the local community is achieving these priority outcomes, and, in terms of identified shortcomings, what needs to be done to address these. It is also important that processes associated with aligning local community planning with broader state and federal priorities does not lead to a lack of flexibility in the way funding is provided. If this happens, this will prevent potentially successful community driven initiatives from ÷getting offø the ground.

One issue that continually stands out in relation to our assessments of agency programs and trials in very disadvantaged Aboriginal communities is that the more agencies do in certain areas, the more gaps in service delivery and capacity they are likely to find. Improving capacity in one area can often highlight other issues that must be addressed. For instance, programs to address infant health can lead to disclosures of previously unreported domestic violence. Action on domestic violence offences can highlight deficiencies in community-based victim support. Programs to tackle substance abuse can raise issues of inter-generational abuse. Employment programs are essential, but are likely to be limited without concurrent action to reduce high rates of truancy, improve school retention, and provide training opportunities for adults who need a second chance at obtaining an education.

The connected nature of these issues is at least partly because of the significant concentrations of disadvantage and the limited agency and community capacity to respond. Communities with the greatest needs are also often among the least equipped to deal with these deficiencies because of resource and skill constraints, the limited availability of community-based services in those locations, and the challenges of delivering investigative, medical, mental health, family support and other such specialist services to far-flung communities. The prevalence of complex, inter-generational and inter-connected issues in some communities can also easily overwhelm the limited capacity of services to respond. For this reason, the various primary, secondary and tertiary services available to local communities need to be delivered in a coordinated way to address Aboriginal disadvantage and related child protection issues in a holistic way. The Commissionøs *Early Intervention Facts Sheet* notes a number of programs aimed at dealing with these issues in this way.

In our submission to the Commission on early intervention and assessment practices, we acknowledged the need to enhance universal and targeted support services for all vulnerable families, but noted data indicating compelling reasons for prioritising Aboriginal families and communities. With Aboriginal child deaths representing around 20% of the child deaths that we review each year, and with around 70% of Aboriginal child deaths occurring within the first 12 months of a childøs life, we welcomed a DoCS and NSW Health agreement to facilitate Aboriginal access to existing prevention and early intervention programs. This measure is consistent with research literature pointing to the benefits of multi-layered strategies and ongoing comprehensive support, particularly for those most vulnerable. Similarly, in commenting on the Aboriginal Maternal and Infant Health Strategy, we noted

that its strength lies with a range of services provided in a coordinated way in recognition of the disparate needs of the service receivers.

The interconnected nature of issues affecting families in high-need areas, underlines the importance of effective communication and planning between government agencies, the NGOs funded by State and Federal agencies, and local Aboriginal community partners. This work is critical if innovations in this area are to make efficient use of scarce resources and respond effectively to community need at the local level. In emphasising the importance of this type of ÷interactionø, the Productivity Commission noted in its *Framework for reporting on Indigenous Disadvantage* that:

> *While information on the delivery of outputs is valuable, this Report does something different. The Report framework emphasises the importance of interaction — between sectors and between governments, and with Indigenous people themselves — in achieving good outcomes. Improvements in the wellbeing of Indigenous Australians will require the involvement of more than one government agency, and will need action on a whole-of-government basis*[28].

Although our work in reviewing agency partnerships with local Aboriginal communities and services has shown that programs and services are often delivered in a fragmented way at the local community level, recent developments in this area are encouraging. The Department of Premier and Cabinetøs submission to the Commission regarding its recent work with the Commonwealth through the COAG working group on Indigenous disadvantage, included considering the ÷development of collocated family centres serving Aboriginal communitiesø as a possible priority initiative.[29] Although there is little available detail on what this scheme might involve, if it is effectively implemented it has the potential to give Aboriginal communities much easier access to suites of services aimed at providing a continuum of care. Clearly, DoCSø interest in trialling ways to enhance case worker support for high-need areas should be factored into planning for the collocated family centres.

Finally, in order to support planning processes, there is a need to capture solid data in relation to the nature and extent of need in local communities, and build a strong evidence base about the type of programs and services that appear to work. These issues are discussed in further detail in section 3.3 of this submission.

NSW policy to coordinate action on child sexual assault

The need to tackle the issue of Aboriginal child sexual assault is perhaps the best illustration of the need for agencies to build partnerships with local Aboriginal communities in order to effectively implement important federal and state policy objectives.

It is important to note significant developments at a Federal level, such as the recently completed review of the Northern Territory Emergency Response. As this review process will be ongoing, any lessons learnt from this exercise, together with relevant initiatives from other jurisdictions, should be used to help inform our response to tackling Aboriginal child sexual assault in NSW.

Of the many areas where closer interagency cooperation is needed to enhance service delivery to Aboriginal communities, the *Interagency plan to tackle child sexual assault in Aboriginal communities 2006-2011* is arguably the most significant. The initial focus has been on identifying agenciesø various responsibilities for undertaking specified actions under the plan. While the planning work appears to be reasonably well advanced, there is clearly a great deal to be done.

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[28] *Overcoming Indigenous disadvantage 2007 'The Framework',* p.2.1

[29] Department of Premier and Cabinet, *Submission to Special Commission of Inquiry into Child Protection Services,* April 2008.

Published in 2007, the plan is meant to be a ÷whole of governmentø response to child sexual abuse within NSW Aboriginal communities. It essentially outlines the NSW Governmentøs strategic policy response to the Aboriginal Child Sexual Assault Taskforceøs 2006 report, *Breaking the Silence: Creating the Future*, and focuses on law enforcement, child protection, early intervention and prevention, and community leadership and support. The report emphasises that interagency cooperation and community support are needed to achieve progress in relation to each of the four key areas.

A related development is the *NSW Joint Investigation Response Team (JIRT) Review* conducted by NSW Health, DoCS and the NSW Police Force and completed in November 2006. The review explained key deficiencies in current investigative work involving Aboriginal communities, and set out ways that agencies could use JIRTs to address these issues. Five of the reportøs 18 recommendations related to targeting Aboriginal sexual assault, noting the need for:

a designated support person for every Aboriginal child

JIRTs with significant numbers of Aboriginal referrals to develop a plan for regular pro-active engagement with Aboriginal communities in the area

JIRT agencies to attract and retain more Aboriginal staff

relevant cultural awareness training for all JIRT staff, and

a working party of Aboriginal representatives and JIRT staff to develop a culturally appropriate JIRT model of intervention.

Significantly, the NSW Police Force has incorporated a number of these recommendations into its revised Aboriginal policy. With the introduction of the *Aboriginal Strategic Direction 2007-2011,* the NSW Police Force signalled a clear commitment to developing and extending its work in at least two key areas:

1. The new policy includes a specific objective (with associated strategies) to improve the police response to sexual assaults in Aboriginal communities, including specific measures to improve JIRTs and the investigation of child sexual assaults; and

2. It outlined a plan for police to develop a strategic response to Aboriginal substance abuse.

As the new *Aboriginal Strategic Direction* was being developed, we advised police that our auditing of police work with Aboriginal communities should also change to accommodate these two new elements. For this reason, we plan to adopt a more targeted approach, conducting fewer comprehensive audits and focusing more on police progress in developing strategies to tackle sexual assault and address substance abuse, and the links with other services and groups needed to achieve positive outcomes. As a first step, we sought police advice on how measures to implement the plan will intersect with related strategies, including police policies and plans, those of other agencies, and ÷whole of governmentø instruments such as the State Plan. The detailed response recently provided by police will help shape our auditing of police work with other agencies and Aboriginal communities.

The success of our use of local command audits and assessments to hold police to account for delivering on their policy commitments was commended by the Aboriginal Child Sexual Assault Taskforce and noted in its *Breaking the Silence* report:

> *ACSAT has noted that NSW Police is being held accountable against its Aboriginal Strategic Direction policy through regular audits by the NSW Ombudsman. This is proving effective and*

> *real improvements have been made in police relationships with Aboriginal communities and in service delivery.* [30]

ASCAT subsequently advocated that this Office be given powers to play a more direct role in reviewing or auditing the implementation of its recommendations and hold various agencies to account for their commitments in this area:

> Recommendation 21. Legislate [for] the NSW Ombudsman to conduct a review/audit of the implementation of the Aboriginal Child Sexual Assault Taskforce Recommendations in a holistic context. This review would consider whole of government responses as well as the responses of:
>
> i. NSW Police
> ii. Department of Community Services
> iii. NSW Health
> iv. Joint Investigative Response Teams
> v. Department of Education and Training
> vi. Department of Corrective Services
> vii. Department of Juvenile Justice.

In relation to this recommendation we note that no legislation has been passed or any approach made to this Office to review/audit the implementation of the taskforceøs recommendations.

We also note that the DAA has the primary responsibility for coordinating a ÷whole of governmentø approach to implementing the interagency plan to tackle child sexual assault. However, we remain committed to examining at least the policing side of this issue ó as far as our resources allow ó and have met with the DAA to ensure our own work in considering the response by police to this issue complements rather than competes with DAA priorities.

While we have yet to finalise our methodology for examining this issue, our Aboriginal Unit is currently meeting with communities across the state for the purpose of assisting us in determining which particular issues we should target. These consultations have included meeting with key service providers, elders forums, and a number of womenøs groups and menøs groups that are emerging in many locations.

Similarly, through our discussions with Aboriginal communities about police programs to address family violence and divert youth from offending behaviour, we are often given insights into sexual assault and risk-taking behaviour. For instance, in several country commands we have been approached by individuals voicing concerns about minors in their community regularly meeting truck drivers at particular locations and agreeing to have sex in exchange for alcohol, cannabis and/or amphetamines. In other locations, we have been told about sexual assault allegations involving family members, members of community or outsiders. These issues are almost always raised by senior Aboriginal women in the community, and occasionally by advocacy services or other services working closely with local people.

On each occasion, we obtain the informantøs agreement for us to provide particulars to the local commander so police can investigate the allegations and look at what action can be taken. Commanders invariably undertake to speak to the people involved, but are often already aware of the allegations and, in many cases, had already tried to obtain formal statements or some other investigative action. A common problem is that victims rarely come forward, even when approached and even when they want the abuse to stop. Aboriginal leader Lowitja OøDonoghue recently commented on why Aboriginal communities often resist, and

[30] ACSAT, *Breaking the silence: Creating the future,* Attorney Generaløs Department NSW, 2006, p.143.

sometimes strongly resist, police and welfare agency attempts to address issues such as child sexual assault:

> *Many of my people have deep-seated fears about being removed from their communities by white fellas. It is a real issue in relation to welfare interventions and imprisonment. It is partly why a code of silence surrounds abuse in Aboriginal communities because people do not want to see the fracturing of families and communities again.* [31]

Police have a responsibility to act and must start somewhere. Although charges and successful prosecutions are rare, police occasionally have success implementing prevention strategies, such as using PCYC or youth officers to devise ways to engage young people who have sex with adults in order to obtain drugs. Even if they canøt get the evidence to prosecute the perpetrators, police can at least work with communities on strategies that attempt to prevent the behaviour.

In our view, the most urgent area that needs to be addressed is to find ways to get victims to come forward and to have their matters put before the courts. The JIRT review recommended ways to provide better support to Aboriginal communities in relation to investigating sexual assault allegations. While it is important to implement these kinds of strategies as part of good investigative work, there is also a need for additional measures to build trust in the quality of services provided and strengthen agenciesø relationships with local Aboriginal communities. Without strong links between local service providers and the communities they work in, investigators are unlikely to overcome the ÷code of silenceø that can prevail.

In terms of the police role, they cannot build an environment for ÷disclosureø on their own. In most cases, they will need to work closely with members of the community and staff from other services ó government and non-government services ó to gain the trust of victims and provide necessary supports. It is also important to note that success in building community and agency capacity in this area may lead to disclosures of inter-generational abuse. As such, agencies and their community partners must be ready to find ways to support women who were victimised as children, as well as the current generation of children and young people subject to various forms of abuse and neglect. This is where Aboriginal staff recruited, trained and supported by agencies can play a critical role in providing crucial supports.

The difficulties that agencies are experiencing in responding to child sexual assault in Aboriginal communities highlight some of the many practical challenges for agencies required to deliver on their policy commitments to Aboriginal people. Even when supported by extensive policy and planning, and subject to various reporting and monitoring requirements, there is no guarantee of success. And although child sexual assault is necessarily a priority issue, it is just one of many policy areas requiring urgent attention.

We also have a number of specific concerns about some of the challenges relating to responding to Aboriginal child sexual assault.

One concern relates to the fact that the JIRT team based at Dubbo must service a range of communities across a very broad area. This raises real questions about how effectively child sexual assault can be dealt with in many of these areas.

A further concern relates to the adequacy of support provided to Aboriginal child sexual assault victims. While the recommendation from the JIRT review regarding the provision of a designated support person for every Aboriginal child sexual assault victim is a positive initiative, it will be important to assess what kind of real support will be able to be provided. We understand that ÷cross agency planningø is currently taking place to outline the nature of

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[31] ÷O'Donoghue bows out, her heart heavy over inactionø, *Sydney Morning Herald*, p6, 28 May 2008.

the support required. The current lack of Aboriginal child sexual assault counsellors across NSW is but one illustration of the need to translate policy into practice in this critical area of support. While in some areas ÷mainstreamø sexual assault counsellors are available; in other areas, particularly more remote communities, there are no services of this kind available.

A related problem is how to support adult victims who were abused as children. We believe that this group represents a potentially significant source for reporting child sexual assault offenders. For this reason, we believe that the work which is being done around supporting child sexual assault victims should also take this group into account.

Another issue relates to the lack of availability of forensic medical services for sexual assault victims in certain parts of the state. For example, a child who has been sexually assaulted in Brewarrina may have to travel to Orange or Bathurst for a medical examination. A relevant factor is the requirement for general practitioners rather than registered nurses to perform sexual assault examinations on children under 16 years of age. It has been suggested to us that, if appropriately trained and supported registered nurses were able to perform this role through local Aboriginal medical services and/or other local health services, this would encourage reporting by victims and reduce the trauma associated with this type of examination. In any event, what needs to be addressed as a matter of urgency is the completely unacceptable situation of sexual assault victims having to travel large distances for the purpose of forensic medical examinations.

While the *Interagency plan to tackle child sexual assault in Aboriginal communities* and related agency plans strongly emphasise building trust within communities as an important part of encouraging victims to report, this is likely to require a significant long-term commitment of staff performing this kind of work before ÷resultsø will be evident. For example, the work carried out in the Halls Creek area of Western Australia in successfully bringing a number of matters to the prosecution stage, came on the back of relationship-building over a significant period of time. Therefore, we believe that it is critical to examine whether we have the resources on the ground to invest in this kind of relationship-building and if so, whether it actually translates into measurable outcomes which indicate important breakthroughs in identifying offenders and/or protecting victims.

The NSW government recently announced an injection of $22.9 million of funding over four years to ÷combat child sexual abuse through the expansion of Safe Families in the Orana Far West region.ø What will be important to assess is the impact of this additional funding and whether other high need communities would benefit from similar levels of support.

Following the *Breaking the Silence* report, community members regularly spoke to us about their hope that things would change. Subsequently, the National Indigenous Violence and Child Abuse Intelligence Task Force (NIITF) representatives commenced their consultations with Aboriginal communities in NSW. From our discussions with these representatives, we are aware that significant numbers of disclosures of abuse have been made across communities. We know that the issue of child sexual assault is being discussed at local community forums, in connection with the work being done around the implementation of the *Interagency plan to tackle child sexual assault in Aboriginal communities* and the NIITF consultations.

Against the background of all this activity, we are concerned that, if there is a continuing sense from within Aboriginal communities that nothing has changed because known perpetrators remain untouched, this is almost guaranteed to lead to a cycle of cynicism and/or despair. For this reason, we believe that how well the issue of child sexual assault is addressed will come to represent an important symbol for Aboriginal people in this State.

In January 2008, the NSW Government submission to the Inquiry into Overcoming Indigenous Disadvantage,[32] the areas where it believed ÷significant progressø had been made in implementing the *Interagency plan to tackle child sexual assault in Aboriginal communities*. While we acknowledge the importance of a number of the areas outlined, it is clear that much still needs to be done. In this regard, we are keen to see whether the many ÷activitiesø taking place lead to increased formal reporting to police of child sexual assault by victims and other community sources along with the development of successful strategies to prevent and/or reduce the incidence of child sexual assault. The success of the plan should also be measured in terms of whether there is an increase in the number of prosecutions and convictions over time. However, a long term goal should be a reduction in the incidence of child sexual assault.

Finally, we note that as Aboriginal child sexual assault is a significant issue on the national agenda, it is important for NSW to seek to align its practices with what is shown to work in other jurisdictions. We also note that, as the Northern Territory Emergency Response illustrates, responding appropriately to child sexual assault also involves responding to broader social issues which leave children vulnerable.

3.3 Building an evidence base

Performance reports and related data capture

Earlier in this submission we noted moves to align state and Federal planning in the areas of Indigenous disadvantage and child protection. The Federal Governmentøs discussion paper on building a national child protection framework also acknowledges that both the AIHW and the Productivity Commission have highlighted the need for jurisdictions to move towards more consistent data, information and performance measures for child protection and welfare issues. The paper also specifically recognises the need to capture specific data relating to Aboriginal children to enable the measurement of progress towards reducing the over-representation of Aboriginal children in the child protection system. (As noted previously, there is also a strong relationship between child protection indicators and the broad welfare indicators which have been developed by the Productivity Commission.)

It is worthwhile noting that the DAAøs *2007 Report on Indicators* attempts to more closely align its performance indicators with the indicators in the Productivity Commissionøs Overcoming Indigenous Disadvantage framework and the State Plan. However, the DAAøs 2007 report acknowledges that more needs to be done to improve the alignment of these indicators with the federal OID framework.

The Productivity Commissionøs *Overcoming Indigenous Disadvantage: Key Indicators* reports have been an important part of broader Council of Australian Governments (COAG) efforts to improve accountability and track progress in this area. The 2008 Federal Budget includes additional spending to improve data collection on Indigenous children. This will assist in providing the necessary data to allow us to determine whether the targets set by the Federal Government to close the gap in disadvantage between Indigenous and non-Indigenous Australians are being met over time.

On 13 May 2008, the Minister for Families, Housing, Community Services and Indigenous Affairs, the Honourable Jenny Macklin, MP released a statement commenting on the budget in the context of the Federal Governmentøs closing the gap commitments. In relation to the need for transparency and accountability, the Minister commented:

[32] Outlined at pages 29 to 30.

Through the COAG Working Group on Indigenous Reform we will be progressing arrangements for independent national monitoring and reporting of progress against agreed targets.

On 20 March 2008 the Prime Minister announced the establishment of a new National Indigenous Health Equality Council to assist in the development and monitoring of targets relating to life expectancy and child mortality.

These arrangements will complement, and not duplicate, other accountability arrangements including the Overcoming Indigenous Disadvantage reporting framework, program performance reporting, the National Aboriginal and Torres Strait Islander Health Performance Framework, and new arrangements being established to monitor performance through Specific Purpose Payments. They will complement the framework being developed by Commonwealth and State Treasurers to report on overall expenditure on Indigenous services funded from mainstream and Indigenous-specific sources.[33]

We believe that it is important that the Ministerøs statement recognises not only the importance of improved data collection and associated reporting but also the need to ÷complement and not duplicateø existing reporting frameworks.

While it is important to monitor progress from a State and Federal level, we also believe that it is important for ÷the dataø to tell us whatøs happening at a local community level. Furthermore, the type of information collected about local trends should be consistent with the broad indicators adopted at the State and Federal levels.

On 21 June this year, the *Sydney Morning Herald* ran an article about living conditions in Toomelah. The article illustrates the need for data to be available about local communities. An underlying theme was whether circumstances had improved in Toomelah since the time of Justice Marcus Einfeldøs visit in 1987. The difficulty in answering this question relates to the lack of available data. One important element of the Northern Territory Emergency Response is the commitment to an evidence-based approach to assess the extent to which the measures being implemented are making a difference to the lives of the children within the affected communities. Given the diversity of Aboriginal communities, and the high levels of need in particular communities, we believe that there should be a similar commitment within NSW to capturing ÷localø data across communities as an integral part of the planned improvement to data collection and reporting processes.

Associated research

In addition to capturing and analysing data, there is also the need to better evaluate what does and what doesnøt work. Our research indicates that in NSW and elsewhere, there is currently a lack of available information about the effectiveness of particular initiatives and the reasons why they fail or succeed. In this regard, the DAAøs 2007 report acknowledges that:

Many of the initiatives aimed at reducing Aboriginal disadvantage are targeted in specific locations', in recognition of the need to avoid the 'one size fits all' approach. Ultimately such information is required to build an evidence base of what works to close the disadvantage gaps.

We fully support the need for further research of this kind to be conducted. Information provided by the DAA in its 2007 report relating to ÷Families and Young Peopleø provides descriptions of several initiatives such as the Aboriginal Intensive Family Based Service and the Aboriginal Child, Youth and Family Strategy. However, there is neither information about the reasons why these particular strategies have been highlighted nor any information about

[33] Statement by the Honourable Jenny Macklin, MP, Minister for Families, Housing, Community Services and Indigenous Affairs on the budget as it relates to closing the gap between Indigenous and non-Indigenous Australians 13 May 2008.

their success or otherwise in the report. By contrast, the NSW Governmentøs submission to the Inquiry into Overcoming Indigenous Disadvantage has reported on a number of concrete results over a ten year period in relation to the Aboriginal Communities Development: Housing for Health Program including:

> Since 1998 *Housing for Health* has been delivered to approximately 2,100 houses in 66 communities in NSW. With some 38,400 items fixed, approximately 8,500 people have benefited from HIH. Recent analysis by NSW Health has indicated improvements in some environmental health conditions (such as skin infections and gastrointestinal infections) in Aboriginal people in local government areas where Housing for Health has been delivered; however, direct cause and effect relationships are unable to be established.
>
> - A 10-fold increase in electrically safe houses (which reduces injuries and saves assets);
> - A 5-fold increase in fire safety in houses (which reduces injuries and saves assets);
> - A 3-fold increase in ability to wash people, particularly children (which reduces infections);
> - A 7-fold increase in ability to wash clothes/bedding (which reduces infections);
> - A doubling of satisfactory waste removal ó such as a working toilet (which reduces infections); and
> - A 6-fold increase in ability to store, prepare and cook food (improving nutrition).[34]

Earlier in this submission we highlighted the outcomes from the Aboriginal Maternal and Infant Health Strategy ó the results from this program were also referred to in the NSW Governmentøs submission to the Inquiry into Overcoming Indigenous Disadvantage.

As previously noted, the need to evaluate the effectiveness of programs aimed at strengthening Aboriginal communities is not only a challenge for this state. In this regard, the Productivity Commissionøs reports on overcoming Indigenous disadvantage have sought to address the dearth of research about ÷what worksø by including case studies that highlight positive outcomes. While this is a good practical measure, to some extent it underscores, rather than resolves, this need for robust research. Against this background, it is worthwhile noting the Federal Governmentøs recent commitment in the 2008-09 budget to building policy and practice upon a solid evidence base through the establishment of a national clearinghouse on best practice and successful Indigenous programs.

When considering the diverse range of federal, state and local programs which have relevance to addressing Aboriginal disadvantage and child protection, and the significant funds expended, there is an overwhelming case to support building a much better base of knowledge about what works and what doesnøt. In this state, a number of key child protection initiatives relevant to Aboriginal communities either have been or are being rolled out, including:

- integrated case management
- Tirkandi Inaburra
- the Aboriginal intensive family based services
- Brighter Futures and its proposed link to the Aboriginal Maternal and Infant Health Strategy
- various community consultation mechanisms that focus on involving Aboriginal people in planning and change initiatives [35]

[34] NSW Government submission to the Inquiry into Overcoming Indigenous Disadvantage, p10
[35] We note that the community working parties established as part of the Murdi Paaki COAG trial have been the subject of an independent evaluation.

- care circles
- KARI Aboriginal Resources Inc. Health care trials
- cultural support planning for Aboriginal children in out-of-home care
- various employment initiatives developed by agencies and Aboriginal services
- specific initiatives associated with the *NSW Interagency plan to tackle Aboriginal child sexual assault,* including the Nowra Aboriginal child sexual assault project[36]
- the Toomelah/Boggabilla project and, in particular, the impact of the child protection teamøs work as a part of this project, and
- JIRT reforms, particularly those relating to Aboriginal children.

In noting these initiatives, it is important to recognise that a number of these programs have been or will be evaluated and that DoCS has substantially improved its research capacity over recent years. Nevertheless, consistent with the Federal Governmentøs commitment, we believe that there is considerable scope to improve the extent and quality of our research (and related data collection and analysis) to determine the strengths and weaknesses of particular initiatives and the impact that they have delivering solid results across communities against the key ÷welfareø indicators.

3.4 Expanding the frontline workforce

From our work, we have found that a significant challenge agencies need to confront is the requirement to have significant numbers of high quality staff working in Aboriginal communities. If this is not achieved, then any attempt to improve service delivery will fail.

Providing the necessary number of frontline workers requires concerted action on at least two fronts:

measures to specifically recruit, retain and train additional Aboriginal staff, and

attracting suitably experienced Aboriginal and non-Aboriginal staff to high-need locations, particularly in rural and remote areas.

Recruiting and retaining Aboriginal staff

An agencyøs efforts to recruit and retain Aboriginal staff can play a critical role in shaping Aboriginal community perceptions of that agency, and of its willingness to work with Aboriginal people. In this context, it is important to note the considerable time, effort and funding that DoCS has invested in strategies to enhance its Aboriginal workforce. As part of its *Aboriginal Strategic Commitment 2006-2011* to provide better services for Aboriginal people, DoCS has succeeded in increasing its Aboriginal caseworkers and other staff from 2.5% of all DoCSø staff in 2002-03, to 7% today. This is a considerable achievement. In addition, 10% of all DoCS case workers are now Aboriginal, retention rates are improving, and there are enhanced training, mentoring and other programs to improve the skills and career prospects of these recruits. According to figures provided to the Commission, 20% of DoCSø casework staff in the Northern and Western regions are Aboriginal. However, DoCS concedes that many more are needed in these areas, and that the organisation faces particular difficulties in attracting and retaining staff ó not just Aboriginal staff but staff generally ó to work in complex, high-need Aboriginal communities.[37]

[36] Other sites will be identified in due course.

[37] *Aboriginal Communities,* DoCS submission to the Special Commission of Inquiry into Child Protection Services in NSW, April 2008, p 9-10.

There is scope for other agencies to do more to enhance the recruitment and retention of Aboriginal staff. In the case of police, for some time we have been pressing for improvements in their recruitment of Aboriginal staff, including the need for much tighter counting rules to provide a more accurate picture of how many Aboriginal employees are entering and leaving the NSW Police Force.[38] Until mid-2006, we had been receiving regular updates on the forceøs commitment to reviewing and revitalising its Aboriginal employment strategies ó a key recommendation of our 2005 report to Parliament, *Working with local Aboriginal communities.* By June 2006, police had even produced a draft *Aboriginal Employment Strategy 2006-09*. Despite positive and sometimes very creative Aboriginal employment initiatives implemented in a handful of individual commands in 2006 and 2007, it became apparent that progress in other parts of the organisation had stalled. In late 2007 we formally sought the Commissionerøs advice on the organisationøs progress towards formalising its policy. We have recently been advised that the police Aboriginal employment policy has been updated and will be released soon. A draft copy provided to us for comment indicates that the revised strategy has the potential to produce much-needed progress in lifting recruitment and retention of Aboriginal staff across the NSW Police Force. If this is achieved, it has important implications in terms of the ability of police to respond to child protection and family violence issues within Aboriginal communities.

Utilising Aboriginal staff

A related challenge is how increases in Aboriginal recruitment might be used to complement agency efforts to address the particular needs of Aboriginal client groups. In evidence to the Special Commissionøs public forum on Aboriginal Communities on 24 April 2008, Mr Julian Pocock, executive director of the Secretariat of National Aboriginal and Islander Child Care (SNAICC), cautioned against recruiting big numbers of designated Aboriginal staff to suddenly tackle the legacy of years of neglect in Aboriginal communities. He said that after the Gordon Inquiry in Western Australia, the then Department of Community Development succeeded in recruiting significant numbers of Aboriginal staff, but:

> *... the first thing they got them all to do was to go out to all the communities and tidy up all the dirty business that the department hadn't sorted out for many years, chase up all the funding agreements that no one had done an acquittal for, talk to all the communities about all the really hard things, and that is what often tends to happen, in our experience, in these large departments. The Aboriginal workers get sent out to do the really hard, dirty work that no one else in the department wants to do, and then people get surprised when they meet conflict and potential breaks of those positions are rife.*[39]

In our auditing of police work with Aboriginal communities we have found that Aboriginal police officers can sometimes face similar issues when posted to communities with large Aboriginal populations. This is especially challenging if the communities they work in are high-need and include a number of their own relatives. The NSW Police Force generally tries to accommodate the desire of many Aboriginal police officers to live and work relatively close to their home communities so they can maintain their connections with family, kinship networks and country, but it tends to avoid placing them directly in their home communities where they risk being confronted with having to police family or friends. On the other hand, we have also found instances where Aboriginal officers can succeed in these situations, especially more experienced officers. Despite intense community scrutiny and other challenges associated with such postings, these officers can be very effective in the work they do ó especially after gaining good professional experience elsewhere.

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[38] At least part of the recent lift in the number of Indigenous people employed by the NSW Police Force can be attributed to an increase in the number of existing employees willing to identify as Aboriginal or Torres Strait Islander. While this is positive, as it indicates that the organisation is creating a culture that is more accepting of Aboriginal people, it is also important to establish whether recruitment programs are successfully attracting new Aboriginal recruits.

[39] Transcript, Aboriginal Communities forum 24 April 2008, p16.

While police Aboriginal Community Liaison Officers perform a different role to Aboriginal police officers, it is nevertheless significant that over the years, we have found many examples of ACLOs who are adept at balancing their position as community members with their professional responsibilities. However, from our work it would appear that what is needed is for agencies to recognise the unique pressures on frontline Aboriginal staff who opt to work in communities where they have strong family or kin connections, and to provide them with appropriate supports.

A related issue is the importance of mentoring Aboriginal staff to encourage retention, especially in the early stages of their careers. This is especially the case in criminal justice, welfare and other agencies, as the history of poor relationships with Aboriginal people can create additional pressures on Aboriginal staff in those agencies. Peer support networks can also be useful in helping these staff through difficult periods and in developing their potential. This issue of mentoring is particularly important in situations where there is only one Aboriginal staff member employed by an organisation.

Agencies also need to ensure that they use their staff effectively, and value the goodwill that their work can generate among Aboriginal communities. Sometimes, simply having Aboriginal people in key positions can make a huge difference to how an organisation is perceived. For instance, many health sector agencies have made their services more responsive to Aboriginal communities by employing and training Aboriginal outreach staff, creating teams of Aboriginal and non-Aboriginal staff with a mix of skills to support each other when working with communities, and in placing Aboriginal people in key positions of responsibility.[40]

Where Aboriginal staff are performing a relationship-building or educative role beyond that expected of their non-Aboriginal peers, there can be a need to recognise this through higher remuneration or adjusting their workloads. DoCS noted this issue in its *Aboriginal Communities* submission:

> *Many other agencies rely on Aboriginal Community Liaison Officers to support non-Aboriginal professional staff in engaging Aboriginal communities. DoCS' strategies build this community engagement aspect of DoCS' work within the care functions of caseworkers. This means that DoCS' Aboriginal staff have time allocated in their workload planners in recognition of the different communication requirements, respectful cultural approach and trust building strategies required. Different program streams may engage in particular ways for example Brighter Futures caseworkers may have differing approach to JIRT caseworkers.*[41]

However, we also recognise that it is important that agencies do not rely too heavily on Aboriginal staff to build bridges with local Aboriginal communities. While important, their work in relationship-building should be part of wider actions and initiatives. For attitudes to change and programs to be effective, individual agency staff at all levels must play their part in improving communication and creating partnerships with key Aboriginal individuals and organisations.

Our extensive work in the policing field has clearly demonstrated to us the excellent relationships which can be built when there is a shift in the culture of a workplace towards forming genuine partnerships with Aboriginal people. We have found that the quality of relationships is largely dependent on how the day-to-day work is carried out within communities and can be reinforced through formal and informal relationship-building

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[40] In this regard, we are aware of programs run through the Aboriginal Maternal and Infant Health Strategy and in the Aboriginal mental health field that have adopted the approach to which we have referred.

[41] *Aboriginal Communities,* DoCS submission to the Special Commission of Inquiry into Child Protection Services in NSW, April 2008, p14.

measures. Formal initiatives include senior and specialist staff participating in key interagency groups, convening community forums or establishing programs to tackle specific issues. Informal measures are also important, enabling agencies to focus on breaking down barriers by creating positive contact between staff at all levels and members of the community, including staff attending NAIDOC celebrations, Aboriginal gatherings or organising sport for young people.

Resourcing high-need locations, especially in rural and remote areas

While enhancing and developing agenciesø Aboriginal workforces may expand the opportunities for, and capacity of, agencies to engage with Aboriginal people generally, this will not necessarily resolve the capacity shortfalls that frequently impair service delivery to outlying locations. As noted above, DoCSø apparent success in recruiting significant numbers of Aboriginal employees has not resolved the particular difficulties associated with attracting both Aboriginal and non-Aboriginal staff to complex, high-need Aboriginal communities. Specific measures are often needed to address this issue.

Our work with frontline agencies and Aboriginal communities across NSW has repeatedly highlighted the importance of the adequate resourcing of high-need locations. As the following example shows, staffing shortfalls can impact significantly on an agencyøs capacity to deliver services. Conversely, dealing effectively with basic service capacity issues can pave the way for engaging Aboriginal communities on more difficult issues:

RECRUITMENT PAVES WAY FOR SERVICE INNOVATION

Our initial review of police work with Aboriginal communities in Walgett and surrounding towns in September 2003 found that chronic staff shortages were crippling any prospect of positive work with the community. Staff numbers were well below the command's authorised allocation of 59 officers. Of the 12 sergeant positions, nine were vacant for extended periods, including supervisory roles at Lightning Ridge and Coonamble. Staff turnover was high, requiring officers from smaller centres to travel long distances to fill in at busier stations. Goodooga and Collarenebri police regularly filled in at Lightning Ridge and Walgett, and Coonamble relied heavily on neighbouring sectors for support, worsening already-poor response times and adding to the pressures on police. This also reduced the police capacity for crime prevention or other essential planning, giving frontline police few options when responding to high levels of family violence and youth crime, and leaving Aboriginal Community Liaison Officers unsupported and under-utilised. Community and police dissatisfaction was high.

Filling those vacancies was a critical step in turning this situation around. Our follow-up audit in 2005 found vast improvements, with vacancies filled throughout the command, a fully staffed crime management unit, strong and diverse police links with Aboriginal communities, innovative crime prevention strategies in place, and much better police support for outlying communities. The enhanced supervisory and frontline capacity greatly improved service delivery, lifting staff morale and boosting community confidence in police. For instance, the improved staffing – including the recruitment of a female ACLO – and various other relationship and capacity-building measures enabled police to establish innovative partnerships with local organisations and individuals to address high rates of domestic and family violence. For the first time, local organisations and individuals became involved in coordinated police attempts to prosecute more domestic assault offences, provide better follow-up and support to victims, and trial measures to rehabilitate perpetrators. [42]

[42] Ombudsman audits of police work with local Aboriginal communities in Castlereagh Local Area Command, 2003 and 2005.

Resourcing in the Western region

On this issue of resourcing high-need locations, a particular concern that we have is the need for DoCS and other service providers to address certain resource deficiencies in the Western Region.

Concerns raised with us by the Brewarrina Shire Council in August 2007 about family violence and child protection issues in that area, together with information we have received from our own work in the Western Region led to us:

- pursuing with DoCS how it might improve its caseworker presence and service delivery in that region
- seeking specific advice from NSW Police Force as to the status of its plans for responding to Aboriginal child sexual assault, and
- consulting with DAA on its coordinating role in relation to the NSW interagency plan to tackle child sexual assault.

From these discussions we are aware that DoCS is considering particular strategies to both increase caseworker numbers to cover high-need areas and provide its staff with better infrastructure and support. In supporting this initiative, we have asked DoCS to identify the communities likely to benefit the most from this approach and the anticipated increase in the number of operational positions. We have also asked DoCS to consider this planned increase in child protection case workers in the context of its other work in this region such as out-of-home care and family support services (including early intervention services). We are mindful that an increased child protection presence without a corresponding strengthening of family support services may result in a community backlash. Furthermore, increased child protection intervention is also likely to require increased out of home care options across the region. Although we put these issues to DoCS in the form of a written request for information in November 2007, the department is yet to provide us with specific advice on these issues. Furthermore, recent police advice regarding agenciesø respective contributions to implementing actions in the interagency plan to tackle child sexual assault in Aboriginal communities indicates that police are also awaiting DoCS advice on a number of important issues.

The current lack of detailed plans from DoCS might be viewed negatively. However, we are optimistic that the delay is more about the need to ÷get rightø a range of initiatives that are designed to strengthen service coordination and responses to vulnerable communities. In this regard we were pleased to see the $22.9 million announcement in the State budget to combat child sexual abuse through the expansion of the Safe Families to the Orana Far West Region. In the context of recent discussions that we have held with a number of key stakeholders about the needs of the Western Region and other ÷isolatedø areas across the state, we are hopeful that this announcement is linked to a broader response for dealing with serious child abuse and neglect issues in these areas.

The need for incentives

What also needs to form part of any strategy to attract staff to outlying locations is incentives. The use of incentives to fill vacancies in rural and remote locations is often the fastest and most effective way for frontline agencies to attract suitably qualified staff and address service deficiencies in those areas. The law enforcement and education sectors have had proven success in attracting staff to remote locations, largely through incentives such as providing their remote area staff with:

preferential placement at other locations after serving a set period in remote communities

higher remuneration and other allowances for additional costs associated with living in outlying locations

longer annual leave and other special leave entitlements

purpose-built accommodation, and

training opportunities and experience to enhance their promotion prospects.

Increasingly, agencies that recognise the importance of employment incentives are also beginning to include partners and families in recruitment and induction processes, assist partners to find work with other agencies in the same remote locations, contribute to travel expenses and fees associated with families sending their children away to school, and provide extended leave and other incentives to encourage good staff to extend their tenure beyond the minimum period. These kinds of incentives recognise the hardship, expense and challenges that can be associated with remote-area work.

While higher remuneration and other incentives will be required as part of the strategies that DoCS and other key agencies develop, high quality staff in these locations will also need to feel that they are being well supported to provide good services. In this regard, it is worthwhile noting the concerns expressed during the Commissionøs public hearing at Boggabilla on 11 June 2008, during which a number of staff from agencies spoke about service deficiencies and their desire to see an improvement.

A good return on investment

It is also important to acknowledge that we have often received positive feedback from communities in remote locations following the successful recruitment of staff, particularly in circumstances when the new recruit(s) demonstrate that they can work well with communities. This has highlighted to us that key agencies will be much better received by communities if they can demonstrate a genuine commitment to communities through the successful recruitment of high quality staff. In fact, we have found that the successful recruitment of even relatively small numbers of high quality staff can result in very positive community feedback. Conversely, ongoing failure to address staffing and other shortfalls in service capacity can seriously erode a communityøs confidence in an agencyøs capacity to deliver effective services. Agencies need to staff these areas adequately if they are to provide effective services, respond to risks and perform early intervention work.

Other options for strengthening service delivery

There are also additional measures agencies can consider to enhance their frontline capacity in remote locations or locations with particular needs. One strategy for towns with large Aboriginal populations, high needs and few frontline services, is to share a designated liaison officer to represent several agencies, coordinate agency outreach visits and assist local Aboriginal residents to access their services. For instance, our review of police work in Narrandera in late 2005 found wide community and agency support for trialling a Multi-Agency Support Officer (MASO) position.

Another approach is to collocate teams made up of staff from different agencies. Collocating teams of staff in this way could enhance agenciesø presence and provide easier access to their services, while providing members of the team with better back-up and professional peer support. Earlier in this submission we noted the advice from the Department of Premier and

Cabinet regarding its work through the COAG working group on the viability of collocated family centres to serve Aboriginal communities. This type of innovative thinking represents an important acknowledgement across governments of the need to consider ways in which we can provide a more viable service base to significantly disadvantaged communities.

The SNAICC executive director, Mr Pocock, has presented evidence before the Commission that a more sustainable approach would be for agencies to explore ways to expand their own capacity, while also looking for opportunities to build up the skills within established and emerging NGOs based in the communities they need to engage. Mr Pocock argued that this kind of developmental approach should ideally include a commitment to establishing and mentoring Aboriginal and other community-level NGOs that could, over time, take on more complex and sensitive duties ó including certain statutory child protection functions ó as part of a broader and more holistic suite of services. The aim would be for government and other agencies to build capacity in community-based Aboriginal organisations, and to eventually situate care and protection services within genuinely grassroots organisations that deliver a range of services, from early intervention to parenting and family support. However, community-based Aboriginal organisations should only take on these broad responsibilities when they are ready for it, and only if they are properly resourced to perform the work.

Although developing this kind of capacity within communities would be difficult and time-consuming, there would be considerable advantages in creating and enhancing the capacity of Aboriginal NGOs to deliver a range of services such as play groups, family support, school transition, therapeutic healing for adult victims of abuse and other such programs. However, in supporting this vision we are not blind to the challenges. Particularly in those communities with the highest levels of need, sourcing significant numbers of Aboriginal staff to deliver these kinds of services would currently be impossible due to acute skill shortages directly linked to the level of disadvantage. In addition, attracting suitably qualified Aboriginal staff from outside these communities to run these services would be difficult to achieve. Therefore, in supporting Mr Pocockøs vision, we believe it is important to stress the level of commitment, planning and practical support which would be required to successfully provide a broad range of Aboriginal services which are delivered by Aboriginal people, particularly in relation to certain remote or isolated communities. Having said this, if, over time, we are unable to move in this direction, this potentially raises significant questions about the long term viability of at least some of these communities. On this issue, the lessons which will be learnt from the Northern Territories intervention should be instructive.

4. CONCLUSION

Underpinning much of what we have said in this submission is about the need to see change. In this respect, our unique role has given us access to thousands of community members who have expressed this view to us over the years. Consensus about the need for change is one thing: achieving it is another.

In this submission, we have not seen a need to move away from what has been unfolding at a state and federal level in relation to tackling issues associated with Aboriginal disadvantage and child protection. In this regard, we have spoken about the need for consistency around broad planning frameworks to help meet targets aimed at reducing the level of disadvantage across key ÷socialø indicators. We have also emphasised the need to map out what needs to be done at a local community level to achieve real progress against these indicators.

It is essential to ensure that base-line data on indicators of need is systematically collected and reported on. A related activity is the need for research about what works and what doesnøt. Creating a solid evidence base is critical to informing future planning and program delivery. It is also crucial to establishing a more transparent monitoring and accountability process. We

have also stressed the importance of this kind of base-line data being captured and tracked even down to the local community level. It is essential that we get a good understanding of the circumstances and needs of individual communities and ascertain whether progress is being made.

In concluding this submission, it is apposite to illustrate what we believe needs to take place through giving an example of recent discussions that we have had with leaders from one community in the Western region. In discussions with a community working party representative, he spoke about the desire of the working party to work with the education department to reduce the drop-out rate of Aboriginal children as they move from primary school to high school. His focus was on developing strategies that would lead to measurable increases in the numbers of students who successfully make that transition. Another working party member spoke to us about a forum he was proposing to deal with the impacts of substance abuse on his community. We were also present during earlier working party discussions related to the establishment of a safe house for local children. (Notwithstanding the working partyøs support and broader involvement from other community members, we have recently learned that there is little likelihood of the safe house proposal being progressed in the immediate future.) If community members who are committed to change do not see results then, over time, this will translate into despondency and inaction.

From our perspective, in order for this to occur, we need to examine:

the quality of current planning, implementation and accountability processes (including the alignment of these processes with state and federal objectives)

existing data collection practices and agency performance measures (including the need to provide more detailed information about results rather than activities and outputs)

the type of partnerships that need to be built between agencies, Aboriginal services and communities to deliver a broad range of holistic services

the complexity of current funding arrangements and whether there is sufficient flexibility to promote genuinely innovative local initiatives

what kind of service models are required to respond to the complexity of need, particularly in high need communities, and

workforce capacity and other resulting requirements to make these models work (including an expansion of the Aboriginal workforce).

Finally, we believe that progress reports need to present a realistic picture not only of the successes but also the unmet challenges in individual communities.

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Bruce Barbour
Ombudsman

í í í í í í í í í í ..
Steve Kinmond
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